GRADUATION STRATEGY FOR USAID ASSISTANCE TO THE INDONESIA NATIONAL FAMILY PLANNING PROGRAM

USAID/ INDONESIA

March 2004

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EXECUTIVE SUMMARY

The Indonesian family planning program is internationally recognized for its success in reducing fertility, increasing modern contraceptive prevalence and improving the status of infants and children. This success is due, in significant measure, to a 30-year USAID-GOI partnership in support of Indonesia's family planning program.

In light of that success – and in view of USAID/Indonesia's launching of a new five-year strategy (2004-2008) – USAID has concluded that the time and conditions are right to undertake a gradual phase out (graduation) of US population assistance for the Indonesia family planning program. (USAID assistance for other health sector priorities, including maternal and neo-natal health and child survival, will continue beyond graduation of population assistance). Consequently, USAID worked closely with host country partners and stakeholders to develop a family planning graduation strategy that will support the development and transfer of the skills needed to sustain family planning as a significant component of basic health services in all of the country's districts.

The family planning graduation strategy has three stages:

- *Stage 1, 2004: Immediate phase out*: Several activities are in late/final stages of implementation, and can be completed this fiscal year. These include support for voluntary sterilization (VS) and implants, the quality mass media campaign, policy studies and efforts to promote commercial sector involvement in contraceptive marketing.

- *Stage 2, 2004-2006: Phased graduation*: Focused, district-level investment in four intervention areas. These include: **advocacy** (with civil society, professional associations, NGOs, community organizations, etc), **private sector enhancement** (with the National Midwives Association – IBI; and such faith-based organizations (FBOs) as Muhammadiyah and Nahdatul Ulama); **quality improvement** (promotion, dissemination and application of national standards, guidelines and tools supporting quality care); and **management information** (an "early warning system" to identify problems or program lapses in sentinel districts). USAID and its partners/stakeholders have concluded that success in these areas will help ensure the long-term sustainability, post-graduation, of family planning services at the district level in Indonesia.

- *Stage 3, 2004-2008: Transition to USAID's new Basic Human Services strategy*. Beginning immediately, the graduation strategy will be incorporated into the Mission's overall strategy. After Phase 2 ends in 2006, some population-funded support will continue under the Basic Human Services strategy for a broader advocacy program, as will modest funding to ensure inclusion of family planning services in district level integrated health services supported by USAID under the new strategy. Funding for both of these elements will end in 2007. However, implementation of some activities will carry over into 2008.

- *Post-graduation*, USAID looks forward to a new relationship with Indonesian partners – not as a relationship of donor and client, but as a "partnership of equals." The process leading up to this transformation will be signaled by public events and press coverage that will recall the history of U.S.-Indonesian cooperation in family planning and population. The graduation will culminate in a public graduation ceremony attended by U.S. and Indonesian leaders. This event will also launch the new US-Indonesian partnership that will include professional and scholarly exchanges and US-Indonesian consultations to harmonize policy positions at international and regional fora on population issues.

INTRODUCTION

A. Background

USAID/Indonesia is embarking on a new five-year strategy (2004-2008) with an overarching goal to strengthen a more moderate, stable and productive Indonesia. The new country strategy reflects a shift in focus from central government partners and processes to more direct engagement with citizens, communities, private sector and local governments. As an integral component of the new mission strategy, USAID will execute a well-planned Family Planning Graduation Strategy that phases out population assistance to Indonesia.

Internationally, the Indonesia FP/RH program is Well-known for its tremendous success in reducing fertility, increasing modern contraceptive prevalence and improving the health status of infants and children. The Government of Indonesia (GOI) and USAID have successfully worked together in close partnership with the NGOs and private sector to develop a successful and sustainable FP/RH program. As one of the leading donors in population assistance in Indonesia, USAID has played an active leadership role in Indonesia's successful National Family Planning Program. Given the new mission strategy and the high level of success in family planning, USAID is working closely with host country partners and stakeholders to develop a Family planning graduation strategy that provides a rational and orderly phase out of population assistance. USAID and Indonesian partners are well positioned to develop a successful strategy that completes the process of skill transfer already underway and ensures that family planning remains a significant component of a package of basic health services at the district level.

1. Purpose and Methodology

The purpose of developing a family planning graduation strategy is to provide an approach and blueprint for the USAID Mission that will describe a smooth transition to the new Basic Human Services strategy. The overall objectives for this family planning graduation strategy are to:

1. Specify the parameters for the strategy;

2. Describe the rationale and key principles for the graduation;

3. Articulate the strategic vision and identify key interventions and benchmarks;

4. Propose staffing, management, and budget considerations; and

5. Examine post-graduation linkages and recommendations for USAID/Washington and the Mission.

A three-person Team made up of two external consultants and one Mission staff person developed this strategy. The strategy development process reflects a high level of participation from USAID/Washington, USAID/Indonesia and in country stakeholders. The Team consulted with a variety of host country partners including: the government (National Family Planning Coordinating Board, Ministry of Health, etc), private sector representatives, NGOs, advocacy groups, donors, implementing partners, parliamentarians and research experts. The Team also met with diverse staff from national, provincial and district level to discuss the implications of decentralization on the quality and access to family planning and reproductive health services.

2. USAID's Technical Assistance to Date

For the past three decades, USAID has provided technical assistance to the Government of Indonesia, NGOs and the private sector to improve access and quality of family planning and other health services. USAID has contributed financial and technical support to the National Family Planning Program to strengthen overall management and human capacity, social marketing, contraceptive supplies, behavior change communication, private and public sector initiatives, clinical training, policy development and the implementation of the Demographic and Health Surveys for both family planning, reproductive health and child survival.

