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DEPARTMENT OF STATE
AGENCY FOR INTERNATIONAL DEVELOPMENT
Washington, D.C. 20523

122p

PROJECT PAPER

Proposal and Recommendations
For the Review of the
Development Loan Committee

INDONESIA - ORAL CONTRACEPTIVES

AID-DLC/P-2283

UNCLASSIFIED

DEPARTMENT OF STATE
AGENCY FOR INTERNATIONAL DEVELOPMENT
WASHINGTON, D. C. 20523

UNCLASSIFIED

AID- DLC/P-2283

March 13, 1978

MEMORANDUM FOR THE DEVELOPMENT LOAN COMMITTEE

SUBJECT: Indonesia - Oral Contraceptives

Attached for your review are recommendations for authorization of a loan to Indonesia (the "Cooperating Country") in an amount not to exceed Forty Million United States Dollars (\$40,000,000) to help in financing certain foreign exchange costs of goods and services required for the project.

This loan is scheduled for consideration by the Development Loan Staff Committee on Monday, March 20, 1978, at 2:30 p.m., in Room 3886 New State. If you are a voting member, a poll sheet has been enclosed for your response.

Development Loan Committee
Office of Development Program
Review and Evaluation

Attachments:

Summary and Recommendations
Project Analysis
Annexes A - R

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FIGURE 1

INDONESIA

POPULATION : 133-135 MILLION

Oral Contraceptive Prevalence



<u>PROGRAM</u>		<u>ORAL CONTRACEPTIVE USE *</u>	
<u>AREA</u>	<u>%POPULATION</u>	<u>ACTUAL 1977</u>	<u>ESTIMATED 1985</u>
■ JAVA & BALI	64	14.3	25.0
▨ OUTER ISLANDS I	26	4.5	12.1
□ OUTER ISLANDS II	10	-	7.6
INDONESIA	100	11.1	20.3

* PERCENT M W R A USING ORAL CONTRACEPTION

GLOSSARY

ABS	Annual Budget Submission
A/DAA/Asia	Acting Deputy Assistant Administrator, Asia Bureau
AG	Auditor General
AID/W	Agency for International Development Washington, D. C.
BAPPENAS	National Economic Development Planning Board
BKKBN	National Family Planning Coordinating Board
BPS	Central Bureau of Statistics
CBR	Crude Birth Rate
CDR	Crude Death Rate
CP	Congressional Presentation
CRNI	Crude Rate of Natural Increase
CY	Calendar Year
CYP	Couple-year-of-protection
FY	Fiscal Year
GAO	General Accounting Office
GNP	Gross National Product
GOI	Government of Indonesia
IBRD	World Bank
IEE	Initial Environmental Examination
IGA	Inspector General Foreign Assistance
ISS	Inspections and Investigations Service
IPPA	Indonesia Planned Parenthood Association
K.A.P.	Knowledge, Attitude and Practice
MC	Monthly cycle
MOH	Ministry of Health
MT	Metric Ton
MWRA	Married women of reproductive ages 15-44
OC	Oral contraceptive
PES	Project Evaluation Summary
PHA/POP	AID Office of Population
PIACT	Program for Introduction and Adaptation of Contraceptive Technology
PIO/C	Project Implementation Order for Commodities
PP	Project Paper
PRP	Project Review Paper
REPELITA	Five Year Development Plan
SER/COM/PROC	AID Office of Procurement
STMK	Sub-Mobile Medical Team
TFR	Total Fertility Rate
TQ	Transitional Quarter
UNFPA	United Nations Fund for Population Activities
USAID	United States Agency for International Development, Indonesia
USAID/PH	USAID Office of Population and Health
USAID/MGT	USAID Office of Management
USG	United States Government
VFP	Village Family Planning
VS	Voluntary Sterilization
VSC	Voluntary Sterilization Center

Revised per APAC with USAID concurrence

AGENCY FOR INTERNATIONAL DEVELOPMENT
PROJECT PAPER FACESHEET

TRANSACTION CODE
 A ADD
 B CHANGE
 C DELETE

PP
 2. DOCUMENT CODE
 3

3. COUNTRY ENTITY
INDONESIA

4. DOCUMENT REVISION NUMBER
 1

5. PROJECT NUMBER (7 digits)
 497-0271

6. BUREAU OFFICE
 A. SYMBOL PHA
 B. CODE 07

7. PROJECT TITLE (Maximum: 40 characters)
 ORAL CONTRACEPTIVE LOAN

8. ESTIMATED FY OF PROJECT COMPLETION
 FY 8 2

9. ESTIMATED DATE OF OBLIGATION
 A. INITIAL FY 7 8
 B. QUARTER 3
 C. FINAL FY 8 2
 Enter 1, 2, 3 or 4

10. ESTIMATED COSTS \$5000 OR EQUIVALENT \$1 -

A. FUNDING SOURCE	FIRST FY			LIFE OF PROJECT		
	B. FA	C. LC	D. TOTAL	E. FA	F. LC	G. TOTAL
AID APPROPRIATED TOTAL (GRANT)	7,000		7,000	40,000		40,000
LOAN	7,000		7,000	40,000		40,000
OTHER U.S. 1. 2.						
HOST COUNTRY	1,185		1,185	19,120		19,120
OTHER DONOR(S)						
TOTALS	8,185		8,185	59,120		59,120

11. PROPOSED BUDGET APPROPRIATED FUNDS \$5000

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	PRIMARY TECH. CODE		E. 1ST FY 78		H. 2ND FY 79		K. 3RD FY 80	
		C. GRANT	D. LOAN	F. GRANT	G. LOAN	GRANT	LOAN	GRANT	LOAN
(1) PH	B400		430		7,000		7,000		9,000
(2)									
(3)									
(4)									
TOTALS									

A. APPROPRIATION	N. 4TH FY 81		O. 5TH FY 82		LIFE OF PROJECT		12. IN-DEPTH EVALUATION SCHEDULED MM YY 04 80
	P. GRANT	Q. LOAN	R. GRANT	S. LOAN	T. GRANT	U. LOAN	
(1)		9,000		8,000		40,000	
(2)							
(3)							
(4)							
TOTALS							

13. DATA CHANGE INDICATOR. WERE CHANGES MADE IN THE PID FACESHEET DATA BLOCKS 12, 13, 14, OR 15 OR IN PRP FACESHEET DATA, BLOCK 12? IF YES, ATTACH CHANGED PID FACESHEET.

1 NO
 2 YES

14. ORIGINATING OFFICE CLEARANCE

SIGNATURE _____

TITLE _____

DATE SIGNED
 MM DD YY

15. DATE DOCUMENT RECEIVED IN AID W. OR FOR AID W. DOCUMENTS. DATE OF DISTRIBUTION
 MM DD YY

PROJECT PAPER

PROJECT NUMBER: 497-0271

PROJECT TITLE: ORAL CONTRACEPTIVE LOAN

CLEARANCES:

D/DIR:SJLittlefield (in draft)

PRO:WGBollinger (in draft)

MGT:SDMitchell (in draft)

LEG:JRKahle (in draft)

OPH:THReese (in draft)

OPH:CWTerry (in draft)

Project Officer:OPH:WHJohnson

A handwritten signature in black ink, appearing to read "William H. Johnson", is written over a horizontal line. The signature is fluid and cursive, with a large loop at the end.

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ORAL CONTRACEPTIVE LOAN

PART I. SUMMARY AND RECOMMENDATIONS

A. Project Paper Facesheet (see Page iii)

B. Recommendations

Under grant project 497-15-580-188 and Loan 497-045, USAID population assistance to Indonesia U.S. FY 1968-77 has totaled around \$43 million. GOI population program inputs during the same period have totaled over \$73 million.

Beginning in FY 78, USAID plans two population projects with the GOI: a \$25 million FY 78-82 Family Planning Development and Services grant described in Project Paper 497-0270; and a \$61 million FY 78-84 Oral Contraceptive Loan described in this Project Paper. The two projects are closely related.

The purpose of the grant project is to collaborate with the Indonesian National Family Planning Coordinating Board (BKKBN) in improving and extending the family planning delivery system. The project is designed to assist BKKBN to undertake improvements in five interrelated areas: Program Development and Evaluation; Family Planning Services; Voluntary Surgical Contraception; Training; and, Population Policy Studies. With this assistance, the BKKBN is expected to: double the number of contraceptive outlets from 2.4 per 1000 married women ages 15-44 to around 5.0; increase total contraceptive use prevalence from 18.4% to 47.6%; and, reduce the Crude Birth Rate (CBR) from 36 to 21. An adequate supply of contraceptives will be essential to the attainment of these objectives.

IUDs and condoms will be supplied by the GOI and/or other donors. The \$61 million loan project described in this Project Paper will ensure continued availability of oral contraceptives in quantities sufficient to allow planned program expansion while beginning transition from USG to Indonesian financing of oral contraceptive requirements. Although a seven-year period is contemplated to reach 100% of requirements from local production, this project will provide only for five years' targets. The project may be extended with justification satisfactory to AID.

USAID estimates that during the next five years (1978-82) total direct population program support will be around \$317 million proportionally contributed as follows: GOI 69%; USAID 20%; IBRD 8%; UNFPA and other donors 3%.

The population program's largest supporter after the GOI and USAID is IBRD. The IBRD and GOI have recently signed a \$24.5 million loan project that plans to: enhance the mobility of family planning staff; widen and strengthen education and motivation activities; support administration by improving facilities; study the feasibility of producing oral contraceptive raw materials in Indonesia. See Annex F of PP 497-0270 for a more complete description of planned IBRD inputs.

1. Loan and Terms

Annual loans for FY 1978-82 are requested to finance the foreign exchange costs of the Oral Contraceptive Loan Project as described below:

Amount: \$40,000,000 in five (5) authorizations.

Maturity: Thirty (30) years including a ten (10) year grace period.

Interest: Two (2) percent per annum during the grace period and three (3) percent per annum thereafter.

Currency: Interest and principal repayable in U.S. dollars.

2. Borrower and Executing Agency

The borrower is the Government of Indonesia (GOI). The executing agency is the BKKBN.

3. GOI Contribution

The total GOI contribution is estimated at \$19,120,000 in local currency to finance 32.3% of total project costs.

C. Description of the Project

1. Why: Role of Population Control in Development and Role of Oral Contraceptives in Family Planning Program.

In the face of rapid population growth, the GOI is finding it very difficult to achieve meaningful progress in combating its food, employment, health, education, housing and environmental problems. Population is clearly one of the most pervasive and important factors in Indonesia's socio-economic development efforts. The GOI has launched an ambitious family planning program to deal with population growth. During the first decade of its existence, the national family planning program has gained considerable ex-

perience and produced impressive results. The oral contraceptive has played a critical role in producing the success achieved to date.

Since 1968, USAID has been the major donor of oral contraceptives to the Indonesian National Family Planning Program. USAID has provided grant assistance for oral contraceptives (OCs) in the following amounts of monthly cycles (MCs):

<u>U.S. FY</u>	<u>MCs</u>
1968	90,000
1969	1,100,000
1970	1,100,000
1971	2,000,000
1972	9,000,000
1973	29,000,000
1974	20,000,000
1975	34,240,000
1976	47,080,000
1977	<u>15,000,000</u>
Total	158,610,000

In addition to the above grant OC assistance, USAID has signed a U.S. FY 1977 loan with the GOI for \$7.3 million to provide 42 million cycles of OCs. Thus, total USAID OC assistance FY 1968-77 exceeds 200 million cycles.

The liberal provision and wide distribution of OCs has been an important factor in the rapid increase in family planning acceptance. The high proportion of new acceptors choosing the OC is illustrated below:

<u>GOI FY</u>	<u>NEW ACCEPTORS</u>	<u>OC ACCEPTORS AS % TOTAL NEW ACCEPTORS</u>
70/71	181,276	43%
71/72	519,330	54%
72/73	1,078,889	56%
73/74	1,369,077	63%
74/75	1,475,016	69%
75/76	1,966,585	68%
76/77	2,212,790	58%

The evidence available, based on limited samples, indicates that Indonesian oral contraceptive continuation rates compare favorably to world experience:

<u>CALCULATED BY:</u>	<u>OC CONTINUATION RATES</u>	
	<u>12 months</u>	<u>24 months</u>
First Method *	61%	45%
All Methods **	67%	55%

- * started and continue with OCs
- ** started OCs and continue with OCs or other contraceptives

It is estimated that approximately 2.3 million women are currently using the OC. Although the prevalence of OC usage has increased dramatically over the last few years, the rate of increase in OC usage is expected to gradually taper off to about a 10% annual increase by 1980. While the rate of increase is expected to taper off, the absolute consumption levels, given historical continuation rates, will be of the following approximate range of magnitude:

<u>CY</u>	<u>OC CYCLES (Millions)</u>
1977	30.6 - 31.0
1978	34.0 - 38.4
1979	36.6 - 45.1
1980	39.1 - 51.8
1981	41.7 - 58.5
1982	44.4 - 65.2
1983	46.7 - 71.8

Such consumption levels and the trend of the program toward village and household distribution of OCs by paramedical personnel make OCs the sine qua non of the future of the Indonesian family planning program. These facts mandate consideration of transition to local financing to secure the OC supply line.

2. What: To insure continued availability of oral contraceptives (OCs) in sufficient quantities to allow continued program expansion while beginning transition from USG to GOI financing of OC funding.

The GOI is concerned about being independently capable of meeting OC requirements and rightly so. It is unlikely that concessional OC assistance will be available forever. For this reason, the GOI has adopted the goal of attaining self-sufficiency in OC supplies over the next decade.

It is hoped that the GOI can achieve self-sufficiency in OC supplies by gradually phasing in Indonesian Government financing of OC raw materials which will be produced and packaged with GOI funds at Kimia Farma in Bandung or at other local facilities. At the same time, with IBRD assistance the GOI will explore the feasibility of eventual production of OC raw materials in Indonesia.

However, the Kimia Farma OC facility has not yet begun production. Initial trial production is scheduled for July 1978. Thus, local OC production capability is as yet untested. For this reason the GOI is committed to self-sufficiency achieved by an orderly phase-in of GOI financing of either raw materials and locally produced OCs or finished OCs.

Due to the high priority of the family planning program and the important role of the OC in that program, uninterrupted OC supply sufficient to meet requirements during the transition period to self-sufficiency must be insured. USAID is the only donor with a proven capability for providing such insurance. The insurance is to be found in the flexible response capacity of this project.

While striving toward OC self-sufficiency, the GOI hopes to achieve total OC independence by 1985. However, it is impossible at this point to determine how close they will come to realizing this goal. For this reason GOI inputs are realistically defined in a range of possibilities. AID's flexibility will allow us to pick up the balance of the annual OC requirement while progressing toward full transition.

It is currently estimated that the total OC delivery requirement CY 1978 through CY 1985 is approximately 387,067,000 cycles. Through either importation of raw materials and local production, importation of finished cycles, or local procurement of finished cycles, the GOI plans to supply between 115 million cycles and 247 million cycles of OCs during this eight (8) year period. Since the GOI OC input represents 29.7% to 63.8% of total estimated OC requirements, additional inputs will be necessary.

To fill the balance of the OC delivery requirements, USAID plans to finance CY 1979-85 importation of 140,067,000 to 272,067,000 cycles of finished OCs.

In order to safeguard the program, the higher figure of 272 million cycles of AID inputs is being used for long-range planning. However, each year OC forecasts will be revised and actual annual obligations will be adjusted in accordance with these forecasts. The annual loan agreements will be limited to finished cycles of OCs which we expect the GOI will request USAID to procure through the AID/W central OC procurement procedures as was done for Loan 497-045.

3. Who: USAID Direct Hire, BKKBN and National Economic Development Planning Board (BAPPENAS).

USAID direct hire population staff of three professionals will work with the BKKBN and BAPPENAS to stay abreast of and

facilitate GOI OC inputs and OC usage prevalence. Based on these factors, USAID/BKKBN will make annual estimates of OC requirements. These estimates will form the basis of annual loan agreements which USAID will execute with the GOI's BAPPENAS. It is expected that BAPPENAS will authorize at least two BKKBN officials to work with USAID in loan implementation. It is further expected that BKKBN will authorize and request USAID procurement of the finished OCs. USAID will prepare a PIO/C co-signed by BKKBN which will be sent to AID/W to request that the loan financed procurement be integrated with AID/W's grant central OC procurement effected at least annually through GSA.

4. How (Basis for Expectations).

This project continues the OC supply activities carried out in U.S. FY 1968-77 under Project 497-188.0. It is hoped that with the inputs provided under this Project and inputs from Project 497-0270, the GOI can generate the following:

- a) Outputs - double the OC service outlets from 2.4/1000 MWRA to 5.0 per 1000 MWRA.
- b) Purpose - double the number of current OC users from 2.4 million (1977) to 5.2 million (1985), while beginning transition from USG to GOI financing of OC inputs.
- c) Goal - decrease the natural rate of increase of population from 2.0% per annum to around 1.1% per annum by 1985 by decreasing the CBR from 36/1000 to 21-23/1000 while the Crude Death Rate (CDR) decreases from 16/1000 to 10-12/1000.

The GOI record in utilizing USAID family planning inputs to achieve purpose and goal is good, and there is no reason to believe that this performance will change. As evidence of the GOI capability, from U.S. FY 75 through FY 77 with \$25.826 million of Project 188.0 USAID inputs (including 96.3 million cycles of OCs funded by AID/W), the GOI achieved the following: increased OC prevalence of use on Java/Bali from 7.3% to 15.2% of MWRA; doubled Java/Bali total contraceptive prevalence from 13.1% to 26.1%; decreased fertility (i.e., TFR) on Java/Bali 15% from the late 1960s to 1976. During AID's November 1977 evaluation, the Project received the highest outstanding performance rating due to success in meeting objectives and the lack of significant implementation problems. This history bodes well for the continued successful application of USAID inputs to meet Project objectives.

The goal of reducing the annual population growth rate from 2.0% to 1.1% is admittedly optimistic. This goal has been chosen for two reasons. First, USAID/BKKBN strategy is to plan for success with sub-sector project objectives (i.e., a CBR of 21 by 1985) that exceed the formally stated sector objectives (i.e., a CBR of 20 by 2000). Second, mortality in Indonesia is comparatively high and prospects for rapid reduction in the CDR over the next few years are not bright. Although some reductions in childhood mortality are believed essential for continued fertility reduction, it is believed that fertility will continue to fall faster than mortality for the next few years. Note that the CDR of around 10 projected for Indonesia in 1985 is about the same as the current (1977) CDR of Thailand and higher than the current (1977) CDR for Malaysia and the Philippines.

D. Summary Findings

This Project is ready for implementation. The recipient institution has demonstrated its capability to effectively utilize the planned inputs. USAID has demonstrated its capability to effectively manage OC supplies over the last seven (7) years. The Project is economically viable, technically feasible, socially and environmentally sound. The Project does not duplicate GOI or other donor activities. The likelihood of success is enhanced by the Project's flexible design which is responsive to foreseeable contingencies that may be encountered during implementation. The Project meets all applicable statutory criteria (reference Statutory Criteria Checklist, Annex B).

E. Project Issues

The majority of issues raised in prior reviews of this Project focused at the input level on various aspects of USAID financing of raw materials for local OC production. These issues have been mediated by two changes in Project design: (1) AID is now planning to finance finished OCs only; (2) GOI OC inputs will be phased-in either with GOI financed raw materials and local production or with GOI financed importation or local procurement of finished OCs. Thus, USAID financing of raw materials for local OC production is no longer an issue. To the extent that GOI inputs are not met via local production, they shall be met via GOI procurement of finished OCs.

At the output and purpose level, a number of constraints are discussed in Part III. The major issue at this level is whether the inputs planned for the Outer Islands will be sufficient to produce the desired results. This issue is discussed in detail in Project Paper 497-0270 and will be an important element of the 1979 in-depth field evaluation of that project.

At the goal level, the major issue surrounds the need for improvements in the general welfare and reductions in mortality

believed necessary to enable continued change of norms in favor of smaller families. The demographic transition theory of a lead-lag relationship between mortality decline and fertility decline is widely accepted. In the face of slowly falling mortality, at what point does fertility decline become inelastic? Obviously this question is beyond the scope of this Project. It is conceded that socio-economic progress, environmental improvements and better health care leading to lower mortality will be necessary to achieve replacement level fertility in Indonesia. How much mortality must fall to achieve a CBR of 21 is a matter for conjecture.

PART II. PROJECT BACKGROUND AND DETAILED DESCRIPTION

A. Background

Population growth is a multi-dimensional problem which shows little respect for national boundaries and poses dangers to mankind. These dimensions include impending food shortages, pollution and disruption of the earth's ecosystem, depletion of mineral and water resources, energy shortages, erosion, deforestation, expanding deserts, unemployment, overcrowded cities, crime and juvenile delinquency, deteriorating living conditions, social unrest, authoritarianism, and political conflict. Many of these serious manifestations of overpopulation can be found in Indonesia.

The official estimated 1977 population of Indonesia is 138 million*, the fifth largest in the world. The population is characterized by uneven distribution among the various Indonesian islands. Java and Madura, which comprise only 6.7% of the land area, have 63.2% of the population. Kalimantan which accounts for 27.3% of the land area has only 4.3% of the population.

The country's population profile reflects a largely agrarian population with 83% of the people living in rural areas and 17% in urban areas. The population is young with 44% of the population below 15 years of age and 60% below the age of 25.

The most pressing problem presented by this large, maldistributed population is the increasing demand for job opportunities. Unfortunately, Indonesia's agricultural economy has not been able to cope with the swelling labor force. In the next five years the working age population will increase by more than 10 million and the GOI will face the challenge of providing an additional 5.7 million people with jobs. Most of these job seekers will be young (age 10 to 24), unskilled and undereducated.

Rapid population growth coupled with the rising aspirations and expectations of the people has increased the demand for educational opportunities. This is especially true at the elementary level where in 1973 only 57% of the population age 7-12 was in school. The school age (5-19) population will expand by 16% from 1975-1981 with increased demand for new schools and teachers.

In the area of housing, the GOI is concerned about providing low cost housing for its population. From 1975-79, the number of houses required to match the population increase is 440,000

*Based on the preliminary findings of the Intercensal Survey, the 1977 population is reported to be only 133,000,000. USAID uses the estimate of 133-135,000,000.

per year, while the capacity to build houses at present is only 230,000 per year.

In terms of food - the delicate food/population balance - the GOI is determined to become self-sufficient, especially in rice. Continued rapid population growth, coupled with a strong drive on the part of the populace to increase their level of living, will increase the demand for food. This increasing demand combined with natural setbacks such as droughts, floods, and rice pests have slowed the drive for self-sufficiency. Indonesia continues to need to import annually 0.5 to 2.5 million MT of rice. Based on present population growth rates and increasing consumption patterns the cereal deficits could reach 6 to 8 million MT by 1985.

In the health field, the GOI places top priority on improved family welfare. Most health problems are complicated by poor sanitation, nutrition and crowded living conditions. The most prevalent diseases are: respiratory diseases, skin infections, tuberculosis, diarrhea, malaria; eye infections, anemia and nutritional deficiencies. Half of all deaths are among pre-school children and the leading causes of death are: diarrhea, enteritis, pneumonia and bronchitis. With limited capital and a population doubling every 36 years, it is difficult to make inroads into poor sanitation, nutrition and crowded living conditions.

