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A.I.D. POPULATION ASSISTANCE STRATEGY
FOR INDONESIA: 1993 - 1998

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Preface

This paper was written at the request of the Office of Human and Institutional Resource Development of the USAID Mission in Indonesia. Over the past year, the Mission has been engaged in an exercise to review and focus its development program in Indonesia. The Government of Indonesia (GOI) is also beginning a new five-year planning period. At the same time, the Office of Population in A.I.D. Washington has developed a Priority Country Strategy to channel resources to the most demographically-significant countries in order to increase the impact of A.I.D.'s population assistance. Indonesia, the fourth largest country in the world with an estimated 1992 population of over 184 million, is considered a priority by the Office of Population because of its size, unmet family planning needs, and maternal health risks.

This paper was written to examine the future needs of the Indonesian national family planning program and to outline an appropriate strategy for continued A.I.D. assistance in the population sector. The report contains a review of program achievements and challenges and describes A.I.D.'s program objectives and implementation mechanisms.

The report was prepared initially in Indonesia in May of 1992 by Leslie B. Curtin and Janet M. Smith, both of whom have experience in the Indonesian demographic and family planning setting. The report was revised subsequently by Ms. Curtin to reflect the changing environment. Leslie B. Curtin is a career foreign service officer with A.I.D. She is currently deputy chief of the Family Planning Services Division, Office of Population. Janet M. Smith is the Director of the OPTIONS II Project, The Futures Group.

The strategy was developed through an agency-wide cooperative effort involving the Mission, the Asia regional bureau, and the Office of Population. The authors wish to thank the staff of USAID/Jakarta, in particular Charles Weden, Edward Greeley, John Rogosch and Kenneth Farr for their valuable suggestions during the preparation of this paper.

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Executive Summary

The purpose of this paper is to outline a strategy for A.I.D. population assistance in Indonesia during the next five years (1993-1998). It contains a review of family planning program achievements and program challenges; describes A.I.D.'s program objectives and implementation mechanisms; and provides estimated funding requirements for FY 93 - FY 98.

The Indonesian family planning program has gained world recognition for its notable success in reducing fertility in the last two decades, from an average of 5.6 births per woman in 1971 to 3.0 births per woman in 1991. Because of fertility reduction, the rate of population growth has also declined, from an estimated 2.5 percent in 1970 to an estimated 1.6 percent in 1991. The reduction in fertility has come about primarily as a result of the increase in contraceptive use, which has risen rapidly, from less than 10 percent of married women age 15-49 in 1971 to 49.7 percent in 1991. For a more detailed description of the evolution of the Indonesian family planning program, key factors of success, and A.I.D.'s two decades of assistance, please refer to "Indonesia's National Family Planning Program: Ingredients of Success," Curtin et al., POPTTECH Occasional Paper No. 6, 1992.

In 1993, the Indonesian family planning program is at a critical juncture. Despite the successes achieved to date, the program's greatest challenge lies ahead. The current goal of the national program is to reach a two-child family size (replacement level fertility of approximately 2.1 births per woman) by the year 2005. This goal will require an additional 30 percent reduction in fertility over the next 14 years (from 3.0 in 1991 to 2.1 in 2005). In order to achieve the targeted total fertility rate of 2.1, contraceptive prevalence must rise from 49.7 percent to between 63 and 70 percent of married women (depending on population age structure and family planning method mix) by the year 2005.

The challenge for program managers to increase contraceptive prevalence by this amount is daunting. First, the program seems to have hit a plateau. That is, over the last four years (1987 and 1991) contraceptive use rose a total of only two percentage points. Until then, the pace of growth was about two percentage points per year. Thus, the rate of program growth must accelerate in comparison to the rate of growth over the past several years. Second, the number of users needed to achieve a minimal contraceptive prevalence rate of 63 percent is enormous, because of the size of the population and the young age structure. The total amount of family planning users will need to increase from 15 million to over 25 million by 2005, or by nearly two-thirds. Many large countries do not even have total populations of 25 million. The program must recruit an increasing number of new users every year in order to both increase the overall total of users as well as replace those users who drop out of the program. The

net amount of new users needed, 10 million, represents more than all of the contraceptive users in all of sub-Saharan Africa. Achieving this accelerated rise in contraceptive use will require a tremendous program effort each year.

To recruit couples currently not using contraception, the program will need to expand to the approximately 14 million currently married women with unmet need for family planning. The program will need to attract couples who still have high family size preferences and low motivation to use birth control. The program will require additional outreach effort among "hard-to-reach" segments of the population: clients in heavily populated urban slums, clients in rural and coastal areas, and women with lower levels of education.

Program effort will need to expand and focus its efforts on two major groups: (a) women aged 15-24 who need to use family planning earlier in their reproductive life cycles to delay childbearing and who require temporary methods to space their children; and (b) women aged 25-49 who have had two children and who require long-term and permanent methods to limit family size.

Indonesia's family planning method mix is unbalanced in favor of temporary methods, with the three most popular methods being the pill (15% of users), followed closely by the IUD (13%) and injectables (12%). The use of implants (NORPLANT®) has increased rapidly in Indonesia in recent years but still constitutes only 3 percent of users. Voluntary male and female sterilization use is relatively low when compared with other Asian countries. In Indonesia, only three percent (3%) of all users were voluntary sterilization clients. Other Asian programs which have reached replacement level fertility generally have much higher levels, with sterilization accounting for between 25-40 percent of total contraceptive use. Promoting greater use of effective contraception must become an increasingly important program priority in the coming years.

Budget requirements will be enormous. The program aims to expand current users from 15 to 25 million, improve program quality, and improve use effectiveness. The challenge posed by rapidly escalating recruitment and demand for family planning in Indonesia will require that every available resource be mobilized. At present, program management and financing is highly centralized. Roughly three-quarters of clients receive family planning services through the public sector. An encouraging development is that reliance on private sector sources has increased from 12 percent in 1987 to 22 percent in 1991. The large increase is due to the BKKBN's rapid expansion of a family planning policy which encourages clients to pay for services and the expansion of a commercial social marketing program which relies on trained private sector service providers. The Government of Indonesia (GOI) recognizes the importance of developing the private sector as a partner in family planning service delivery and anticipates that half of clients will receive contraceptive services from private sector sources by the year 2005.

Beyond the need to recruit more family planning acceptors, promote effective methods, and provide more service delivery options for clients, the GOI recognizes that there is an important need to develop program strategies to enhance the welfare of mothers and children and to promote greater economic opportunities for families.

The A.I.D. family planning program will focus its efforts on three major objectives in order to assist the GOI to achieve its fertility reduction and family welfare goals. These objectives are:

- Increase contraceptive prevalence in the most heavily populated provinces and among hard-to-reach segments of the population.
- Increase the availability, utilization and quality of long-term, effective family planning methods: IUD, NORPLANT®, and male and female voluntary sterilization.
- Improve the sustainability and impact of family planning services delivered through commercial and non-governmental sectors.

These objectives are consistent with the USAID Mission's overall strategic objectives. In a recent strategic planning exercise (PRISM), USAID/Jakarta articulated the following Strategic Objective:

"Improved balance in public and private provision of basic services."

The Mission is focusing on two program outcomes to achieve this objective: (a) an improved enabling environment for public and private delivery of basic services; and (b) improved private and public sector capacity for delivery of basic services.

The A.I.D. population program will consist of support which contributes to the Mission's strategic objective of creating an improved balance in public and private provision of basic services. This support will be provided through three principal mechanisms:

- the bilateral Private Sector Family Planning project, which continues through 1995;
- a new five-year program support grant to BKKBN and selected non-governmental organizations; and
- technical and financial assistance from selected Office of Population centrally-funded projects.

1. Indonesian Family Planning Program Achievements

1.1 Demographic Achievements

Since 1967, rapid population growth has been viewed as a major impediment to Indonesia's social and economic development prospects. Since 1971, the Government of Indonesia (GOI) has given strong support to the country's family planning program. This investment has nearly halved the Total Fertility Rate (TFR) in a period of only 20 years. Indonesia's rapid decline in fertility has considerably slowed the rate of population growth.

- The Total Fertility Rate has fallen by 46 percent since 1971, when women were having an average of 5.6 births. By 1991, the fertility rate was 3.0 (see Figure 1). Most of this decline took place during the second ten years of program expansion, between 1980 - 1991. This can be attributed to major initiatives undertaken by the National Family Planning Coordinating Board (BKKBN) to significantly expand the coverage of family planning information and services in densely populated urban areas and through the private sector.
- There has been a dramatic decline in the rate of population growth in the last two decades: from 2.5-2.7 percent in 1970 to 1.6 percent in 1991. This represents a 41% reduction in the population growth rate. If the population growth rate had remained constant at 2.5 percent between 1970-1990, the total population in 1990 would have been 191.7 million, rather than the actual 1990 figure of 179.3 million. Thus, Indonesia's total population in 1990 was 12.4 million persons smaller than it would have been had the growth rate remained constant.
- While a gradual increase in age at marriage has been a contributing factor to the fertility decline, most of this decline is attributed to the rapid rise in the contraceptive prevalence rate (CPR) -- the percentage of married women aged 15-49 using contraception. The CPR rose from less than 10 percent in 1971 to 49.7 percent in 1991 (see Figure 2). Indonesia is among the few developing countries that have achieved a CPR in the range of 50 percent.
- Contraceptive use is considerably higher on Java and Bali than on the outer Islands. Five out of Indonesia's 27 provinces have achieved replacement level fertility (approximately 2.1 given current levels of mortality): Jakarta, Yogyakarta, East Java, Bali and North Sulawesi (see Figure 3).

- The rapid increase in use of contraception between 1971 and 1991 has contributed to a decline in infant and child mortality by providing women with the means to space children and restrict child bearing to lower ages of maternal risk. In 1971, 13 percent of infants died before reaching their first birthday; as of 1987, only 7 percent did not survive their first year.

1.2 The Program: "Concentrated, Steadfast, Visionary"

Indonesia has succeeded in overcoming the odds against its population growth due to a combination of determination and commitment by its leadership and the support of international donors.

- Gradual slowing of the population growth rate is the direct result of the concentrated, steadfast, and visionary approach that the Government of Indonesia has taken towards population and family planning.
- Strong, continuous, and open political support has been given by President Suharto. Program plans with quantifiable targets for reducing population growth rates have been adopted by the supreme legislative body of Indonesia and have been included in every five year plan since 1970. Active, broad-based support exists at every level from the President down to the local government and non-government health, education, religious, and political community leaders.
- Political commitment has been translated into on-going fiscal support to family planning. The National Family Planning Coordinating Board (BKKBN) was established in 1970 as an autonomous coordinating body, reporting directly to President. At inception, the national program was almost exclusively donor funded, with A.I.D. as the largest donor, providing 80 percent of resources. Today, donor support provides less than 20 percent of program costs, an achievement often expressed publicly by BKKBN Chairman, Dr. Haryono.
- Political commitment to the program, which has resulted in sustained GOI financial resources, has been due to BKKBN's effective coordination and public relations efforts. BKKBN has coordinated large amounts of A.I.D. and other donor support provided throughout the years, which has leveraged GOI support. It has provided the program with extremely high visibility which has resulted in sustained political commitment.

- BKKBN has matured into a strong institution which is unique in its governmental influence and its worldwide reputation. The BKKBN has offices in all 27 provinces and 301 regencies. It effectively manages a staff of 48,000 employees, including a cadre of over 33,000 paid family planning fieldworkers who provide information, motivation, counseling and family planning services throughout the 27 provinces. BKKBN has effectively coordinated a wide range of implementing units, including Ministry of Health facilities, non-governmental organizations, and other Ministries, and an extensive network of volunteers and voluntary groups. It supports a network of 500,000 village family volunteers and 76,000 village contraceptive distribution centers throughout the country.
- The program has been fortunate to have consistent leadership which is willing to test innovative ways of bringing family planning to the people in a culturally acceptable way. A variety of service delivery approaches has evolved over the program's twenty year history, and BKKBN is constantly looking for innovations and ways of improving itself.
- The first great program initiative -- Village Family Planning -- was developed throughout the 1970's and 1980's to reach the majority of couples in rural areas who had limited access to fixed Ministry of Health facilities. Village volunteers with limited training were recruited, supervised and supported by the government network of family planning fieldworkers to serve as community distribution agents for oral contraceptives and condoms.
- Family planning was the first social service GOI program to reach effectively into all of Indonesia's 66,000 villages. In addition to providing information and basic contraceptives, village volunteers now provide integrated nutrition and health services. Thus, the family planning program served as the model for the successful introduction of other social services into the villages.
- Extensive information has been provided through traditional forms of communication as well as mass media to educate communities about the benefits of planning one's family. The concept of family planning has been removed from the realm of private, unspoken behavior and placed squarely in the public domain as a point of community conversation and concern. Motivation is based on the concept of the "small, happy, and prosperous family" norm for long-term, future benefits.