For the past 15 years, USAID has provided more focused support to assist the Indonesian family planning program to become more self-sufficient. From 1990-1996, the bilateral Private Sector Family Planning Project was designed to assist the Indonesian Family Planning Program to expand availability and quality of private sector services. This very successful program was followed by the Service Delivery Expansion Support Project (1994-2000), which was designed to increase the availability, utilization and quality of contraceptive services (particularly long-term methods) and to improve the sustainability of services delivered through the public and private sectors. Presently USAID is providing the majority of its family planning technical assistance through the STARH Program (Sustaining Technical Achievements in Reproductive Health). The STARH program was designed to build upon Indonesia's successful history in family planning and to support the BKKBN with its New Era Strategy, which focuses on quality improvements and informed choice.

Over the past decade, USAID has also played a major role in strengthening non-governmental and professional organizations that are channels for family planning services, information, and advocacy, such as IBI (the Indonesian Midwives Association), IDI (the Indonesian

Medical Association), PKMI (the Indonesian Association for Permanent Contraception), Nahdatul Ulama, Muhammadiyah, and the Coalition for a Healthy Indonesia (KuIS). These NGOs play a major role as catalysts for change and provide leadership on key issues that influence policy and quality service delivery at both the national and district levels.

B. Summary of the Demographic and Family Planning Situation

Indonesia is the fourth largest country in the world. Internationally, the Indonesia family planning program is known for its success in reducing fertility, increasing modern contraceptive prevalence and improving the health status of infants and children. With the rapid increase in modern contraceptive use, fertility has dropped significantly from an average of 5.6 children per woman in 1971 to 2.6 children in 2002. In 1971 fewer than 10 percent of married women aged 15-49 used modern contraceptives. Today that figure has climbed to 56.7 percent. As a result of the wider acceptance and use of family planning, birth spacing and improvements in other child health services, infant mortality has declined dramatically to 35 infant deaths per 1000 live births.[1]

The high level of private sector involvement in family planning in Indonesia has created a strong and vibrant national family planning program that reaches across the archipelago. The private sector provides the majority of family planning services and products (63 percent) while the government portfolio continues to decline from 43 percent in 1997 to 28 percent in 2002-2003. Also, 89 percent of family planning users pay for their contraceptives and only 11 percent receive free services.[2] The success of private sector provision and the ability and willingness of the clients to pay for family planning services demonstrates the tremendous potential for the long-term sustainability of the program.

Indonesian couples continue to want smaller families and to limit childbearing. The 2002-2003 IDHS notes that 50 percent of all married women want no more children and 4 percent have been sterilized. There is a continued acceptance of the small family norm with substantially increased desire to stop childbearing after a woman has had two or more children.

However, the Indonesian demographic situation is not all positive. Demographers and economists are very concerned about population momentum, the population growth rate and implications for sustainable development. Although the total fertility rate (TFR) has been decreasing, since 1991 its decline has been slower and the current rate is well above replacement level. Projections show that replacement fertility (2.1) may not be reached until 2016, and could occur even later given the reduction in family planning services under decentralization. During the projected 13 years that it will take to reach replacement level, more than 35 million more people will be added to the population. This additional population burden will have serious ramifications for the economic and social development of the

[1] Indonesian Demographic and Health Survey, 2002/2003.

[2] Ibid.

country.[3]

Although Indonesia has one of the highest numbers of contraceptive users in the world, the program is very vulnerable. The current method mix is dominated by temporary, supply-dependent methods. During the past five years there has been a dramatic shift in Indonesia to the injectable contraceptive. Indonesia has a world record 27 percent of all married women using it – nearly half of all users in the country. Injectable use has increased significantly, at the expense of the pill and IUD. The IUD has undergone a steady, long-term decline from 13 percent in 1991 to a current rate of 6 percent. Very few couples opt for either male or female sterilization (4 percent).

Quality problems continue to plague the family planning program. A comprehensive quality survey showed significant shortcomings in infection prevention, interpersonal communication, counseling and adherence to clinical standards.

Large geographical disparities also exist across provinces and districts. TFRs range from 1.9 children in Yogyakarta to 3.6 and 4.1 children per women in Southeast Sulawesi and East Nusa Tenggara, respectively. These differences are affected by such factors as age at first sexual intercourse, age at first marriage, age at first birth, birth intervals, fertility preferences and unmet need for family planning, all of which vary due to socio-economic, educational, cultural, access and other variables.

The difference is also significant when comparing contraceptive use among the poor and the wealthy. Not surprisingly, use of any family planning method increases with increasing wealth, from 52 percent for women in the lowest quintile to 64 percent in the highest.

Many Indonesians still experience unwanted or mistimed pregnancy – one-sixth of all births are not wanted. Indonesia continues to have one of the highest maternal mortality ratios (MMR) in the South East Asian region. Estimates of the MMR range from 198/100,000 in Bali to over 1000/100,000 in Papua. The official MMR is 305/100,000.[4]

There are more than 40 million young Indonesians (15-24 years) who make up almost 20 percent of the population. This is an extremely vulnerable group in need of access to timely and quality information, counseling and services. It is still not legal to provide family planning services to unmarried adolescents and youth. As a result, unwanted pregnancies, HIV/AIDS, unsafe abortion and sexual exploitation continue to plague this vulnerable population.

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[3] John Ross, Recent Demographic Trends in Indonesia, with Implications for Program Strategies, The Futures Group International, December 2003.

[4] IDHS, op. cit.

D. Decentralization and Family Planning

In January 2001, the GOI implemented a decentralization policy. Decentralization in the Indonesian context involves the transfer to districts of authority to manage, plan, implement and monitor government services. Eleven sectors, including the health, were decentralized in 2001, but the National Family Planning Program was excluded from this initial phase. A World Bank Decentralization Report notes that most districts were not fully prepared to take on all the tasks and responsibilities. Nonetheless, the majority of services continued to be provided at the local level with no massive breakdowns in service delivery.