In short, Indonesia is a developing country facing many hurdles on its road to progress - employment, education, housing, food and health problems. In the face of rapid population growth, progress in any of these problem areas is exceedingly difficult. Population is clearly one of the most pervasive and important factors in Indonesia's socio-economic development efforts.

1. National Family Planning Program

Under former President Sukarno, the official attitude of the Government was strongly pro-natalist. Sukarno called for more children and proclaimed the country could easily support 250 million people. He saw the need for more people to exploit Indonesia's wilderness areas. Notwithstanding this official policy, the Indonesian Planned Parenthood Association (IPPA) was formed in 1957 and pioneered family planning services in Jakarta.

The change of Government in 1965 brought a transformation in the official attitude toward family planning. In 1967 the IPPA organized the first national congress of family planning in Jakarta. In 1968 a National Family Planning Institute was set up as a semi-governmental body to direct family planning activities. In January 1970 it was replaced by a Government unit, the National Family Planning Coordinating Board (BKKBN).

Government policy at that time was formulated primarily in terms of the social objective of improving the health and welfare of the mother, child and family. Increasingly, Government statements emphasized the economic objective of the program to raise the standard of living by limiting the birth rate so that population growth would not exceed the increase of food production.

The First Phase (1969 to 1974)

During the initial phase, family planning activities were limited to the islands of Java and Bali. The emphasis was on integrating family planning services into health service clinics on these islands.

By late 1974 there were some 2,400 clinics on Java and Bali offering services. In addition to making family planning available, the GOI endeavored to win the support of formal as well as informal community leaders and create a general awareness and support for the program among the people.

From 1969 to 1974 the BKKBN made creditable progress in promoting the program and recruiting the family planning acceptors. Family planning acceptors increased from 53,100 in 1969 to 1.5 million in 1974. It is particularly interesting to note the rapid increase in the use of the pill in the program. Oral pill acceptors increased from 27% of all acceptances in 1969/70 to 60% in 1974/75. USAID believes this was due to increasing availability of the pill and ease-of-use by the acceptors.

In terms of achieving a demographic impact as well as providing a service to the low income families on Java and Bali, age and parity characteristics of the acceptors have been encouraging. Age of acceptors dropped from an average of 29.0 years in 1971 to 27.9 years in 1974, while the number of living children per acceptor fell from 4 to 2.8. At the end of 1974, 82% of acceptors reported the head of household as either a farmer, fisherman, manual laborer or unemployed. 37% of acceptors described themselves as illiterate and 92% as having had six years or less of schooling. This suggests that younger women with fewer children were entering the program. Moreover these women were representative of the rural poor.

In summary, the first phase of the program aimed at consolidating Government support, winning local formal and informal leader support, introducing services into the public health clinic system, and of critical importance, building a viable administrative organization.

The Second Phase (1975 to 1979)

The evolution of the Indonesian family planning program is evidenced by the reformulation of the goal of the program from a qualitative statement - "... to improve the health and welfare of the mother, child and family..." - to a quantitative one. Policy explicitly stated in Repelita II (the national development plan), now calls for a 50% reduction in the current fertility level by the year 2000. The evolution of the program is also marked by an increased emphasis on continuance of contraceptive practice. The 7,000 fieldworkers employed on Java and Bali have had their job description broadened to include follow-up activities. They are to ensure that acceptors return for periodic medical checkups and are provided with an adequate supply of contraceptives.

The Government has continued to encourage the participation in the program of various other Government agencies such as the Ministries of Health, Social Affairs, Education and Culture, Religion, Information, as well as private organizations such as the Indonesian Council of Churches, the Muhammadiyah and women's organizations.

In addition, the Government has actively encouraged the participation of the private sector in expanding and extending the family planning program. These efforts have focused mainly on the condom. Condoms are currently being distributed through traditional herbal preparation (jamu) dealers in Java.

The BKKBN, with USAID assistance, has launched an impressive village family planning (VFP) program that seeks to place the responsibility for recruiting new acceptors and supporting and maintaining family planning users at the village level. Village family planning is a generic term and individual regional programs are tailored by the provinces to suit their needs. Although local organization and administration may differ, village family planning usually involves the establishment of a contraceptive depot in the village and formation of sub-village family planning groups. The depot is supervised by a family planning clinic and provides contraceptive supplies of oral pills and condoms. The family planning group dispenses contraceptive supplies obtained from the depot and reinforces its members, as well as seeks to recruit new family planning acceptors. Thus, the family planning "chain" reaches from the clinic to the smallest community unit. USAID estimates that on Java there are currently (1977) 25,000 depots and 20,000 family planning groups.

In 1974 clinical family planning services were officially offered by the BKKBN in 10 of the 21 Outer Island provinces. Recently (early 1977) pilot village family planning projects have been established covering about 25% of the villages in these provinces to test the feasibility of implementing village family planning in the Outer Islands.

In summary, the second phase of the program to date has: quantified the goal of the program; shifted from an emphasis on new acceptors to continuing users; broadened the participation in the program of various governmental and non-governmental groups; expanded the program into the private sector to take advantage of commercial distribution systems; launched a research and development program to stimulate local problem identification and resolution; and implemented "village family planning" on a massive scale on Java and Bali and on a pilot basis in the Outer Island provinces.

2. Program Results

The program to date has produced impressive results. From the 1974 total of 1.5 million new acceptors, Java/Bali increased recruitment to 2.0 million new acceptors in 1976 for a cumulative total since 1969 of over 9.0 million new acceptors. From 1974 the Outer Islands have registered a total of 722,000 new acceptors. As illustrated in Table 1, over half of the married women of reproductive age (MWRA) on Java/Bali have become new acceptors and an estimated 25% are currently using contraception. On the Outer Islands 14% of MWRA have become acceptors and an estimated 7% are currently using contraception.

TABLE 1

PROGRAM RESULTS (as of 9/77)

	<u>Java/Bali</u>	<u>Outer Islands</u>
Total New Acceptors	9.0 million	.72 million
New Acceptors per 1000 MWRA	644 (64.4% MWRA)	143 (14% MWRA)
Current Users	3.5 million (25% MWRA)	.36 million (7% MWRA)

Source: BKKBN Service Statistics

As Table 2 illustrates, the program is continuing to reach the rural poor. The "average acceptor," on Java/Bali and the Outer Islands may be described as follows:

Java/Bali - 27 year old woman with less than primary school education with 2.54 living children, whose husband is a farmer, laborer, fisherman, or unemployed.

Outer Islands - 28 year old woman with primary school or better education with 3.60 living children, whose husband is a government official or tradesman.

TABLE 2

FAMILY PLANNING ACCEPTOR CHARACTERISTICS
(3rd Quarter 1976/77)

<u>Characteristics</u>	<u>Java/Bali</u>	<u>Outer Islands</u>
Age-Percent women 15-29	66.7	57.0
Parity-Number of living children	2.54	3.64
Education-Percent acceptors with less than 6 years of education	58.3	32.0
Husband's occupation-percent acceptors whose husband is farmer, laborer, fisherman, or unemployed	81.8	58.0
Desire for additional children-percent acceptors with 3 living children who do not desire additional children	41.7	22.0

In 1976 an Intercensal Survey was conducted by the GOI Central Bureau of Statistics with considerable USAID financial assistance. The Survey consisted of a 250,000 household listing, a 60,000 household population survey and a 11,000 Java and Bali fertility survey. The third phase is known as the Indonesia World Fertility Survey.

The results of the World Fertility Survey are now becoming available. The survey results indicate that considerable progress toward the goal of fertility reduction has been achieved on Java/Bali, especially in the provinces of East Java and Bali. Further, the survey discovered that most of the fertility decline

is due to changes in marital fertility rates (i.e., rather than change in proportion of females age 15-44 married) as a result of use of modern methods of family planning. Quantitatively, on Java/Bali the Total Fertility Rate (TFR or total number of live births a woman would have if she lived through her entire reproductive period and experienced currently existing age-specific fertility rates) declined 15% (i.e., from 5.29 to 4.51) from 1967-71 to 1976; and the Crude Birth Rate (CBR or total annual births per 1000 persons in population) declined 11% (i.e., from 38 to 34) for the same period. Since Outer Islands I (10 of 21 outer island provinces) only entered the program in April 1974, it is too early to expect any fertility decline. Those persons wishing a more detailed analysis of goal (i.e., fertility reduction) progress should see Annex C which is a summary of the World Fertility Survey results for Indonesia.

Two independent surveys (the 1973 Fertility-Mortality Survey and the 1976 Intercensal Population Survey) have shown that the BKKBN service statistics estimates of current users are actually conservative in that they slightly understate the total number of contraceptive users (See Sinquefield and Jones, "Evaluating the Validity of the Indonesian Family Planning Service Statistics," July 1976 and Sinquefield and Sungkono "Fertility and Family Planning in Java and Bali 1967-76," September 1977). Independently derived (by Central Bureau of Statistics) 1976 estimates of contraceptive prevalence on Java/Bali are: Bali (38%), East Java (29%), Central Java (26%), Jakarta and Yogyakarta (19%), West Java (15%), and Java/Bali (28%).

A more detailed analysis of the demographic impact of the family planning program and the expected impact of the family planning program over the next five years is included in Annex D.

The total estimated cost of the program from 1968 through 1977 is 158.5 million dollars, around \$1.25 per capita. The GOI has financed 46% of this cost, USAID 27% and the other donors combined 27%. Details of the USAID FY 68-77 activities are presented in Annex E. The estimated cost effectiveness indices of these inputs over the 1968 to 1977 period are impressive and are as follows: cost per acceptor of \$14.28; cost per couple year of protection \$12.00; and cost per birth averted of \$48.00 as shown in Annex F.

The results could not have been achieved without strong GOI support. President Suharto continues to meet quarterly with the provincial governors to review family planning progress. Ministry of Interior officials at the provincial, regency and sub-regency levels share responsibility with the BKKBN for family planning progress. This governmental support from the top down to the village has been instrumental in creating a socio-political climate conducive to progress. In addition, the family size implications of Government policies, laws, programs, and activities are frequently under review.

In the legal area, for example, the following actions have been taken:

- (a) Compilation of laws as they directly or indirectly relate to population;
- (b) Involvement of the law departments of various regional universities in the population/law issue;
- (c) Elimination of import duty on contraceptives;
- (d) Revision of the marriage law to set a minimum age of marriage of 19 for males and 16 for females;
- (e) Promulgation of decree that the rice ration for dependents of government workers and military personnel will only be provided through the third child;
- (f) Reduction of the cost of public schooling for the first 3 children only.

The project is of the highest priority with the GOI. In September 1977 a special family planning exhibition was held at the President's offices (Bina Graha) where President Suharto reiterated his support and urged that efforts to institutionalize family planning be accelerated. GOI support can be evaluated in a number of ways. In terms of moral backing and wide cooperation from other governmental agencies, the GOI record is good. Family planning is probably the most integrated GOI development effort with the involvement of the Ministries of Education, Health, Interior, Information, Religion, Armed Forces and numerous private groups.

In terms of GOI budgetary support, development budget inputs have shown continued growth:

GOI FY	(\$000)	GOI FY	(\$000)
1968/69	75	1973/74	5,885
1969/70	300	1974/75	8,400
1970/71	1,323	1975/76	12,500
1971/72	2,300	1976/77	15,600
1972/73	5,134	1977/78	22,207

Total GOI budgetary support for FY 1977/78 is \$33,131,000 comprised of \$10,904,000 from the routine budget and \$22,207,000 from the development budget. The family planning appropriations

represent 0.4% of the total GOI budget for GOI FY 1977/78. This compares favorably with family planning budgetary commitments of other Asian countries as follows: 1/

FAMILY PLANNING BUDGET

<u>Country</u>	<u>As % Total Budget</u>	<u>Applicable Year (most recent available)</u>
Thailand	0.04%	1975
Taiwan	0.07%	1976
Korea	0.07%	1975
Singapore	0.10%	FY 1975
Malaysia	0.11%	1976
Phillipines	0.40%	FY 1976
Indonesia	0.40%	FY 1977/78
Nepal	0.60%	FY 1974

Given multitudinous needs and scarce resources, we believe the GOI record of support is good. Total program inputs FY 1978-82 as described in Annex G should be about \$317 million with at least 68% from GOI, 20% (\$64 million) from AID and 11% from IBRD, UNFPA and other donors.

B. Detailed Description

The Project is a seven year (FY 1978 - FY 1984) activity succinctly described in the Logical Framework Matrix presented in Annex H. A seven year framework was chosen because seven years is the minimum time in which the GOI might be capable of assuming 100% of OC inputs. The key to success of the Project is input flexibility. Consequently, the Project is designed to be responsive to a range of input requirement possibilities.

1. Inputs: Finished Cycles of OCs

The first question that must be analyzed in determining OC inputs is: How many OCs are likely to be consumed over the next eight years?

Estimating OC consumption eight years in the future cannot be done with much accuracy because of the externalities involved. Such things as acceptor targets, contraceptive method mix, background and preferences of service personnel, consumer behavior, new data on contraceptive health risks, etc. can

1/ Nortman, Dorothy and Ellen Hofstatter, "Population and Family Planning Programs: A Factbook," Reports on Population Family Planning, the Population Council, October 1976.

significantly influence future consumption. Thus the confidence interval attached to any OC forecast drops considerably and continually as the years advance.

Two additional factors are important in forecasting OC usage: the reason for the forecast and the strategy for market development. The forecast developed for this Project Paper should be high enough to cover most eventualities for two reasons: (A) Obligations will be spelled out in annual loan agreements. Authorizations lower than planned cause no major problems; authorizations higher than planned require the advice and approval of Congress. (B) The cost of error of a low forecast is greater than the cost of error of a high forecast. It would be most unfortunate if a low forecasting error resulted in constriction of supply and retardation of program growth. On the other hand, if a forecasting error is on the high side, corrective measures can quickly be taken by reducing following authorizations and agreements, and all that suffers is the accuracy of the plan. The success of the Project and the national program is more important than the accuracy of the input plan. Our strategy for market development is to plan for success. Since forecasts can be self-fulfilling in many situations, there is no apparent advantage in planning for anything less than the continued successful growth of OC usage.

Mindful of the above, three OC usage forecasts were prepared: maximum, minimum and most likely. The Maximum Forecast presented in Annex I is derived from a linear regression of historic OC usage on ordinal months. The Minimum Forecast presented in Annex J is derived by discounting BKKBN OC acceptor targets on the basis of currently estimated OC continuation rates. The Most Likely Forecast, an average of the maximum and minimum values, is presented in Annex K with the reasons for its use. Using the above methodology, the following OC consumption figures currently appear most likely:

CY	OC Usage Forecast (millions cycles)
1977	30.8
1978	36.2
1979	40.9
1980	45.5
1981	50.1
1982	54.8
1983	59.3
1984	64.0

Next the OC usage estimates must be integrated with the OC pipeline. With the above fix on OC consumption, Annex L

presents an accounting of deliveries planned (from U.S. FY 76/TQ and FY 77 inputs) for CY 1977 and 1978 along with a schedule of OC deliveries required to maintain a projected one year's OC consumption in country for CY 1979 and beyond. These annual OC delivery estimates, foundations for determining Project inputs, are as follows:

<u>CY</u>	<u>Estimated OC Delivery Requirement (000s cycles)</u>
1979	18,867
1980	50,100
1981	54,800
1982	59,300
1983	64,000
1984	68,000
1985	72,000

The underlying principle in AID input determination is that in order to achieve an orderly transition to GOI financing of OCs, AID should finance the balance of annual OC requirements as long as the GOI portion of the total OC delivery requirement is showing reasonable growth. Reasonable growth must be determined on the basis of annual reviews. For planning purposes, however, boundaries must be set on a definition of reasonable growth in the GOI portion of total OC inputs.

The GOI goal is to achieve self-sufficiency in OC supplies over the next decade. It is expected that the earliest that could be achieved would be by 1985.

The GOI plans to phase-in their OC inputs by importing raw materials for local OC production. Financing for an annual OC production capacity of 18 million cycles (using one daily eight-hour shift) has been secured from the Indonesian Development Bank. The production equipment has been ordered, the factory has been erected and trial production is scheduled to begin in July 1978. The GOI owned factory is located at Kimia Farma in Bandung, West Java. The success of local OC production, the cost of raw materials and local production, the availability of GOI funds, the success in producing with two shifts, the availability of additional funds for expansion of plant capacity and many other factors will influence the rate at which GOI inputs are phased-in via local production of OCs. However, a minimum acceptable phase-in rate must be established. Therefore, the GOI agrees that through either local production in a GOI facility or procurement of finished OCs in the local private sector (i.e., from Schering, Organon or Wyeth) or international procurement of finished OCs the minimum phase-in of GOI inputs

described in Table 3 will be maintained. Kimia Farma personnel support the maximum phase-in of GOI inputs to the extent that this can be achieved. USAID believes the phase-in schedule achieved will be somewhere inbetween the minimum and maximum values; but to insure that project objectives can be met, USAID inputs are flexibly defined as the difference between the annual OC delivery requirement and the maximum or minimum GOI input as follows:

TABLE 3

OC PROJECT INPUTS (000s cycles)

CY	Delivery Requirement	GOI Input Range		USAID Input Range	
		Maximum	Minimum	Maximum	Minimum
1979	18,867	15,000	4,000	14,867	3,867
1980	50,100	25,000	8,000	42,100	25,100
1981	54,800	25,000	12,000	42,800	29,800
1982	59,300	30,000	16,000	43,300	29,300
1983	64,000	30,000	20,000	44,000	34,000
1984	68,000	50,000	25,000	43,000*	18,000*
1985	72,000	72,000	30,000	42,000*	-0-
Total	387,067	247,000	115,000	272,000	140,067

*Last two years of USAID inputs not included in project.

GOI inputs will represent 29.7% to 63.8% and USAID inputs 36.2% to 70.3% of the CY 1978-85 OC delivery requirement.

2. Outputs: Availability at all Contraceptive Service Outlets of Sufficient Numbers of Cycles of OCs

The output generation of this Project is closely linked to outputs created under Project 497-0270. For this reason the numbers of OC service centers in the output indicators is the same for the two projects even though the projects have slightly different completion dates (i.e., 1982 vs 1985).

The availability of family planning services will be evidenced by the increase of family planning service outlets from the 1977 level of 2.38 outlets per 1,000 married women of reproductive age (MWRA) to 5.35 outlets per 1000 MWRA.

Family planning service outlets are of four types. The principal outlet is the clinic, usually located at the sub-regency level and providing services for a population of 30,000-40,000. Clinics are static and multi-purpose with integrated health and family planning services. Generally clinics offer IUDs, pills and condoms for family planning. On Java and Bali there is a village depot system linked to the clinic with an average of 7.5 depots per clinic. The depot is run by a villager and may be located in a private home, the village head-

man's house, the village office, or an auxiliary building. Contraceptive stocks of pills and condoms are maintained in the depot and simple records are kept, which feed into the clinic record system. This allows month-to-month monitoring of the system of contraceptive stocks and flows. Below the village depot, there are sub-village family planning groups formed to insure contraceptive resupply. As some villages on Java are widely dispersed, a member from the sub-village "group" will go to the depot for contraceptive supplies for her sub-village, which generally consists of 30-50 members.

On Java and Bali, USAID estimates that for 1977 there are 25,000 village depots and 20,000 sub-village family planning groups. A precise count is difficult as the depot and sub-group formation process is continual and reporting of the number of depots and groups is still not complete or regular. USAID is assisting the BKKBN with the development of a simple, quarterly report on depots and family planning groups. At the end of the project USAID estimates there will be 30,000 depots and 50,000 groups on Java and Bali as illustrated in Table 4.

In the ten Outer Island provinces now participating in the family planning program, village family planning is being pilot tested by local BKKBNs. As Table 4 shows, USAID expects that by the end of the project there will be 22,000 depots and 20,000 groups in these ten provinces. A final group of 11 additional Outer Island Provinces should enter the program in 1979. It is estimated that these provinces will contain 3,000 depots and 3,500 groups by the end of the Project.

The final element in the family planning delivery system is the voluntary sterilization (VS) facility. VS services usually will be located in a provincial, regional or sub-regional hospital. USAID expects there will be 285 VS facilities on Java and Bali by the end of the project, 221 in the first ten Outer Island provinces and 15 in the remaining 11 Outer Island provinces that will enter the national program in 1979.

TABLE 4

INDONESIA FAMILY PLANNING SERVICE POINTS 1977 - 1982

Year Area	1977	1978	1979	1980	1981	1982
Java/Bali (65% of population)						
Clinics	2,750	2,750	2,750	2,750	2,750	2,750
VSC	35	49	92	145	171	285
Depots	25,000	30,000	30,000	30,000	30,000	30,000
Groups	20,000	25,000	35,000	40,000	45,000	50,000
Outer Islands-I (26% of population)						
Clinics	890	920	1,100	1,100	1,100	1,100
VSC	40	62	94	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	20,000
Outer Islands-II (9% of population)						
Clinics	---	---	200	300	400	460
VSC	---	---	---	5	10	15
Depots	---	---	---	500	1,000	3,000
Groups	---	---	---	---	1,000	1,000
All Indonesia						
Outlets per 1,000 MWRA	2.38	3.08	3.84	4.42	4.79	5.35

Increasing Service Availability



USAID estimates that the density of contraceptive service centers will more than double during the life of the Project. All outlets, with the possible exception of some Voluntary Sterilization Centers (VSC), will require OC stocks. It is expected that OCs will be available at the following numbers of OC service centers in the levels specified by the end of the Project:

TABLE 5

<u>OC Supply</u>	<u>(3 months)</u>	<u>(1 month)</u>	<u>(1 month)</u>
<u>Level</u>	<u>Sub-Regency</u>		<u>Sub-Village</u>
<u>Area</u>	<u>Clinic</u>	<u>Village Depot</u>	<u>Group</u>
Java/Bali	2,750	30,000	50,000
Outer Islands	<u>1,560</u>	<u>25,000</u>	<u>23,500</u>
Total	4,310	55,000	73,500

A grand total of over 132,810 OC outlets with sufficient cycles of OCs should be available by the end of the Project.

A critical input-output linkage is logistics which includes inter alia: projecting requirements, coordinating orders, programming financing, scheduling production and shipping, monitoring shipment and arrival, effecting customs and port clearance, delivery to warehouse, recording receipts, warehousing, authorizing issuance, recording issuance, financing and effecting distribution to the 16 provincial warehouses, 114 regency warehouses, and 3300 clinics, recording distribution, managing inventory, checking accountability, filing claims for losses and damages. We have provided technical assistance over the years and assisted with a logistics systems development project which was completed in 1975.

Indonesia's contraceptive logistics system has been reviewed on numerous occasions by the IIS, IGA, AG and GAO. All have concluded that the system is basically sound. The Auditor General's report on Indonesia issued August 16, 1976 says: "The storage and management control of contraceptives is satisfactory. We visited Ministry of Health warehouses in Jakarta and South Sulawesi where we noted storage space was adequate and clean. Contraceptives were neatly palletized, with each incoming shipment separately stacked and controlled. The rate of stock turnover muted any question on shelf-life. Internal controls provided for separation of record keeping and physical custody."

The Auditor General's Office reviewed Indonesia's contraceptive logistics system again in June-July 1977. Again the conclusion was that the system is basically sound. Action is

already underway to address recommendations in the draft report concerning the size of regency godowns and consistency of sub-clinical stock issuance practices. In summary, it is believed that the BKKBN logistics system will be capable of linking inputs and outputs.