- The second great program initiative -- Urban Family Planning and Private Sector Promotion -- was developed in the 1980's to meet the needs of the rapidly increasing urban population and to respond to changes in the international and domestic economic climate. Survey data revealed that clients in urban areas preferred to receive information and contraceptives from private doctors, midwives, and pharmacies. At the same time, GOI revenues, including BKKBN's budget, had begun to drop with the rapid decline in world oil prices. This led to a change in government policy, with the focus shifting to increasing private sector involvement in all sectors of the economy.
- These new policies, in conjunction with the receptivity of the urban population to paying for contraceptive services, led the BKKBN to support the establishment of fee-for-service clinics and set up a condom sales program which sold condoms at discounted prices in commercial retail outlets. The success of the condom sales program encouraged BKKBN to expand the program to include pills, IUDs, injectables, and NORPLANT® under the "Blue Circle" label. A major advertising campaign was developed to inform urban residents about the availability of Blue Circle contraceptives from private physicians, midwives, and pharmacies.
- In 1992, BKKBN announced the introduction of "Gold Circle" contraceptives to provide clients with more product choice and availability. It is envisioned that Gold Circle contraceptives will be sold in rural areas by a growing cadre of village midwives. These contraceptive social marketing programs support BKKBN's policy of family planning self-reliance (KB Mandiri) which was developed to strengthen the sustainability of the program by encouraging individuals and communities to assume greater responsibility for family planning, including paying for services. The 1991 Indonesian Demographic and Health Survey indicates that 22 percent of couples now obtain for family planning services through private sector sources.

1.3 A.I.D. Contribution to Program Achievements

Financial and technical support from donors, including the World Bank, IPPF, the Netherlands, the Japanese, and A.I.D., has been critically important to the development and success of the Indonesian family planning program.

- A.I.D. has provided the largest amount of sustained support, estimated at \$250 million since the late 1960's. Assistance has been provided through a combination of bilateral and centrally-funded resources--strong in-country technical presence supplemented with key short-term expertise.
- A.I.D. assistance has been provided at critical stages of village and urban program development for testing innovative concepts, ideas and strategies. A major result of A.I.D.'s assistance has been to leverage GOI and other donor resources for family planning.
- A.I.D. inputs have been provided for the expansion and improvement of family planning services and for strengthening the institutional capability of BKKBN and other local institutions to organize, implement, and evaluate their family programs. Key A.I.D. inputs have included:
 1. Continuous supply of contraceptives (\$80 million) during the early years of the program, and development of a computerized logistics and management information system to manage contraceptive supply and distribution;
 2. Technical expertise and equipment to establish local production of oral pills, IUDs, condoms, and injectables;
 3. Financial and technical support, medical equipment, and training for the expansion of voluntary sterilization services throughout Indonesia. During the past 17 years, a total of 1.4 million voluntary sterilization procedures have been performed.
 4. Financial support for advertising and technical assistance to promote the use of private doctors, nurses, and midwives to expand family planning service delivery.
 5. Extensive long-term and short-term training in the U.S. and in Indonesia. Over 1,300 Indonesians have received advanced training

to gain management and technical skills in family planning. Tens of thousands of Indonesians involved in field operations for village and urban family planning have received training with funds provided by A.I.D.

6. Assistance to BKKBN in data processing to improve its operational, financial, and administrative management systems.

7. Key operations research and national Demographic and Health Surveys to measure program performance and impact.

2. Challenges and Opportunities

2.1 Demographic Challenges

Despite the impressive successes the program has achieved to date, the program's greatest challenge lies ahead if Indonesia is to achieve its national goal of a two child family size.

- The stated goal of the national program is to reach a two child family size (replacement level fertility, TFR of 2.1) by the year 2005. **Fertility must decline from 3.0 to 2.1, or by 25-30 percent, within the next 15 years** if this goal is to be met. If fertility declines to this level, the total population would be 222 million by 2005.
- **This level of fertility will require a significant increase in the level of contraceptive use.** International experience indicates that most countries do not achieve replacement fertility until about 70 percent of married women aged 15 to 49 are using contraception. Projections for Indonesia indicate that prevalence might only need to reach 63 percent, instead of 70 percent. Factors that may be working in Indonesia to contribute to low fertility include high divorce rates, low coital frequency, and high infecundity. In any case, it means that **contraceptive use must increase dramatically -- from 49 percent to an estimated 63 to 70 percent by the year 2005** (see Figure 2).
- Nearly half (49.7%) of currently married women are using any contraceptives. Forty-seven (47.1%) percent are using modern methods. While this is an impressive achievement, it still means that **half of the eligible couples are NOT using any form of contraception.**
- Urban areas are growing rapidly. **While population growth is 1.6 percent nationwide, it is 5-10 percent in the largest cities.**

2.2 Service Delivery Challenges

To achieve a contraceptive prevalence rate of at least 63 percent, given population momentum from past fertility patterns, the program will have to attract a growing number of couples into the program. This growth will require renewed strategic planning efforts and an intensive effort to understand, motivate, and deliver high quality services which meet the needs of various segments of the population. In addition, the rate of program growth will need to accelerate in comparison to the slow rate of growth over the past four years.

- **The total number of current contraceptive users will have to increase from 15.6 million in 1991 to at least 26 million by the year 2005.** This represents an increase of nearly two-thirds (64%) over the present level of program performance.
- The sheer magnitude of 10 million additional current users is daunting. This projected increase is larger than all of the current contraceptive users in sub-Saharan Africa. From the perspective of program managers, the challenge is even greater than the numbers would suggest. To achieve an increase of 10 million current users, over eight times that number would have to be recruited over the 13-year period. New acceptors need to be added to the total annually to increase the total volume of users, and they must also be recruited to replace the large number of women who stop using contraceptives each year. In Indonesia, the total number of new acceptors needed from 1991 to 2005 would increase gradually from 4.6 million per year to 7.2 million per year (see Figure 4).
- This growth will place considerable new demands on Indonesia's family planning service providers since it **will depend on recruiting and motivating "hard-to-reach" new users:** (1) young couples who need to use family planning earlier in their reproductive life to space their children; (2) clients age 20-35 who wish to limit their family size to two children; (3) couples with higher family size preferences who are less highly motivate to use family planning; (4) clients from poor, densely populated, rapidly growing urban areas; (5) couples in outlying rural areas; and (6) women with lower levels of education.

- **Over 70 percent of the population (126 million persons) of Indonesia is concentrated on seven provinces: North Sumatra, South Sumatra, Lampung, West Java, Central Java, East Java, and South Sulawesi (see Figure 5, Map).**
- **Contraceptive prevalence rates vary across these seven provinces, from a low of 37 percent in North Sumatra and South Sulawesi, to a high of 55 percent in East Java (see Figure 6). Fertility rates also vary across provinces, from a high of 4.1 in North Sumatra to a low of 2.1 in East Java. Because of the large proportion of the population concentrated in these seven provinces, targeted efforts are needed to increase prevalence and reduce fertility.**
- **Since 1987, the Indonesian program has experienced only a modest growth in contraceptive prevalence: two percent in four years. This indicates that the program may be experiencing a "plateau effect," common to programs at this stage of development -- evidence that continued and improved program efforts are required. If the CPR is to increase by 13 percentage points (50 percent to 63 percent) over a period of 14 years (1991 to 2005), the rate of growth will need to accelerate in comparison to the slow rate of growth over the past four years.**
- **Indonesia's contraceptive method mix is unbalanced in favor of temporary methods, which in 1991 accounted for 27 percent of users. The most popular method was the pill (14.8 percent of users), followed by the IUD (13.3 percent) and injectables (11.7 percent). Use of highly effective methods such as NORPLANT® and voluntary sterilization is much lower: NORPLANT® (3.1 percent), and voluntary sterilization (3.3) percent (see Figure 7).**
- **An important aspect of quality is the ability of programs to meet the evolving needs of couples for more use-effective and cost-effective methods. The relatively low levels of effective methods in the method mix highlight the need to strengthen use of the IUD, NORPLANT® and voluntary sterilization.**
- **Among the 50 percent of currently married women who were NOT using any form of contraception, 45 percent stated that they did not want any additional children.**

- While knowledge of "any" contraceptive method is nearly universal (94.6%), knowledge of implants and sterilization is much lower (see Figure 8). Just over half of all currently married women had heard of tubectomy whereas not quite 30 percent had heard of vasectomy. **Additional efforts are needed to promote all effective methods and to inform interested clients on their benefits and availability.** Program acceptors will require more sophisticated information, which in turn will require that providers become more highly skilled in counseling.
- **Indonesia has the lowest levels of voluntary sterilization of any other program in the Asia region.** Other Asian programs which have reached replacement level fertility have much higher levels of use of sterilization with sterilization generally accounting for between 25 and 50 percent of total use (e.g., Korea 48%, Sri Lanka 40%, Thailand 25%). Even other Asian programs that have not yet reached replacement fertility have much higher levels of female sterilization than Indonesia: (Bangladesh 31%, Nepal 45%, and the Philippines 24%).
- **Program managers in Indonesia will need to look to the vast pool of women with unmet need for family planning to recruit the new acceptors needed to increase contraceptive prevalence.** The 1991 IDHS indicates that 14 million currently married women between the ages of 15-49 (approximately 29.6 percent or three out of every ten) have unmet need for family planning. This includes women who stated that they want to space or limit their family size, and women whose reproductive goals are not consistent with Indonesia's national goal of the two child family.
- More than half the women with unmet need are aware of the need for family planning services and therefore would tend to be receptive to program efforts. Of those who are aware of this need, slightly over half require spacing methods (some 7.2 million women), with the remainder requiring limiting or permanent methods (some 6.7 million women).
- As one would expect, spacing need is concentrated primarily among women aged 15 to 24. Limiting need is most common among women aged 25 and above, and over three-quarters of women with unmet need are 25 years or older. There are particularly high proportions of women in the 25 to 39 age groups with unmet need for limiting methods (see Figure 9). **If this unmet need can be satisfied in future years, contraceptive prevalence should increase to about 70 percent.**

- Despite declining fertility, Indonesia's population is still concentrated in the younger ages and will continue to grow for because of past high fertility patterns. As fertility continues to decline, however, the cohort of women aged 30-49 will eventually grow faster than the cohort of women aged 15-29 through the year 2020 (see Figure 10). **These findings suggest that the program will need to expand and focus its efforts on two groups: (a) younger women who need to be encouraged to adopt family planning earlier, and (b) women who already have two children who require long-term and permanent methods to limit their family size.**

2.3 Policy Challenges: Increasing the Financial Resource-Base While Maintaining Equity.

Budget requirements for the Indonesian family planning program, which aims to increase current contraceptive users from 15 to 26 million, improve program quality, and improve use-effectiveness, will be enormous.

- If the size of the BKKBN program is to expand by nearly two-thirds, then its budget will also need to increase by an estimated \$50 million, and donor contributions will also have to grow.

This highlights two critical necessities: (a) the necessity of relying on methods which are highly effective in both use and cost, and (b) the need to develop a broad base of financial support which maximizes private sector participation.

The family planning program faces important and evolving directions in which critical policy decisions must be made. These policy decisions bear on key aspects program development:

- needs and preferences of women as they move toward a smaller family size;
- optimal method mix to achieve replacement level fertility;
- segmentation of the market for contraceptive products;
- the potential role of the private sector;
- contraceptive social marketing;
- public sector recurrent costs and cost recovery;
- optimal pricing of contraceptives with respect to usage.

It is vital to support policy decisions with the fundamental analyses needed to ensure the best results.

Recently Indonesia has put increased emphasis on the private sector as a partner in development. The GOI has expressed a goal that 50 percent of couples will be receiving family planning services through private sector sources by the year 2005. As stated earlier, the family planning program set up the "Blue Circle" commercial program to put affordable contraceptives in the marketplace. Another part of the program promotes Blue Circle products through trained private sector providers such as physicians, nurses, and pharmacists. Blue Circle sales have grown steadily, although more slowly than projected. Its efforts to develop the commercial market have been successful in attracting additional manufacturers to introduce affordable products.

- According to the 1991 IDHS, family planning services offered through the private sector have increased considerably--from 12 percent in 1987 to 22 percent in 1991 (see Figure 11).

There is some concern, however, that the proportion of family planning services offered in the private sector may be inflated. People may be paying for public sector products, which are supposed to be provided for free by BKKBN, and therefore not obtaining them in the commercial private sector.

Despite the noted increase in private sector service delivery from 12 to 22 percent, the public sector is still the predominant supplier of services (75 percent). The public sector program relies heavily on distribution of pills through its fieldworkers. According to the 1991 DHS, of the 47.1 percent modern method prevalence, public sector pill provision had the largest share (13%) and private sector pill provision (including private sales of BKKBN pills) was eighth with (1.5%). The pill, however, is a method ideally suited for commercial private sector provision.

The Government of Indonesia has recently launched a new subsidized contraceptive social marketing program, the "Gold Circle" program. This program may formalize and expand the present informal system of consumers paying for public sector contraceptives. As stated earlier, the GOI has a policy of KB-Mandiri, self-reliant family planning, where the consumer, as much as possible, assumes the responsibility of paying for services. This increases the private resource base for family planning. The objectives of the Gold Circle program are to increase the line of contraceptive products available and to broaden the coverage of distribution of products to suburban and rural areas to increase the number of couples who contribute to KB Mandiri. The proposed subsidized Gold Circle program has potential impact on the commercial Blue Circle program. It

may also affect access of the poor to free services. Thirdly, it may affect families' use of more effective methods as their needs change.