BKKBN (the National Family Planning Coordinating Board) has a history of being a strong, visible, centralized agency with a nationwide presence at the grass roots level. January 2004 represented an historical and critical turning point for the BKKBN as the institution officially decentralized. Authority over family planning services was transferred to more than 425 local districts. Planning for decentralization was rushed and many issues related to contraceptive security, roles and responsibilities, funding and reporting remain unclear. Recently, teams from BKKBN traveled to each province and carried out a formal "transfer of authority ceremony" to officially hand over responsibility to each district chief (known as Bupati). All decentralized government programs at the district level are now under the Bupati's office and controlled by the local parliament (DPRD).

Decentralization of BKKBN offers many opportunities to make local governments responsible and accountable for providing quality services to their citizens. During these initial years of decentralization, much work still remains to ensure the availability of quality services, especially for the poor. Over the next few years, three critical issues may significantly affect the outcome of family planning service delivery at the local level including. These are: 1) establishment of a locally-defined administrative structure for family planning; 2) commitment for funding and budget allocations for family planning staff and contraceptive supplies for the poor; and 3) development of a family planning monitoring system to track key information and resolve systemic problems as they develop.

Under decentralization, each district can decide on the management and administrative structures for their family planning program within parameters set by the Ministry of Home Affairs. There are three options for the district government: 1) a family planning Office (dinas) directly within the Bupati's office; 2) a coordinating office (badan) under the Bupati's office; or 3) a regular office (kantor) outside the Bupati's office. In addition, the family planning program could be situated in a Dinas office along with one or more other programs, such as public works, women's social affairs, health, population, etc. The Dinas is seen as the most effective approach because it provides staff with access to key decision-makers on a day-to-day basis. Since February 2004, more than 80 percent of the districts have set up a family planning office or plan to establish one. Twenty percent of the districts have no family planning structure or plan for such a structure. However, this number is decreasing rapidly as BKKBN staff continue to visit districts to help set up administrative and management functions.

Funding issues for BKKBN represent a major constraint and serious concern. BKKBN was rapidly decentralized in 2003 and insufficient attention was given at the central and local levels to ensure budgets for 2004-2005. In principle, the district government should use its General Allocation Grant (DAU) to fund the district family planning program. However, The Ministry of Finance and the Ministry of Home Affairs agreed to provide special funds for family planning in 2004 and 2005, but it is unclear how districts will access these special funds.

Lastly, during the first years of decentralization the reporting and recording systems of most sectors have broken down. Very few districts have reported their family planning statistics to BKKBN for January 2004. Without a reporting system, BKKBN and the district management teams will not be able to monitor the impact of decentralization on family planning services and utilization. BKKBN requested technical assistance from USAID to help establish a temporary early warning and rapid response system to identify systemic problems and help resolve them.

II. GRADUATION STRATEGY

A. Rationale for the Graduation

USAID support for the Indonesian population program over the past 30 years has played a critical role in the development of what is arguably one of the most successful family planning programs in the world. Today, the Indonesian family planning program serves as a model for other country programs – a role reflected in BKKBN's provision of training and technical assistance to family planning managers from other developing countries.

As the Indonesia program matured over the years, USAID assistance also evolved to address the changing nature and requirements of BKKBN and other partners involved in the delivery of family planning services. For example, USAID no longer provides any contraceptive supplies to the country program; nor does USAID provide support for operational costs, infrastructure improvements, salaries or other budgetary support (with the exception of some very modest training costs for midwives). Virtually all USAID assistance is limited, rather, to the provision of technical assistance designed to promote advocacy in support of family planning, and to help develop improved standards of quality and enhanced delivery mechanisms that would be scaled up by Indonesian partners. This assistance is valuable to – and highly valued by – our Indonesian partners. But its nature as an almost wholly technical assistance program evokes the profile of a program poised for an orderly completion and for a transition to a different kind of US-Indonesian relationship.

Even as USAID support for the Indonesia family planning program is winding down, however, new and serious challenges to the program's long-term success have emerged. With decentralization, budgetary decisions affecting the family planning program are shifting from the central government to the leaders and parliaments in over 425 districts. Given the many, sometimes conflicting local demands these leaders will face, it would be unrealistic to expect that they will all assign to family planning the same high priority that family planning has

enjoyed under the central government's highly directive mode of program management. Post-crisis scarcities, moreover, still affect the family planning program. BKKBN has had to reduce its purchase of contraceptives and has announced a policy (not uniformly enforced) that BKKBN-provided contraceptives should be distributed only to the poor. The increased role of the private sector has been crucial, as described above, in meeting couples' family planning needs during and since the crisis.

In light of these concerns, USAID worked closely with BKKBN, the Ministry of Health, private sector stakeholders and other donors to develop the framework for an assistance program that would at once address the more recent challenges to the family planning program, while also continuing an orderly progression toward a graduation that all parties would acknowledge to be timely and warranted. The primary objective of those consultations was to identify the key constraints and opportunities posed by decentralization, but with specific attention to those factors that 1) are critically important to the long-term reach, quality and sustainability of the country's family planning program; and 2) can be impacted in very substantial measure by the limited USAID resources available over the life of the Basic Human Services strategy. The family planning graduation strategy discussed herein reflects the results of those consultations. The four critical intervention areas identified (district level advocacy, private sector enhancement, quality improvement and management information strengthening) will be the focus of USAID's Population Assistance funding over the next several years.[5] Recalling the selection criteria for these intervention areas, moreover, USAID is confident that the successful implementation of this strategy will bring USAID and its partners to a point beyond which USAID assistance would have only marginal impact, i.e., when further success is wholly dependent on Indonesian, rather than US, inputs. This point – the graduation date – will mark the beginning of a new, positive and very different phase in the US-Indonesia partnership in the population sector.