3. Purpose: To Approximately Double Prevalence of Use of Oral Contraceptives Throughout Indonesia and Begin Transition from U.S.G. to GOI Funding of OC Requirements of National Family Planning Program

USAID estimates that OC prevalence of use for all Indonesia will approximately double from 11.1% in 1977 to 20.3% of MWRA by 1985. Tables 6, 7, 8 and 9 illustrate the annual Indonesia, Java/Bali, Outer Island I and Outer Island II OC use prevalence rates to be achieved during the course of the Project. At the same time, transition to GOI financing of OC inputs will begin and by the end of Project, the GOI will be financing at least 40% of its OC delivery requirements.

TABLE 6

ALL INDONESIA OC USE PREVALENCE

<u>CY</u>	<u>Estimated OC Users (000s)</u>	<u>Estimated MWRA (000s)</u>	<u>OC Users as % MWRA</u>
1977	2,369	21,300	11.1%
1978	2,785	21,800	12.8%
1979	3,146	22,400	14.0%
1980	3,500	22,900	15.3%
1981	3,854	23,500	16.4%
1982	4,215	24,100	17.5%
1983	4,562	24,700	18.5%
1984	4,923	25,200	19.5%
1985	5,231	25,800	20.3%

TABLE 7

JAVA/BALI OC USE PREVALENCE

<u>CY</u>	<u>Estimated OC Users (000s)</u>	<u>Estimated MWRA (000s)</u>	<u>OC Users as % MWRA</u>
1977	2,101	14,700	14.3%
1978	2,470	14,900	16.6%
1979	2,741	15,200	18.0%
1980	3,014	15,500	19.4%
1981	3,273	15,800	20.7%
1982	3,543	16,200	21.9%
1983	3,799	16,500	23.0%
1984	4,070	16,800	24.2%
1985	4,283	17,100	25.0%

TABLE 8

OUTER ISLANDS-I OC USE PREVALENCE

<u>CY</u>	<u>Estimated OC Users (000s)</u>	<u>Estimated MWRA (000s)</u>	<u>OC Users as % MWRA</u>
1977	268	5,100	5.3%
1978	315	5,300	5.9%
1979	375	5,500	6.8%
1980	436	5,600	7.8%
1981	501	5,800	8.6%
1982	572	5,900	9.7%
1983	638	6,100	10.5%
1984	703	6,200	11.3%
1985	773	6,400	12.1%

TABLE 9

OUTER ISLANDS-II OC USE PREVALENCE

<u>CY</u>	<u>Estimated OC Users (000s)</u>	<u>Estimated MWRA (000s)</u>	<u>OC Users as % MWRA</u>
1977	-0-	1,500	-0-
1978	-0-	1,600	-0-
1979	30	1,700	1.8%
1980	50	1,800	2.8%
1981	80	1,900	4.2%
1982	100	2,000	5.0%
1983	125	2,100	5.9%
1984	150	2,200	6.8%
1985	175	2,300	7.6%

4. Goal: To Decrease the Natural Rate of Increase of Population by a 50% Reduction in the CBR Currently Estimated at 36 per 1000 Population by the Year 2000. A Corresponding Decrease in the Death Rate Over This Period Would Yield a Population Growth Rate of Around 1.1% a Year by End of Project

The goal of the Indonesian National Family Planning Program is to reduce fertility 50% by the year 2000. This target is explicitly stated in the second five-year development plan (1974-1979), and translates into a reduction in the country CBR from a 1973 estimated level of 40 births per thousand population to 20 births per thousand population. USAID and the BKKBN believe this goal - a CBR of 20 per 1000 - can be met some 10 to 15 years ahead of schedule. USAID estimates that by the end of this project (1985) the CBR of Indonesia will be 21, 12 on Java and Bali and 28 for the Outer Islands. Based on these projections, Indonesia will attain its target of a CBR of 20 by 1985-1990.

USAID expects a corresponding reduction in the death rate from the current (1977) level of 16 deaths per 1000 population to around 10 by 1985. The population growth rate will be in the range of 1.1 per thousand population - down 42% from a level of 1.9% in 1976.

The reader is referred to Annex D for a more detailed analysis of the projected program impact 1977-1985.

PART III. PROJECT ANALYSIS

A. Technical Analysis and Environmental Assessment

This project is feasible and builds upon a solid base of more than seven years of experience by the GOI in implementing a national family planning program. The goal of the program is a 50% reduction in the birth rate by the year 2000. The current contraceptive technology is appropriate and widely in use on Java and Bali.

Over the past few years, the GOI has presented strong evidence of its technical capability to harness resources to achieve contraceptive prevalence increases and fertility reduction. Given the comparatively successful experience in Indonesia with family planning inputs, USAID sees no point in conjecturally belaboring possible future constraints at the purpose and goal level. They are too numerous to mention, very difficult to pinpoint via presumptive abstraction and outside the scope of this project.

Constraints at the output and input level can be identified. At the output level the major program constraints are viewed as the time and distance involved in attempting to accelerate the family planning program in the Outer Islands. Lack of sufficient, committed manpower is also a problem in rapidly stimulating village family planning on the Outer Islands.

At the input level, USAID sees two major constraints. One is that transition to GOI funding of OC inputs may encourage the GOI to try to force a change in the contraceptive method mix by decreasing OC acceptance and increasing acceptance of the cheaper IUD. USAID predicted in 1975-76 that this constraint would evolve and there are signs that the phenomenon is starting to occur. The second input constraint centers on BKKBN capability to manage GOI OC inputs. BKKBN skills in contraceptive forecasting, procurement and supervising local production need to be improved. The Ford Foundation sponsored Program for Introduction and Adaptation of Contraceptive Technology (PIACT) and IBRD plan to assist BKKBN in this area. USAID can also be of assistance under Project 497-0270.

USAID believes the project is reasonably priced and designed. A cost-effectiveness analysis is contained in Part III-D which presents past cost-effectiveness indicators and projects future cost-effectiveness results through 1982.

An Environmental Assessment is not required as the "Negative Determination" recommended in the Initial Environmental Examination (IEE) of the PRP was approved by A-DAA/Asia, Donald D. Cohen on November 17, 1976. A copy of the approved "Negative Determination" is attached as Annex M.

B. Financial Analysis and Plan

The philosophy behind the flexible input plan of the Project is fully described in Part I C and Part II B of this Project Paper. The key to success of the Project is input flexibility. Consequently, the Project is designed to be responsive to a range of possible input requirements. The GOI strategy is to achieve self-sufficiency in OC supplies over the next decade. USAID's strategy is to insure program continuity and growth by financing the difference between the annual OC delivery requirement and the GOI OC input as long as the GOI OC input shows "reasonable" growth over time. Reasonable growth is defined as the following minimum GOI OC inputs:

TABLE 10

<u>CY</u>	<u>000s Cycles</u>
1979	4,000
1980	8,000
1981	12,000
1982	16,000
1983	20,000
1984	25,000
1985	<u>30,000</u>
Total	<u>115,000</u>

The minimum GOI OC input CY 1979-85 constitutes 29.7% of presently estimated OC delivery requirements CY 1979-85.

The maximum USAID OC inputs presented below is the difference between the estimated annual OC delivery requirement and the minimum GOI input:

TABLE 11

<u>CY</u>	<u>000s Cycles</u>
1979	14,867
1980	42,100
1981	42,800
1982	43,300
1983	44,000
1984	43,000
1985	<u>42,000</u>
Total	<u>272,067</u>

The maximum USAID OC input represents 67.7% of presently estimated OC delivery requirements CY 1979-83.

The estimated CY 1979-85 OC delivery requirement, estimated price per cycle, number of cycles and dollar range of GOI inputs, and number of cycles and dollar range of USAID inputs are presented in Table 12, Page 30. The minimum GOI dollar inputs and the maximum USAID dollar inputs for OCs are as follows:

TABLE 13

<u>MINIMUM GOI OC INPUTS</u>		<u>MAXIMUM USAID OC INPUTS</u>	
<u>GOI FY</u>	<u>\$000s</u>	<u>U.S. FY</u>	<u>\$000s</u>
1978-79	\$ 1 185	1978	\$ 7,000
1979-80	3,007	1979	7,000
1980-81	3,941	1980	9,000
1981-82	4,997	1981	9,000
1982-83	5,990	1982	8,000
Total	<u>\$19,120</u>	Total	<u>\$40,000</u>

Cost per cycle estimates for this financial plan are derived from the cost experience of AID central OC procurement. The GOI is expected to request and authorize AID to use loan funds and AID's central OC procurement to implement AID inputs of finished cycles of OCs. The GOI believes that the cost of their OC inputs in the form of local production will be the same or cheaper than the AID OC central procurement costs per cycle. USAID assumes based on advice of OC manufacturers that the cost per cycle of the locally produced OC will be roughly equivalent to the cost of the finished OC procured via the AID central OC procurement mechanism.

Experience to date with AID central OC procurement is summarized below:

TABLE 14

<u>CY</u>	<u>FY</u>	<u>Contract</u>	<u>Cost per Cycle</u>	<u>Total AID/W Cycles Purchased</u>
1974	73	14291	\$0.1394	102,700,000
1975	74	22788	\$0.1378	72,000,000
1976	75	22892	\$0.1498	99,804,915
1977	76	15052	\$0.1494	110,441,400
1978	77	59077	\$0.1565	93,162,600

TABLE 12

SUMMARY COST ESTIMATE AND FINANCIAL PLAN

CY	Est. OC Delivery Require- ment (000s)	Est. \$ Price Per Cycle	Range of GOI Inputs				RANGE OF USAID INPUTS			
			High Cycles (000s)	Low Cycles (000s)	High (\$000s) Est.	Low (\$000s) Est.	High Cycles (000s)	Low Cycles (000s)	High (\$000s) Est.	Low (\$000s) Est.
1979	18,867	0.1803	15,000	4,000	\$ 2,705	\$ 721	14,867	3,867	\$ 2,681	\$ 697
1980	50,100	0.1929	25,000	8,000	4,823	1,543	42,100	25,100	8,121	4,842
1981	54,800	0.2064	25,000	12,000	5,160	2,477	42,800	29,800	8,834	6,151
1982	59,300	0.2208	30,000	16,000	6,624	3,533	43,300	29,300	9,561	6,469
1983	64,000	0.2263	30,000	20,000	6,789	4,526	44,000	34,000	9,957	7,694
1984*	68,000	0.2528	50,000	25,000	12,640	6,320	43,000*	18,000*	10,870*	4,550*
1985*	72,000	0.2705	72,000	30,000	18,202	7,584	42,000*	-0-	11,361*	-0-
Totals	387,067	N/A	247,000	115,000	\$56,943	\$26,704	272,067	140,067	\$61,385	\$30,403

* Last two years of USAID inputs not included in project.

The current delivery cost per cycle of \$0.012 is added to the 1978 material cost per cycle of \$0.1565 for a total 1978 delivered cost per cycle of \$0.1685. The estimated CY 1979-85 cost per cycle estimates used in this Financial Analysis are obtained by inflating the CY 1978 delivered OC price per cycle by seven percent (7%) a year CY 1979-85.

The summary Financial Plan and Cost Estimate table must be supplemented with other planned program inputs to analyze the financial soundness of the national program. As presented in Annex G a total of \$317 million total family planning program inputs are planned 1978-82. These inputs should translate into a cost-per-acceptor of \$15.23, cost-per-couple-year-of-protection of \$9.19 and a cost-per-birth-averted of \$36.75. Costs beyond 1982 cannot yet be formulated because the fourth GOI 5-year development plan has not yet been prepared.

In summary, it is concluded that the Project is financially sound and adequately planned. The societal benefits of one birth averted will vastly exceed the estimated cost of \$36.75.

C. Social Soundness Analysis

1. Socio-Cultural Feasibility

a. Target Population

The obvious ultimate target of this Project is the population in general. Indonesia's population of 133-135 million persons is spread over 3000 islands varying in size from small reefs to areas the size of California. There are over 300 ethnic groups and dialects which can be loosely grouped as follows: (a) wet rice farmers such as Javanese, Balinese, Sundanese, Acehnese, Sasak, etc.; (b) coastal peoples such as Makasarese, Buginese, Coastal Javanese and Malays, etc.; (c) interior tribesmen such as Iban, Dayak and Toradja peoples; (d) others such as Bataks, Ambonese, Chinese, etc. Although ethnic awareness is strong, there is general linguistic solidarity, and ethnicity has not been a significant handicap in generating national loyalty for development.

The first phase of the family planning program focused primarily on wet rice farmers on Java and Bali. For centuries these people have practiced intensive, irrigated rice growing which has supported the development of dense populations, early advanced civilizations and very early sophisticated political organizations. This background makes these peoples comparatively easy to reach.

The second phase of the program, which began in

1974, extended to ten outer island provinces comprised of a roughly equal mix of wet rice farmers, coastal peoples mostly supporting commerce and others more difficult to categorize. Among these groups, large scale socio-political organization is generally more recent, less sophisticated and highly variable. This makes these groups somewhat more difficult to reach with family planning services.

The third phase of the program, which is scheduled to begin in 1979, will extend services to the final eleven provinces comprised mostly of interior tribesmen, some wet rice farmers, coastal peoples and many other assorted groups. These often more primitive groups with great socio-cultural diversity will be the most difficult to reach with family planning services.

While the program is aimed equally at all ethnic groups, it is realistically being implemented in stages to prevent overextension of capabilities. No major ethnic issues have arisen to date. Some provinces have expressed concern regarding the participation of the Indonesians of Chinese descent, but research has shown that their participation, albeit mostly via the private sector, is usually equal to or greater than that of the Indonesians of Malay descent.

The more immediate target of this Project is the 21.3 million married women ages 15-44 or fertile couples. These married women have been selected because they are the childbearers. Incidence of child-birth out-of-wedlock in Indonesia is quite small.

Although studies have shown (see "Measuring Socio-economic Differences in Child Survivorship in Indonesia" presented by Terrence H. Hull, IUSSP 1977 General Conference, Mexico City) that Indonesian families of high socio-economic status have more children because of higher fertility and lower childhood mortality, this group is small in numbers and demographically not very significant.

Thus, the Project focuses primarily on the poor majority. To date the rural poor have been the primary target, however, efforts are underway to strengthen the focus on the urban poor. Acceptor characteristics vividly demonstrate the recipients of Project benefits: primarily wives of farmers, fishermen, laborers and unemployed.

b. Motivation and Organization

The GOI is strongly in favor of this Project. The technocrats engaged in outlining development policies for Indonesia are well aware of the causes and consequences of rapid population growth. They are also cognizant of the criticality of the population factor in macro-economic planning. Thus, to the extent political and administrative realities and family decisions allow, viable voluntary population control schemes will be supported. The BKKBN, as the GOI agency charged with implementing population control efforts, is strongly desirous of this Project. The role of the OC in Indonesia's fertility reduction efforts has been and will continue to be great.

Among the contraceptive services being offered in Indonesia, the OC is socio-culturally the most acceptable. There are no known socio-cultural barriers against OC use. IUD use is less acceptable because of perceived Islamic restrictions surrounding insertion and mode of action. Condoms are often connected with extra-marital sex and prostitution and are not popular. Voluntary sterilization is viewed as unacceptable practice by some Islamic groups. Approximately 90% of Indonesia's population is Islamic, but, of course, there is wide disparity of views among Moslems regarding acceptable forms of contraception. The important point is that no known socio-cultural group in Indonesia has taken a position against OC use.

To date the family planning program has been well received on Java and Bali, and, as noted previously, currently 26% of the MWRA are using contraception through the program. The strategy on Java and Bali of moving to the village has been successful. VFP is in full operation and USAID and the BKKBN expect this program will be supported by the GOI and local regions within the next two to three years.

The national family planning program moved to the ten Outer Island provinces in 1974 and the initial determination is that there are no insuperable socio-cultural barriers to the rapid expansion of this program. Pilot VFP projects have been launched in the ten provinces and the preliminary results are encouraging. Formal and informal leaders from the Governor to regency, district, sub-district and village heads have endorsed the village family planning approach. Conversations with village informal leaders (religious, women's clubs, social organizations, etc.) have not reflected opposition or hostility toward the introduction of family planning into village life.

Such conversations, admittedly brief and non-random, have impressed USAID and the BKKBN that villagers readily perceive the benefits from family planning and are willing to participate in the birth control program. Desired family size in the Outer Islands is often still large (4-5 living children), but couples interviewed are clearly interested in controlling and spacing their families.

There is also an expressed willingness at local levels to assume responsibility for the VFP program. The BKKBN has been unambiguous about local responsibility when explaining the VFP approach to provincial and local level officials. A 2-3 year time frame is outlined for people to be briefed, trained, supervised, records established and the VFP system to operate.

USAID believes that one of the great strengths of the Indonesian family planning program is the decentralized planning approach that has been used in promoting VFP. The country is a diverse, multi-ethnic one and it is USAID's opinion that it would be impossible - even foolish - to attempt to plan an innovative village family planning trial from Jakarta. The BKKBN has not made this mistake.

Planning for VFP is largely conducted in the provinces with provincial family planning officials. Even on Java and Bali there is a wide variance of traditions and cultures and the provincial VFP programs on these two islands reflect these differences.

On the ten Outer Island provinces, the BKKBN is attempting to repeat the decentralized VFP planning process. In each area, the socio-cultural nuances are studied and a joint determination is made as to how best to proceed with VFP. In South Sumatra the "Dusun" leader (village headman) is critical for gaining support of VFP. In North Sulawesi it is the "Hukum Tua." In West Sumatra, the village structure is similar to that in Bali and the "Dukta," (a traditional leader), is important if the VFP program is to become part of village life.

c. Participation

As noted earlier, family planning is one of the most integrated GOI development efforts. At the central, provincial, district and sub-district levels, the Ministries of Health, Interior, Information, Education, Religion, Armed Forces and numerous private groups support the BKKBN coordinated efforts. Family planning efforts at the village level enjoy the support of elected village leaders, informal and religious leaders, village depot

holders and spontaneously organized groups of contraceptive users. Participation of target populations is strongly encouraged by the providers. The long-term goal is to make the village the starting point rather than the terminating point for services.

d. Obstacles

As noted earlier, as the program moves off Java/Bali into the next two phases of development in more remote areas, progress will be more difficult due to several obstacles:

- population densities are lower and delivery efficiencies less likely achieved;
- socio-economic and geopolitical circumstances are more heterogeneous;
- regency level BKKBN program administration does not exist;
- there are no FP fieldworkers;
- transportation and communications are more difficult;
- fertility is higher.

These obstacles will present challenges to program managers. The BKKBN is rationally addressing these obstacles and is optimistic that solutions can be found. However, solutions will not come easily.

Take, for example, the case of fieldworkers for Outer Islands I. In comparison to Java/Bali, Outer Islands I falls short in four input areas: accessibility of clinics, regency level BKKBN program management, fieldworkers and village level services. Java/Bali has one clinic per 51 square kilometers or 32,500 persons. Outer Islands I has one clinic per 36,800 persons; but these people are spread over 882 square kilometers per clinic. All 114 regencies on Java/Bali have BKKBN full-time paid program managers. None of the 107 Outer Islands I regencies have BKKBN program managers. Java/Bali has village family planning in every village, whereas BKKBN is in the process of establishing village family planning in roughly one-fourth of the 25,191 villages in Outer Islands I. Java/Bali has roughly 7000 fieldworkers (approximately one fieldworker per 20 square kilometers) while Outer Islands I currently has no fieldworkers. To add one fieldworker for every 20 square kilometers

on Outer Islands I would annually cost an estimated \$14,672,160 (40,756 fieldworkers times \$30 times 12 months). Thus, the question that must be answered is what is the most cost effective way to achieve better coverage in Outer Islands I? BKKBN/USAID believe the most cost effective investments in descending order are: village family planning; regency BKKBN program management; fieldworkers; clinics. All of the above alternatives carry obstacles which necessitate flexibility in design for Project 497-0270 and this Project.

In addition to the above input and output obstacles there are purpose and goal obstacles as follows:

- fertility appears to be positively correlated with the mother's level of education from no schooling through high school. Much less than one percent of Indonesian women reach the university where this relationship begins to reverse itself.
- mortality is still comparatively high; and declines in fertility could be more than compensated for by declines in mortality, although this is not immediately foreseen.
- Malthusian checks (famines, natural disaster) could set in and increase mortality which might induce temporarily increased fertility.
- There is a need to create jobs for the rapidly swelling working age population in order to maintain relative political stability.

2. Spread Effects

The major participants in this project will be rural couples who will have - some for the first time - ready access to modern family planning methods. An unexpected spillover effect has been observed on Java and Bali where family planning groups have begun to expand their interests beyond the field of family planning. Formed at the sub-village level to insure contraceptive resupply, these groups are currently engaging in a variety of development activities. Some groups are receiving lectures on other development programs such as health and nutrition and also have received lectures by local (district and regency) officials. Other family planning

groups have diversified into economic activities such as raising chickens and making and selling handicrafts. USAID suspects the reason family planning has catalyzed these women is that they tend to be slightly "different." Although many villages have women's clubs, such established groups tend to be dominated by the older, more conservative women in the village. The family planning groups, on the other hand, are younger (most in the 15-44 age group) and the fact that they are family planning acceptors indicates they are forward thinking. Grouping these women, USAID believes, tends to create a dynamism that is directed toward self-improvement and development. USAID and the BKKBN expect that assistance will be provided in Project 497-0270 to these groups to test the feasibility of integrating more formalized developmental programs such as primary nutrition education into their activities.

The GOI plans to move prudently with the expansion of the VS program and it will be rapidly expanded only in those areas such as North Sulawesi and North Sumatra where there is strong support for VS and a recognized unmet demand for these services. In other areas such as Aceh, West Sumatra and South Sulawesi, VS will be introduced slowly and in stages. The GOI's approach to VS is to introduce these services throughout the country in regency hospitals as backup family planning services for those women who are interested in VS. The GOI does not, and USAID believes will not, consider mass sterilization campaigns; any form of compulsory sterilization; or, incentives or disincentives that attempt to "induce" sterilization.

3. Social Consequences and Benefit Incidence

The primary beneficiaries of the successful implementation of this project will be married women between the ages of 15-44 who will be able to gain control over their child-bearing through the use of oral contraceptives. These women will benefit socio-economically by conception becoming largely a matter of choice and not chance. Control over fertility will free some of these women from the threat of maternal mortality (estimated to be in the range of 150-200 maternal deaths per 100,000 births) as well as directly relieving them from the debilitating effects of one child bearing experience after another. In addition, couples will have the option of planning the size of their families as well as the spacing of children. Living children will also benefit as it has been shown that too many children too closely spaced can result in detrimental childhood development effects.

Married women between the ages of 15-44 have been selected as the target for this activity as they are the childbearers. This does not, of course, exclude men from responsibility for family planning. The BKKBN is promoting the use of the condom through its public program as well as private commercial condom sales. Male sterilization is also available on a limited basis and will be developed further.