The Gold circle initiative can have positive impact on the commercial market if it is effectively and strategically implemented. Increased competition will stimulate the market. However, care needs to be taken in the provision and control of initial consignment stocks, and in discounting the sale of these stocks. Subsidized distribution may stimulate widespread use of reduced-price contraceptives, but it also locks-in recurrent costs to the government of procurement of contraceptives. The practice of consumer payment will expand the private resource base for family planning. Widespread availability of reduced-price contraceptives does not encourage consumers who could otherwise afford commercial products to use them. This raises the necessity of targeting subsidies to those who need them most.

With respect to equity participation, there is a continued need to provide free services to the poor to sustain their use of family planning. Finally, it will also be important to develop mechanisms to insure use of the long-term effective methods by all families for whom they are appropriate.

In the evolution of the programs for contraceptive sales and social marketing in Indonesia, analysis of the implications of various scenarios is vital with respect to four key questions:

- What will be the recurrent cost burden to the GOI, given population and expected program growth, if the subsidized Gold Circle sales program succeeds? If this is too great, how can the program maximize sustainability? Could volunteer distributors share the cost of the contraceptives with the GOI?
- How should prices be set to best target GOI subsidies on different groups of consumers? With incentives for distributors based on sales, what mechanism will assure access of the poor to free services?
- With incentives related to sales of supply methods, what mechanism will assure increasing use of long-term effective methods as families' needs change?
- Could a strategy of market segmentation be employed with market niches to maximize the role of the Blue Circle commercial social marketing program for consumers who can afford to pay a commercial price and to meet the needs of other consumers through other mechanisms?

Analysis of these questions may make it possible to bring market segmentation directly into the national system. Based on an understanding of the consumer market for products of all types at every price level--from the most expensive to free supplies--a range of market niches could be identified, and products could be priced, packaged and actively marketed to their target audiences. The objective of the system would be appropriate use of family planning and maximum financial participation of families who can afford to pay. With the analytic basis and commitment to market segmentation in policy and practice, such a system should flourish in a thriving program like Indonesia's.

Conclusion

The challenges described in previous sections imply that the Indonesian family planning program must expand significantly over the next 14 years in order to reach the GOI's fertility reduction goals. The demographic goal and the value system accompanying this goal suggests that the program has three over-arching principles for the next evolutionary stage: (a) increase contraceptive prevalence; (b) develop broad-based resource support; and (c) address equity needs of the poorest consumers.

In order to achieve a two child family norm by the year 2005, the GOI has developed a comprehensive family welfare strategy which will lead the family planning program into its next stage of development. This strategy involves the following five elements:

- promotion of the small family as a social norm;
- improved health and status of the mother;
- improved family welfare through community economic development;
- strengthened management and coordination; and
- improved program quality.

Each of these elements will play an important role in the achievement of the family planning program objectives:

- **Increase Contraceptive Prevalence.** Achieving replacement level fertility will require a substantial increase in contraceptive prevalence. The small family norm will be achieved if couples are motivated to limit their family size. Enhancing the health and status of mothers will help women to exercise their reproductive rights to determine the number and spacing of their children. High quality, effective contraceptive services, which respond to users' needs must be available and accessible. Program expansion throughout all parts of Indonesia and in all sectors will require good

coordination among implementing units. Institutions will need to strengthen their management capabilities in order to meet the needs of increasing numbers of users.

- **Develop Broad-based Resource Support.** The GOI policy calls for increased individual and community responsibility in family planning--KB Mandiri, or self-reliant family planning. The KB Mandiri policy recognizes that not all families or communities are ready to bear the full cost of participation, but it seeks to maximize their participation. Private sector service delivery will increase as families and communities develop the economic resources to invest in family planning. Consumers and communities will increasingly exercise choice in purchasing family planning products and services.
- **Address equity and well-being needs of poorest consumers.** As the system grows to reach more families, it will have to penetrate hard-to-reach groups which may include poor families and consumers with little education. The needs of these families for free services are an important aspect of equity in the program.

To meet these challenges, the program will have to think strategically--using continuous flows of consumer and program data--to address where to focus efforts to achieve the greatest impact in increasing contraceptive use; how to increase use of appropriate long-term effective methods; and how to increase private resources and delivery of family planning services.

3. A.I.D. Strategy

3.1 Key Objectives

The Government of Indonesia has articulated a national goal of reducing the total fertility rate from 3.0 to 2.1 by the year 2005. The preceding analysis describes the major demographic, service delivery, and policy challenges that the program will face in the coming years as it expands to achieve its goal. This analysis suggests that A.I.D.'s population program should focus on the following three major objectives for the next five years:

- Increase contraceptive prevalence in the seven most heavily populated provinces and among hard-to-reach segments of the population.
- Increase the availability, utilization and quality of long-term, effective family planning methods: IUD, NORPLANT®, and male and female voluntary sterilization.
- Improve the sustainability and impact of family planning services delivered through commercial and non-governmental sectors.

These objectives take into account A.I.D.'s comparative advantage, relative to other donors, in the areas of clinical training and service delivery of effective methods, and in the development of private sector service delivery systems. These objectives build on accomplishments gained during A.I.D.'s twenty years of experience in Indonesia.

3.2 Consistency with USAID Development Strategy

The objectives above are consistent with USAID/Jakarta's overall strategic objectives. In a recent strategic planning exercise (PRISM), USAID articulated the following as one of its focal strategic objectives:

"Improved balance in public and private provision of basic services."

The Mission is focusing on two program outcomes to achieve this objective:

Program Outcome 1. Improved enabling environment for public and private delivery of basic services. This requires that conditions favorable to private sector participation be established, specifically: (a) that government formulates and implements policy changes to delineate how it and the private sector will interact

to provide services; and (b) that people who have traditionally procured services from the public sector be made aware of products and services offered by the private sector.

Program Outcome 2. Improved private and public sector capacity for delivery of basic services. The Mission is focusing on activities which will improve the financial viability of public and private organizations. The Mission will also support activities which lead to greater adoption of proven technologies and practices in order to strengthen the capacity of private and public institutions to deliver basic services.

3.3 Recommended Programming Approach: 1993-1998

The population program will consist of support which contributes to the Mission's strategic objective of creating an improved balance in public and private provision of basic services. Program inputs are complementary and will contribute to the two program outcomes articulated by the Mission which are implicit in the specific family planning program objectives stated earlier.

The population program will rely on technical and financial support provided through three principal mechanisms:

- (a) the USAID/Jakarta bilateral Private Sector Family Planning project;
- (b) a new service delivery program support grant through the Office of Population's cooperative agreement with Pathfinder International; and
- (c) key inputs from several other Office of Population centrally-funded projects.

Bilateral Private Sector Family Planning Project

The USAID/Jakarta bilateral project (497-0355), Private Sector Family Planning (PSFP), will continue to be implemented as planned. This six-year \$20 million project was authorized in August 1989 "to expand the availability, quality, sustainability and use of private sector family planning services in Indonesia." The project was designed to be the last family planning bilateral project in Indonesia. The project provides valuable in-country technical expertise and support to the BKKBN in the following program areas: (1) contraceptive social marketing, particularly the Blue Circle campaign; (2) training of private doctors and midwives to serve as family planning providers; and (3) clinical

service delivery through IEC, referrals, and improved quality. The project assistance completion is December 31, 1995.

There are three in-country resident advisors whose contracts extend until November 1994. Technical assistance provided under this project will be carefully coordinated with technical assistance provided by other mechanisms. Annual workplans will be developed which clearly define activities, roles and responsibilities of implementing organizations. An interim project evaluation, scheduled for late 1993, will examine technical assistance requirements and project amendment options in light of the overall population program.

**Service Delivery Expansion Support Grant (SDES)
through Pathfinder International**

The Service Delivery Expansion Support (SDES) grant is a major new initiative which will provide broad-based program support to BKKBN and selected non-governmental organizations in Indonesia.

Early in the process of strategic planning, the Mission had considered designing a bilateral Non-Project Assistance sector support grant to BKKBN. Congressional language issued in a House of Representatives report in July 1992, however, indicated that "cash transfers should not be provided to the Government of Indonesia." This report language precluded the Mission from pursuing the NPA option.

The Service Delivery Expansion Support (SDES) grant is a program which is available through the Office of Population's worldwide Cooperative Agreement with Pathfinder International. SDES is a new performance-based funding mechanism designed to expand service delivery in demographically-significant countries. SDES provides financial and technical assistance to well-developed institutions to influence national level contraceptive use and fertility. Priority is given to program strategies that expand family planning service access within a quality of care framework. Proposals are developed jointly between Pathfinder and the local organizations and financial disbursements are made according to mutually-selected indicators of outputs and program outcomes.

A five-year program support grant is envisioned for Indonesia under the SDES mechanism. The purpose of the SDES program in Indonesia is fully consistent with the Mission population strategy: (a) To increase the availability, utilization, and quality of long-term family planning methods; and (b) To improve the sustainability of family planning service delivery through the non-governmental sector. The SDES would have

two major components:

(i) program support to the BKKBN to strengthen the use of long-term methods and to strengthen community networks in order to expand service delivery among hard-to-reach groups. Program efforts would be focused on seven densely populated provinces which contain around 72 percent of the population.

(ii) program support to selected leading non-governmental organizations to strengthen management capability and improve service delivery through the private sector.

Additional support would also be provided for innovative and pilot activities. The estimated budget for this activity is \$50 million over a five-year period. The source of funding would be determined each year. It is envisioned that funding would be shared by the Mission and the Office of Population, subject to the availability of funds. An expanded program description on the SDES program developed to date is provided in Appendix 1.

Centrally-Funded Projects

The bilateral project and the SDES program would be supplemented with highly leveraged inputs from several Office of Population centrally-funded projects. These projects would provide additional financial and technical assistance in key program areas: (a) strategic planning and operational policy development; (b) private sector service delivery; (c) provision of long-term effective methods; and (d) survey research and program evaluation. The current portfolio of centrally-funded projects would be reduced from ten to five cooperating agencies and would include only those projects involved directly in implementing the Mission population strategy. These projects are:

- Options for Population Policy II (The Futures Group);
- Association for Voluntary Surgical Contraception (AVSC);
- The Johns Hopkins Program for International Training in Reproductive Health (JHPIEGO); -
- Promoting Financial Investments and Transfers (Deloitte and Touche); and
- Demographic & Health Surveys III (Macro International).

Other cooperating agencies, which are currently active in Indonesia and which will be completing project activities within the next year, include: East-West Population Institute, Population Council and Population Communication Services. The Population

Information Program, administered by the Johns Hopkins University Center for Communication Programs, would continue to provide Indonesian language translations of Population Reports.

Below is a brief description of activities that would be implemented in the key program areas.

- Strategic Planning and Operational Policy Development. The OPTIONS II project will provide limited technical assistance for operational policy development and analysis in order to improve the environment for public and private service delivery. OPTIONS II will mobilize analytic capability to support strategic planning, effective resource allocation, and a constructive legal and regulatory environment. Technical assistance provided by OPTIONS II will strengthen the analytic capability of local institutions and family planning officials at the national and provincial levels. There is an effort to have greater participation in planning from each of the 27 provinces and understanding the needs of users and the comparative advantages of each provider are key issues.

The following program areas will receive priority attention:

- (a) planning quantified targets for changes in fertility, contraceptive prevalence, and method mix; (b) developing plans for various service delivery models in the public and private sectors;
 - (c) estimating costs, including recurrent costs, and comparing the cost-effectiveness of different service delivery strategies;
 - (d) targeting GOI subsidies; and
 - (e) conducting cost-benefit analyses of maintaining or changing regulations.
- Private Sector Service Delivery. The Private Sector Family Planning Project will continue to provide financial and technical support to the BKKBN and to private organizations such as the Indonesian Doctors Association (IDI), the Indonesian Midwives Association (IBI), the Indonesian Pharmacists Association, and Yayasan Kusuma Buana (YKB), a network of self-supporting clinics, to increase private sector service delivery. Over the next several years, as the bilateral project winds down, Pathfinder, through the SDES program, will increase financial support to these and other leading private organizations to strengthen their management, training and service delivery capabilities.

The PSFP will also collaborate with the bilateral Health Sector Financing Project and other donors to ensure that family planning is included to the greatest degree in the national health insurance program. OPTIONS II could provide technical input on the economics of family planning service delivery, if necessary.

The PROFIT project will expand employment-based service delivery, a promising strategy for expansion of the private sector. The first PROFIT initiative will be with P.T. JIEP, a large industrial complex outside of Jakarta consisting of over 275 firms which employ over 30,000 persons. This project may be expanded to other industrial complexes if feasible (e.g., Batam island, factories of Asian investors, etc). In collaboration with PSFP, PROFIT may work with YKB to expand the network of fee-for-service clinics. Eventually, PROFIT may provide start-up capital for private physicians and midwives who wish to provide family planning services. PROFIT may also investigate advertising and marketing of the new injectable, Cyclofem.