B. Graduation Parameters

The strategy development process that USAID conducted with its partners and stakeholders focused primarily on the technical concerns that argued for or against the inclusion of various interventions in the USAID graduation strategy. In addition to these factors, however, USAID identified a set of non-technical considerations that served to instruct and frame the strategy development process. The primary purpose of these parameters was to ensure consistency between the family planning graduation strategy and the Mission's overall country strategy; and to help avoid any ambiguity in our discussions with partners and stakeholders. These parameters were as follows:

1. Graduation timetable: Most USAID support for the Indonesia family planning program would end no later than 12/31/2006 (first quarter of FY 2007). Some support would continue through FY07 to cover the family planning costs of the integrated health services package to be supported under the Mission's Basic Human Services

[5] Family planning support in Indonesia is drawn from USAID Population funds.

strategy. Because of USAID's funding cycle, some activities funded in 2007 will carry over into 2008.

2. The family planning graduation strategy would have to support and complement the new Mission Basic Human Services strategy and its Intermediate Results (Advocacy, Basic Services and Behavior Change).
3. The overriding theme of the family planning graduation strategy would be decentralization. The strategy would focus on interventions that address the challenges and opportunities posed by decentralization.
4. Strategic interventions identified in the family planning graduation strategy would focus on ways to strengthen family planning capacity and sustainability in all districts, not just in demonstration/pilot projects in a few districts.
5. USAID would work identify and work through intermediaries that have a presence in a large number of districts to establish mechanisms that will continue to expand coverage of as many districts as possible after USAID funding ends.
6. The strategy would be used to leverage other donors to assume family planning support, including technical assistance, if needed.
7. The strategy development process must be transparent to partners and stakeholders
8. USAID strongly values its 30-year relationship with BKKBN and other partners. The strategy should chart a course to a graduation – not termination – of the US-Indonesian relationship in the population field.

C. Graduation Vision and Objectives

Within these parameters, including the time frame, USAID's post-graduation vision is to leave Indonesia with the capability to provide quality family planning contraceptives and services in all districts. The objective of the strategy is to ensure that mechanisms are in place, post-graduation, for district level advocacy, private sector enhancement, quality improvement and management strengthening. USAID will not attempt to reach all districts itself, but would rely on intermediaries that already have a presence in a large number of districts.

D. Graduation Phasing

Not all of the current interventions need to be completed at the same time. Some activities can be phased out now; others will require 1-2 more years of support before they can be completed. Some interventions will begin immediately as part of the Mission's new Basic Human Services strategy and others will be phased in over time. Thus, the family planning graduation strategy is divided into three stages: immediate phase out, phased graduation and transition to the new strategy.

1. Immediate Phase Out (2004)

A number of interventions will be completed and transferred to Indonesian stakeholders as soon as possible. Some will be continued until awhile longer, based on prior commitments. Others do not seem worth pursuing further at this time either because of the lack of success in

the past, legal obstacles, lack of time or other practical reasons. These are summarized below:

a. Supply side interventions

Long-term methods: Aside from the IUD, USAID will phase out most of its voluntary sterilization (VS) and implant activities in the third quarter of FY 2004. STARH will continue to provide limited technical assistance over the next year to the World Bank-funded Centers of Excellence program. After that responsibility for TA will be turned over to a

Table 1: Graduation Funding and Timeline

	FY	04		FY	05			FY	06			FY	07			FY	08	
Graduation Timeline	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Immediate phase out	X																	
Long-term methods (except IUD)	X																	
Contraceptive security (excpt Advocacy)	X																	
Mass Media	X																	
Commercial sector involvement	X																	
Policy issues	X																	
Policy studies	X																	
Phased graduation	X	X	X	X	X	X												
Advocacy	X	X	X	X	X	X												
Private sector enhancement	X	X	X	X	X	X												
Quality of care	X	X	X	X	X	X												
Management information	X	X	X	X	X	X												
Transition to new strategy	X	X	X	X	X	X	X	X	X	X	X	X	X	X				
Advocacy and investment	X	X	X	X	X	X	X	X	X	X	X	X	X	X				
Decentralized service delivery	X	X	X	X	X	X	X	X	X	X	X	X	X	X				
Behavior change	X	X	X	X	X	X	X	X	X	X	X	X	X	X				
Other	X	X	X	X	X	X	X	X	X	X	X	X	X	X				

Note: This chart represents the phasing out of funding (cells with X) and activities (shaded cells). Because of USAID's funding cycle, some activities funded in 2004 may carry over to 2005 and likewise some activities funded in 2006 and 2007 will carry over into 2007 and 2008 respectively.

stakeholder. Aside from that, there is little that USAID can do at this time with respect to VS and implants. Thirty years of promotion of VS have yielded little in the way of increased use of this method. Any meaningful effort in this area must be preceded by: 1) a government policy and campaign to promote VS; 2) clear assignment of responsibility for VS to a government agency; and 3) substantive measures to address reimbursement problems; and 4) a commitment to improving quality of care . It is not likely that any of these requirements will be addressed in the foreseeable future. With respect to implants, the government is pulling away from their promotion due to cost and other factors. There seems to be little need for USAID to get involved in capacity development, quality assurance or other types of support for these two methods. USAID has made significant investments in the development of the PKMI and the National Clinical Training Network (NCTN). It is appropriate that support for them be turned over to the government at this time.