Obviously oral contraception carries with it the risk of morbidity. Morbidity, evidenced by so called side effects, appears in about 40 percent of pill users and can be classed into three categories: those annoying and sometimes uncomfortable but seldom dangerous to health; those carrying significant health risks (not life threatening, but may lead to permanent damage); those life threatening as follows:

Fairly Minor

Nausea, weight gain, headaches, spotting, decreased menstrual flow, missed periods, vaginal infection or discharge, depression, acne, chloasma, etc. Many of these minor side effects can be minimized by switching to a pill with a different estrogen/progestin mix. Choices of other OCs will be maintained in the program with BKKBN purchases and the assistance of other donors.

Not Life Threatening but Significant

Gallbladder disease, hypertension, jaundice, diabetes.

Life Threatening

Blood Clots (thromboembolism).

The major concern with the use of oral contraceptives is a measurable increase in morbidity and mortality due to thromboembolic disease. Nevertheless, such a risk is negligible when compared to maternal morbidity and mortality that would result from not using contraception. In economically developed countries the mortality associated with pregnancy and childbirth can be compared to mortality

associated with the use of OCs as follows: 1/

TABLE 15

MORTALITY

<u>Age Group</u>	<u>Pregnancy and Childbirth*</u>	<u>Oral Contraception**</u>
15-19	10.8	1.3
20-24	8.5	1.3
25-29	12.1	1.3
30-34	25.1	4.8
35-39	41.0	6.9
40-44	69.1	24.5

* Ratio per 100,000 live births, U.S. 1973

** Rate per 100,000 users per year, data from U.S.,
England and Wales

The above illustrates that, even in economically developed countries, women of reproductive age are less likely to die if they use OCs than from complications of the reproductive process. In Indonesia where maternal mortality is 4 to 6 times higher than in the U.S. the hazard to life from unwanted pregnancy is at least tens of times greater than from the use of oral contraceptives - even if one assumes the risk of thromboembolism to be the same as in the U.S. and Britain. There is some data to suggest that the risk of thromboembolism among fertile women with different ethnic composition and diet, living in developing countries near the equator, who are leaner, more active and do not smoke cigarettes, the incidence of thromboembolic phenomena is probably much lower and may be negligible. 2/

As outlined earlier, Project beneficiaries will be primarily rural, poor married women ages 15-44. The current 2.4 million direct beneficiaries (i.e., OC users) is expected to double by FY 1983. The Project will assist over 17 million persons in OC user families and especially benefit children under age 5. The cost per additional family benefited is around \$22. The cost per additional family member benefited is around \$4.

1/ Christopher Tietze et al, "Mortality Associated with Control of Fertility," Family Planning Perspectives, January/February 1976.

2/ Ravenholt, R.T., Speidel and Perry, "Nonclinical Distribution of Oral Contraceptives," presented at Tenth Annual Meeting of American Association of Planned Parenthood Physician, Detroit, 1972.

D. Cost-Effectiveness

In late 1972, an extensive analysis was carried out by the Demographic Institute, University of Indonesia on the relationship between population growth and economic growth.* Among other things, the report showed the improvement in per capita income that results from reduced fertility. This is due to the numerator (gross national product) being divided by a smaller denominator (the size of the population).

In 1975, a monograph was published by the BKKBN that analyzed the cost-effectiveness of the national program for the years 1971-1973.** The report showed that for the latest year (1973) the cost-per-acceptor of the program was \$11.02, cost-per-couple-year-of-protection (CYP) \$9.28 and cost-per-birth-averted \$39.98.

USAID has attempted to update this report by estimating the cost-effectiveness indicators for the period 1968-1977, then projecting estimated cost-effectiveness indicators for 1978-1982. These figures are presented in Annex F and Annex G.

A word of caution in reviewing these figures. USAID has found it difficult to account for all inputs into the program. Donors, unfortunately, do not maintain accessible expenditure figures; also, fiscal years of the donors and GOI often overlap. Still, for the period 1968-1977, USAID believes the figures presented are a reasonable estimate of the direct inputs into the Indonesian National Family Planning Program. If the average population over this period is considered to be 127 million, the cost-per-capita is on the order of \$1.25.

USAID estimates that \$158.5 million has been spent by the GOI and donors for the period 1968-1977. This results in a cost-per-acceptor of \$14.28, cost-per-CYP of \$12.00 and a cost-per-birth averted of \$48.00. The cost-per-acceptor is derived by dividing the total number of acceptors for the period 1968-1977 into the total amount spent. The same process is repeated for couple-years-of-protection and births averted. Couple-years-of-protection is estimated from the BKKBN service statistic data and USAID calculates that over this time period four years of CYP is equal to one birth averted.

For the forward period 1978-1982, USAID has estimated the

* See "Beberapa Keuntungan Sosial Ekonomis Karena Reduksi Fertilitas." Lembaga Demografi, Fakultas Ekonomi, Universitas Indonesia. Jakarta 1972.

** See "The Indonesian National Family Planning Program: A Cost-Effectiveness Analysis 1971/72-1973/74." "Technical Report Series, Monograph No. 10, Soedarmadi and Reese, National Family Planning Coordinating Board, Jakarta, April 1975.

total costs of the program and similar cost-effectiveness indicators. USAID estimates that \$317 million will be spent on the national family planning program over this period. GOI expenditures will be about 69% of the total. If the World Bank loan is added to the GOI expenditures, the GOI proportion is 77% of the total. Over this period, USAID inputs will be about 20% of the total.

In terms of cost-effectiveness, USAID estimates the cost-per-acceptor will be around \$15.23, the cost-per-CYP \$9.19 and the cost-per-birth-averted \$36.75. These are obviously order-of-magnitude figures as budgets and program performance could change significantly over the five-year period.

PART IV. IMPLEMENTATION ARRANGEMENTS

A. Analysis of the Recipient's and AID's Administrative Arrangements

1. Recipient

This project will be administered for the GOI by the BKKBN. The BKKBN is a separate GOI Agency that reports to the President through the Ministry of Social Welfare. An organizational chart is shown in Figure 2 on Page 45.

The BKKBN is directed by a Chairman and three Deputy Chairmen. Deputy I is responsible for Support and Planning, Deputy II is responsible for Operations; Deputy III is responsible for Research and Development and will be USAID's counterpart in the day-to-day administration and implementation of this Project.

At the provincial level, the six provinces on Java and Bali and the ten on the Outer Islands have provincial BKKBNs with staffs ranging from 60-75 people on Java and Bali and 10-15 people in the Outer Islands. Below the province level there are regency staff. On Java and Bali each one of the 114 kabupatens has a BKKBN office and staff of from 5-10 people; on the Outer Islands there is currently only one BKKBN person at the regency level.

On Java and Bali there are 7,000 fieldworkers who report to the regency BKKBN. The fieldworkers are charged with recruiting new acceptors; supporting continuing family planning users; and, assisting with the VFP program. At this time, the BKKBN does not plan to introduce large numbers of fieldworkers on the Outer Islands.

The BKKBN has a proven record of effective program administration and management; it has developed a unique method of decentralized planning and administration. The Central BKKBN:

- a) Sets policy - a 50% reduction in birth rates by the year 2000;
- b) Defines program parameters - no abortion; no promotional sterilization;
- c) Sets targets - acceptors and users by province; and
- d) Allocates budgets - by province.

Within this "guided framework," the provincial BKKBNs are given flexibility in designing their respective family planning programs. The result is that the provincial programs - especially the provincial VFP programs - are different. West Java, for example, has initiated the STMK (the two-person family planning-health teams that recruit new pill acceptors door-to-door). Bali, on the other hand has rooted its program within the communal traditions of the sub-village (Banjar).

USAID anticipates that this management style will be followed in expanding OC availability in the Outer Islands.

Development and evaluation activities will largely be conducted by other agencies and institutions. The Central Bureau of Statistics (BPS) will conduct fertility and mortality analyses as well as a variety of population data gathering activities. BPS is the GOI's principal statistical agency and is increasingly well regarded. The BPS conducted the 1971 census and detailed analyses of the results. It also conducted the three-phase 1976 Intercensal Survey in addition to a variety of other multi-purpose surveys. BPS has a good team of M.A. and Ph.D. level staff and is actively upgrading additional staff with long-term academic training.

In addition to BPS, USAID and the BKKBN expect that various population research activities in cooperation with the BKKBN will be conducted by the Demographic Institute, University of Indonesia and the Population Institute, Gadjara Mada University. Both institutions have conducted meaningful population research and have proven staff capability. Both Institutes have made effective use of foreign advisors in the population/social science field.

The Demographic Institute undertook a 1973 fertility/mortality survey, which has provided baseline fertility/mortality data. The Population Institute conducted a transmigration study and a large survey of the value of children in 1974.

The BKKBN will contract program evaluation to provincial universities with expertise in population survey methodology. For example, regional universities are currently conducting family planning acceptor surveys for the BKKBN. Although these regional universities have

limited capability and manpower, they generally have some staff trained in demographic methods. Many regional staff have attended the one-year demographic course at the Demographic Institute and are interested in remaining active in population activities.

The Ministry of Health will support the clinic family planning program through its clinic system. The MOH has a good clinic infrastructure that reaches to the district level. There is approximately one clinic per 30,000-40,000 population throughout the country.

USAID believes the BKKBN is well organized and capable of administering and coordinating these project inputs. The institutes that will be involved in the implementation of the Project are capable of conducting the activities contracted to them as long as planning and scheduling are closely coordinated to insure that any one agency or institute is not overburdened. In the past, the BKKBN has shown good judgment in selecting agencies and institutions to conduct coordinated population activities. Private agencies have been given roles in reaching selected audiences such as religious groups. The Ministry of Education and Culture is heavily involved in population education activities funded by the World Bank.

Primary recipient constraints operating at the input and output level are discussed under Part III, Section A and are:

- a) time and distance difficulties and insufficient manpower for developing the Outer Islands program; and
- b) inadequate BKKBN skills in OC forecasting, procurement and supervising local production.

Efforts are underway with the assistance of UNFPA, Ford Foundation, PIACT, IBRD and AID to address these constraints. USAID will continue to pursue with BKKBN the desirability of institutionalizing a small contraceptive input management unit. We are optimistic that such a unit will evolve during the course of the Project.

B.K.K.B.N. ORGANIZATION CHART

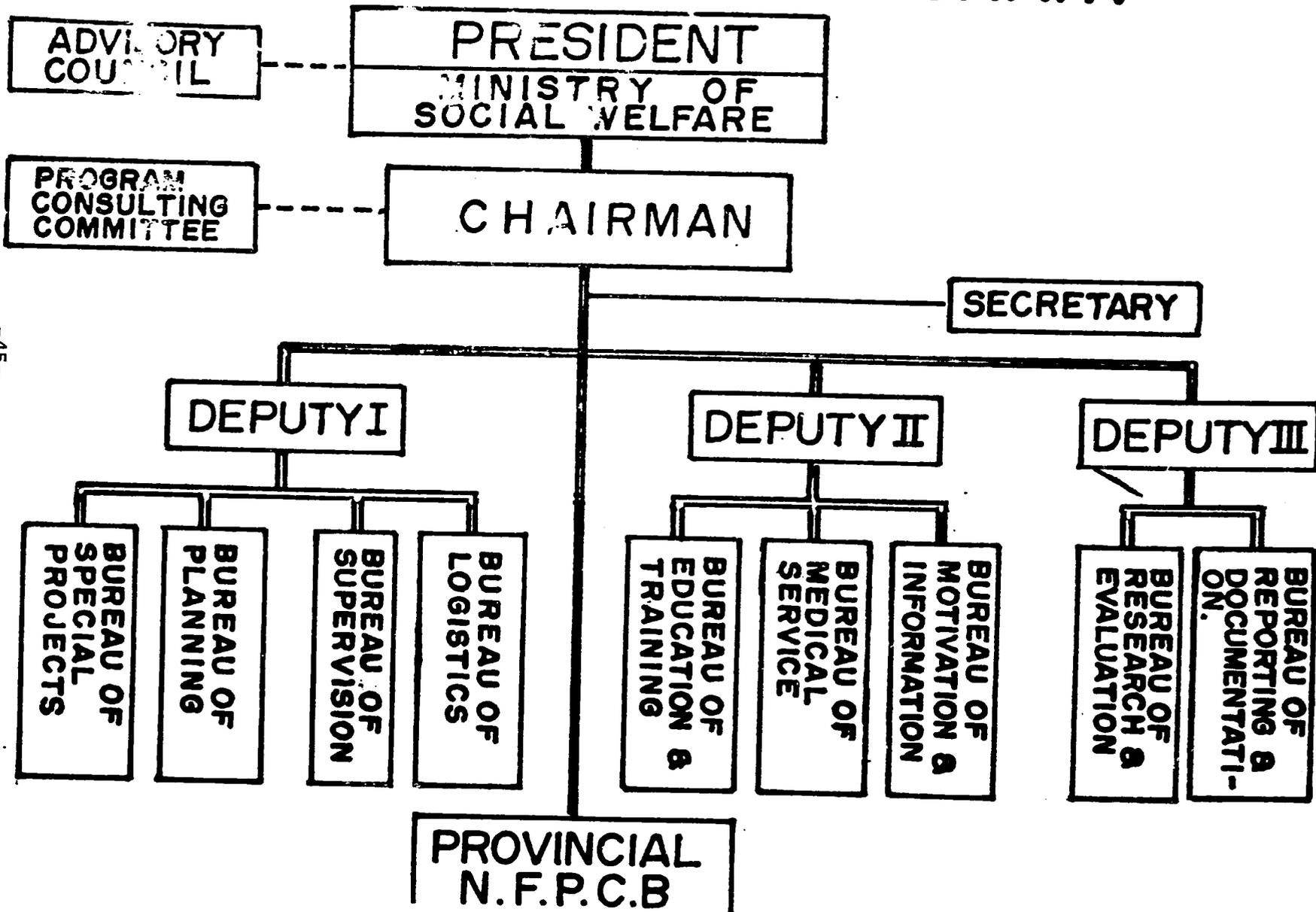


FIGURE 2

2. AID

USAID will increase its staff from two population officers to three. One population officer will be the project officer monitoring inputs of the OC Loan. This project officer will continue to actively pursue improvements in the fields of logistics and consult with the BKKBN on institutionalizing improved contraceptive input management. This person will continue to be assisted, especially in logistical record keeping, by one direct hire local employee.

At least annually the AID project officer will forecast OC consumption with BKKBN and develop new OC delivery requirements estimates which will form the basis of funding requests for the Annual Budget Submission (ABS), Congressional Presentation and annual loan agreement. In addition, OC consumption will be charted monthly and compared with forecasted consumption.

It is expected that BKKBN will be charged with executing the annual loan agreements. Once the Conditions Precedent to disbursement are met, BKKBN is expected to annually send letters requesting USAID to procure and authorizing AID to utilize loan funds to purchase and ship OCs in the amount required. Upon receipt of such a letter, USAID will draw up a Project Implementation Order for Commodities (PIO/C) which will be co-signed by USAID and BKKBN and transmitted to AID's SER/COM/PROC (Office of Procurement in Washington, D.C.). The loan funded PIO/C will be integrated with AID's central OC procurement which is effected annually. If desired by the GOI, it could put conditional language in the PIO/C designating GSA as the authorized agent, providing GSA with a maximum unit price acceptable to GOI, and perhaps including a formulation limitation similar to that for raw material procurement. This would allow GSA to contract for the delivery of orals within the above limitations and if these limitations could not be met to continue with the procurement process for grant fund orals for other AID programs. Thereafter, if agreement on a way to utilize the subject loan funds for OC procurement cannot be reached, the loan would be deobligated. The loan PIO/C portion of the central procurement is fulfilled with funds controlling (i.e., the total number of cycles that can be procured and shipped within the funds authorized will be procured and shipped).

USAID will continue to need the assistance of SER/COM/PROC, PHA/POP and GSA in effecting procurement and scheduling shipment.

The above procedures are being utilized in Loan 497-045 OC procurement and have been found to be quite adequate. Thus, present AID administrative arrangements are judged to be sufficiently adequate.

B. Implementation Plan

The BKKBN will coordinate the implementation of this Project.

AID and Recipient administrative arrangements essential for smooth implementation are described in Part IV A. Project performance may be tracked using the annual CY 1977-1985 OC prevalence estimates projected in Part II B 3 for Indonesia, Java/Bali, Outer Islands I and Outer Islands II.

At the end of each GOI fiscal year (March 31), USAID and BKKBN will update the forecast of OC consumption, analyze the GOI and USAID OC input delivery plan and estimate future OC delivery requirements. During this review, the GOI and USAID input portions of the total OC delivery requirement will also be determined within the range of inputs defined in Part II B 1.

These estimates of future annual OC delivery requirements along with the portions of the annual OC requirements to be supplied by GOI and USAID will be submitted to AID/W in July of each year in the contraceptive tables of the Annual Budget Submission. These data will be the basis for budgeting annual requirements for USAID inputs.

In October of each year the Congressional Presentation (CP) will be submitted to AID/W confirming or revising as necessary the estimates of the Annual Budget Submission. Funding data in the CP will be the controlling data for loan authorization.

Around November of each year, AID/W will authorize a current U.S. fiscal year (i.e., November 1978 for U.S. FY 79) loan for the following calendar year (i.e., CY 1980) USAID OC input. USAID will negotiate and sign the loan prior to January of the following year.

Once the loan is signed and the Conditions Precedent are met, BKKBN will send USAID a letter authorizing AID expenditure of loan funds and requesting USAID assistance in procuring the requisite number of finished cycles of OCs through the AID central OC procurement mechanism.

Upon receipt of this letter, USAID will prepare a PIO/C which will be co-signed by USAID and BKKBN to officially order the OCs and specify shipping instructions.

AID/W then integrates the PIO/C into the next central OC procurement. Once the bids are available, AID/W informs USAID by telegram of the product and price of the low bidder. USAID then signs a brief letter of agreement with BKKBN to formally secure GOI approval for the product and price. The contract will then be executed by GSA and shipments will be made under the PIO/C with funds available controlling the number of cycles shipped.

Similar procedures are being effectively utilized for pro-

curement of finished OCs under Loan 497-045.

The Project development schedule and implementation plan are as follows:

December 1977	PP 497-0271 submitted to AID/W requesting approval for FY 78-84 Project.
January 1978	PP reviewed by AID/W.
February 1978	PP approved by AID/W. AID/W authorizes FY 78 loan of \$7.0 million.
March 1978	USAID negotiates FY 78 OC loan with GOI.
April 1978	USAID signs FY 78 OC loan with GOI. GOI authorizes BKKBN to execute the loan. USAID/BKKBN re-estimate GOI and USAID OC input requirements for CY 1980 and beyond.
May 1978	USAID forwards PIO/C for FY-78 OC procurement for CY 79 delivery to AID/W. AID/W includes FY-78 PIO/C in next central OC procurement.
July 1978	USAID submits FY 1980 ABS confirming FY-79 Project inputs (cycles) and estimating FY-1980-83 requirements.
August 1978	AID/W ABS Review
September 1978	USAID firms estimates of FY-79 Project inputs (dollars) for the Congressional Presentation (CP).
October 1978	CP forwarded to AID/W
November 1978	AID/W authorizes FY 1979 loan for CY 1980 USAID Project inputs.
December 1978	USAID negotiates FY-1979 loan with GOI.
January 1979	USAID signs FY-1979 loan with GOI. GOI authorizes BKKBN to execute loan.

February 1979	BKKBN meets Conditions Precedent and sends letter requesting/authorizing USAID to procure FY-79 USAID OC inputs for CY 1980 delivery.
March 1979	FY-79 PIO/C for CY 80 OC delivery inputs signed by USAID/BKKBN and forwarded to AID/W.
April 1980	Shipments to Indonesia for CY 1980 delivery begin.

The April 1978 through March 1979 process will be repeated each year for the life of Project. The cycle of April through March is chosen because the GOI fiscal year ends March 31. The review held in April of each year will examine GOI OC inputs realized over the prior GOI FY in addition to re-estimating future OC requirements.

The complex documentation process used for receipt and distribution of USAID OC inputs is described in Annex N.

C. Evaluation Plan

The Project will be evaluated annually in accordance with Agency evaluation procedures. The evaluation review will be chaired by the USAID Director and reported in the Project Evaluation Summary (PES). It is expected that this annual evaluation followed by the PES report will be held in November of each calendar year. This would continue the pattern established over the last two years. In addition, USAID plans more extensive field evaluations during the course of the Project.

The goal, purpose and output objectives of the Project are closely linked to the goal, purpose and output objectives of Project 497-0270. Therefore, this Project will be field evaluated at the goal, purpose and output level in FY 1979 concurrent with the first field evaluation under Project 497-0270 (Family Planning Development and Services).

The field evaluation team will consist of AID/Washington, USAID, BKKBN officials, plus a team member from a private or academic group in the United States. In addition, USAID urges that one or two Indonesians not associated directly with the BKKBN be included in the evaluation team. These could be well known individuals from academia, government or non-government institutions or perhaps another government body such as BAPPENAS. Another possibility is someone from the BKKBN's Advisory Board.*

*Dr. Sulianti, Ministry of Health; Dr. Sadli, Faculty of Psychology, University of Indonesia; Dr. Selo Soemardjan, Secretary, Vice President of Indonesia.

The 4-6 person team will review BKKBN activities and program progress with senior BKKBN officials. The latest estimates of contraceptive use and fertility/mortality estimates will be presented. A series of field trips will be undertaken by the team to review family planning on Java and Bali and the Outer Islands. Special attention will be paid to the self-sufficiency of the Village Family Planning on Java and Bali and the progress of VFP on the Outer Islands. Special attention will also be paid to the VS program to insure that it is progressing and in accordance with the GOI's desires. Outlet targets have been set for VFP and VS so progress can be measured against the planned outputs.

Upon completion of the field trips, the team will gather in Jakarta and review its findings with senior BKKBN and USAID officials. An evaluation report will be presented.

The input objectives of the Project will require a separate field evaluation. USAID and GOI input progress will be reviewed and reported in March of each year in accordance with the implementation plan. It is proposed that in March 1980 a special field input evaluation team composed of USAID, one person from AID/W and/or one outside consultant (team leader) and one BKKBN person be fielded to evaluate: GOI input progress; USAID input progress; GOI progress in institutionalizing contraceptive input management; progress in transition from USG to GOI financing of OC inputs. In addition to this special input evaluation effort, it is expected that contraceptive supply audits which have occurred at least once a year will continue.

Month-to-month project evaluation will be through study and analysis of the BKKBN's family planning service statistic system. This data system reports on family planning activities monthly down to the regency level. It is a powerful tool for monitoring outputs of the family planning program. There is homogeneous reporting on new family planning acceptors as well as current family planning users. For a detailed description of the system, the reader is referred to Haryono, Clinton, et. al., "Family Planning Service Statistics System: The Indonesian Experience." Technical Report Series, Monograph No. 11, National Family Planning Coordinating Board, Jakarta, Indonesia, August 1975.

For a validation of the system, the reader is referred to: Singuefield and Jones, "Evaluating the Validity of the Indonesia Family Planning Service Statistics," 1973, Bulletin of Indonesia Economic Studies, Australian National University, Canberra, Australia, November 1976.