- Social Marketing. The bilateral Private Sector Family Planning Project would continue to provide the major source of financial and technical support for the Blue Circle commercial activity. As the environment for this activity changes, with the GOI increasing subsidized social marketing under the Gold Circle program, OPTIONS II, in collaboration with PSFP, could conduct resource allocation studies to examine the GOI's recurrent subsidy costs, to address equity access, and to conduct market segmentation studies.
- Effective Methods. The PSFP will continue to provide financial support and a technical advisor to the Indonesian Association for Secure Contraception (PKMI) to strengthen service delivery of effective methods. The PSFP is providing technical assistance to: (a) strengthen the national supervision system; (b) implement operations research studies to improve quality of care at service delivery sites; and (c) implement pilot projects to expand social marketing of voluntary sterilization in hospitals.

The SDES program will provide financial and technical support to BKKBN and several private organizations, including, IDI, PKMI, and the Indonesian Public Health Association (IAKMI) to expand the availability and use of effective methods. Interventions will include: (a) intensification of information, education and communication (IEC) efforts for long-term

methods; (b) increasing the number of private sector providers (e.g., physicians, midwives, pharmacists) who are capable of providing long-term methods; (c) enhancing the competence of existing providers through improved clinical training and counseling training; (d) equipping facilities, renovating or adding service sites; (e) increasing contraceptive supplies where appropriate; and (f) targeting expansion to under-served areas (e.g., urban slums, coastal areas, rural areas not yet covered by the program).

JHPIEGO will provide technical support to the SDES program, to local private institutions, and to BKKBN to strengthen the quality of IUD and NORPLANT® training. JHPIEGO will also work to develop the Raden Saleh Clinic in Jakarta to become an international training site for NORPLANT® insertions and removals.

AVSC will provide continuing support to PKMI and the PSFP to: (a) strengthen referral systems for voluntary surgical contraception; (b) strengthen quality of service in voluntary surgical contraception sites; (c) develop a national master training team; (d) increase utilization of existing facilities; (e) strengthen information, education and promotional efforts; and (f) increase the annual numbers of voluntary sterilizations performed.

- Research and Evaluation. It is essential that program performance be monitored carefully over the next several years in order measure program impact.

The BKKBN collects service statistics but service statistics must be supplemented by community and national survey data.

The Demographic and Health Survey (DHS), a joint effort of the BKKBN, the Central Bureau of Statistics, the Ministry of Health, and Macro International, Inc., is a large-scale household survey which will be conducted periodically. The DHS provides nationally representative data on fertility, infant and child mortality, maternal and child health service utilization, contraceptive use dynamics, and patterns of family planning service utilization. More than 27,000 households throughout the 27 provinces of Indonesia are included in the survey. Funds will provided to undertake a DHS survey in 1994 by the PSFP, BKKBN, the Ministry of Health, and the Office of Population. Another DHS is recommended for 1997.

4. Summary of Projects and Estimated Financial Requirements

Bilateral Project

Title: Private Sector Family Planning Project (497-0355)
Implementing Agencies: BKKBN and University Research Corporation
Estimated FY 93 budget: \$3.400 million.
Estimated FY 94 - 95 funding: to be determined

The bilateral PSFP project provides in-country technical expertise for the following program areas: (1) contraceptive social marketing, particularly the Blue Circle campaign; (2) training of private doctors, midwives, and pharmacists; and (3) strengthening the service delivery of long-term methods. The project assistance completion date is December 31, 1995. An interim project evaluation is scheduled for late 1993. Project amendment options will be considered at that time.

Service Delivery Expansion Support Grant

Title: Expansion of Family Planning Service Delivery.
Cooperating Agency: Pathfinder International
Estimated FY 93 budget: \$10.5 million
Estimated FY 94-97 funding: \$40.0 million

This is a major new five-year program support effort designed to assist the GOI achieve its goal of reducing total fertility from 3.0 to 2.1 by the Year 2005. The purpose of this project is: (a) To increase the availability, utilization, and quality of long-term family planning methods, and (b) To improve the sustainability and impact of family planning services delivered through the private and non-governmental sector. Five grants will be awarded during the first year of implementation. One grant would be awarded to the central office of BKKBN to strengthen service delivery of long-term methods in six provinces, which contain 70 percent of the population. One smaller grant would be awarded to a BKKBN province directly in order to strengthen provincial sustainability. Three grants would also be developed between Pathfinder and three leading non-governmental organizations to strengthen NGO management capability and improve service delivery through the private sector. These organizations are: the Indonesian Doctors Association; the Association for Secure Contraception; and the Indonesian Public Health Association.

During FY 93, funding will be provided through a fund transfer from the Mission to the Office of Population. Funding for subsequent years will be based on the successful achievement of program outcomes, which will be specified in each grant proposal. It is envisioned that funding would be shared between the Mission and the Office of Population over the five-year period. A summary of the SDES plans developed to date is provided in Appendix 1.

Office of Population Centrally-funded Projects

Financial and technical support through the projects listed below would be provided from Office of Population central funds.

Title: Options for Population Policy II (OPTIONS II)

Contractor: The Futures Group

Estimated FY 93 budget: \$200,000

Estimated FY 94 budget: \$150,00

The OPTIONS II project will provide limited technical assistance for policy development and analysis during FY 93 and FY 94. OPTIONS will strengthen the analytic capabilities of BKKBN and non-governmental organizations to design policies, plans, and services which support program goals. Technical assistance will be provided to support: (a) strategic planning efforts; (b) effective resource allocation; and (c) a constructive legal and regulatory environment. Data analyses will be used to reduce economic, legal, and medical barriers to service delivery.

Following is a list of suggested activities the OPTIONS II project may carry out to support family planning development.

- Develop targets for changes in fertility, contraceptive prevalence and method mix at the national and provincial levels using *Determining an Appropriate Method Mix*, a manual with a simple methodology of how to use DHS data to design a mix of contraceptive methods, and the *Target* model which is a user friendly computer program which can be used to develop targets for the level of contraceptive prevalence in each province.
- Develop plans for appropriate service delivery mechanisms in each of the seven priority provinces, and estimate the cost of services for each province with the *Target-Cost* model which will calculate the difference in needs for

services and personnel for each province, and calculate the number of users and the number of each method, from each sources, each year, in each province.

- Build the capability of provincial level officials to develop their own plans by holding seminars and making technical assistance visits to selected provinces to work through each step of developing an effective plan and budget using the tools and processes described above.
- Develop plans to address possible changes in proximate determinants to fertility other than contraceptive use.
- Support greater family planning self-reliance by analyzing how many communities and users are participating in KB Mandiri, and at what level (pre, partial or full participation). Also, analyzing which communities and users could participate more fully in KB Mandiri (based on household possessions or socio-economic characteristics). Analyses could include a confirmation that women who pay for their family planning are better family planning users.
- Estimate actual costs of specific services to compare the cost effectiveness of different family planning options and to justify sudden increases in specific budget line items. This can rely on quick assessments based on international standards or on-site surveys of time use.
- Estimate the costs and benefits to consumers and providers of maintaining or changing regulations (e.g., prohibitions on the sale of oral contraceptives in certain places and restrictions on advertising).
- Develop a cost-benefit analysis of expenditures on family planning to develop an adequate appreciation of the financial advantages of investments in family planning.
- Prepare presentations to justify increases in budget allocations including references to the importance of family planning in Indonesia's overall development plan; a summary of BKKBN's innovative program approaches for service delivery and self-reliant family planning; a non-technical explanation of how costs were carefully calculated; and the cost-benefits of the proposed increase in expenditures.

Additional detail on the OPTIONS II program may be found in the references cited at the end of the report.

Title: Program for Voluntary Surgical Contraception

**Cooperating Agency: Association for Voluntary Surgical
Contraception (AVSC)**

Estimated FY 93 budget: \$750,000

Estimated FY 94-97 funding: \$4.0 million

AVSC has worked in Indonesia for 17 years to build institutional capability for voluntary sterilization services. AVSC has provided sustained technical assistance and core support to strengthen the management and service delivery capability of the Indonesian Association for Secure Contraception (PKMI). PKMI has been designated by the GOI to improve the quality and quantity of voluntary male and female sterilizations throughout Indonesia. Since sterilization is not an official method of the program, the financial and technical viability of this private organization is essential. Over the coming decade, use of long-term methods, including voluntary sterilization, must expand considerably to meet demand and to serve women's fertility preferences. AVSC provides technical expertise and training in all aspects of medical care and supervision, clinical training, infection control, quality assurance, and counseling.

AVSC has gradually reduced its support to the Indonesian program over the last several years for a number of reasons. It is recommended that AVSC renew and significantly expand its efforts in Indonesia. Following are illustrative activities which AVSC may carry out to strengthen the availability, quality, and use of voluntary surgical contraception.

- Improve referral systems for voluntary surgical contraception, including:
(a) referral training for private doctors and midwives; (b) referral training for fieldworkers and informal leaders; (c) referral training for satisfied acceptors; and (d) experimenting with the actual system for referring clients from field to clinical facilities.
- Improve education and information for voluntary surgical contraception, including: (a) expansion of social marketing projects currently underway as a pilot effort in two cities; (b) strengthen and target information, education, and communication (IEC) efforts around existing facilities, particularly those which are underutilized.

- Institutionalize new training elements and approaches into voluntary surgical contraception training programs in the eleven national training centers, particularly for infection prevention, compliance to standards, and clinical coaching.
- Set up master trainer (Training of Trainer - TOT) program for voluntary surgical contraception.
- Strengthen provincial medical supervision system program by: (a) training of supervisors; (b) ensuring stronger central support and involvement; (c) improving feedback at provincial and central level; (d) developing newsletter; and (e) expanding to other clinical methods.
- Continue to strengthen the quality of voluntary surgical contraception programs by: (a) working to improve standards; (b) working to improve compliance to standards; (c) establishing continuous quality improvement systems at clinical facilities; (d) continuing to improve clinical training; and (e) continuing to improve the counseling program.
- Provide continuing technical and financial support to PKMI.

One of the AVSC's first efforts will be to develop a multi-year country workplan, which specifies program objectives, activities, implementation process, collaborating institutions, program outputs, expected achievements, and funding requirements. This country workplan would be prepared collaboratively with the long-term resident advisor of the PSFP project, PKMI, and JHPIEGO.

Title: Program for International Training in Reproductive Health
(JHPIEGO)

Cooperating Agency: Johns Hopkins University Program
for International Training in
Reproductive Health

Estimated FY 93 budget: \$900,000

Estimated FY 94-97 funding: \$4.0 million

This is an on-going program in which JHPIEGO provides technical support to the BKKBN national program for IUD and NORPLANT® clinical training. JHPIEGO works primarily with BKKBN to develop national and provincial training plans and training centers. JHPIEGO also works with selected non-governmental organizations, hospitals,

and medical schools to institutionalize training capabilities. JHPIEGO provides technical assistance to: (a) strengthen pre-service and in-service clinical skills of physicians and other health care providers; (b) develop supervision and medical monitoring systems for clinical contraceptive methods; and (c) improve the quality of services delivered.

Title: Promoting Financial Investments and Transfers
(PROFIT)

Contractor: Deloitte and Touche

Estimated FY 93 budget: \$500,000

Estimated FY 94-96 funding: \$3.0 million

PROFIT's involvement in Indonesia is proposed as a new initiative to develop private commercial employer-provided services, particularly in industrial parks. The most immediate intervention would be to provide support to a local non-profit foundation (YKB) to operate a pre-paid Health Maintenance Organization or fee-for-service clinic in the JIEP Industrial Estate, which contains over 275 firms and employs over 30,000 workers. PROFIT would provide start-up funds for equipment, enrollment, advertisement, training, and technical assistance. Additional information on PROFIT activities may be found in the Country Assessment which PROFIT conducted recently. The reference is cited at the end of this report.

Title: Demographic and Health Surveys III

Contractor: Macro International, Inc.

Estimated FY 93 funding: \$190,000

Estimated FY 94 funding: \$300,000

Estimated FY 97 funding: To be determined

Funds will be provided for Macro International, Inc. to undertake a national Demographic and Health Survey in 1994. Funds for this survey will also be provided through the bilateral PSFP, by BKKBN and the Ministry of Health. This survey will provide nationally representative data on fertility, mortality, health, child survival and AIDs. Another DHS survey is recommended in 1997.