Contraceptive security. USAID has provided a good deal of technical assistance in this area over the years. STARH has been working with BKKBN in developing and testing a variety of guidelines and tools for use by districts to manage and protect contraceptive security. Three sets of tools are being developed and field-tested in Boyolali, Central Java and Malang, East Java. By June 2004 the tools will be ready to be scaled up. At that time the tools can be turned over to BKKBN for implementation as well as inclusion in management capacity development interventions supported by such other donors as the World Bank. USAID can then turn its focus to advocating the adoption of these tools by the districts. USAID will continue to address the issue of contraceptive security through other means, most notably through support for expansion of the private sector's role in the provision of contraceptive services.

b. Demand side interventions

Mass media. The 2003 IDHS shows that demand for family planning services remains high. There is no further need for USAID to support interventions to stimulate demand. Quality is another issue, and that will be emphasized in the phased graduation. However, mass media campaigns to create demand for quality family planning services, such as SAHABAT, do not make enough of a contribution to make them worth continuing. Responsibility for these interventions can be turned over to the government, which can decide whether it wishes to continue supporting them or not. An exception is the mass media campaign planned to promote the *Bidan Delima* program (see page 16).

Commercial sector involvement. USAID has tried for many years to encourage pharmaceutical companies to expand their commercial marketing outside urban areas and to the poor. These efforts have not been successful, in part because of government policies that put it in competition with the private sector in these markets. Until that obstacle is removed, there seems to be little reason to continue promoting commercial expansion. STARH's operations research investments in this area will be directed toward other needs and opportunities.

c. Enabling environment interventions

Policy. The government is considering a number of laws and policies stemming out of decentralization that need to be addressed. USAID cannot get involved in this highly political process. Thus, there is little that can be done and little or no return on any further investment in population policy development at this time. A number of activities are planned or underway that are not likely to have a short-term impact and will probably be discontinued, given the amount of time left in the graduation strategy. These include further analysis of the IDHS, the Youth Survey, SPM socialization and analysis of the family planning policy functions of districts, provinces and central government agencies.

2. Phased Graduation (2004-2006)

Four principal components will be emphasized over the next two years and phased out gradually. These components are: advocacy, private sector enhancement, quality and management information. These will all focus on the districts, be national in scope and require little, if any, new interventions. Each of these interventions is a high-priority for ensuring that mechanisms are in place after graduation to imbed quality family planning services in district health care packages. These interventions are already underway, in whole or in part, and will continue for different periods of time, depending on current status, availability of funds and so forth. These four components are expected to be completed by December 31, 2006, at the latest. Some elements of the advocacy and quality components will be transitioned into the Mission's new Basic Human Services strategy.

a. Advocacy

The current **problem** is that decentralization has the potential to produce gaps in the provision of quality family planning contraceptives and services. Districts are no longer required to report to BKKBN. Some do not yet have family planning included in their health programs. Funding is uncertain. Contraceptives are not available in all districts. This component attempts to address these gaps through targeted advocacy activities.

The **objective** of this component is to ensure that a mechanism is in place for post graduation advocacy of quality family planning services and contraceptives in all districts.

Advocacy topics. This component would build on current activities but would focus on districts and selected advocacy topics that are critical to the success of decentralized family planning services. The first priorities are contraceptive security and implementation of family planning services. Secondary priorities are capacity development of family planning service providers and quality of care. Tertiary priorities are: community support; healthy life styles among vulnerable youth; and family planning-HIV linkages.

Advocates and targets. For each of these topics USAID would need to identify advocacy targets and advocates. For example, IBI, Muhammadiyah and Nahdatul Ulama (advocates) could encourage advocacy efforts among their members and affiliates (advocacy targets). Other possible advocates include existing advocacy teams at the district level, local KuIS

coalitions and the Indonesian Women's Congress (KOWANI). Advocacy targets could include: national, provincial and local politicians and staff (to provide financial support to family planning services and to provide funds for contraceptives); communities (to demand quality family planning services and contraceptives); NGOs (to promote healthy life styles among vulnerable youth); and service providers (to include HIV/AIDS in family planning counseling and vice versa).

The family planning portion of the advocacy strategy will be integrated into the target districts of the new USAID strategy. Even more important, advocacy efforts will be scaled up to cover all districts. This will be done, in part, by working through existing national and provincial organizations that can expand advocacy to other geographic areas where they have a presence. Prime candidates for this role are IBI, Muhammadiyah, Nahdatul Ulama and KuIS coalitions.

Illustrative activities.

1. Complete the capacity building of advocacy and journalist teams in selected districts and at the national level.

2. Finalize FP advocacy tools and approaches on critical issues related to quality, district funding for family planning and contraceptive security, especially for the poor.

3. Develop an advocacy scale-up schedule and phase-out plan with KuIS for covering all districts using intermediary organizations such as IBI, FBOs, KuIS coalitions, local advocacy teams and others that have broad geographic presence and high credibility among the Indonesian population.

Implementing mechanisms. STARH and KuIS will be the principal technical assistance agencies during the graduation period. They will develop a joint workplan through 2006 with KuIS continuing to provide TA afterwards as part of its larger role on behalf of the Mission's new advocacy strategy.

Illustrative benchmarks.

1. Number of institutions and coalitions using advocacy materials and tools developed by STARH and KuIS.

2. Number of public/publicized meetings between advocacy organizations local and national governments to discuss concerns regarding family planning issues.

3. Number of local districts with increased budgets for family planning.

b. Private Sector Enhancement

The current **problem** is that public sector family planning services and contraceptives are inadequate in some districts and it is uncertain whether the public sector will be able to meet

current demand. The private sector is now the dominant provider of family planning services and contraceptives and could expand even further to help fill this gap.

The **objective** of this component is to ensure that mechanisms are in place for post graduation expansion and scaling up of private sector provision of quality family planning services and contraceptives. This component has the potential for having a significant impact on a number of family planning program objectives.