PART V. ANNEXES

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ANNEX A

POPULATION ESTIMATES BY PROVINCE AND FAMILY
PLANNING PROGRAM AREA, MID-YEAR 1976 1/

<u>A. Java/Bali</u>	<u>1976 Population</u>
1. Jakarta (DKI)	5,366,692
2. West Java	23,454,342
3. Central Java	23,557,796
4. East Java	27,103,027
5. Yogyakarta (DIY)	2,624,827
6. Bali	2,293,430
Sub-total	<u>84,400,114</u> (64%)
<u>B. Outer Islands - I</u>	
1. Aceh	2,226,210
2. North Sumatra	7,466,858
3. West Sumatra	2,994,571
4. South Sumatra	3,870,836
5. Lampung	3,438,843
6. West Kalimantan	2,283,197
7. South Kalimantan	1,845,637
8. North Sulawesi	1,898,770
9. South Sulawesi	5,681,119
10. Nusa Tenggara Barat	2,401,485
Sub-total	<u>34,107,526</u> (26%)
<u>C. Outer Islands - II</u>	
1. Riau	1,842,888
2. Jambi	1,103,177
3. Bengkulu	566,625
4. Central Sulawesi	1,014,162
5. Southeast Sulawesi	784,516
6. Central Kalimantan	811,839
7. East Kalimantan	927,127
8. Nusa Tenggara Timur	2,490,274
9. Maluku	1,227,849
10. Irian Jaya	1,034,740
11. East Timor	685,602
Sub-total	<u>12,488,799</u> (10%)
1976 Grand Total	130,996,439 <u>2/</u>

1/ USAID estimates based on information collected (primarily from Intercensal Population Survey).

2/ Assuming a 2% growth rate, the 1977 population of Indonesia is 133,616,350.

STATUTORY CHECKLISTCountry ChecklistA. GENERAL CRITERIA FOR COUNTRY

- | | |
|---|---|
| 1. FAA Sec. 116. Can it be demonstrated that contemplated assistance will directly benefit the needy? If not, has the Department of State determined that this government has engaged in consistent pattern of gross violations of internationally recognized human rights? | Yes. Page 14 of the PP notes the family planning program is effective in reaching the rural poor. |
| 2. FAA Sec. 481. Has it been determined that the government of recipient country has failed to take adequate steps to prevent narcotics drugs and other controlled substances (as defined by the Comprehensive Drug Abuse Prevention and Control Act of 1970) produced or processed, in whole or in part, in such country, or transported through such country, from being sold illegally within the jurisdiction of such country to U.S. Government personnel or their dependents, or from entering the U.S. unlawfully? | No. |
| 3. FAA Sec. 620(a). Does recipient country furnish assistance to Cuba or fail to take appropriate steps to prevent ships or aircraft under its flag from carrying cargoes to or from Cuba? | No. |
| 4. FAA Sec. 620(b). If assistance is to a government, has the Secretary of State determined that it is not controlled by the international Communist movement? | Yes. |
| 5. FAA Sec. 620(c). If assistance is to government, is the government liable as debtor or unconditional guarantor on any debt to a U.S. citizen for goods or services furnished or ordered where (a) such citizen has exhausted available legal remedies and (b) debt is not denied or contested by such government? | No. |
| 6. FAA Sec. 620(e) (1). If assistance is to a government, has it (including government agencies or subdivisions) taken any action which has the effect of nationalizing, expropriating, or otherwise seizing ownership or control of property of U.S. citizens or entities beneficially owned by them without taking steps to discharge its obligations toward such citizens or entities? | No. |

A

7. FAA Sec. 620(f); App. Sec. 108. Is recipient country a Communist country? Will assistance be provided to the Democratic Republic of Vietnam (North Vietnam), South Vietnam, Cambodia or Laos? No to both questions.
8. FAA Sec. 620(i). Is recipient country in any way involved in (a) subversion of, or military aggression against, the United States or any country receiving U.S. assistance, or (b) the planning of such subversion or aggression? No.
9. FAA Sec. 620(j). Has the country permitted, or failed to take adequate measures to prevent, the damage or destruction, by any action, of U.S. property? No.
10. FAA Sec. 620(l). If the country has failed to institute the investment guaranty program for the specific risks of expropriation, inconvertibility or confiscation, has the AID Administrator within the past year considered denying assistance to such government for this reason? N/A
11. FAA Sec. 620(o); Fishermen's Protective Act, Sec. 5. If country has seized, or imposed any penalty or sanction against, any U.S. fishing activities in international waters,
a. has any deduction required by Fishermen's Protective Act been made?
b. has complete denial of assistance been considered by AID Administrator?
N/A
12. FAA Sec. 620(q); App. Sec. 504. (a) Is the government of the recipient country in default on interest or principal of any AID loan to the country? (b) Is country in default exceeding one year on interest or principal on U.S. loan under program for which App. Act appropriates funds, unless debt was earlier disputed, or appropriate steps taken to cure default? No to (a) and (b)
13. FAA Sec. 620(s). What percentage of country budget is for military expenditures? How much of foreign exchange resources spent on military equipment? How much spent for the purchase of sophisticated weapons systems? (Consideration of these points is to be coordinated with the Bureau for Program and Policy Coordination, Regional Coordinators and Military Assistance Staff (PPC/RM).) About 22% of the FY 1973/74 budget was for defense. This has not changed significantly. Less than 10% of the military budget as allocated for foreign exchange purchases. No sophisticated weapons have been purchased to our knowledge.

14. FAA Sec. 620(t). Has the country severed diplomatic relations with the United States? If so, have they been resumed and have new bilateral assistance arrangements been negotiated and entered into since such resumption?

No.

15. FAA Sec. 620(u). What is the payment status of the country's U.N. obligations? If the country is in arrears, were such arrears taken into account by the AID Administrator in determining the current AID Operational Year Budget?

U.N. obligations are current.

16. FAA Sec. 620A. Has the country granted sanctuary from prosecution to any individual or group which has committed an act of international terrorism?

No.

17. FAA Sec. 666. Does the country object, on basis of race, religion, national origin or sex, to the presence of any officer or employee of the U.S. here to carry out economic development program under FAA?

No.

18. FAA Sec. 6n(). Has the country delivered or received nuclear reprocessing or enrichment equipment, materials or technology, without specified arrangements on safeguards, etc.?

No.

19. FAA Sec. 901. Has the country denied its citizens the right or opportunity to emigrate?

No.

B. FUNDING CRITERIA FOR COUNTRY

1. Development Assistance Country Criteria

a. FAA Sec. 102(a), (d). Have criteria been established, and taken into account, to assess commitment and progress of country in effectively involving the poor in development, on such indexes as: (1) small-farm labor intensive agriculture, (2) reduced infant mortality, (3) population growth, (4) equality of income distribution, and (5) unemployment.

Yes, criteria have been established and will be refined by the GOI Central Bureau of Statistics.

b. FAA Sec. 201(b)(5), (7) & (8); Sec. 201; 217(d)(4), (2). Describe extent to which country is:

- (1) Making appropriate efforts to increase food production and improve means for food storage and distribution.
- (2) Creating a favorable climate for foreign and domestic private enterprise and investment.

This is a high priority in the current 5-year plan and the following 5-year plan.

The GOI has recently simplified both foreign and domestic investment regulations.

- (3) Increasing the public's role in the developmental process.
- (4) (a) Allocating available budgetary resources to development.
 (b) Diverting such resources for unnecessary military expenditure and intervention in affairs of other free and independent nations.
- (5) Making economic, social, and political reforms such as tax collection improvements and changes in land tenure arrangements, and making progress toward respect for the rule of law, freedom of expression and of the press, and recognizing the importance of individual freedom, initiative, and private enterprise.
- (6) Otherwise responding to the vital economic, political, and social needs of its people, and demonstrating a clear determination to take effective self-help measures.

c. IAA Sec. 201(b), 211(a). Is the country among the 20 countries in which development assistance loans may be made in this fiscal year, or among the 40 in which development assistance grants (other than for self-help projects) may be made?

d. IAA Sec. 115. Will country be furnished, in same fiscal year, either security supporting assistance, or Middle East peace funds? If so, is assistance for population programs, humanitarian aid through international organizations, or regional programs?

2. Security Supporting Assistance Country Criteria

a. IAA Sec. 50(b). Has the country engaged in a consistent pattern of gross violations of internationally recognized human rights? Is program in accordance with policy of this Section?

b. IAA Sec. 531. Is the Assistance to be furnished to a friendly country, organization, or body eligible to receive assistance?

c. IAA Sec. 604. If commodities are to be granted so that sale proceeds will accrue to the recipient country, have Special Account (counterpart) arrangements been made?

(3) The GOI is increasingly stressing the importance of popular participation in the development program, while at the same time increasing its development activities.

(4) Only about 22% of the budget is spent on defense

(5) The GOI is increasingly improving government administration and making progress in increasing individual freedoms.

In the current planned 5-year plans, emphasis is on food production, employment and health, family planning and nutrition.

Yes.

No.

N/A

N/A

N/A

Project Checklist

A. GENERAL CRITERIA FOR PROJECT.

1. App. Unnumbered; FAA Sec. 653(b)

(a) Describe how Committees on Appropriations of Senate and House have been or will be notified concerning the project; (b) is assistance within (Operational or Budget) country or international organization all action reported to Congress (or not more than \$1 million over that figure plus 10%)?

(a) Committees notified by FY 1978 CP (new project). (b) No.

2. FAA Sec. 611(a)(1). Prior to obligation in excess of \$100,000, will there be (a) engineering, financial, and other plans necessary to carry out the assistance and (b) a reasonably firm estimate of the cost to the U.S. of the assistance?

Yes-cost estimates are in most part based on past project experience.

3. FAA Sec. 611(a)(2). If further legislative action is required within recipient country, what is basis for reasonable expectation that such action will be completed in time to permit orderly accomplishment of purpose of the assistance?

N/A

4. FAA Sec. 611(b); App. Sec. 101. If for water or water-related land resource construction, has project met the standards and criteria as per Memorandum of the President dated Sept. 5, 1973 (replaces Memorandum of May 15, 1962; see Fed. Register, Vol 30, No. 174, Part III, Sept. 10, 1973)?

N/A

5. FAA Sec. 611(w). If project is capital assistance (e.g., construction), and all U.S. assistance for it will exceed \$1 million, has Mission Director certified the country's capability effectively to maintain and utilize the project?

N/A

A.

6. FAA Sec. 209, 619. Is project susceptible of execution as part of regional or multi-lateral project? If so why is project not so executed? Information and conclusion whether assistance will encourage regional development programs. If assistance is for newly independent country, is it furnished through multi-lateral organizations or plans to the maximum extent appropriate?

No.

7. FAA Sec. 601(a); (and Sec. 201(f) for development loans). Information and conclusions whether project will encourage efforts of the country to: (a) increase the flow of international trade; (b) foster private initiative and competition; (c) encourage development and use of cooperatives, credit unions, and savings and loan associations; (d) discourage monopolistic practices; (e) improve technical efficiency of industry, agriculture and commerce; and (f) strengthen free labor unions.

N/A

8. FAA Sec. 601(b). Information and conclusion on how project will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise).

N/A

9. FAA Sec. 612(b); Sec. 636(b). Describe steps taken to assure that, to the maximum extent possible, the country is contributing local currencies to meet the cost of contractual and other services, and foreign currencies owned by the U.S. are utilized to meet the cost of contractual and other services.

GOI will gradually assume ongoing local costs obligations

10. FAA Sec. 612(d). Does the U.S. own excess foreign currency and, if so, what arrangements have been made for its release?

No.

B. FUNDING CRITERIA FOR PROJECT

1. Development Assistance Project Criteria

a. FAA Sec. 102(c); Sec. 111; Sec. 281g. Extent to which activity will (a) effectively involve the poor in development, by extending access to economy at local level, increasing labor-intensive production, spreading investment out from cities to small towns and rural areas; and (b) help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward better life, and otherwise encourage democratic private and local governmental institutions?

N/A

b. FAA Sec. 103, 103A, 104, 105, 106, 107. Is assistance being made available: [include only applicable paragraph -- e.g., a, b, etc. -- which corresponds to source of funds used. If more than one fund source is used for project, include relevant paragraph for each fund source.]

(1) [103] for agriculture, rural development or nutrition; if so, extent to which activity is specifically designed to increase productivity and income of rural poor; [103] if for agricultural research, full account taken of needs of small farmers;

N/A

(2) [104] for population planning or health; if so, extent to which activity extends low-cost, integrated delivery systems to provide health and family planning services, especially to rural areas and poor;

Project will assist GOI in developing low-cost village family planning system, which is integrated with the GOI health delivery system.

(3) [105] for education, public administration, or human resources development; if so, extent to which activity strengthens nonformal education, makes formal education more relevant, especially for rural families and urban poor, or strengthens management capability of institutions enabling the poor to participate in development;

N/A

(4) [106] for technical assistance, energy, research, reconstruction, and selected development problems; if so, extent activity is:

N/A

(a) technical cooperation and development, especially with U.S. private and voluntary, or regional and international development organizations;

N/A

(b) to help alleviate energy problem;

N/A

(c) research into, and evaluation of, economic development processes and techniques;

N/A

(d) reconstruction after natural or manmade disaster;

N/A

(e) for special development problem, and to enable proper utilization of earlier U.S. infrastructure, etc., assistance;

N/A

(f) for programs of urban development, especially small labor-intensive enterprises, marketing systems, and financial or other institutions to help urban poor participate in economic and social development.

N/A

(5) [107] by grants for coordinated private effort to develop and disseminate intermediate technologies appropriate for developing countries.

N/A

FAA Sec. 110(a); Sec. 208(e). Is the recipient country willing to contribute its share to the project, and in what manner? Or will it provide assurances that it will provide at least 25% of the costs of the program, project, or activity with respect to which the assistance is to be furnished (or has the latter cost-sharing requirement been waived for a "relatively least-developed" country)?

GOI planned family planning budgets exceed 25% of the total inputs into this project. Assurances will be sought in annual agreements.

d. FAA Sec. 110(b). Will grant capital assistance be disbursed for project over more than 3 years? If so, has justification satisfactory to Congress been made, and efforts for other financing?

N/A

e. FAA Sec. 207; Sec. 113. Extent to which assistance reflects appropriate emphasis on: (1) encouraging development of democratic, economic, political, and social institutions; (2) self-help in meeting the country's food needs; (3) improving availability of trained worker-power in the country; (4) programs designed to meet the country's health needs; (5) other important areas of economic, political, and social development, including industry; free labor unions, cooperatives, and Voluntary Agencies; transportation and communication; planning and public administration; urban development; and modernization of existing laws; or (6) integrating women into the recipient country's national economy.

(1) This project eases population pressures by reducing fertility. (2) N/A (3) N/A (4) The program extends the outreach of the GOI health system. (5) The project brings health and family planning services to the rural poor. (6) Through planned family formation women have a greater opportunity to participate in the labor force.

f. FAA Sec. 281(i). Describe extent to which program recognizes the particular needs, desires, and capacities of the people of the country; utilizes the country's intellectual resources to encourage institutional development; and supports civic education and training in skills required for effective participation in governmental and political processes essential to self-government.

There is great interest in family planning in Indonesia. Currently 26% of the couples on Java and Bali are using contraception. The birth rate on Java and Bali has fallen 11%. The total fertility rate has fallen 15%.

g. FAA Sec. 201(b)(2)-(4) and -(8); Sec. 201(e); Sec. 211(a)(1)-(3) and -(8). Does the activity give reasonable promise of contributing to the development: of economic resources, or to the increase of productive capacities and self-sustaining economic growth; or of educational or other institutions directed toward social progress? Is it related to and consistent with other development activities, and will it contribute to realizable long-range objectives? And does project paper provide information and conclusion on an activity's economic and technical soundness?

Yes.

h. FAA Sec. 201(b)(6); Sec. 211(a)(5), (6). Information and conclusion on possible effects of the assistance on U.S. economy, with special reference to areas of substantial labor surplus, and extent to which U.S. commodities and assistance are furnished in a manner consistent with improving or safeguarding the U.S. balance-of-payments position.

Total project expenditures will be for U.S. produced oral contraceptives.

2. Development Assistance Project Criteria (Loans only)

a. FAA Sec. 201(b)(1). Information and conclusion on availability of financing from other free world sources, including private sources within U.S.

Other sources are not available

b. FAA Sec. 201(b)(2); 201(d). Information and conclusion on (1) capacity of the country to repay the loan, including reasonableness of repayment prospects, and (2) reasonableness and legality (under laws of country and U.S.) of lending and relending terms of the loan.

(1): Indonesia is current in its international obligations and attaches high priority to its population program
(2): Yes

c. FAA Sec. 201(e). If loan is not made pursuant to a multilateral plan, and the amount of the loan exceeds \$100,000, has country submitted to AID an application for such funds together with assurances to indicate that funds will be used in an economically and technically sound manner?

Yes

d. FAA Sec. 201(f). Does project paper describe how project will promote the country's economic development taking into account the country's human and material resources requirements and relationship between ultimate objectives of the project and overall economic development?

Yes

e. FAA Sec. 202(a). Total amount of money under loan which is going directly to private enterprise, is going to intermediate credit institutions or other borrowers for use by private enterprise, is being used to finance imports from private sources, or is otherwise being used to finance procurements from private sources?

All commodities under the loan will be procured for private sources.

f. FAA Sec. 620(d). If assistance is for any productive enterprise which will compete in the U.S. with U.S. enterprise, is there an agreement by the recipient country to prevent export to the U.S. of more than 20% of the enterprise's annual production during the life of the loan?

N/A

3. Project Criteria Solely for Security Supporting Assistance

FAA Sec. 531. How will this assistance support promote economic or political stability?

N/A

4. Additional Criteria for Alliance for Progress

[Note: Alliance for Progress projects should add the following two items to a project checklist.]

N/A

a. FAA Sec. 251(b)(1), -(8). Does assistance take into account principles of the Act of Bogota and the Charter of Punta del Este; and to what extent will the activity contribute to the economic and political integration of Latin America?

N/A

b. FAA Sec. 251(b)(9); 251(h). For loans, has there been taken into account the effort made by recipient nation to repatriate capital invested in other countries by their own citizens? Is loan consistent with the findings and recommendations of the Inter-American Committee for the Alliance for Progress (now "CEPCILS," or Permanent Executive Committee of the OAS) in its annual review of national development activities?

N/A

FERTILITY AND FAMILY PLANNING IN JAVA AND BALI, 1967-76

By

Jeanne Cairns Siquefield

and

Bambang Sungkono

There has been considerable interest in Indonesia concerning the impact that the National Family Planning Program has had on fertility in Java and Bali since its inception in 1970-71. To assess such impact the Central Bureau of Statistics in collaboration with the World Fertility conducted in 1976 a fertility/family planning survey covering Java and Bali. In this paper I will present some of the major findings from this survey, which will be forthcoming in a monograph. (See Siquefield and Sungkono, 1977, BPS).

A. Estimates of Fertility in Java and Bali

Estimates of fertility by province in Java and Bali in the late 1960's are now available from three sources: 1971 Census (Cho et. al, 1976, BPS), 1973 Fertility Mortality Survey (McDonald et.al, 1976) and 1976 Java Bali Fertility Survey (Siquefield and Sungkono, 1977). Their results are presented in Table 1 (Total Fertility Rates) and Table 2 (Crude Birth Rates). The Total Fertility Rate was estimated to be between 5.9-6.1 for West Java, 5.3 for Central Java, 4.4-4.6 for East Java, 5.8 for Bali, 4.4-4.6 for Yogyakarta, and 5.1-5.9 for Jakarta, with 5.2-5.3 for Java and Bali as a whole. The Crude Birth Rate, using the more reliable survey data, was estimated to be 38 in the late 1960's for Java and Bali, ranging from 43-44 in West Java followed by Jakarta 43, Bali 39, Central Java 36-37, East Java 33-35, and Yogyakarta 32.

The 1976 Java-Bali Fertility Survey provides the first reliable estimates of fertility for Java and Bali in the early 1970's (see Table 1 and 2). More recently available, but unpublished are the "own children" estimates of fertility based on the Part I of the 1976 Intercensal Census. Since both estimates were very compatible,

we will only discuss the former estimates. We estimate for 1972-3 a Total Fertility Rate of 5.0 for Java and Bali, with 5.8 for West Java, 5.0 for Central Java, 4.1 for Yogyakarta, 4.4 for East Java and 5.2 for Bali. The 1976 estimates were 4.5-4.6 for Java and Bali, with 5.3-5.5 for West Java, 4.4 for Central Java, 3.9-4.0 for East Java, and 3.8 for Bali. The Crude Birth Rate for Java and Bali in 1972-3 was estimated as 36, and as 34 in 1976.

Based on these results, we find that the Total Fertility Rate has declined by 15 percent from 1967-71 to 1976 (i.e. from 5.29-4.51), while the Crude Birth Rate has declined by 11 percent for the same period (i.e. from 38 to 34). This decline is due to both changes in marital fertility rates, and increasing age at first marriage. To analyze the impact of changes in marriage patterns and marital fertility on fertility, we generated estimates of TFR and CBR while holding constant and not holding constant marriage patterns. If only marital fertility had changed from 1967-71 to 1976, (no changes in the percent currently married by age) TFR would only have declined by 10 percent (i.e. from 5.29 to 4.75) instead of by 15 percent. The CBR would only have declined by 6 percent (i.e. from 38 to 36) instead of 11 percent. Thus changes in marital fertility account for 70 percent of the change in TFR's and 46 percent of the decline in CBR's. The young age structure of Indonesian's population causes marriage patterns to be a more important factor in affecting CBR's than TFR's.

The above results are encouraging since both marriage patterns and marital fertility is changing to reduce fertility in Java and Bali. This suggests that basic cultural and social adaptations to population pressures are occurring. However, the amount of fertility decline does vary dramatically by area with such declines being lowest in West Java followed by East Java, Central Java, Jakarta and Bali.

B. Estimates of Childhood Mortality and Children Surviving to Age 5 for Java and Bali.

Childhood mortality rates were still very high in Java and Bali in the late 1960's, with 21 percent of children dying before age 5. Combining mortality with fertility, we estimated that a woman was having 4.18 children surviving to age 5. Comparing across regions we found childhood mortality to be highest in West Java (24%) followed by Central Java and Yogyakarta (21%), Bali (20%), Jakarta (19%) and finally

East Java (18%). (See Table 3). Infant mortality rates were 144 per 1000 live births for Java and Bali, ranging from 161 in West Java to 119 in East Java.

Childhood mortality decreased by about 8 percent from 1965-69 to 1970-74. This was primarily due to large declines in Jakarta and Central Java (-21%). Only small declines occurred in East Java and Bali (-6%), and no change in West Java and Yogyakarta. Improvements in childhood mortality were found to be related to general improvement in public health facilities.

From the late 1960's to 1972-73 there was little change in average number of children surviving to age 5 (-2.9%), (i.e. from 4.18 to 4.06) in Java and Bali. Declines in fertility during this period were offset by declines in childhood mortality. From 1972-73 to 1976 changes in childhood mortality were more than compensated for by changes in fertility. Under such conditions, we would expect the growth rate in Java and Bali to have declined, if adult mortality remained constant. If the growth rate for the 1960's was 1.9 (BPS, 1977), a decrease in the number of children surviving to age 5 from 4.18 to 3.74 could have reduced the growth rate to 1.7.

C. Estimates of Use of Family Planning in Java and Bali.

In 1973 in Java and Bali, 12 percent of married women aged 15-44 had ever used family planning. 11 percent were currently using any method; 9 percent using modern methods (Pill, IUD, Condom, Spermicides); and 8 percent using modern methods obtained from the family planning program. Current use of all methods was highest in Bali (25%), followed by Jakarta (15%), East Java (15%), Yogyakarta (13%), Central Java (10%) and West Java (6%). (Table 4).