Title: International Population Fellows Program

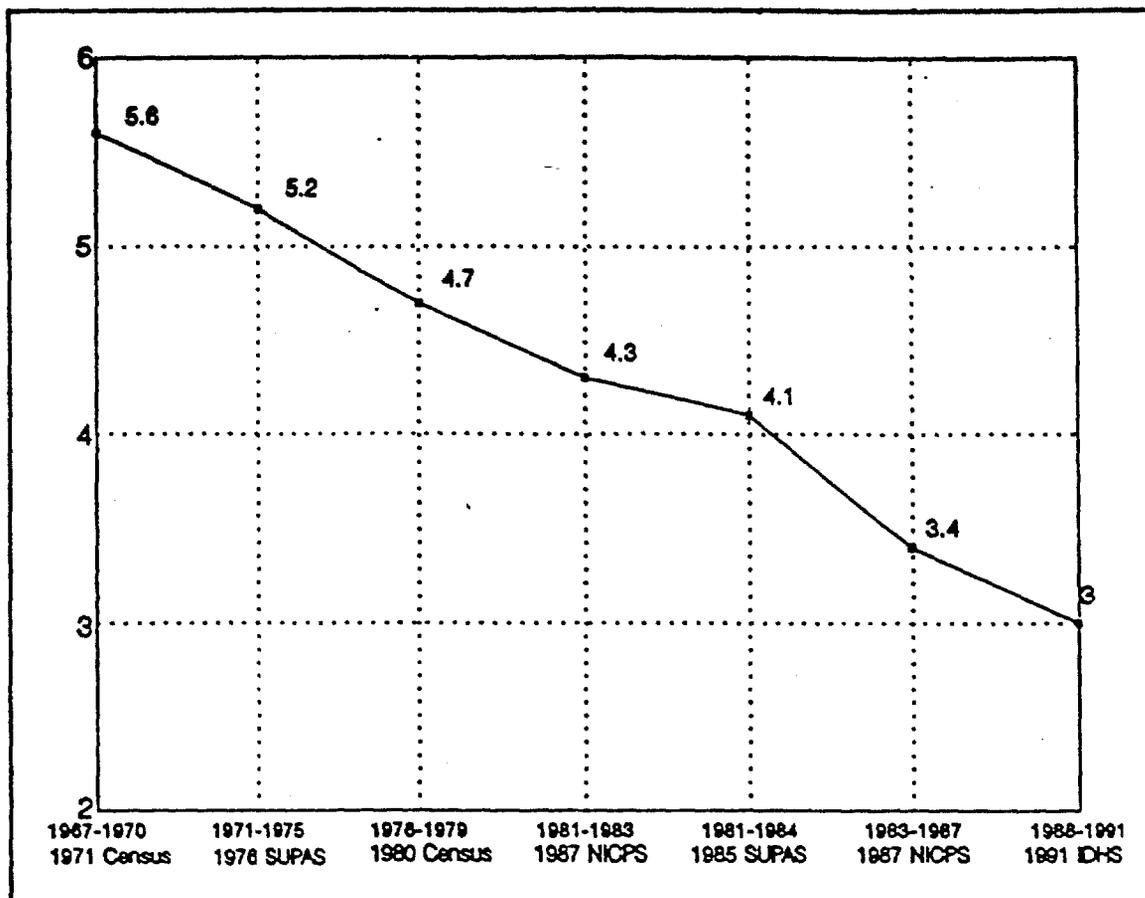
Cooperating Agency: University of Michigan

Estimated FY 93 funding: \$200,000

Estimated FY 94-96 funding: 400,000

A senior Population Fellow will be assigned to Indonesia for a period of two to four years. The scope of work for this fellow will be to assist the Mission provide technical and financial monitoring of the centrally-funded population project portfolio.

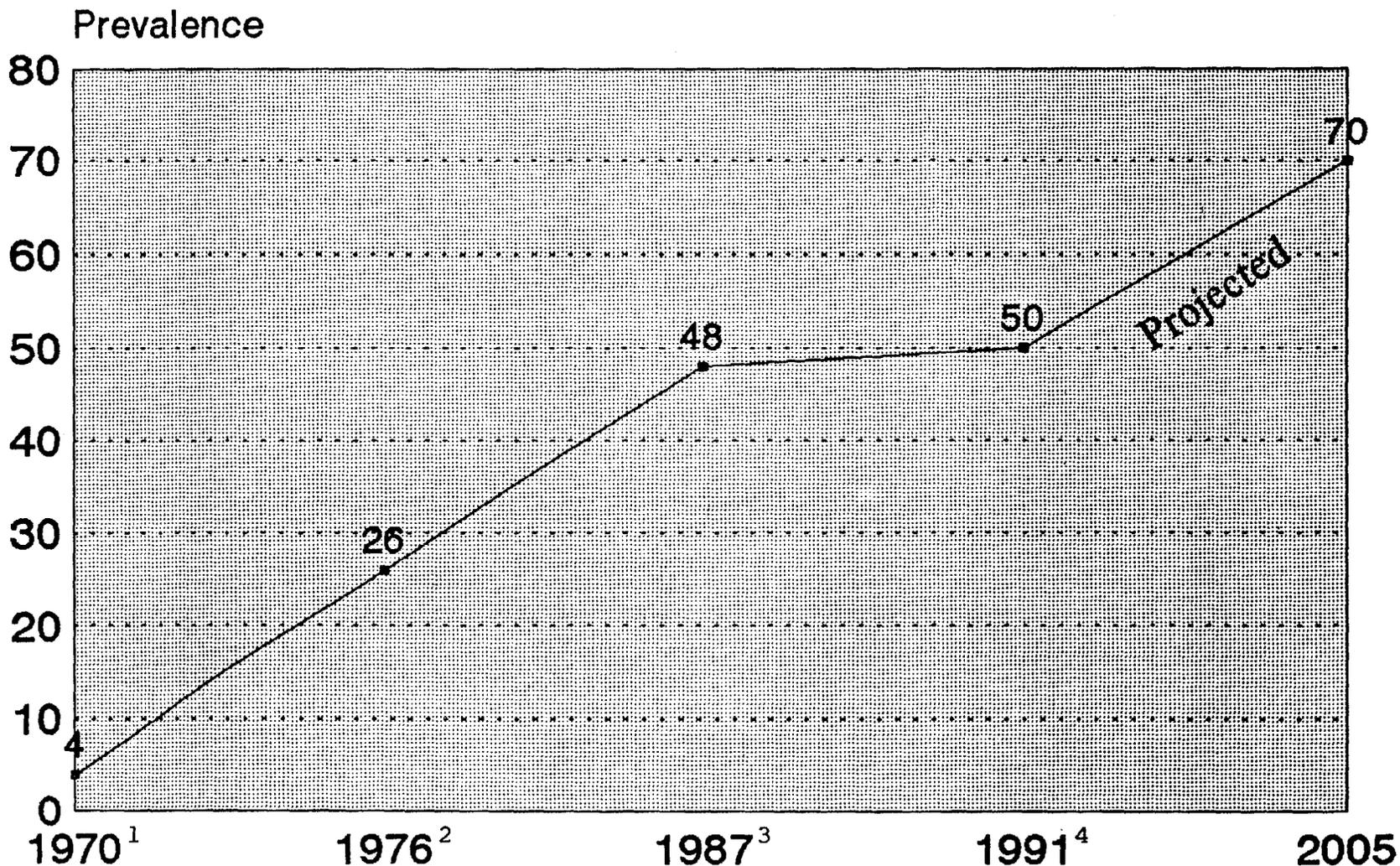
**Indonesia: Total Fertility Rates
(1971-1991)**



Source: Indonesia Demographic and Health Survey, 1991: Preliminary Report, (1991:24).

Note: 1971 Census, 1976 SUPAS, 1980 Census, and 1985 SUPAS estimated using the "own children" method. 1987 NICPS and 1991 IDHS calculated directly from birth history data. SUPAS = Inter-Censal Population Survey, NICPS = National Indonesian Contraceptive Prevalence Survey, IDHS = Indonesia Demographic and Health Survey

Percent of Currently Married Women Aged 15-49 Using Contraception in Indonesia, 1970-2005



Source:

1. Estimated Prevalence.
2. Java-Bali only. 1976 SUPAS.
3. 1987 National Indonesian Contraceptive Prevalence Survey.
4. 1991 Indonesia Demographic and Health Survey (1991 IDHS).

—●— CPR

Figure 2

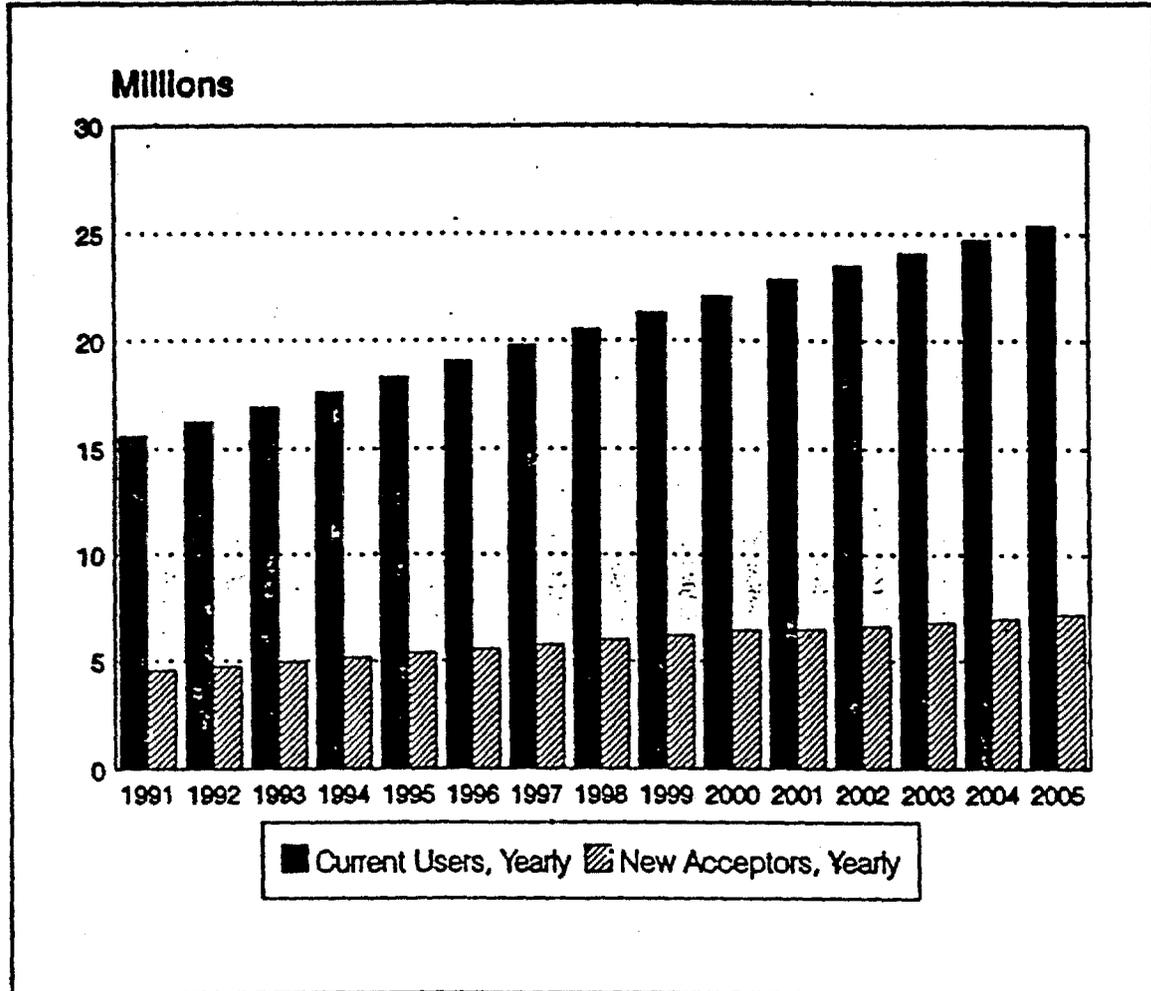
**Percent of Currently Married Women Using Contraception
and Total Fertility Rate (Selected Provinces)
(1976, 1987 and 1991)**

Region	CPR	TFR ¹
Java-Bali	53.4	2.68
Jakarta	56.0	2.14
West Java	51.0	3.37
Central Java	49.7	2.85
Yogyakarta	71.3	2.04
East Java	55.4	2.13
Bali	71.9	2.22
Outer Islands I	43.5	3.50
Outer Islands II	42.8	3.75
Indonesia Total	49.7	3.02

Source: Indonesia Demographic and Health Survey 1991

^{1/} TFR = Sum of age specific fertility rates or the average number of births a hypothetical group of women would have at the end of their reproductive lives if they were subject to the currently prevailing ASFR age 15-49