Priority providers. This component will focus on accelerating the scaling up of the family planning capacity of IBI, Muhammadiyah and Nahdatul Ulama. IBI members comprise the majority of family planning providers in both the private and public sectors. Muhammadiyah and Nahdatul Ulama are large FBOs that can make a significant contribution to the expansion of private sector services. Expansion of capacity will enhance: 1) geographic coverage of family planning; 2) private sector market share; 3) quality of care in both the public and private sectors (since many IBI members also work in government clinics); 4) improvement in IUD use; 5) expansion of training capacity; and 6) provision of family planning services to the poor. All three organizations are already decentralized, largely self-sustaining and committed to improving the quality of care.

Bidan Delima. Midwives are the driving force of the Indonesia. As a group, the 76,000 public and private midwives account for 75-85 percent of all family planning services delivered nationwide. The *Bidan Delima* program is a new mechanism for improving the quality of care provided by private sector midwives (bidans). Candidates go through a process that helps them improve their knowledge and skills. On successful completion they are certified and branded as providers of high-quality services. The *Bidan Delima* program will begin in April 2004 in 60 districts (6 provinces). Interest in this program is high among midwives, many of whom are willing to pay for the course, as they see it as a way to enhance their marketability. IBI expects to enroll 30 percent of its 45,000 private sector midwives by 09/05. Under the phase-out strategy enrollment and training will be expanded even further to cover all of the districts in the six provinces, amounting to 60 percent of IBI's members. A mass media campaign will inform the public of and promote services provided by bidans that display *Bidan Delima* signs. After that, IBI will continue to expand the program on its own to the other provinces. However, some support may be needed by the national IBI office to extend training to lower-performing midwives. IBI will also address other important needs, including refresher training for staff and members in contraceptive technology; skills training in the copper T for providers; development of family planning training facilities in provincial clinics owned by IBI chapters; practical training for *Bidan Delima* candidates; funding of training costs of poor and isolated midwives and other providers; and assistance in purchasing contraceptives from distributors and pharmaceutical companies. *Bidan Delima* has long-term potential to serve as a national accreditation mechanism for midwives as well as a participant in national insurance programs.

Muhammadiyah and Nahdatul Ulama are in the early stages of a performance assessment to identify their capacity development needs. Under its current work plan STARH will help both organizations develop their family planning capacity to provide quality services,

especially to the poor. STARH's primary objective is to get them recognized as providers, increase their caseload and then ensure that quality services are provided. Its second goal is to build a formal network of facilities (from the current informal network) so that interventions, standards and resources can be more effectively introduced. In phase one, STARH is currently working with 30 Muhammadiyah and 15 Nahdatul Ulama clinics to identify their needs and expects to receive capacity development proposals by March 2004 from these clinics. Under the graduation strategy, capacity development will expand to cover all Muhammadiyah and Nahdatul Ulama hospitals and clinics. The MCH-related work of all three organizations warrants their inclusion in the Mission's new Basic Human Services strategy.

Illustrative activities:

1. Complete first phase of Bidan Delima implementation in six provinces (60 districts).
    - Expand Bidan Delima to all remaining districts in the six provinces.
    - Expand Bidan Delima to at least 13 more provinces.
    - Expand Bidan Delima to all 13 remaining provinces with support from other donors, as necessary.
2. Complete performance needs assessments in Muhammadiyah and Nahdatul Ulama and arrange for needed capacity development.
    - Assist Muhammadiyah and Nahdatul Ulama to formalize their loose networks of health facilities.
    - Assist Muhammadiyah and Nahdatul Ulama to expand FP services to all of their health units.
3. Conduct IUD (copper-T) in-service and refresher training for public and private midwives who need such training.
4. Assist IBI to provide FP training in its 32 chapter-owned, provincial clinics.

Implementing mechanisms. STARH will be the principal technical assistance agency during the graduation period, after which all three organizations are expected to continue without further assistance. However, USAID will work with other donors to ensure that further financial and technical assistance will be provided, if necessary.

Illustrative benchmarks:

1. Increase in the percentage of users receiving contraceptive services from private sector midwives.

2. Annual targets met for establishment of provincial and district Bidan Delima programs.

3. Annual targets met for establishment of quality FP services in Muhammadiyah and Nahdatul Ulama health units.

4. Annual targets met for establishment of FP training facilities in IBI provincial clinics.

c. Quality of Care

Problem. The quality of family planning/RH services in Indonesia is often poor in both the public and the private sectors. STARH and others are addressing this problem. *Bidan Delima* is the private sector approach to quality improvement that complements the public sector approach in the MOH known. The challenge will be to expand both programs to as many districts as possible.

The **objective** of this component is to ensure that by the end of the graduation period, mechanisms exist to ensure that family planning quality standards and procedures are incorporated and maintained in all districts.

Standards. Family Planning Standards and Guidelines (BP3K) have been developed, tested, adopted and are being disseminated through multiple channels in an effort to achieve their broadest possible use and application. These standards have been accepted by all key provider organizations, including the MOH, BKKBN, IBI, IDI, POGI, the NCTN and others. They are incorporated in the *Bidan Delima* and MOH quality programs. This has been a major achievement.

STARH and others will continue to disseminate and promote the BP3K while working with the MOH, BKKBN and Yayasan Bina Pustaka (YBP) to take responsibility for periodic updating of the standards and guidelines; respond to requests for copies of such materials; distribute the materials in a timely and efficient manner; and serve as the focal point for future donor input on the standards.