In 1976 in Java and Bali 39 percent of married women aged 15-44 had ever used family planning. 28 percent were currently using any method, 23 percent using modern methods, and 21 percent using modern methods obtained from the family planning program. Approximately 1 in 4 married women were trying to prevent pregnancy. Current use of modern methods was highest in Bali (38%), followed by East Java (29%), Central Java (26%), Jakarta and Yogyakarta (19%) and West Java (15%).

Current use of family planning, especially modern methods has dramatically increased from 1973 to 1976. The family planning program is currently (1976) supplying 75 percent of all methods used, and more importantly 90 percent of all modern methods used. (Table 4). Comparing estimates of family planning program users provided by survey and BKKBN (National Family Planning Program) figures, we can support the validity of the BKKBN service statistics.

D. Evaluating the Impact of the Family Planning Program on Fertility in Java and Bali.

Marital fertility declined in Java and Bali by 7 percent (using Coale's ^g measure) from 1967-71 to 1976, based on the 1976 Java Bali Fertility Survey. From 1973 to 1976, use of modern methods of family planning has more than doubled (i.e. from 9 to 23 percent of married women using). A pressing question for the Indonesian government is how much of this fertility decline can be attributed to the national family planning program. Unfortunately without control groups (to allow comparison of changes in fertility where there was no government program with places where there was) we cannot prove that changes in marital fertility were due to the program per se. What we can try and show is whether or not changes in marital fertility were related to changes in modern use of family planning. We can then separately argue (or discuss) what might have caused such changes in use. That is, is it feasible to argue that use changed because of the family planning program, or would it have changed without.

Our first question, is what relationship can we find between use of family planning and marital fertility in Java and Bali? We found that marital fertility declined most in Java and Jakarta who had very high levels of marital fertility in 1972-73 and moderate levels of use of family planning during the period 1973 to 1976. When marital fertility is high, improvements in use of family planning should have a greater impact than in areas where fertility is already being suppressed by traditional and modern methods of family planning.

Marital fertility declines were smaller in East and Central Java which had moderate levels of marital fertility in 1972-73 and moderate levels of use of family

planning during the period 1973 to 1976. This suggests that part of the increase in use of modern methods of family planning in these areas is merely substitution for traditional means of limiting fertility. However, increased use has had a moderate impact on fertility.

Marital fertility did not appreciably change in West Java, although use of modern methods did increase from 1973 to 1976. However, some reduction of marital fertility was noted for older women (over 30), while fertility for younger women increased. This may be reflecting more stable marriage patterns of younger women, and increased use of family planning by older women.

Increase in use of modern methods of family planning had a more important impact on reducing marital fertility in areas where fertility was high, yet did reduce, although substantially less, fertility in areas which already had lower fertility. These results suggest that proportionate increases in use of family planning in Java and Bali will have less total impact as fertility continues to decline. Such conditions will increase the absolute number of family planning acceptors needed to further reduce fertility.

If use of modern methods of family planning is having an important impact on fertility in Java and Bali, areas with high levels of use should have lower levels of marital fertility and vice versa. For 1976, we can compare levels of use of modern methods with levels of marital fertility (as measured by Coale's I_g Index). (See Figure 1) We find a strong negative relationship between use of modern methods by married women and marital fertility. This suggests a causal relationship between use of modern methods and lower marital fertility. The same relation also occurs when we compare use of modern program methods and marital fertility.

An inconstant relationship occurs when we compare use of all methods (i.e. including traditional methods) and marital fertility. This suggests that use of traditional methods (especially in Jakarta and Yogyakarta) is not substantially reducing marital fertility. Perhaps traditional users are older and/or subfecund women; or traditional methods because of their lower effectiveness do not provide much protection.

We found a strong negative relationship between use of modern methods and levels of marital fertility in 1976; and that increased use of modern methods had some impact on limiting marital fertility in Java and Bali from 1972-3 to 1976. The next step is to discuss "why" such levels of use of family planning increased from 1973 to 1976. There are two possible explanations. First, social and economic development generated a latent demand for family planning and lower fertility. This latent demand would have been filled with or without the government family planning program. Second, the national family planning program through its active program both generated demand for family planning while providing access to supplies which would not have been available on a mass basis without the program.

Most likely the truth falls somewhere in between the above arguments. The national family planning program had an important role in improving use of contraception, but their task was facilitated by improvements in basic social and economic conditions. Importantly, use of modern methods of family planning is limiting marital fertility in Java and Bali.

Table 1. Estimates of Total Fertility Rates for Java and Bali based on the 1973 Fertility Mortality Survey, 1971 Census and 1976 Java Bali Fertility Survey (SUPAS III).

Source and Year (s)	Total Fertility Rates						
	Region						
	West Java	Jakarta	Central Java	Yogya- karta	East Java	Bali	Total (Java-Bali)
1973 FM Survey ¹⁾							
1965-70	6.6	NA	5.3 ²⁾	NA	5.0	5.9	5.5
1965-70 (Revised)	6.1	NA	5.0 ²⁾	NA	4.4	5.8	5.1
1971 Census ³⁾							
1967-70	5.9	5.1	5.3	4.7	4.7	5.8	5.2
1976 JBF Survey ⁴⁾							
1967-71	6.0	5.9	5.3	4.4	4.6	5.8	5.3
1972-1973	5.8	5.4	5.0	4.1	4.4	5.2	5.0
1976 (Preg. Status) ⁵⁾	5.3	4.5	4.4	4.4	3.9	3.8	4.5
1976 (Linear) ⁶⁾	5.5	4.6	4.4	3.5	4.0	4.3	4.6

- 1). See McDonald, Yasin & Jones, Levels and Trends in Fertility and Childhood Mortality in Indonesia, 1976, pg. 49 and pg. 31. Revised estimate multiplies estimated age specific marital fertility rates (pg. 34) times proportion women currently married from 1971 Census.
- 2). FM Survey estimate for Central Java includes Yogyakarta.
- 3). See Central Bureau of Statistics, Estimates of Fertility and Mortality in Indonesia based on the 1971 Population Census, 1976, pg. 1-12.
- 4). 1967-71 estimates obtained by multiplying 1967-71 age specific marital fertility rates (Table 3) times proportion women currently married by age from 1971 Census. 1972-73 estimates obtained by multiplying 1972-73 ASMFR's times proportion currently married by age interpolated from 1971 Census and 1976 SUPAS I estimates.
- 5). For method see Squirefield, "Estimating Fertility from Data on Current Pregnancy Status on Women", April, 1977. 1976 estimate obtained by multiplying ASMFR's from 1976 times proportion currently married by age from 1976 intercensal Census (SUPAS I).
- 6). Projected linear decline based on estimates from JBF Survey for 1967-71 and 1972-73. The figure is a December 1976 estimate, to match the 1976 pregnancy status estimate.

Table 4. Estimates of Crude Birth Rates in Java and Bali, late 1960's through early's.

Source and Year (s)	Crude Birth Rate						Total (Java-Bali)
	Region						
	West Java	Jakar- ta	Central Java	Yogya- karta	East Java	Bali	
PM Survey							
1965-70	48	NA	38	NA	38	41	41
1965-70 (Revised)	44	NA	36	NA	33	39	38
1971 Census							
1967-71	44	43	38	32	36	42	39
1976 JBF Survey							
1967-71	43	45	37	29	35	39	38
1972-73	42	41	35	26	32	36	36
1976							
a). constant marital fertility changing marriage patterns	41	42	35	28-29	34	37-38	37
b). constant marriage patterns changing marital fertility	42	43	35	31	32	29	36
c). both change marriage patterns & marital fertility	39-40	32	30	30	28	34	

** Crude birth rates are calculated using appropriate ASFR's found in Table 2 and estimates of population by age and sex (Sinquefield and Yunus, 1976, Appendix A). Crude Birth Rates for the late 1960's use 1970 estimated population figures, CBR's for 1972-73 use 1973 population estimates, and CBR's for 1976 use 1976 population estimates.

For 1976 we provide three estimates of CBR's for 1976. The first estimate uses 1967-71 estimates of age specific marital fertility rates and 1976 Census estimates of proportion currently married to generate age specific fertility rates (constant fertility). The second estimate uses 1976 estimates of ASMFR's and 1971 Census estimates of proportion currently married to generate ASFR's. (Constant Marriage). The third estimate, uses 1976 estimates of ASMFR's and 1976 Census estimates of proportion currently married to generate ASFR's. (Changing marriage patterns and marital fertility).

Table 3. Estimates of Average Number of Children Surviving to Age 5 (T.F.R. * q_5) in Java and Bali, based on the 1976 Java Bali Fertility Survey.

Years	Average Number of Children Surviving to Age 5						
	West Java	Jakarta	Central Java	Yogyakarta	East Java	Bali	Total (Java-Bali)
1967-71							
T.F.R. ₁	6.01	5.89	5.34	4.39	4.58	5.83	5.29
$q(5)$	.242	.187	.209	.219	.176	.198	.206
T.F.R. * $q(5)$	4.56	4.79	4.22	3.43	3.77	4.66	4.18
1972-73							
T.F.R. ₂	5.83	5.40	4.97	4.06	4.36	5.23	4.51
$q(5)$	.243	.143	.165	.213	.168	.186	.189
T.F.R. * $q(5)$	4.41	4.60	4.15	3.20	3.63	4.26	4.06
1976							
T.F.R. ₃	5.34	4.54	4.41	4.44	3.92	3.84	4.51
$q(5)$	.219	.133	.149	.192	.151	.167	.170
T.F.R. * $q(5)$	4.17	3.94	3.75	3.59	3.33	3.20	3.74
% Change							
1967-71 to 1976	-8.6	-17.7	-11.1	+ 4.7	-11.7	-31.6	-10.5
1967-71 to 1972-73	-3.3	- 4.0	- 1.7	- 6.7	- 3.7	- 9.0	- 2.9
1972-73 to 1976	-5.4	-14.0	- 9.6	+12.2	- 8.3	-24.9	- 7.9

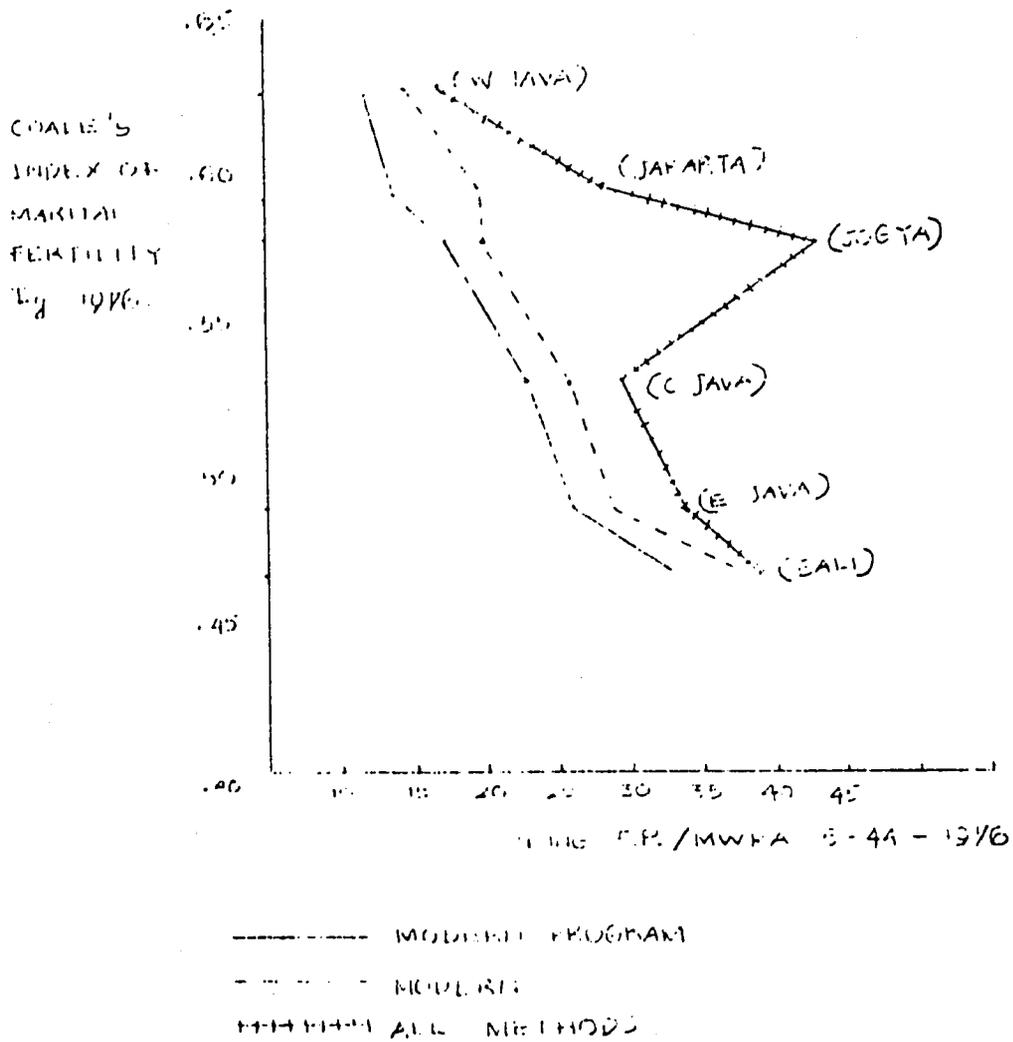
- 1). Uses adjusted estimates from 1965-69. See Table 5.
- 2). Uses adjusted estimates from 1970-74. See Table 5.
- 3). Uses adjusted estimates from 1970-74 minus 10%.

Table 4. Estimates of Use of Family Planning by Currently Married Women Aged 15-44 in Java and Bali By Regions Based on the 1973 FM Survey and the 1976 JBF Survey: 1) Percent Ever Use; 2) Percent Currently Using All Methods; 3) Percent Currently Using Modern Methods; 4) Percent Currently Using Modern Program Methods; 5) Percent Total User Who are Using Modern Methods; 6) Percent of Total Users who are Using Modern Program Methods; Percent of Modern Method Users who are Using Modern Program Methods.

Year	Region						
	Total	West Java	Jakarta	Central Java	Yogyakarta	East Java	Bali
% Ever Use Family Planning/MWRA							
1976	38.7	25.6	36.3	38.6	57.0	48.0	45.9
1973	12.4	7.9	NA	11.5	14.0	16.0	26.1
% Currently Using All Method of Family Planning/MWRA							
1976	28.0	17.4	29.1	29.8	43.1	33.8	39.1
1973	10.5	5.9	15.5 ³⁾	10.1	12.8	14.6	23.0
% Currently Using Modern Methods of Family Planning/MWRA							
1976	23.4	14.9	19.9 ³⁾	26.0	19.9	29.2	36.3
1973	9.4	5.5	10.6 ³⁾	9.5	11.1	13.6	21.0
% Currently Using Modern Methods From Program/MWRA							
1976 ⁵⁾	20.5	12.1	11.2 ³⁾	23.0	17.8 ⁴⁾	26.3	33.3
1973	8.5	4.2	7.1 ³⁾	8.1	8.3 ⁴⁾	11.5	19.4
Modern Methods / Total Methods							
1976	.84	.85	.68	.67	.35	.89	.98
1973	.90	.89	NA	.94	.87	.93	.90
Modern Methods From Program / Total Methods							
1976	.73	.63	.18	.68	.46	.69	.85
1973	.81	.68	NA	.80	NA	.79	.84
Modern Methods From Program / Modern Methods							
1976	.88	.81	.71	.89	.89	.90	.88
1973	.90	.76	NA	.85	NA	.85	.93

- 1). FM Survey estimates of Central Java include Yogyakarta.
 - 2). FM Survey estimates of Yogyakarta based on women aged 15-49.
 - 3). 1973 Jakarta estimates use BKKBN estimates of 7.4% program users in March 1973, and assume .7 of all modern users obtained method from program, and .684 of all method users are modern methods. (See Table II footnotes).
 - 4). Yogyakarta estimate assumes .75 of current modern users obtained method from program.
- For more details on how estimates were obtained see Table 9-11.

Figure 4. Comparison of Marital Fertility (I_g) and Proportion Married Women Using Planning: All methods, Modern Method, Modern Program Methods by Region 1976, based on 1976 JBF Survey.



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ANNEX D

Projected Program Impact 1977-1985

New Family Planning Acceptors

Although there is increased attention and priority by the BKKBN to tracking contraceptive users, i.e., the percent of married women of reproductive age (MWRA) using contraception, the BKKBN has not lost sight of the fact that users are largely a function of new acceptances. Table 1 presents new acceptor figures for 1974-1982. The BKKBN exceeded new acceptor targets in 1974 by 5%, in 1975 by 10% and in 1976 by 12%. In order to reach the level of use estimated by USAID, the BKKBN will have to exceed new acceptor targets by 17% in 1977 and by 35% in 1982.

USAID notes that the MWRA will be "turning over" during this period. New women will be entering the fertile age period, while older women will be departing. The age groups 15-49 will grow 2.3% a year from 1977-1982. Women who drop out for child-birth, then return are considered new acceptors by the BKKBN. These women could "turn over" 2-3 times during their reproductive life.

TABLE 1

Indonesia
New Family Planning Acceptors
1974-1982

Actual

<u>Year</u>	<u>BKKBN Target</u>	<u>Achieved</u>	<u>% Over</u>
1974	1,400,000	1,475,016	5
1975	1,796,000	1,966,585	10
1976	1,976,000	2,206,013	12

Planned

<u>Year</u>	<u>BKKBN Target 1/</u>	<u>Estimated 2/</u>	<u>% Over</u>
1977	1,976,000	2,350,000	17
1978	2,142,000	2,650,000	24
1979	2,618,000	3,300,000	26
1980	2,816,000	3,700,000	31
1981	3,000,000	4,000,000	33
1982 <u>3/</u>	3,189,000	4,300,000	35

1/ BKKBN new acceptor targets based on GOI inputs.

2/ USAID estimates of new acceptors based on additive USAID and IBRD project inputs.

3/ Acceptor targets beyond 1982 have not yet been formulated.

Oral Contraceptive Use

USAID estimates that the proportion of MWRA using contraception in Indonesia will increase from 18.4% in early 1977 to 55% in early 1983. This means an increase in usage of around 5% a year. Most of this increase will be in program contraceptive use. This will be achieved through increased acceptance and improved continuation rates. Since VFP has been initiated in East Java oral contraceptive first method 12 month continuation rates have increased from 59% to 63%, or by 7%. 1/ USAID expects this trend to continue as VFP is extended and improved.

Table 2 contains family planning program use estimates for March 1976-March 1985 for Java and Bali, the Outer Islands and all Indonesia. The data for 1976 and 1977 are actual use figures derived from the BKKBN data system. 2/ The figures for 1978-1985 are projected from prior year usage trends.

USAID estimates that family planning usage will increase from 19% in 1976 on Java and Bali to 60% by 1985. For the Outer Islands, the projection assumes that the BKKBN will be successful in stimulating family planning development. Family planning usage is estimated to increase from a current 6% in 1977 to 45% in 1985. USAID believes the estimate to be realistic, if the GOI follows through on its plan to increase Outer Islands program activity. USAID estimates country-wide use will be 55% by 1985.

1/ See "Contraceptive Use Effectiveness in Mojokerto Regency, East Java," Sullivan, Jr., et. al., National Family Planning Coordinating Board, Monograph No. 9, October 1974, Jakarta, Indonesia. And also: Preliminary Report on 2nd Quarter Java/Bali Acceptor Survey, unpublished BKKBN Report, May 1977, Jakarta, Indonesia.

2/ For a validation of BKKBN data system see: Sinquefield and Jones, "Evaluating the Validity of the Indonesian Family Planning Service Statistics" August 1976 (Memo).

For an excellent description of the system see: Haryono and Clinton, "Family Planning Service Statistics System: The Indonesian Experience," BKKBN Technical Report Series, 1976.

TABLE 2

Family Planning Use
March 1976 - March 1985
% MWRA Using Program Contraception

<u>Period</u>	<u>Java and Bali</u>	<u>Outer Islands</u>	<u>Indonesia</u>
3/76	19	3.4	14.1
3/77	25.6	6.4	18.4
3/78	30.0	10.0	22.9
3/79	35.0	14.0	26.7
3/80	40.0	19.0	32.6
3/81	44.0	24.0	37.3
3/82	48.0	29.4	41.4
3/83	52.0	35.0	47.6
3/84	56.0	40.0	51.3
3/85	60.0	45.0	55.0

Source: USAID projections based on BKKBN family planning data.

Estimated Fertility Decline

The crucial question remains: What will be the impact of the program on fertility? USAID has derived an equation from pilot vital registration data and family planning use estimates that relates fertility to contraceptive use. Using this equation and the projected contraceptive use rates, we attempt to estimate future fertility levels. These estimates must, of course, be viewed with tolerance.

The figures in Table 3 are mid-year crude birth rates and are derived from estimates of contraceptive use. USAID believes the 1977 mid-year CBR for Indonesia is 34. By mid-year 1985, USAID estimates the CBR of Java and Bali will be 18, 28 on the Outer Islands and 21 for all of Indonesia.

Death Rate

The death rate remains clouded. Evidence from the 1976 Intercensal Survey indicates the mortality is falling slowly. USAID has projected the death rate in Table 4. USAID assumes a decline in mortality from an estimated crude death rate of 21 in 1971 to 10 by 1985.

Impact on Population Growth

The implications of the above are dramatic. Put simply, the Indonesian population will be significantly smaller than otherwise thought. Table 5 reflects five population projections for the year 2000 with the population growth rate and the year the crude birth rate reaches 20 - approximately a two-child family.

According to USAID estimates, the CBR for Indonesia will reach 20 sometime between 1980-1990. This translates into an Indonesian population of between 180-200 million by the year 2000.

Recently the GOI published a study "Indonesia in the Year 2000" in which the population in the year 2000 is estimated at 254 million. This implies an average population growth rate of 2.6% a year (the current rate is 2.0%) and apparently ignores the family planning program effort and the signals that fertility is falling on Java and Bali.

Given continued political, social and budgetary support, no major upheavals, or behavioral turnarounds, USAID considers the 180-200 million figure to be more realistic.

TABLE 3

USAID Estimates
of Indonesian Fertility 1976 - 1982
(Mid-Year)

<u>Year</u>	<u>Java and Bali</u>	<u>Outer Islands</u>	<u>Indonesia</u>
1977	31	41	34
1978	30	40	33
1979	28	38	31
1980	25	36	27
1981	23	33	26
1982	21	31	24
1983	20	30	23
1984	19	29	22
1985	18	28	21

TABLE 4

Indonesia Vital Rates
1971 - 1982

Year	Crude Birth Rate 1/	Crude Death Rate 2/	Crude Rate of Increase 2/
1971	43	21	2.2
1972	42	20	2.2
1973	41	19	2.2
1974	40	19	2.1
1975	38	18	2.0
1976	36	17	1.9
1977	<u>34</u>	<u>16</u>	<u>1.8</u>
1978	<u>33</u>	<u>16</u>	<u>1.7</u>
1979	31	15	1.6
1980	27	13	1.4
1981	26	12	1.4
1982	24	11	1.3
1983	23	11	1.2
1984	22	10	1.2
1985	21	10	1.1

Source: USAID estimates from various sources

1/ Births and deaths per 1,000 population

2/ Percent increase of population

Table 5
 Indonesia Population Projections*
 Year 2000

Projection	Total Population	1975-2000 Rate of Growth	Year CBR =20
A	253,000,000	2.6%	2037
B	236,000,000	2.3%	2015
C	212,000,000	1.9%	2000
D	200,000,000	1.7%	1990
E	180,000,000	1.2%	1980

* Population projections from various sources. All assume continued gradual declines in mortality. See, for example, "Indonesia-Country Prospects," Population Council 1974.