**Current Users and New Acceptors, Yearly,
to Achieve a CPR of 62.7 by 2005**



Source: 1991 IDHS and team calculations

INDONESIA

LOCATION OF SDES

1. NORTH Sumatra

2. South Sumatra

3 Lampung

4 West Java

5. Centre of Java

6. East Java

7. South Sulawesi

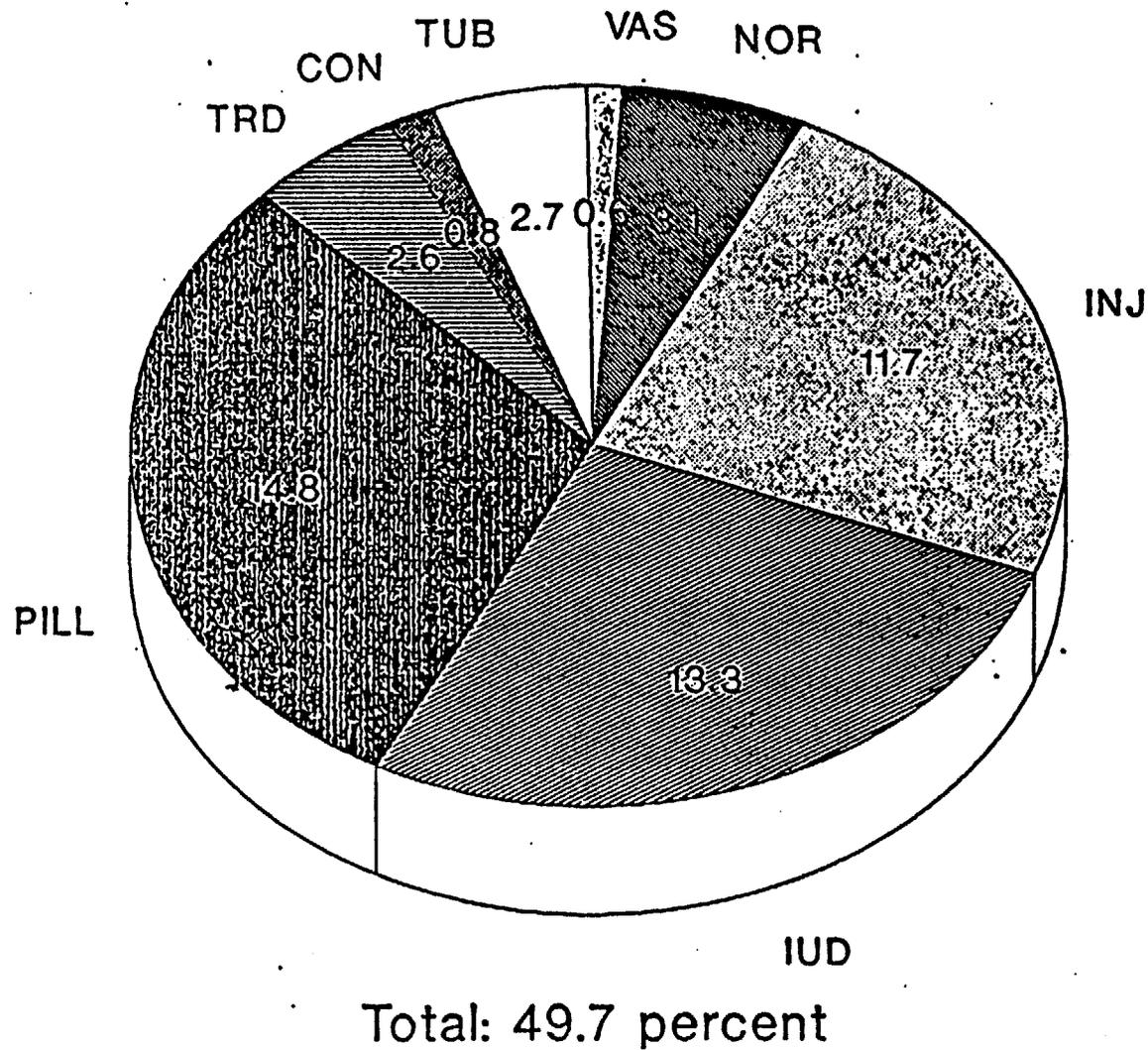
Selected Indicators for Selected Geographic Areas, Indonesia

Province:	Total Fertility Rate (a) 1991	%MWRA Using Any Method (1)	%MWRA Using Long-term Method (1), (2)	Total Population 1990 (3) (000s)
<u>Go.A. - High Fertility</u>				
North Sumatra	4.17	37.2	14.2	10,252
West Java	3.37	51.0	12.8	35,378
South Sumatra	3.43	47.1	16.2	6,276
Lampung	3.20	53.8	18.3	6,004
<u>Go.B. - Moderate Fertility</u>				
South Sulawesi	3.01	37.1	8.3	6,981
Central Java	2.85	49.7	23.0	28,517
<u>Go. C. - Low Fertility</u>				
East Java	2.13	55.4	29.8	32,488
Subtotal 7 Provinces				125,896 (72%)
Total Indonesia	3.0	49.7		179,000

Notes:

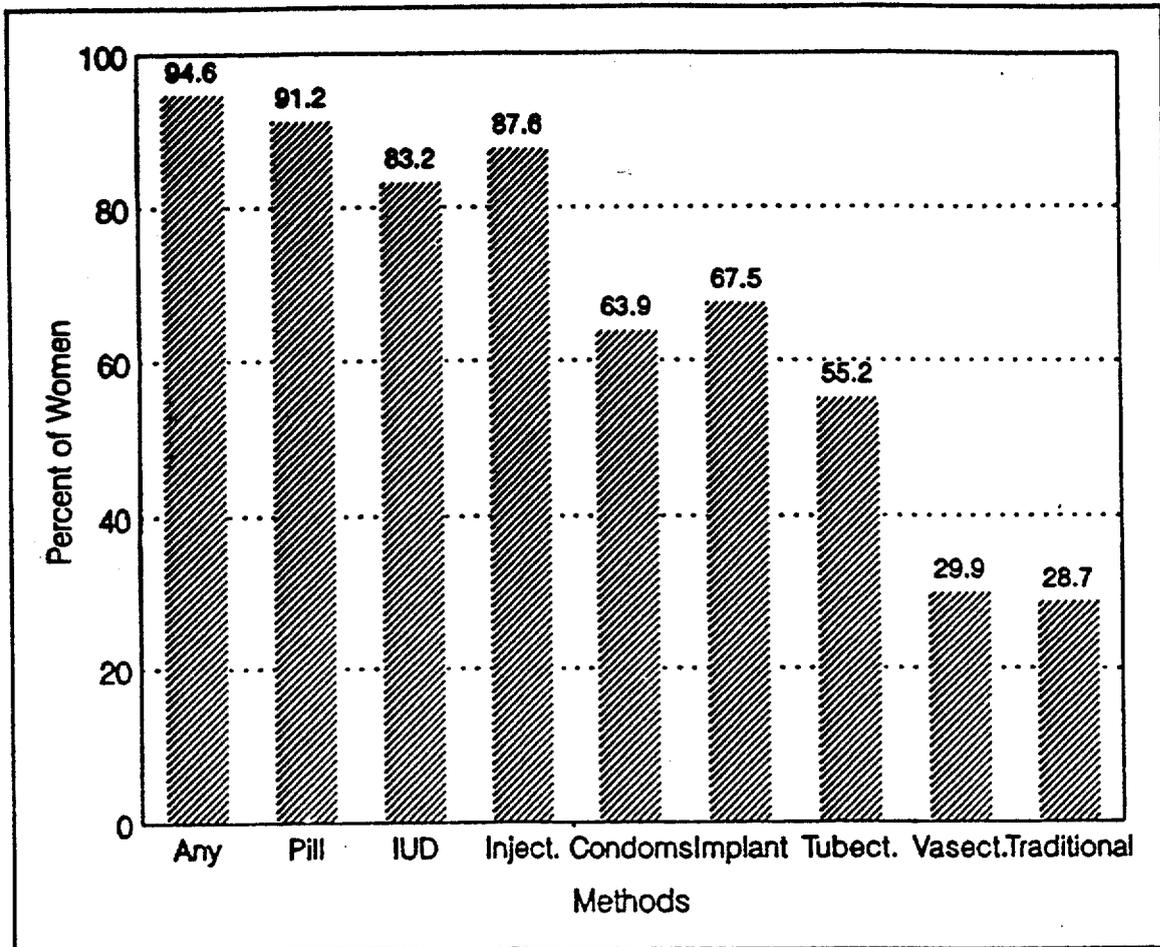
1. Sources: 1991 Indonesian Demographic & Health Survey;
2. Long Term Methods include:
IUDs, Norplant, Male and Female Voluntary Sterilization;
3. Sources: 1990 Census of Population. These seven provinces are the largest in absolute population size, and together comprise over 70 percent of the 1990 total population.

Percentage of Currently Married Women Using Contraception by Methods, 1991



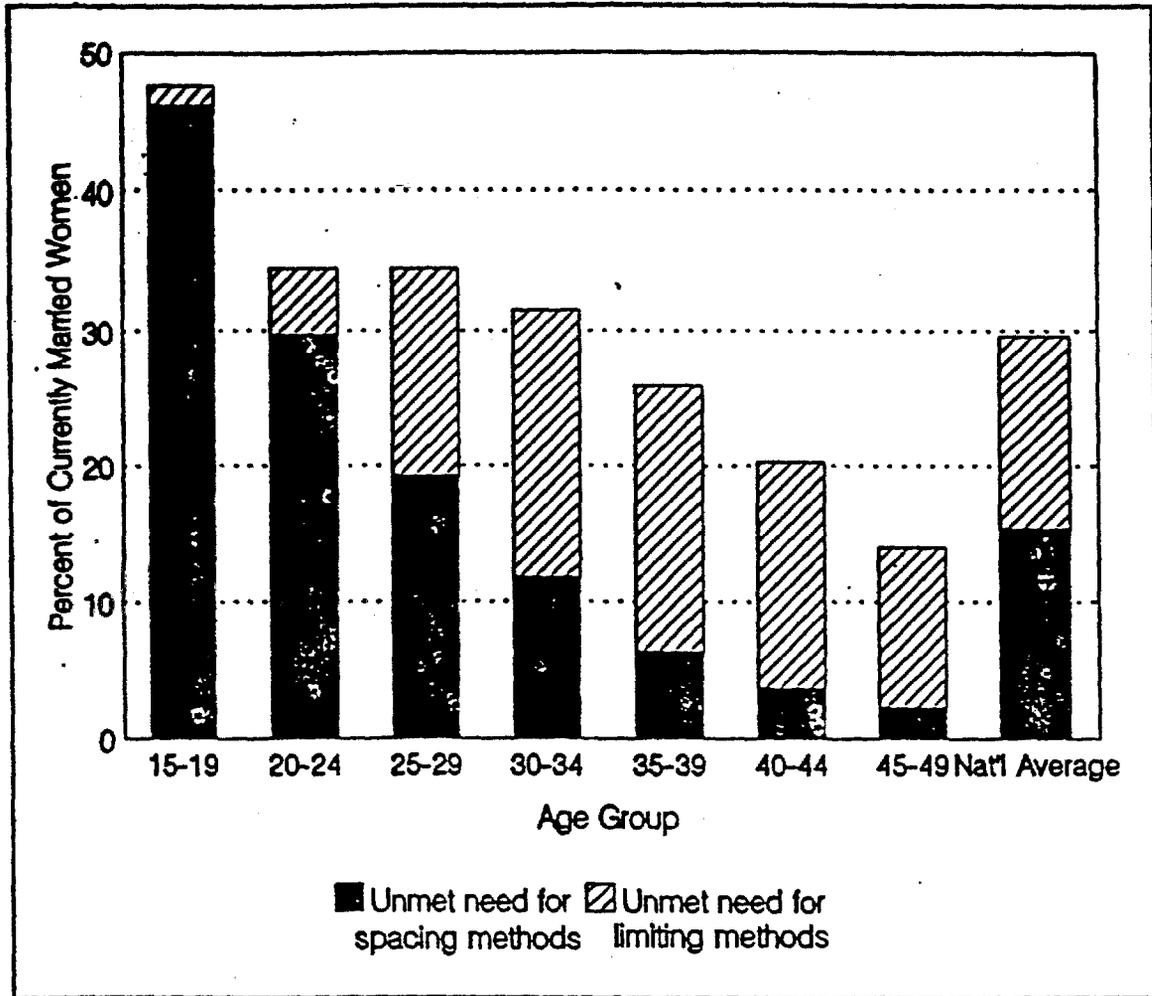
Source: 1991 IDHS

Indonesia
Currently Married Women (ages 15-49):
Knowledge of Particular Methods



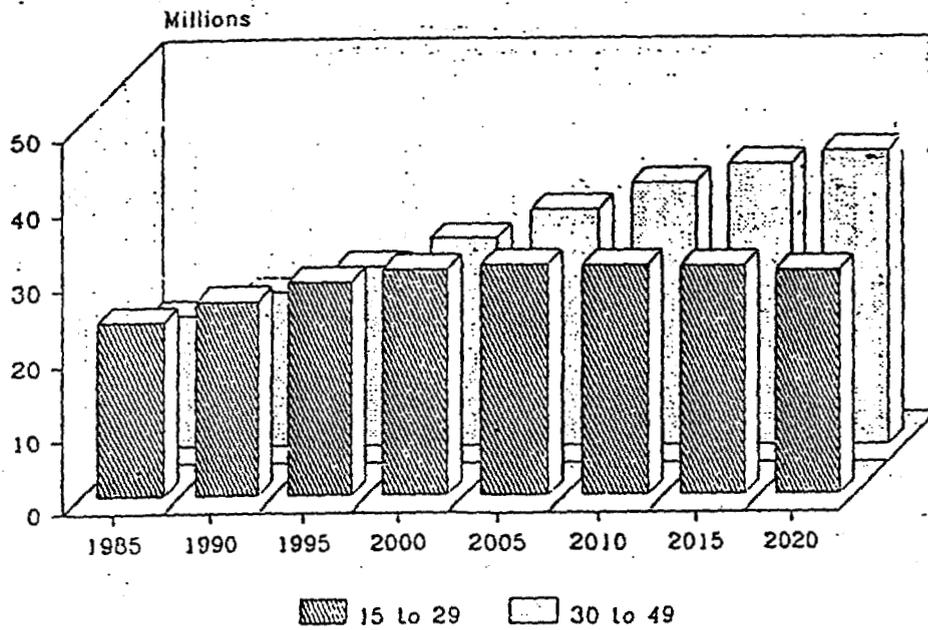
Source: 1991 IDHS

Unmet Need for Family Planning among Married Women of Reproductive Age
(Ages 15 to 49)