Tools and guidelines. STARH has also helped develop an infection prevention manual and a number of other tools (self-assessment, scaling up, interpersonal communication, on-site supervision manual and the QIQ – Quick Investigation of Quality) to promote site-based (primarily *puskesmas*) quality assessment and quality improvement. The publishing house YBP and such intermediary organizations as the MOH, BKKBN, IBI, etc., will be asked to take responsibility for dissemination of the tools at the local level.

Use and application. Just as important as distribution is utilization of the material. This will be addressed, in part, by the use of the material in the *Bidan Delima* program and the Ministry of Health (Depkes) self-assessment program that is ongoing at district health centers. Other mechanisms are being identified and will be tested, including the incorporation of quality guidelines in midwifery schools, medical schools and in the one-day orientations that are underway in districts.

Illustrative activities:

1. Continue disseminating and promoting the application of the national family planning standards and guidelines through orientation workshops at the district, province and central level.

2. Complete the strengthening of strategic provincial training centers to provide training in quality FP/RH standards and tools.

Implementation mechanisms. STARH will continue to provide needed technical assistance through the graduation period, calling on other organizations and experts as needed.

Illustrative benchmarks:

1. Number of selected private and public providers applying national family planning guidelines in service delivery sites.

2. Number of providers with improvements in two quality-of-care indicators: client-provider interaction and infection prevention practices.

3. Provincial training centers functioning independently with multiple stakeholder involvement and ownership (MOH, IBI, NCTN, BKKBN).

d. Management information

Problem. Since decentralization, some districts have stopped collecting and reporting family planning service statistics. Although this makes it almost impossible for BKKBN/central to monitor the national program's progress, it also affects the ability of district managers to monitor their own family planning services.

The **objective** of this component is to ensure that by graduation a mechanism is in place for monitoring of family planning services and distribution in all districts.

National EWRRS. The current BKKBN national information system is in limbo until a decision is made about whether or not districts will be required to submit data to BKKBN. It is unlikely that this issue will be resolved soon. There is little to be gained by starting work on a new national system until this matter is resolved and there is not enough time left in the graduation period to begin this task.

In the interim, Management Sciences for Health (MSH) and STARH are working with BKKBN to establish an Early Warning and Rapid Response System (EWRRS) that will collect data from a 10 percent sample of districts.[6] This information will be used to provide

[6] MSH and STARH. Working Concept Paper: The Use of an Early W1arning and Rapid Response System in the National Family Planning Program After Decentralization, 5 February 2004.

BKKBN with national and provincial estimates on such key indicators as new acceptors, method mix and program activity. The data will also be used to identify problems that need attention in three areas: policy, management and service delivery. This system will begin in April and the first report will be ready in June 2004. MSH and STARH will provide technical assistance to BKKBN for troubleshooting and revisions until June 2005, after which BKKBN will take responsibility for the EWRRS.

District EWRRS. USAID believes that under decentralization, there should be a way to enable all districts to collect and analyze this kind of data. Therefore, USAID will explore with other donors, BKKBN and the MOH to explore short-term MIS options for districts. One option would be to provide technical assistance to the BKKBN to expand the EWRR system to as many of the approximately 425 districts as possible. This would involve tailoring the data collection, tabulation and analysis procedures to reflect district priorities and needs. The districts would not have to report their data to the provincial or central BKKBN unless they agreed to do so. The primary objective would be to enable the districts to do their own monitoring and problem identification using systems that would reflect their individual needs. If such a system were developed for monitoring family planning services, BKKBN central and provincial offices would need training in how to provide technical assistance in a decentralized environment.

IDHS. USAID will also provide modest financial support for the next round of the Indonesian Demographic and Health Survey (IDHS) to track trends in CPR, TFR and other key family planning/RH/MCH behavioral and impact indicators. The IDHS is tentatively scheduled for 2007 or 2008. The Indonesian Government would pay for the survey. USAID would only provide limited technical assistance.

Illustrative activities:

1. Design and test the national EWRRS.

2. Develop, design and test a district EWRRS or alternative MIS.

3. Train BKKBN central and provincial staff in providing TA for district EWRRS/MIS.

4. Provide TA for the 2007/8 IDHS.

Implementing mechanisms. In addition to providing help to BKKBN to set up the national EWRRS, MSH and STARH would (if a viable decentralized MIS were found) provide technical assistance to central and provincial BKKBN and/or the MOH in developing guidelines for setting up and trouble-shooting decentralized family planning monitoring systems. BKKBN would provide needed technical assistance to the provinces and districts.

Illustrative benchmarks:

1. National EWRRS designed, tested and implemented.

2. District EWRRS/MIS designed and tested.

3. BKKBN central and provincial staff trained in providing TA to districts re EWRRS/MIS.

4. BKKBN central and provincial staff using EWRRS data to monitor program performance.

5. TA provided for 2007/8 IDHS.

3. Transition to the New Basic Human Services Strategy (2004-2008)

The Mission's new country strategy is expected to get underway fairly soon. Thus, the four "phased graduation" interventions described above will be incorporated immediately into the new Basic Human Services strategy. That strategy has three Intermediate Results. The family planning graduation strategy described herein will ensure that family planning is included in these three IRs. The IRs and the relevant family planning interventions are summarized below:

IR 1: Advocacy and Investment

The principal intervention will be demand creation for family planning contraceptives and quality services. Target groups include: district governments, community associations, professional associations, public-private partnerships, coalitions and legislators. KuIS will be the principal advocacy agent throughout the new strategy. STARH will contribute to this IR in collaboration with KuIS until STARH ends in 2006. Specific advocacy activities will include those described above and others that are developed by the Mission's Basic Human Services Team.