USAID Population Program Activities FY 68-77
 (Thousand of US \$)

	<u>68-71</u>	<u>72</u>	<u>73</u>	<u>74</u>	<u>75</u>	<u>76+79</u>	<u>77</u>
<u>188.0</u>							
<u>Family Planning Services</u>							
USAID	3084.2	2098.1	4707.6	1493.6	950.6	436.4	1700.0
AID/W Commodities	--0--	--0--	1751.0	3500.0	3018.0	7549.0	2421.0
Sub-Total	3084.2	2098.1	6458.6	4993.6	3968.6	7985.4	4121.0
<u>188.1</u>							
Health Education Manpower Development	295.2	60.3	423.3	225.3	128.6	--0--	--0--
<u>188.2</u>							
<u>MCH/FP/POP/Manpower Development</u>	--0--	--0--	189.7	45.8	103.5	86.2	--0--
<u>188.3</u>							
<u>Population Research and Development</u>	--0--	--0--	--0--	--0--	432.4	427.4	1205.0
<u>188.4</u>							
World Education, Inc.	--0--	--0--	--0--	--0--	62.9	--0--	--0--
<u>045</u>							
Oral Contraceptive Loan	--0--	--0--	--0--	--0--	--0--	--0--	7300.0
TOTAL	3379.4	2158.4	7071.6	5264.7	4701.0	8499.0	12626.0
CUMULATIVE TOTALS	3379.4	5537.8	12609.4	17874.1	22575.1	31074.1	43700.1

ANNEX F

INDONESIA FAMILY PLANNING RESOURCES
1968 - 1977
(Millions)

SOURCE OF FUNDS	1968	1969	1970	1971	1972	1973	1974	1975	1976	1977	TOTALS
Government of Indonesia	.8	.3	1.3	2.3	5.1	5.9	7.7	13.3	15.9	20.7	73.3
USAID	.3	1.5	.7	1.3	2.2	7.1	5.3	4.7	8.5	10.2	41.8
World Bank - 1st Population Project	--	--	--	--	.2	1.5	6.0	6.0	6.0	6.0	25.7
Other Donors	<u>.3</u>	<u>1.4</u>	<u>2.9</u>	<u>1.6</u>	<u>2.2</u>	<u>1.7</u>	<u>2.0</u>	<u>2.0</u>	<u>2.1</u>	<u>1.5</u>	<u>17.7</u>
TOTAL	1.4	3.2	4.9	5.2	9.7	16.2	21.0	26.0	32.5	38.4	158.5

-82-

COST-EFFECTIVENESS
1968-1977
($\$$)

Cost-Per-Acceptor

\$14.28

Cost-per-couple-year-of-protection

\$12.00

Cost-per-birth-averted

\$48.00

ANNEX G

INDONESIA FAMILY PLANNING PROGRAM RESOURCES
1978-1982
(\$Millions)

<u>SOURCE OF FUNDS</u>	1978	1979	1980	1981	1982	<u>TOTAL</u>
Government of Indonesia	33.1	37.0	43.0	48.0	57.0	218.1
USAID						
Grant	4.1	5.2	6.5	4.5	4.9	25.2
Loan	7.0	7.0	9.0	9.0	8.0	40.0
World Bank - 2nd Population Project	3.4	5.1	5.0	6.0	5.0	24.5
Others	<u>2.5</u>	<u>2.5</u>	<u>2.5</u>	<u>1.5</u>	<u>1.0</u>	<u>10.0</u>
TOTAL	50.1	56.8	66.0	69.0	75.9	317.8

COST-EFFECTIVENESS

Cost-per-acceptor

\$± 15.23

Cost-per-couple-year-of-protection

\$± 9.19

Cost-per-birth-averted

\$± 36.75

Project Title & Number: Oral Contraceptive (OC) Loan 497-0271

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATOR																																								
<p>Program or Sector Goal: The broader objective to which this project contributes:</p> <p>To decrease the natural rate of increase of population by a 50% reduction in the crude birth rate (CBR) currently estimated at 36 per 1,000 population, by the year 2000. A corresponding decrease in the death rate over this period would yield a population growth rate of around 1.1% a year.</p>	<p>Measures of Goal Achievement: K.A.P. data indicating a desire by the majority of eligible couples to have small families and control fertility through the use of family planning.</p> <p>A declining country-wide birth rate as follows:</p> <table border="1" data-bbox="832 658 1332 777"> <thead> <tr> <th></th> <th>1970</th> <th>1975</th> <th>1980</th> <th>1985</th> </tr> </thead> <tbody> <tr> <td>CBR</td> <td>4.3</td> <td>3.8</td> <td>2.7</td> <td>2.1</td> </tr> <tr> <td>CDR</td> <td>2.1</td> <td>1.8</td> <td>1.3</td> <td>1.0</td> </tr> <tr> <td>CRNI</td> <td>2.2</td> <td>2.0</td> <td>1.4</td> <td>1.1</td> </tr> </tbody> </table>		1970	1975	1980	1985	CBR	4.3	3.8	2.7	2.1	CDR	2.1	1.8	1.3	1.0	CRNI	2.2	2.0	1.4	1.1																				
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<p>Project Purpose:</p> <p>To approximately double prevalence of use of oral contraceptives throughout Indonesia and begin transition from U.S.G. to GOI funding of OC requirements of the national family planning program.</p>	<p>Conditions that will indicate purpose has been achieved: End of project status. The following percentages of married women of reproductive age 15-44 (MWRA) using oral contraceptives:</p> <table border="1" data-bbox="832 942 1387 1191"> <thead> <tr> <th>CY</th> <th>OC Users (Millions)</th> <th>MWRA (Millions)</th> <th>OC Users as % MWRA</th> </tr> </thead> <tbody> <tr><td>1977</td><td>2.369</td><td>21.3</td><td>11.1%</td></tr> <tr><td>1978</td><td>2.785</td><td>21.8</td><td>12.8%</td></tr> <tr><td>1979</td><td>3.146</td><td>22.4</td><td>14.0%</td></tr> <tr><td>1980</td><td>3.500</td><td>22.9</td><td>15.3%</td></tr> <tr><td>1981</td><td>3.854</td><td>23.5</td><td>16.4%</td></tr> <tr><td>1982</td><td>4.215</td><td>24.1</td><td>17.5%</td></tr> <tr><td>1983</td><td>4.562</td><td>24.6</td><td>18.5%</td></tr> <tr><td>1984</td><td>4.923</td><td>25.2</td><td>19.5%</td></tr> <tr><td>1985</td><td>5.231</td><td>25.8</td><td>20.3%</td></tr> </tbody> </table> <p>In GOI FY 83/84, US FY 84 Indonesia funds at least 40% of its OC delivery requirement for CY 85.</p>	CY	OC Users (Millions)	MWRA (Millions)	OC Users as % MWRA	1977	2.369	21.3	11.1%	1978	2.785	21.8	12.8%	1979	3.146	22.4	14.0%	1980	3.500	22.9	15.3%	1981	3.854	23.5	16.4%	1982	4.215	24.1	17.5%	1983	4.562	24.6	18.5%	1984	4.923	25.2	19.5%	1985	5.231	25.8	20.3%
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<p>Outputs:</p> <p>Availability at all contraceptive service outlets of sufficient numbers of cycles of OCs.</p>	<p>Magnitude of Output: OC availability at the following numbers of OC service centers at the levels specified by end of Project:</p> <table border="1" data-bbox="832 1336 1434 1481"> <thead> <tr> <th>OC Supply</th> <th>(3 months) Sub-Regency</th> <th>(1 month) Village</th> <th>(1 month) Sub-Village</th> </tr> </thead> <tbody> <tr> <td>Java/Bali</td> <td>2,750</td> <td>30,000</td> <td>50,000</td> </tr> <tr> <td>Outer Islands</td> <td>1,560</td> <td>25,000</td> <td>23,500</td> </tr> <tr> <td>Total</td> <td>4,310</td> <td>55,000</td> <td>73,500</td> </tr> </tbody> </table> <p>Continued availability of at least a projected one year's supply of OCs in Indonesia at all times.</p>	OC Supply	(3 months) Sub-Regency	(1 month) Village	(1 month) Sub-Village	Java/Bali	2,750	30,000	50,000	Outer Islands	1,560	25,000	23,500	Total	4,310	55,000	73,500																								
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<p>Inputs:</p> <p>Finished cycles of OCs.</p>	<p>Implementation Target (Type and Quantity) To insure annual delivery of the following range of cycles of finished OCs:</p> <table border="1" data-bbox="832 1709 1293 1916"> <thead> <tr> <th>CY</th> <th>Millions Cycles</th> </tr> </thead> <tbody> <tr><td>1979</td><td>3.9 - 14.9</td></tr> <tr><td>1980</td><td>25.1 - 42.1</td></tr> <tr><td>1981</td><td>29.8 - 42.8</td></tr> <tr><td>1982</td><td>29.3 - 43.3</td></tr> <tr><td>1983</td><td>34.0 - 44.0</td></tr> <tr><td>1984</td><td>18.0 - 43.0</td></tr> <tr><td>1985</td><td>0.0 - 42.0</td></tr> <tr><td>Total</td><td>140.0 272.1</td></tr> </tbody> </table>	CY	Millions Cycles	1979	3.9 - 14.9	1980	25.1 - 42.1	1981	29.8 - 42.8	1982	29.3 - 43.3	1983	34.0 - 44.0	1984	18.0 - 43.0	1985	0.0 - 42.0	Total	140.0 272.1																						
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**SUMMARY
FRAMEWORK**

Life of Project:
From FY 1978 to FY 1984
Total US Funding \$61,385,000
Date Prepared: December 1977

MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p>Surveys, mini-censuses, extensive analyses of existing data, review of research projects coordinated by BKKBN and conducted by units such as Demographic Institute, Faculty of Public Health, Department of Health and others.</p> <ul style="list-style-type: none"> - 1976 Intercensal Population Survey - 1981 Census of Population. 	<p>Assumptions for achieving goal targets:</p> <ul style="list-style-type: none"> - Continued high GOI commitment to rapid fertility reduction as evidenced by population policy and budgetary support to fertility reduction efforts. - General health/welfare of poor majority improves allowing some reduction in childhood mortality which is believed essential for continued reductions in fertility.
<ul style="list-style-type: none"> - BKKBN estimates of current users - Analyses of new acceptor, clinic revisit and contraceptive use data derived from the BKKBN service statistics system. - Surveys of contraceptive prevalence and continuation rates. - 1976 Intercensal Population Survey - 1981 Census of Population 	<p>Assumptions for achieving purpose:</p> <ul style="list-style-type: none"> - Sufficient demand for OCs exists or will be created. - Continued assistance of GOI, UNFPA, USAID, UNFPA and other donors. - GOI cooperation in achieving a phased, orderly transition from USG to GOI funding of OCs. - Estimates of morbidity and mortality associated with OC use do not increase. - AID/W central OC procurement continues to provide an OC formulation acceptable to GOI and Indonesian women.
<ul style="list-style-type: none"> - Review of BKKBN service statistics and logistics data. - Official quarterly and annual reports of BKKBN - Field inspections - Project progress reports - Audits 	<p>Assumptions for achieving outputs:</p> <ul style="list-style-type: none"> - Continued GOI willingness to experiment with OC delivery innovations. - Continued cooperation of provincial, regency, district and village officials in promoting village family planning. - Successful implementation of Family Planning Development and Services Project 497-0270.

- Review of annual loan authorizations, agreements, PIO/Cs, PESs
- Shipping reports and documents
- Arrival and receiving reports
- Logistics reports

Assumptions for providing inputs:

- The number of OC users will continue to grow so that the following numbers of total OCs will be needed.
- GOI provides the following range of inputs via either importation of raw materials for local production and packaging or importation of finished OCs.

CY	Range	
	Estimated OC Requirement (000s)	Delivery of GOI OC Inputs in 000s cycles
1979	18,867	4,000 - 15,000
1980	50,000	8,000 - 25,000
1981	54,800	12,000 - 25,000
1982	59,300	16,000 - 30,000
1983	64,000	20,000 - 30,000
1984	68,000	25,000 - 30,000
1985	72,000	30,000 - 72,000
Total	387,067	115,000 - 247,000

Oral Contraceptive (OC) Forecasting
Methods Used for Maximum Forecast

A. Java/Bali

Linear regression of OC usage (Y) on ordinal months (X) for January 1973 through July 1977 yields:

$$\begin{aligned} r &= .97,942 \\ b &= 38,289 \\ a &= 354,909 \end{aligned}$$

B. Outer Islands - I

Linear regression of OC usage (Y) on ordinal months (X) for January 1975 through July 1977 yields:

$$\begin{aligned} r &= .97,462 \\ b &= 5,969 \\ a &= 47,863 \end{aligned}$$

C. Outer Islands - II

9/25 or 36% of historical OC usage by ordinal month in Outer Island I programbased on relationship in population size between Outer Island II and Outer Island I areas.

D. Data Base and Results

The data base for the above forecasts is given in Table 1. The detailed results of the above forecasts are presented in Table 2 and can be summarized as follows:

CY	OC Usage (millions of cycles)
1977	31.0
1978	38.4
1979	45.1
1980	51.8
1981	58.5
1982	65.2
1983	71.8
1984	78.5

Table 1
Indonesia
Oral Contraceptive Usage
January 1973 to July 1977

<u>Month/Year</u>	<u>Java/Bali</u>	<u>Outer Islands I</u>	<u>Total</u>
1/73	368,836	-	368,836
2/73	409,980	-	409,980
3/73	494,142	-	494,142
4/73	499,830	-	499,830
5/73	536,463	-	536,463
6/73	546,463	-	546,463
7/73	563,595	-	563,595
8/73	598,989	-	598,989
9/73	593,255	-	593,255
10/73	609,928	-	609,928
11/73	662,063	-	662,063
12/73	718,719	-	718,719
1/74	787,608	-	787,608
2/74	851,514	-	851,514
3/74	954,396	-	954,396
4/74	956,362	-	956,362
5/74	1,024,030	N/A	956,362
6/74	1,009,261	N/A	1,024,030
7/74	1,111,304	N/A	1,009,261
8/74	1,075,800	N/A	1,111,304
9/74	1,111,647	N/A	1,075,800
10/74	1,086,077	N/A	1,111,647
11/74	1,247,331	N/A	1,086,077
12/74	1,237,911	N/A	1,247,331
1/75	1,558,848	67,517	1,237,911
2/75	1,449,303	64,327	1,626,365
3/75	1,568,093	74,257	1,513,630
4/75	1,502,234	67,899	1,642,350
5/75	1,560,933	83,429	1,570,133
6/75	1,497,278	79,236	1,644,362
7/75	1,711,461	90,831	1,576,514
8/75	1,646,002	85,601	1,802,292
9/75	1,373,547	84,178	1,731,603
10/75	1,937,398	113,707	1,457,725
11/75	1,818,740	97,336	2,051,105
12/75	1,851,110	119,744	1,916,076
			1,970,854

<u>Month/Year</u>	<u>Java/Bali</u>	<u>Outer Islands I</u>	<u>Total</u>
1/76	1,972,823	134,120	2,106,943
2/76	1,852,079	125,821	1,977,900
3/76	2,084,043	144,565	2,228,608
4/76	1,908,139	123,641	2,031,780
5/76	2,028,877	145,666	2,174,543
6/76	2,031,502	154,350	2,185,852
7/76	2,145,548	134,533	2,280,081
8/76	2,043,009	194,422	2,237,431
9/76	1,953,091	172,088	2,125,179
10/76	2,176,891	199,372	2,376,263
11/76	2,114,911	177,220	2,292,131
12/76	2,259,254	195,435	2,454,689
1/77	2,238,622	203,176	2,441,798
2/77	2,112,754	212,953	2,325,707
3/77	2,395,478	231,670	2,627,148
4/77	2,024,637	198,550	2,223,187
5/77	2,214,229	221,040	2,435,269
6/77	2,120,427	228,242	2,348,669
7/77	2,278,338	219,313	2,497,651

Table 2
Indonesia
Forecast of Oral Contraceptive Usage
August 1977 through December 1984 by Area

Month/Year	Java/Bali	Outer Islands I	Outer Islands II Program Begins April 1979	Total
8/77	2,499,093	238,871	-	2,737,964
9/77	2,537,382	244,840	-	2,782,222
10/77	2,575,671	250,809	-	2,826,480
11/77	2,613,960	256,778	-	2,870,738
12/77	2,652,249	262,747	-	2,914,996
CY Total	<u>28,262,840</u>	<u>2,768,989</u>	-	<u>31,031,829</u>
1/78	2,690,538	268,716	-	2,959,254
2/78	2,728,827	274,685	-	3,003,512
3/78	2,767,116	280,654	-	3,047,770
4/78	2,805,405	286,623	-	3,092,028
5/78	2,843,694	292,592	-	3,136,286
6/78	2,881,983	298,561	-	3,180,544
7/78	2,920,272	304,530	-	3,224,802
8/78	2,958,561	310,499	-	3,269,060
9/78	2,996,850	316,468	-	3,313,318
10/78	3,035,139	322,437	-	3,357,576
11/78	3,073,428	328,406	-	3,401,834
12/78	3,111,717	334,375	-	3,446,092
CY Total	<u>34,813,530</u>	<u>3,618,546</u>	-	<u>38,432,076</u>
1/79	3,150,006	340,344	-	3,490,350
2/79	3,188,295	346,313	-	3,534,608
3/79	3,226,584	352,282	-	3,578,866
4/79	3,264,873	358,251	-	3,647,430
5/79	3,303,162	364,220	24,306	3,690,540
6/79	3,341,451	370,189	23,158	3,738,373
7/79	3,379,740	376,158	26,733	3,780,342
8/79	3,418,029	382,127	24,444	3,830,190
9/79	3,456,318	388,096	30,034	3,872,939
10/79	3,494,607	394,065	28,525	3,921,371
11/79	3,532,896	400,034	32,699	3,963,746
12/79	3,571,185	406,003	30,816	4,007,492
CY Total	<u>40,327,146</u>	<u>4,478,082</u>	<u>251,019</u>	<u>45,056,247</u>

<u>Month/Year</u>	<u>Java/Bali</u>	<u>Outer Islands I</u>	<u>Outer Islands II</u>	<u>Total</u>
1/80	3,609,474	411,972	40,935	4,062,381
2/80	3,647,763	417,941	35,041	4,100,745
3/80	3,686,052	423,910	43,108	4,153,070
4/80	3,724,341	429,879	48,283	4,202,503
5/80	3,762,630	435,848	45,296	4,243,774
6/80	3,800,919	441,817	52,043	4,294,779
7/80	3,839,208	447,786	44,511	4,331,505
8/80	3,877,497	453,755	52,440	4,383,692
9/80	3,915,786	459,724	55,566	4,431,076
10/80	3,954,075	465,693	48,431	4,468,199
11/80	3,992,364	471,662	69,992	4,534,018
12/80	<u>4,030,653</u>	<u>477,631</u>	<u>61,952</u>	<u>4,570,236</u>
CY Total	45,840,762	5,337,618	597,598	51,775,978
1/81	4,068,942	483,600	71,774	4,624,316
2/81	4,107,231	489,569	63,799	4,660,599
3/81	4,145,520	495,538	70,357	4,711,415
4/81	4,183,809	501,507	73,143	4,758,459
5/81	4,222,098	507,476	76,663	4,806,237
6/81	4,260,387	513,445	83,401	4,857,233
7/81	4,298,676	519,414	71,478	4,889,568
8/81	4,336,965	525,383	79,574	4,941,922
9/81	4,375,254	531,352	82,167	4,988,773
10/81	4,413,543	537,321	78,953	5,029,817
11/81	4,451,832	543,290	85,994	5,081,116
12/81	<u>4,490,121</u>	<u>549,259</u>	<u>88,142</u>	<u>5,127,522</u>
CY Total	51,354,378	6,197,154	925,445	58,476,977
1/82	4,528,410	555,228	90,291	5,173,929
2/82	4,566,699	561,197	92,440	5,220,336
3/82	4,604,988	567,166	94,589	5,266,743
4/82	4,643,277	573,135	96,738	5,313,150
5/82	4,681,566	579,104	98,887	5,359,557
6/82	4,719,855	585,073	101,035	5,405,963
7/82	4,758,144	591,042	103,184	5,452,370
8/82	4,796,433	597,011	105,333	5,498,777
9/82	4,834,722	602,980	107,482	5,545,184
10/82	4,873,011	608,949	109,631	5,591,591
11/82	4,911,300	614,918	111,779	5,637,997
12/82	<u>4,949,589</u>	<u>620,887</u>	<u>113,928</u>	<u>5,684,404</u>
CY Total	56,367,994	7,056,690	1,225,317	65,150,001

<u>Month/Year</u>	<u>Java/Bali</u>	<u>Outer Islands I</u>	<u>Outer Islands II</u>	<u>Total</u>
1/83	4,987,878	626,856	116,077	5,730,811
2/83	5,026,167	632,825	118,226	5,777,218
3/83	5,064,456	638,794	120,375	5,823,625
4/83	5,102,745	644,763	122,524	5,870,032
5/83	5,141,034	650,732	124,673	5,916,439
6/83	5,179,323	656,701	126,822	5,962,846
7/83	5,217,612	662,670	128,970	6,009,252
8/83	5,255,901	668,639	131,119	6,055,659
9/83	5,294,190	674,608	133,268	6,102,066
10/83	5,332,479	680,577	135,417	6,148,473
11/83	5,370,768	686,546	137,566	6,194,880
12/83	5,409,057	692,515	139,715	6,241,287
CY Total	<u>62,381,610</u>	<u>7,916,226</u>	<u>1,534,752</u>	<u>71,832,588</u>
1/84	5,447,346	698,484	141,863	6,287,693
2/84	5,485,635	704,453	144,012	6,334,100
3/84	5,523,924	710,422	146,161	6,380,507
4/84	5,562,213	716,391	148,310	6,426,914
5/84	5,600,502	722,360	150,459	6,473,321
6/84	5,638,791	728,329	152,608	6,519,728
7/84	5,667,080	734,298	154,756	6,566,134
8/84	5,715,369	740,267	156,905	6,612,541
9/84	5,753,658	746,236	159,054	6,658,948
10/84	5,791,947	752,205	161,203	6,705,355
11/84	5,830,236	758,174	163,352	6,751,762
12/84	5,868,525	764,143	165,501	6,798,169
CY Total	<u>67,895,226</u>	<u>8,775,762</u>	<u>1,844,184</u>	<u>78,515,172</u>

ANNEX J

Oral Contraceptive (OC) Forecasting
Method Used for Minimum Forecast

The numbers of pill acceptors to be recruited annually per BKKBN targets are presented in Table 1. Using the estimated number of current-users of oral pills at the beginning of 1976-77 and an annual continuation rate of 62%, the current users during each financial year was worked out. The formula used can be stated as follows. If a is the number of current users at the beginning of a financial year and b is the number recruited during the year, the current users during the year is given by the formula:

$$\text{Current users during the year} = \frac{1}{2} \left(a + (.62 + b\sqrt{.62}) \right)$$

The estimated numbers of current-users are given in Table 2. The forecasted usage of oral contraceptives as given in Table 3 is derived from Table 2, assuming that each current-user will require 13 cycles of pills during the year.