Source: 1991 IDHS

Figure 4.5 Reproductive Female Population in Indonesia
1985-2020



Source: Analysis of 1990 Census Data (provided by USAID)

Public & Private Sector Contribution to Program, Method Mix

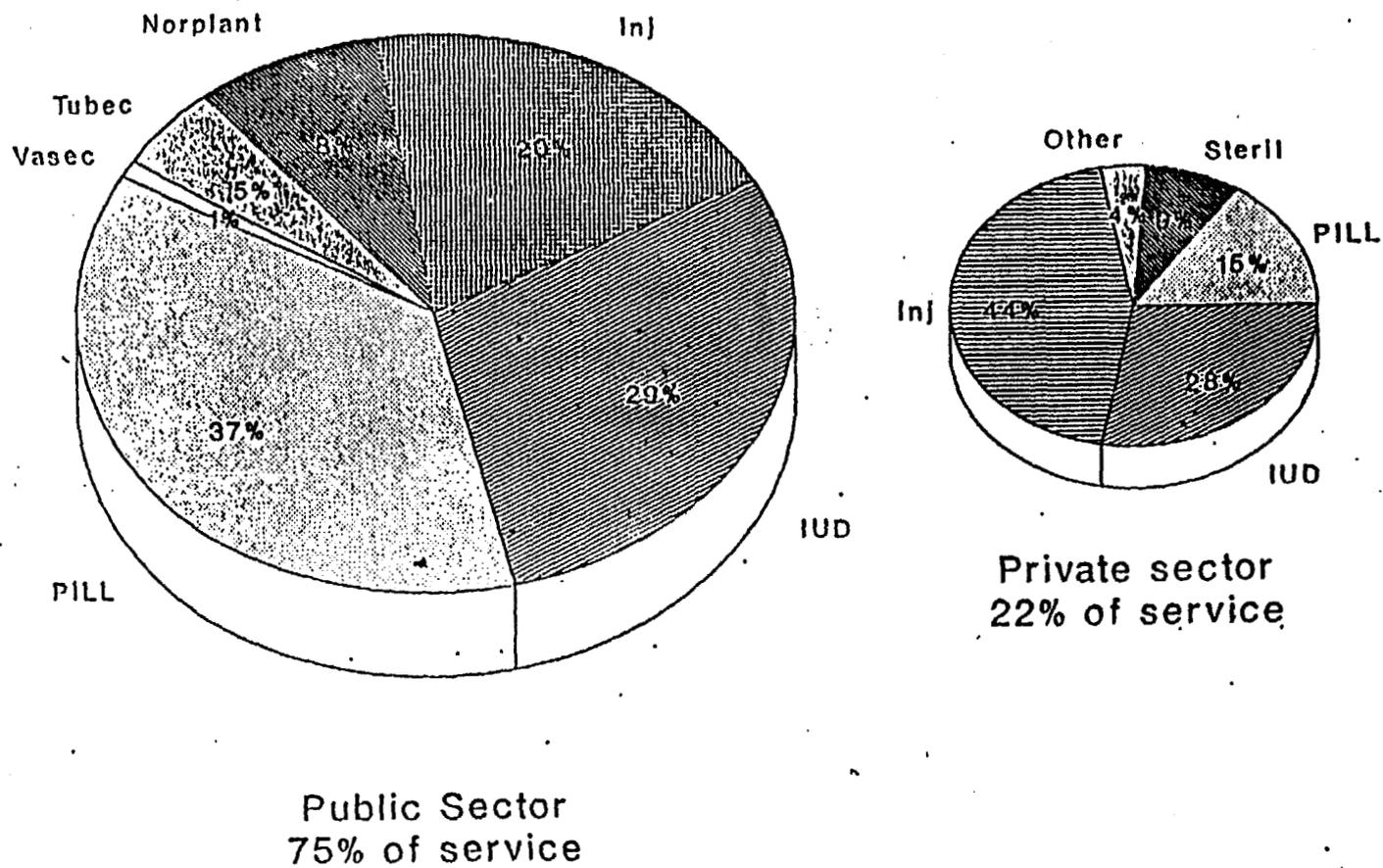


Figure 11

Source: Indonesian Demographic and Health survey, 1991

**COOPERATION BETWEEN PATHFINDER
AND GOVERNMENT OF INDONESIA**

EXPANSION OF FAMILY PLANNING SERVICE DELIVERY

Goal: To assist the Government of Indonesia to achieve its goal of replacement level fertility (TFR 2.1) by the year 2005.

Purpose:

- A. To increase the availability, utilization, and quality of long-term family planning methods.
- B. To improve the sustainability and impact of family planning services delivered through the private and non-governmental sector.

Relationship to USAID/Jakarta Mission Strategy: Provides sector support to achieve Mission Strategic Objective No. 4: "Improved Balance in Public and Private Provision of Basic Services".

Duration: Project duration is five years: May 1993 - May 1998.

Funding: Funding requirements will be based upon the detailed proposals to be developed by around February/March 1993. **ESTIMATED** first year funding is around \$10 million and **ESTIMATED** five-year funding is around \$50 million.

Program Description:

Pathfinder's SDES program in Indonesia will address issues which were identified either by surveys or by the Indonesian Government as areas requiring special attention. Some of these issues and the program focus areas responding to these issues are listed below:

The Issue

- * Seventy-six percent of women who have expressed unmet need for family planning services are over 25 years of age.
- * Of the modern method users 19.7 percent use long acting methods while 26.8 use pill, injectables and condoms.

Program Focus

- * Strengthen service delivery of long term methods; for the limiters, emphasize VSC.
- * Increase the number of service posts where long-term methods are provided; increase the number of long-term methods' service providers.
- * Improve the skills and knowledge of long term methods

service providers.

* 45 percent of married women who are not using any kind of contraception stated that they did not want any additional children (about 7 million women).

* GOI wants private sector to be an important component of family planning service delivery and to increase its share in family planning services from current 22 percent to serving 50 percent of couples by the year 1995.

* There are unexpected differences in the level of fertility between provinces with similar CPRs. This may be due to the difference in the use of effective methods and the continuation of method use. Both of these are closely related with quality of services.

* Increase information and services of long term methods to women who are users of other methods or who are not using any method.

* Strengthen service delivery capacity of private family planning organizations by providing direct support to more mature NGOs and through BKKBN to less mature NGOs.

* Increase the number of private family planning service providers such as private physicians, midwives, and pharmacists.

* Improve the quality of services; emphasize user satisfaction and other quality issues in training programs.

Pathfinder's support for the Indonesian family planning program will have three major components:

- I. Program support to BKKBN to strengthen long-term methods, to strengthen community networks to focus on hard-to-reach groups, to strengthen family planning service provision by less mature non-governmental organizations, and to support the coordination and monitoring function of BKKBN.
- II. Program support to selected, more mature non-governmental organizations to strengthen service delivery capabilities;
- III. Support for innovative and pilot activities.

Each of these components is described more fully below.

At the end of the first year of the program an evaluation will be conducted. These results will determine the share of BKKBN and NGOs, specific objectives and the workplan for the following year.

COMPONENT I. PROGRAMMATIC SUPPORT TO BKKBN.

The National Family Planning Board (BKKBN) is the primary Organization which has the responsibility for family planning programs in Indonesia. Family planning activities of the Ministry of Health, Armed Forces, Other Ministries and NGOs and other voluntary groups are coordinated by the BKKBN. BKKBN has 48,000 employees 33,000 of which are family planning field workers.

The goal of this component of the program will be to increase and improve availability, utilization, and sustainability of family planning services in seven densely populated provinces: East Java, West Java, Central Java, North Sumatra, South Sumatra, Lampung, and South Sulawesi. In 1990, these provinces contained 70 percent of the total population. The number of women in reproductive ages in these provinces exceeds 21 million.

This component will have the following four purposes:

1. To enhance and promote long-term, effective family planning methods, including: IUDs and NORPLANT.
2. To strengthen community participation focused on hard-to-reach groups.
3. To strengthen the capabilities of private sector and non-governmental professional organizations.
4. To support the coordination and monitoring functions of BKKBN.

Illustrative activities which would be conducted in this Component of SDES are described below.

Purpose 1. Enhance and promote long-term methods.

Activities:

- A. Information, Education, and Communication:
 - A.1. Intensification of IEC for long-term methods (materials, interpersonal communications and directed media support).
 - A.2. Strengthen provider training and referral systems to clinical facilities.
- B. Contraceptive Service Delivery to improve the acceptance and effective use of long-term methods in 7 provinces:
 - B.1. Training to refresh the knowledge, attitudes and skills of particular providers: IUD and implant training for medical doctors and midwives;

counseling training for all family planning service providers including field workers; medical IEC training for family planning field workers.

- B.2. Procurement of medical equipment for all training participants, including: IUD kits, implant kits, IEC kits.
- B.3. Training aids procurement and distribution to medical training centers and sub-training centers, such as: NORPLANT training arm models, vasectomy models, guidance books.
- B.4. Quality assurance activities to improve the quality of long-term methods through strengthening quality assurance teams at provincial and district levels. Activities consist of: quality assurance training for quality teams; regional meetings; supervision and review.
- B.5. Coordination, monitoring and evaluation to support project implementation at all levels, as well as annual project assessments and a final evaluation.
- B.6. Policy meeting to address new approaches to service delivery of family planning and roles of NGOs.
- C. Identify economic and medical barriers. Develop pilot projects aimed at testing and implementing policies to lower economic and medical barriers.
- D. Improve quality of family planning services as reflected by improved method mix and continuation rates.

Purpose 2. Strengthen Community Participation among Hard-to-Reach Groups

Specific objectives (in target areas only):

- 1. To strengthen community institutions to become active participants in family planning motivation, management, and distribution of contraceptives.
- 2. To develop and maintain mechanisms among community institutions at the village level (VCDCs, sub-VCDCs, acceptors groups, cadres, cooperative staff) and between the community institutions and providers, especially midwives, at the village level.

Activities:

- A. IEC. Development of IEC interventions from specific target audiences in 4 provinces: South Sumatra, Lampung, North Sumatra, and West Java. Target audiences include:

coastal areas, urban slums, plantation areas.

B. Operational Activities.

- B.1. Training/orientation for cadres (VCDC, acceptors groups), staff of cooperatives, midwives, new field workers, chief of village, head of district.
- B.2. Refresher training for above.
- B.3. Development and distribution of operations manuals for community institutions, referral agents and providers.
- B.4. Performance reviews for community institutions at village levels: quarterly meetings between VCDC and sub VCDC, quarterly meetings between sub VCDC and acceptors groups, and cooperatives, midwives and field workers.etc.
- B.5. Mini surveys to evaluate activities.
- B.6. Supervision and monitoring.

C. Service Expansion which lowers economic, social, and medical barriers to acceptance among hard-to-reach groups.

Purpose 3. Strengthen the Capabilities of Private Sector and Non-Governmental Organizations.

Specific Objectives:

- 1. To strengthen the capability of both NGO and private sector providers and institutions.
- 2. To increase the contribution of private sector and NGO providers and institutions to meeting the GOI's family planning goals.
- 3. To promote program sustainability.
- 4. To strengthen the financial and management capacity of large service provision NGOs to enable them to receive direct SDES funding from Pathfinder.

Activities:

- A. Strengthen family planning service delivery, and technical capabilities of NGOs which provide family planning services but which have not yet reached financial and programmatic capability required for direct funding under SDES. Examples of such NGOs are: the Indonesian Midwives Association (IBI), Mohammadiyah, Nahdatul Ulama, Nahdatul Wathan.
- B. Provide limited support to NGOs which are not engaged in service delivery but which indirectly support family planning, or help to provide a favorable environment for

family planning. Examples of such organizations are: the Indonesian Demographic Association (IPADI), the Indonesian Sociological Association (ISI), the Indonesian Psychological Association (ISPI), and others.

- C. Strengthen administrative, financial and programmatic management capabilities of private sector family planning service provision organizations which have not yet reached the maturity required for direct SDES support. Through this support the volume, quality, and impact of family planning services delivered by private organizations is expected to significantly increase. Types of support BKKBN will provide to these organizations are: technical training for members of IBI; training in the contraceptive distribution system for members of the Indonesian Pharmacists Association (ISFI); procurement of teaching aids; printing of manuals of standards for quality of care; procurement of medical equipment, such as NORPLANT kits, IUD kits, head lamps, and OB-GYN beds (for IBI).
- D. Improve awareness and adoption of voluntary sterilization in private hospitals and reduce medical barriers through information.
- E. Expand the involvement of service providers by giving more opportunities to new private sector and NGO groups and individuals in the provinces.
- F. Develop pilot projects to lessen the economic burden for acceptors in order to maximize both acceptance and sustainability.

Purpose 4. To support the coordination and monitoring function of BKKBN.