Assuming comparability between calendar years and GOI fiscal years (April 1 to March 31), the summary minimum forecast of OC usage may be presented as follows:

CY	OC Usage (millions of cycles)
1977	30.6
1978	34.0
1979	36.6
1980	39.1
1981	41.7
1982	44.4
1983	46.7

Source: IBRD

Table 1

BKKBN
 Oral Contraceptive Acceptor Targets
 (In 000s)

<u>Year</u>	<u>Java/Bali</u>	<u>Outer Islands I</u>	<u>Outer Islands II</u>
1976-77	1134	139	-
1977-78	1200	145	-
1978-79	1218	244	-
1979-80	1232	290	44
1980-81	1242	346	48
1981-82	1296	405	72
1982-83	1300	454	90
1983-84	1300	502	108

Source: IBRD

Table 2

Estimated Current-Users of Oral Contraceptives
from the Indonesian National Family Program
(000s)

Year	Java/Bali	10 Outer Islands included in the program	10 Outer Islands to be included in the program	Indonesia
1976-77	1887	165	..	2052
1977-78	2089	265	-	2354
1978-79	2247	368	-	2615
1979-80	2358	438	18	2814
1980-81	2436	522	48	3006
1981-82	2509	620	77	3206
1982-83	2578	723	112	3413
1983-84	2622	825	147	3594

Source: IBRD

Table 3

Forecast of Oral Contraceptive Usage for the Indonesian National Family Planning Program

<u>GOI *</u> <u>Fiscal Year</u>	<u>Usage of Oral Contraceptives</u> <u>in 000s Cycles</u>
1976-77	26,676
1977-78	30,602
1978-79	33,995
1979-80	36,582
1980-81	39,078
1981-82	41,678
1982-83	44,369
1983-84	46,722

*GOI FY is April 1 through March 31

Source:IBRD

ANNEX K

Most Likely Oral Contraceptive (OC) Forecast

Rationale

During seven years experience in estimating BKKBN's OC usage requirements, USAID has forecast on the basis of BKKBN OC acceptor targets and on the basis of historical OC usage. To date we have found the latter forecasting method to be more reliable. This is because IUD acceptor targets have rarely been achieved and OC acceptor targets have often exceeded in order to meet targets for total acceptors. In addition, targets have occasionally been revised upward. Thus forecasting on the basis of linear regression of consumption (i.e., usage) on ordinal months has proven to be reliable.

However, especially on Java and Bali, it is unlikely that the program can continue to achieve linear growth in OC usage. Eventually the linear pattern must plateau into curvilinear growth. There is some evidence that this process has begun on Java and Bali. This evidence would tend to support using the minimum forecast. However, other factors support use of the maximum forecast: (1) Since forecasts can be self-fulfilling in many situations, we see no advantage in planning for anything less than successful growth of OC usage; (2) USAID and other donor inputs should allow BKKBN to exceed its OC acceptor targets; (3) The cost of error of a low forecast is greater than the cost of error of a high forecast. Given the above, the most acceptable forecast seems to be an average between the minimum and maximum values. Thus the following most likely OC usage values are presented with the caveat that the confidence interval attached to the annual values drops considerably and continually as the years advance. Estimating OC consumption seven years in the future is largely guesswork because of the externalities involved. For this reason, actual OC usage experience must be traced with care during the project and the following data should be updated annually or as necessitated by experience at variance from plan:

OC Usage Forecast (Millions Cycles)

<u>CY</u>	<u>Minimum</u>	<u>Most Likely</u>	<u>Maximum</u>
1977	30.6	30.8	31.0
1978	34.0	36.2	38.4
1979	36.6	40.9	45.1
1980	39.1	45.5	51.8
1981	41.7	50.1	58.5
1982	44.4	54.8	65.2
1983	46.7	59.3	71.8
1984	N/A	64.0	78.5

ANNEX L

Indonesia Oral Contraceptive Requirements
(000s cycles)

	CY	1977	1978	1979	1980	1981	1982	1983	1984
1. Beginning Inventory		30,053	46,733	67,533	45,500	50,100	54,300	59,300	64,000
2. Arrivals		47,480	15,000 (G-F) *	18,867	50,100	54,800	59,300	64,000	69,000
		(G-F) *	24,000 (L-F) **						
			18,000 (L-?) ***						
3. Usage		30,800	36,200	40,900	45,500	50,100	54,800	59,300	64,000
4. Ending Inventory		46,733	67,533	45,500	50,100	54,800	59,300	64,000	69,000

* Grant-Finished OCs

** Loan-Finished OCs

*** Loan-Finished OCs or Raw Materials

ANNEX M

SI. Initial Environmental Examination (IIE)

Project Location : Indonesia

Project Title : Oral Contraceptive Loan

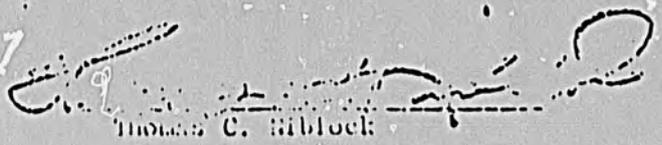
Funding : FY 1977 - \$10.0 million

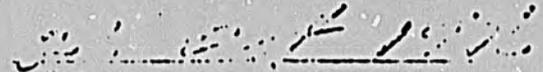
Life of Project : FY 1978-82 - \$56.0 million

IIE Prepared by : William B. Johnson
September 27, 1976

Environmental Action Recommended : Regretive Determination

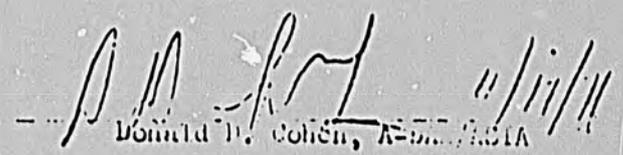
Mission Director's Concurrence :


Thomas C. Hiblock


Date

Assistant Administrator's Decision :

Approved


Donald D. Cohen, R-011, ASIA

Not Approved

Date

1. Examination of Nature, Scope, and Magnitude of Environmental Impacts

A. Description of Project

The proposed project will assist the GOJ to maintain population program momentum by insuring an adequate supply of oral contraceptives.

1. Inputs -- Finished cycles of oral contraceptives (OC's) and/or raw materials for local OC manufacture.

2. Outputs -- Increasing numbers of oral contraceptive service centers with sufficient numbers of cycles of OC's available.

3. Purpose -- Increase the prevalence of use of OC's while beginning transition to local financing of OC's.

4. Goal -- To assist the GOJ in its efforts to decrease the natural rate of increase of population by reducing fertility (i.e. 50% reduction of the CBR currently estimated at 53-60/1000 by year 2000).

B. Identification and Evaluation of Environmental Impacts

Although the mere provision of finished cycles of OC's or OC raw materials will have no environmental impact, proper delivery and use of these commodities to achieve the purpose and goal of this project will have an indirect positive effect in moderating environmental problems. Population growth is the greatest environmental threat in Indonesia. Excessive population growth is compromising the quality of human life by restraining socio-economic development and hampering progress in the areas of employment, education, housing, food and health. In addition, rapid population growth is a substantial factor in the following environmental problems: water pollution derived primarily from human waste; air pollution from refuse burning and vehicle exhaust emissions; soil depletion and erosion; noise pollution; depletion of forest reserves; and endangered wildlife. By providing oral contraceptives that can be used to manage human reproduction and thereby control population growth, this project will hopefully slow the growth in numbers of individuals and theoretically moderate the excessive demands made on finite resources.

As stated in Agency Regulation 16, actions which will have a significant effect on the human environment will require an Environmental Assessment or an Environmental Impact Statement. In making this "Threshold Decision", as explained in Section 216.1 under C, 3: "Actions that should be considered in determining 'significant effects' include those which adversely affect such aspects of the human environment such as air, water, land, flora and fauna and socio-economic conditions".

Because this project will have no adverse environmental impact it will not have a "significant effect" as defined above and therefore warrants a "Negative Determination".

DOCUMENTATION PROCESS FOR RECEIPT AND
DISTRIBUTION OF LOAN FINANCED USAID OC INPUTS

<u>USAID ACTION</u>	<u>BKKBN ACTION</u>
<p>1. <u>Export Shipping Report</u></p> <ul style="list-style-type: none">- sent by Forwarding Agent to USAID/MGT- USAID/MGT sends two copies to USAID/PH- USAID/PH sends one copy to BKKBN	
<p>2. <u>Procurement Status Report</u></p> <ul style="list-style-type: none">- sent by GSA to USAID/MGT- USAID/MGT sends two copies to USAID/PH- USAID/PH sends one copy to BKKBN	
<p>3. <u>Shipping Documents</u></p> <ul style="list-style-type: none">- consist of original and five copies of bill of lading, packing list and export invoice.- forwarding agent sends to USAID/PH- USAID/PH sends to BKKBN	

4. Duty Free Clearance

- BKKBN prepares a ProForma Letter of Credit signed by Ministry of Finance approving duty free entry.

- duty free permit and shipping documents are distributed as follows:

original - Customs
1 copy - Dept. Health
 Handling Unit
1 copy - Expeditor
1 copy - Central Warehouse
1 copy - BKKBN Files
1 copy - Claim preparation, if
 necessary

5. Arrival and Receiving Report (A&R)

- USAID/MGT prepares the A&R (original and 3 copies) and forwards it to USAID/PH prior to arrival of vessel.

- USAID/PH delivers A&R to BKKBN

6. Expeditor's Instructions

- BKKBN obtains from the Department of Health an Instruction Order (Surat Perintah Inklaring) for the Expeditor.

- BKKBN sends the Instruction Order to the Expeditor.

9. Filing A&R

- USAID/PH cosigns the A&R and sends two copies to USAID/MGT
- USAID/MGT files A&Rs by PIO/C to log receipts

7. Ship Arrives

- Expeditor clears the commodities from the port and delivers them to Central Warehouse.
- Central Warehouse prepares SBBM (Form letter evidencing receipt of incoming commodity) and sends it to BKKBN Logistics Division.
- BKKBN and warehouse staff inspect incoming commodities and prepare LPPB (commodity inspection report) and LPMB (Incoming Commodity Inventory Report)

8. Signing A&R

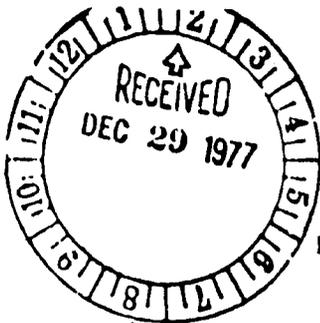
- BKKBN Logistics Chief signs the A&R evidencing receipt and evidencing claim action for shortage or damages.

10. Central Inventory

- Central Inventory records are independently maintained by BKKBN and Central Warehouse.

11. Distribution to Provinces

- BKKBN prepares an issue order (SPMB) and sends one copy to USAID/PH
- Central Warehouse prepares a letter of evidence of outgoing commodity (SBBK).
- Commodities are shipped by commercial transportation
- Provincial BKKBN certifies receipt by signing one copy of SBBK which is returned to BKKBN before payment is authorized.



ANNEX O

REPUBLIC OF INDONESIA
NATIONAL DEVELOPMENT PLANNING AGENCY
JAKARTA, INDONESIA

No. 2906/D.I/XII/1977.-

Jakarta, December 28, 1977.-

Mr. Thomas C. Niblock
Director,
US-Agency for International Development,
American Embassy,
Jakarta.-

Dear Mr. Niblock,

As you are well aware, since 1968 USAID has been the major donor of oral contraceptives (OCs) to the Indonesian National Family Planning Program. From U.S. FY 1968 through U.S. FY 1977 USAID OC assistance has totalled over 200 million cycles. We are currently working toward the goal of self-sufficiency of OC supplies in the next several years. It is hoped that self-sufficiency in OC supplies can be achieved by local production and packaging of OC raw materials at Kimia Farma. At the same time, with IBRD assistance we plan to explore the feasibility of eventual production of OC raw materials in Indonesia.

However, due to the high priority of our family planning program and the important role of the OC in that program, we must insure uninterrupted OC supply sufficient to meet requirements during the transition to self-sufficiency. Thus, we hereby formally request USAID assistance to insure continued availability of OCs to allow continued program expansion while achieving transition to OC self-sufficiency.

It is estimated that the total OC delivery requirement 1978 through 1985 is approximately 387,067,000 cycles. Through either local production or importation of OCs, the Indonesian Government plans to supply between 115 million cycles and 247 million cycles during this period. The exact amount supplied will, of course, be dependent upon progress with local production, the cost of raw materials and the availability of funds. Since the above Indonesian inputs represent 29.7% to 63.8% of total requirements, we will need additional inputs from other sources.

To fill the balance of our OC requirements, we would greatly appreciate USAID's help in planning for U.S. FY 1978 to U.S. FY 1984 assistance of from \$ 30,403,000 to \$ 60,642,000 to finance importation of from 140,067,000 to 272,067,000 million cycles of finished OCs.

Each year new forecasts of requirements will be made, and actual annual obligations will be adjusted accordingly and outlined in annual agreements.

I hope that USAID can favorably respond to this request.

Sincerely yours,



Arif
Arif Afiff
Deputy Chairman

DETERMINATION TO PROCEED WITH LOCAL PRODUCTION SHOULD IT HAVE A HIGHER COST-BENEFIT R

TIO. THIS ANALYSIS SHOULD NOT BE INCLUDED IN PP IF THAT WOULD AROUSE UNNECESSARY GOI SENSITIVITY TO LOAN PROPOSAL. WHAT WE NEED IS EVIDENCE THAT APPROPRIATE ECONOMIC ANALYSIS HAS BEEN CONDUCTED AND CONSIDERED BY GOI IN MAKING DECISION TO ESTABLISH LOCAL OC PRODUCTION.

4. ROLE OF PRIVATE SECTOR: EFFECTIVE USE OF PRIVATE SECTOR (BOTH FOREIGN AND INDONESIAN) WAS ALSO CONCERN OF DLSC. PP SHOULD ELABORATE ON (1) REASONS FOR GOI'S PREFERENCE FOR USING PUBLIC ENTERPRISE TO PRODUCE OC'S AND (2) OPPORTUNITIES FOR FOREIGN PRIVATE INVESTMENT IN AND ASSISTANCE TO LOCAL OC PRODUCTION.

5. BENEFICIARIES: PP SHOULD DISCUSS FOLLOWING ISSUES CONCERNING IMPACT ON BENEFICIARIES: (1) WHAT PROVISIONS EXIST FOR EARLY IDENTIFICATION AND TREATMENT OF OC ACCEPTORS WHO SUFFER SIDE EFFECTS; AND (2) BEFORE FINANCING RAW MATERIALS FOR LOCAL PRODUCTION, HOW WILL USAID MAKE DETERMINATION THAT LOCALLY-PRODUCED OC IS SAFE FOR CONSUMPTION AND THAT PRODUCTION FACILITIES HAVE ADEQUATE QUALITY CONTROL?

6. FINANCIAL PLAN: QUESTION WHETHER IT IS APPROPRIATE TO ATTRIBUTE PROPOSED GOI EXPENDITURES OF DOLS 21 MILLION IN FY 1983 TO HOST COUNTRY CONTRIBUTION SINCE THESE EXPENDITURES WOULD OCCUR AFTER COMPLETION OF AID-FINANCED INPUTS. SINCE CONTRACEPTIVE SUPPLIES ARE INTEGRAL PART OF FAMILY PLANNING PROGRAM, SUGGEST GOI CONTRIBUTION AND AID-FINANCING BE ESTIMATED ON FAMILY PLANNING SUB-SECTOR BASIS FOR FY 1978 - 82.

7. FINANCIAL VIABILITY: WE STILL QUESTION FEASIBILITY OF ABRUPTLY INCREASING GOI FINANCING FOR OC'S FROM DOLS 6.6 MILLION IN FY 82 TO DOLS 21 MILLION IN FY 83. SINCE TRANSITION FROM AID TO GOI-FUNDING IMPORTANT ASPECT OF PROJECT PURPOSE, IT WOULD SEEM DESIRABLE TO PHASE IN GOI CONTRIBUTIONS MORE GRADUALLY, I.E., HIGHER GOI CONTRIBUTIONS IN EARLIER YEARS OF FIVE-YEAR PERIOD. PP SHOULD ELABORATE ON RATIONALE FOR AND PRACTICALITY OF FINANCIAL PLAN.

8. INTERDEPENDENCE WITH FAMILY PLANNING DEVELOPMENT/SERVICES PROJECT - PP SHOULD DISCUSS RELATIONSHIP BETWEEN SUBJECT LOAN AND FAMILY PLANNING DEVELOPMENT/SERVICES PROJECT, ESPECIALLY DEGREE TO WHICH DEMAND ESTIMATES AND BUDGETARY LEVELS FOR OC LOAN DEPEND UPON SUCCESS OF GRANT PROJECT IN INCREASING NUMBER OF ACCEPTORS. SINCE TWO PROJECTS VIEWED AS INTERDEPENDENT, REQUEST USAID LIBERATE TWO PP'S AT SAME TIME TO PERMIT CONCURRENT AID REVIEW.

9. FINANCING OF IMPORTED OC'S AND/OR RAW MATERIALS FOR LOCAL PRODUCTION-IN RESPONSE TO PARA 4, REFTEL, DO NOT BELIEVE DESIRABLE TO PROVIDE SEPARATE GRANT FINANCING FOR IMPORTED OC'S, EITHER FOR PROJECT AUTHORIZED IN TG OR ANNUAL LOANS PROPOSED BY SUBJECT PRP. THERE HAS BEEN NO CHANGE IN OC LOAN POLICY, I.E., LOAN FINANCING OF CCS FOR INDONESIA AND PHILIPPINES STILL PLANNED FOR FY 77 AND FUTURE YEARS. IT HAS BEEN OUR UNDERSTANDING THAT LOAN WILL BE USED TO PURCHASE ALL OC'S ON IMPORT BASIS UNTIL SUCH TIME AS LOCAL PRODUCTION FACILITIES ARE CAPABLE OF PRODUCING ACCEPTABLE OC, AND WE SEE NO REASON TO DEFER LOAN-FINANCING OF OC'S UNTIL LOCAL PRODUCTION FACILITIES ARE SATISFACTORILY ESTABLISHED. PROJECT DOCUMENTATION SHOULD INCLUDE PROVISIONS TO ENSURE THAT ORALS PROJECT WILL IN FACT RESULT IN ORAL CONTRACEPTIVES BEING AVAILABLE IN SUFFICIENT QUANTITY AND ON TIME TO MEET PROGRAM NEEDS.

MATTER PROBABLY CAN BE COVERED BY INCLUDING APPROPRIATE CONDITION PRECEDENT OR COVENANT IN LOAN AGREEMENT TO EFFECT THAT GOI WILL MAKE ARRANGEMENTS SATISFACTORY TO USAID FOR SUPPLY OF ORALS EITHER FROM LOCAL PRODUCTION OR OFFSHORE PROCUREMENT ADEQUATE TO MEET NEEDS FAMILY PLANNING PROGRAM.

KISSINGER

BT
#3786

UNITED STATES GOVERNMENT

Memorandum

ANNEX Q

TO : Mr. Thomas C. Niblock, Director

DATE: December 12, 1977

FROM : 
William H. Johnson, OPH

SUBJECT: Commodities for the Oral Contraceptive Loan Project

SUMMARY

In accordance with AID Handbook 1, Section B, Chapter 3A, USAID has determined that it would not be advantageous for the BKKBN to procure commodities from the United States with funds provided through the Oral Contraceptive Loan Project. The reasons are:

1. By consolidating Project procurement of oral contraceptives (OCs) with centralized procurement procedures established for OCs in AID/W, a lower price per cycle can be obtained because of higher volume purchases.
2. The savings of using central AID OC procurement rather than individual GOI procurement contracts for annual requirements is estimated to be millions of dollars.
3. The central OC procurement mechanism utilized by AID has been functioning well since 1973.
4. Procedures for loan OC procurement via the AID centralized mechanism have already been successfully tested under Project 497-045.
5. In cases where companies are not represented by local agents, procurement by the GOI in the past has proven time-consuming and difficult. During this period of transition from USG to GOI funding of OC inputs, a dual system of procurement (GOI procures GOI OC inputs and GOI requests AID to procure AID OC inputs) provides insurance for the OC supply line.
6. It would be unwise to prematurely put all our



eggs in one basket by asking the GOI to procure GOI and
AID OC inputs for this Project.

RECOMMENDATION

On the basis of the above, I recommend that you determine
that commodities for the Oral Contraceptive Loan Project
497 0271 be procured by USAID with PIO/Cs through AID/W
and GSA.

APPROVED: _____

DATE

29 Dec 1977

DISAPPROVED _____

DATE _____

ANNEX R

DRAFT

PROJECT AUTHORIZATION AND REQUEST FOR ALLOTMENT OF FUNDS

PART II

INDONESIA

Oral Contraceptive Project
A.I.D. Project No. 497-027

Pursuant to Part I, Chapter 1, Section 104(a) of the Foreign Assistance Act of 1961, as amended, I hereby authorize a Loan to Indonesia (the "Cooperating Country") of not to exceed Seven Million United States Dollars (\$7,000,000) (the "Authorized Amount") to help in financing certain foreign exchange costs of goods and services required for the project as described below.

The Project (hereinafter referred to as the "Project") consists of assisting in financing the United States Dollar costs of commodities (and related services) for the family planning program in Indonesia.

I approve the total level of A.I.D. appropriated funding planned for this Project, including the funding authorized above, of not to exceed Forty Million United States Dollars (\$40,000,000) which will be entirely loan funded during the period FY 1978 through FY 1982. I approve further increments of loan funding during that period up to the total of (\$40,000,000) subject to the availability of funds in accordance with A.I.D. allotment procedures.

I hereby authorize the initiation of negotiation and execution of the Project Agreement or Agreements by the officer to whom such authority has been delegated in accordance with A.I.D. regulations and delegations of authority subject to the following essential terms and covenants and major conditions, together with such other terms and conditions as A.I.D. may deem appropriate:

a. Interest Rate and Terms of Repayment

The Cooperating Country shall repay the Loan to A.I.D. in United States ~~211THU~~ Dollars within thirty (30) years from the date of the first disbursement of the Loan, including a grace period of not to exceed ten (10) years. The Cooperating Country shall pay to A.I.D. in United States Dollars interest from the date of first disbursement of the Loan at the rate of (a) two percent (2%) per annum during the first ten (10) years, and (b) three percent (3%) per annum thereafter, on the outstanding disbursed balance of the Loan and on any due and unpaid interest accrued thereon.

b. Source and Origin of Goods and Services

Except for ocean shipping, goods and services financed by A.I.D. under the Project shall have their source and origin in countries included in A.I.D. Geographic Code 941, except as A.I.D. may otherwise agree in writing. Ocean shipping financed under the Project shall be procured in any eligible source country except the Cooperating Country.

Date _____

Signature _____