Activities:

- A. Planning: Provide assistance to BKKBN provincial offices and NGOs in designing grant proposals, especially in setting objectives, establishing performance indicators and targets, and in developing annual activity plans.
- B. Monitoring and Review: Support for monitoring of project activities to assure that projects are implemented as approved and planned.
- C. Support for periodic coordination meetings with provincial offices and NGOs.
- D. Support for project evaluation activities.

**COMPONENT II. STRENGTHEN SERVICE DELIVERY
CAPABILITIES OF NON-GOVERNMENTAL ORGANIZATIONS.**

With BKKBN assistance and approval, Pathfinder will provide direct grants to three major private sector professional organizations under this component.

A. **The Indonesian Association for Secure Contraception (PKMI):** This organization has a demonstrated capability to provide high-quality, voluntary surgical contraception services through its extensive network. Pathfinder will provide support to PKMI in order to assist it to expand and improve male and female voluntary sterilization initially in 14 provinces. These provinces can be divided into two groups according to level of existing of sterilization services.

1. North Sumatra, South Sumatra, Lampung, West Java, Central Java, East Java and South Sulawesi are provinces where VSC services already exist. In fact 90 percent of VSCs in the country take place in these provinces. However, the VSC facilities and the staff are not utilized efficiently and there is still a high level unmet demand for sterilization in these provinces.

BKKBN program with SDES funds will also focus in these seven provinces. Therefore, PKMI, working closely with other public and private family planning service providers, will undertake a program which aims at increasing the demand for and client satisfaction in VSC services and better utilization of the existing VSC services. This will be achieved through development of an effective referral system, establishment of a subsidy program for the VSC service points, and by strengthening the VSC quality assurance program.

TABLE I: NUMBER OF VSC CLINICS AND NEW ACCEPTORS FOR FY 1991/92

PROVINCES	VSC FACILITIES	NEW ACCEPTORS (In Thousands)
West Java	893	28,673
Central Java	602	37,027
East Java	392	29,286
North Sumatra	304	14,438
South Sumatra	177	5,642
Lampung	154	4,004
South Sulawesi	103	979
TOTAL	2,629	120,049

2. The second group of provinces SDES funds will be utilized by PKMI are provinces with high potential for VSC demand and services and relatively large population concentrations but where VSC services are not adequately established. These provinces are: West Sumatra, Riau, West Nusa Tenggara, East Nusa Tenggara, West Kalimantan, South Kalimantan and North Sulawesi.

The program focus for the latter seven provinces would be clinical and counseling training for the VSC service providers, provision of necessary equipment for the VSC clinics, improvement of VSC referral system network and increasing the VSC subsidies for the service points.

The third focus area for the use of SDES funds for PKMI would be activities associated with the improvement of PKMI's management capability.

The total first year budget for the above activities by PKMI is expected to be around \$2 million. It is expected that about 43 thousand additional new acceptors will be generated through this program.

B. Indonesian Medical Association (IDI):

IDI is the only NGO recognized by the Indonesian government which is established with the goal of enhancing health conditions of the Indonesian people through support of and working together with Indonesian physicians. At present IDI has about 30,000 members distributed through 196 IDI branches throughout the country.

In the past, all physicians regardless of whether they had private practice or not were employed by the Government. Therefore, any income they earn through their private practice was supplementary to their government salary. Recently, the Indonesian government declared a policy change in which new medical school graduates will no longer be guaranteed government jobs. Thus, there will be growing number of physicians who would have to earn their living through private practice. This new policy brought a new responsibility and role for IDI-- Provision of on-the-job training to physicians to upgrade their skills and knowledge or gain new skills in various medical areas. Both from the view of National policy regarding demographic targets and its potential income generating effect, family planning skills training for especially general practitioners is a priority for IDI members.

Given the significance of its new expanded responsibility and role and potential impact of its involvement IDI qualifies as one of the major private sector organizations to receive direct SDES funding.

During the first year of SDES program IDI will first establish five training centers in five major provinces to carry out its family planning training activities. Secondly, 16 senior IDI trainers will be trained as family planning service providers' trainers with special emphasis on long term methods and on quality of care, particularly, as it relates to continuity of use of methods. Finally, about 240 doctors from selected 8 provinces will be provided with family planning training. Estimated long term method acceptors resulting from this training during the first year is about 29,000.

IDI will develop and distribute various training materials on quality family planning service delivery.

The amount of SDES funds to be used in support of first year IDI program would be around \$220,000.

C. Indonesian Public Health Association (IAKMI):

Established in 1967 IAKMI has about 2000 members. Each year another 200-300 new members are added to this number. IAKMI members represent a wide range of professional areas. Seventy percent of IAKMI members hold a Masters degree and over 60 of them have Doctoral degrees in various disciplines.

Support to IAKMI will have two main components. First, to enable IAKMI to provide technical assistance to other NGOs which have a critical role in private sector family planning service delivery. Under this component IAKMI initially will provide support to Muhammadiyah and Nahdatul Ulama. Muhammadiyah is an Islamic organization and was established in 1914. This organization in addition to their religious training activities has always had health services and other social programs. In 1970s Muhammadiyah started its first family planning services with the support of Pathfinder. Today there are 276 Muhammadiyah clinics, health centers and hospitals throughout the country. Muhammadiyah also has educational institutions such as the Nursing Academy, Hygienists Academy and Nutritionists Academy.

Nahdatul Ulama (NU) was established in 1926 and like the Muhammadiyah is a religious organization. NU runs thousands of informal religious schools called Pesantren. Membership of NU exceeds 30 million people. NU's primary focus is social services. Through various social units within the organization NU provides social services to its membership. NU family planning services are offered through this network of various units such as, Women Affairs, Mother Affairs, Family Affairs, and Human Resources and Development.

IAKMI's support for these NGOs will focus on family planning training for its staff and technical assistance in the management, supervision and evaluation areas.

Second component of the support for IAKMI will be to assist IAKMI to develop a consultant data base and technical services capability within the organization. The rationale for this component is to enable better utilization of skills of Indonesian trained manpower for the fulfillment of various organizations' technical assistance and management development needs.

In addition to these two components Pathfinder will provide technical assistance to IAKMI to improve its management capabilities and to implement the above two programs effectively. The total amount of first year funding for IAKMI program is expected to be around \$300 thousand.

COMPONENT III. PILOT AND INNOVATIVE OR CATALYTIC ACTIVITIES

This component will provide support to complement, enhance, or accelerate the SDES program through the standard Pathfinder project funding mechanism (e.g., for innovative activities not eligible for SDES support). The highest priority activities in this component will be: (a) activities which test new approaches to service delivery through the private sector or hard-to-reach target groups; and (b) activities which serve to reduce medical, price, and policy barriers to the provision of long-term methods.

PROGRAMMATIC AND FINANCIAL MANAGEMENT

A. Proposal Development

1. Proposals for PKMI, IDI, and IAKMI (NGOs which will receive direct funding from Pathfinder). The Pathfinder country representative, working together with BKKBN, Pathfinder Asia/ Near East regional staff and NGO directors, will develop detailed project proposals according to the format outlined in Pathfinder's project development guidelines. BKKBN central office will approve all proposals for NGOs. Expected completion date for NGO proposals: January 1993.
2. Proposals for BKKBN. Pathfinder provided each BKKBN Provincial Chairman and central office with a questionnaire regarding the description of current family planning activities and funding sources to eliminate potential duplication. BKKBN provinces completed this questionnaire and returned it to the Central BKKBN office in Mid-November. Basic programmatic components of provincial plans, which would be developed according to the format outlined in Pathfinder's project development guidelines, will be submitted to BKKBN central office by November 20th. BKKBN central office will review these documents with Pathfinder's Country Representative. During November 1992 through February 1993, Pathfinder's country representative, Pathfinder's Asia/Near East Regional Office representatives, and a representative from BKKBN, will visit each province to develop detailed project proposals. Expected completion date for BKKBN proposals: February 1993.

B. Financial Management.

Pathfinder's established procedures, namely, development of a payment schedule based on workplan and budget, provision of quarterly advances depending upon receipt and acceptability of required reports (program and financial), pre-award assessment, and compliance auditing will be used.

Pre-award analyses which assess management capability, financial viability, and technical assistance needs, will be performed by Pathfinder's Internal Auditor in January 1993. The decision to fund an organization is made by Pathfinder management including the regional vice president, financial vice president, and in-country staff.

Pathfinder's oversight procedures are designed to assure early detection of inappropriate use of federal funds and/or programmatic failures, and to assure the grantee that it is meeting the requirements it has agreed to in accepting the award.

Funding mechanism for Pathfinder SDES Program:

- (a) AID/Washington will release funds to Pathfinder upon approval of Pathfinder's project proposal by the AID/Washington and concurrence from BKKBN and USAID/Jakarta. From then on, management and accountability for these funds will rest with Pathfinder.
- (b) Pathfinder will disburse funds directly to:
 - i. The central BKKBN office and province(s) designated by BKKBN for expansion of family planning services in seven provinces and management strengthening of service NGOs not yet eligible for direct funding from Pathfinder.
 - ii. The selected NGOs as discussed previously in Component II.
- (c) Depending on the payment schedule to be prepared according to planned project activities and the chronogram, Pathfinder will advance funds at the onset of project activities covering up to the first two quarters of the project. Payment schedules for individual projects will be prepared according to project activity and expenditure workplans.
- (d) After the end of the second quarter, project funds will be released based upon completion of project activities planned for each quarter and actual expenditures that took place during the previous quarters.

Plans will be structured to eliminate the possibility of overlap and budgets will be based, to the extent practical, upon units of accomplishment. Over the five-year life of the program, the funding will increasingly favor the private sector as its capacity is developed. In addition, based upon the experience of the first year of the SDES program, budgets and payment schedules for second and subsequent years will move closer to performance-based payments to the extent permitted by the Pathfinder Cooperative Agreement with AID.

C. Project Oversight.

A Project Advisory Committee will be formed jointly by BKKBN and Pathfinder with representatives from BKKBN, USAID/Jakarta, Pathfinder, and each NGO grantee. This committee will meet quarterly to review program progress and to make recommendations to BKKBN, NGOs, and Pathfinder on any adjustments that might be needed during project implementation.

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The ultimate objective of the SDES support to Indonesia is to assist Indonesia to achieve its demographic goal of reaching replacement level fertility by the year 2005. Therefore, reduction in fertility would be the most direct indicator of any family planning program's success. However, the SDES program will consist of five projects with different objectives, target groups and activities. Therefore, each project will have a set of indicators relevant to project's objectives. Also, performance indicators for short term and for the end of the five years program would be different. All five projects would primarily be service delivery projects so there would be some common objectives. However, the performance indicators may not be necessarily be applicable to all projects. Below are some examples of possible performance indicators for the SDES program.

Appropriate performance indicators for each project will be identified by Pathfinder together with BKKBN and NGOs implementing the project.

Some examples of the indicators relating to service outputs from clients' perspective are:

- . Number of male and female sterilization cases.
- . Numbers of acceptors and continuation rates for IUDs and Norplant.
- . Proportions or numbers of women who have switched from less effective methods to long-term methods.
- . Improved balance between the methods used and women's family planning needs based on fertility preferences (eg. long-term methods for limiters).

From the program perspective are:

- . Increase in the share of family planning services by private sector.
- . Increase in the number of mature private sector family planning organizations which qualify for SDES direct funding.

From the population/impact perspective are:

- . Increase in the use of long-term methods.
- . Contraceptive prevalence level by method.
- . Reduction in the unmet need for family planning.
- . Reduction in Total Fertility Rate.

References

Central Bureau of Statistics, National Family Planning Coordinating Board, Ministry of Health, and Demographic and Health Surveys-IRD/Macro International. *Indonesia Demographic and Health Survey 1991*. October 1992.

Curtin, Leslie B., Charles N. Johnson, Andrew B. Kantner, and Alex Papilaya. *Indonesia's National Family Planning Program: Ingredients of Success*. Occasional Paper No. 6., Population Technical Assistance Project, Arlington, VA. 1992.

Galway, Katrina. "Planning for an Expansion in Family Planning: Suggested Analyses to Help Identify an Age Structure of Contraceptive Use and a Contraceptive Method Mix to Reach Replacement Fertility." Paper prepared for USAID Mission. The Futures Group, Washington, D.C. October 1992.

Haryono, Suyono. "Address of National Family Planning Coordination Board in the Meeting with USAID Representatives." Paper prepared for USAID Mission. BKKBN, Jakarta. October 1992.

Maher, Sheila and Leslie Delatour. "Indonesia Social Marketing: The Role of Blue Circle and Gold Circle Initiatives, and Economics Aspects of the Gold Circle Initiative." Paper prepared for USAID Mission. The Futures Group, Washington, D.C. November 1992.

Nicholson, Donald R., Susan Mitchell, and Gayle Roehm. "PROFIT Country Assessment: Indonesia, 1992." Paper prepared for USAID Mission. Deloitte & Touche, Arlington, VA. September 1992.

Smith, Janet M. "Trends in Contraceptive Sales and Social Marketing." Paper prepared for USAID Mission. The Futures Group, Washington, D.C. July 1992.