IR 2: Strengthened Decentralized Basic Health Services Delivery

The Graduation Strategy's principal intervention in support of this IR will be improved quality family planning services for the poor. This will entail the development, testing and implementation of a basic health services package, including family planning; the introduction of quality assurance for family planning services for the poor; and the expansion of access to quality services. Attention will also be given to strengthening public health management, surveillance and logistics. Again, there will be some carryover from the interventions described previously, but additional service delivery activities may also be introduced.

IR 3: Behavior Change

The principal result of the above advocacy and quality services should be increased use of family planning by the target groups. This includes increases in new acceptors, longer continuation rates, fewer dropouts and improvements in related RH behaviors. KuIS will also promote healthy life styles for youth to prevent unwanted pregnancies, high-risk behaviors

that could lead to HIV/AIDS, drug abuse, smoking and gender violence.

E. Post-graduation Linkages

A key objective of this family planning graduation strategy is to create the conditions for a transformation of the current US-Indonesia relationship in the population sector. Today, that relationship is one of donor and recipient. After graduation, USAID looks forward to a new type of engagement with Indonesian counterparts – a partnership of equals – whereby each party enhances the other's ability to perform its role as a leader in international efforts to address population issues.

Some of the mechanisms that will be used to foster a post-graduation partnership include:

- Compilation of a **history** of US-Indonesian cooperation in family planning.

- A series of **events and press articles** leading up to Indonesia's graduation. These will draw attention to the two countries' collaboration in successfully completing various joint activities over the last 30 years.

- A **Graduation Ceremony** in 2006, attended by the US ambassador, senior leaders of the Indonesian Government and civil society, other donor representatives, USAID staff and, if possible, senior representative(s) from USAID/Washington.

- **Indonesian participation in the Public Diplomacy programs of the US Embassy/Jakarta.** The US Embassy's **International Visitors Program** will enable key Indonesian partners to visit counterpart institutions in the US; to consult with technicians, scientists, program managers and decision makers in US government agencies, universities, think tanks, service delivery organizations, etc. Indonesian participation in the US Embassy's **Visiting Scholars Program** will enable Indonesian leaders, scientists, teachers, etc., to serve as visiting lecturers at US universities, think tanks, government institutions and to host scientific and/or teaching staff from US counterpart institutions. The USAID/Indonesia Mission Director will take the lead in pursuing this initiative with the US Country Team in Jakarta.

- **US-Indonesia consultation/coordination on international population policy**. As international leaders in the population field, the US and Indonesia have a strong interest in the maintenance of a consultative process that would enable the two countries to harmonize their positions on population and related issues at international and regional conferences, in the UN General Assembly and at special events of global or regional significance. USAID/Indonesia and the US Embassy/Jakarta will consult to determine how these consultations can best be institutionalized in cooperation with the GOI Ministry of Foreign Affairs, BKKBN and other partners.

- **Indonesian participation as members of technical consultative groups for USAID grantee institutions responsible for provision of international population**

assistance. An extensive network of universities, consulting firms, NGOs, and foundations is working in over 60 countries to help implement USAID-funded population programs. These organizations frequently create consultative groups and/or technical advisory groups (TAGS) to provide technical oversight and advice to the organizations' program managers. USAID/Indonesia will ask that the Global Health Bureau take the lead in advising these grantee institutions that a significant body of technical expertise is available in Indonesia.

Finally, USAID/Indonesia proposes that USAID/Washington consider the development of a new program – a "Graduate Country Initiative" – that would help the Agency maintain contact with countries that have graduated from USAID assistance, but which still have important regional and even international roles to play in furtherance of development issues. Under current arrangements, USAID essentially loses substantive contact with such graduate countries as Morocco, Tunisia, Turkey, Brazil and Portugal. The Agency also risks losing sector-specific contact with countries that have phased out one or more sectors of USAID assistance (e.g., population sector in Mexico and Indonesia). Specifically, USAID/Indonesia proposes that USAID/W take the lead in exploring the interest of regional and pillar bureaus in the creation and funding of a mechanism that would provide travel grants, conference support, and TA/mentoring arrangements between graduate country experts and their counterparts in neighboring non-graduate countries.

IV. KEY ASSUMPTIONS, CONSTRAINTS AND FACILITATING FACTORS

Several factors will influence the likelihood of the strategy's success. On one hand, USAID has over 30 years of experience with the Indonesia family planning program. This long-standing relationship has helped USAID: develop a deep understanding of the program; forge valuable professional linkages with Indonesian program managers; and create a deep reservoir of good will with our counterparts and partners. On the other hand, the decentralization process has introduced a new and largely unknown variable into the equation – particularly with regard to a family planning program that was, until now, subject to a very high degree of direction (and support) from the central government. As the family planning graduation strategy is focused heavily on the development of district-level interventions, the Mission expects to grow increasingly knowledgeable and adept at the process. At this time, however, the location of all potential trip-wires is unknown and some fairly general assumptions about the assistance environment must be made. These are:

- Indonesia will enjoy political and economic stability throughout the strategy period.
- Willing, competent partners (public sector, private and professional organizations, religious leaders, etc) will work with USAID in the design and implementation of the strategy.
- Adequate USAID population funds will be available to implement the strategy.
- USAID will continue to elicit counterpart cooperation and support during a period of

declining population assistance.

Full and successful implementation of the strategy may be constrained by a number of factors. These include:

- The very large number of districts, each of which is virtually autonomous in deciding how (indeed whether) to support/fund the delivery of family planning services.
- Concomitantly, the loss of BKKBN ability to provide substantive technical, financial and contraceptive support for the national program.
- A tightly scheduled, modestly funded family planning graduation strategy that leaves little room for program setbacks.

Compensating somewhat for these concerns, the strategy will be able to count on a number of positive, facilitating factors during the life of the strategy. These include:

- The apparent readiness of highly qualified partner organizations (IBI, Muhammadiyah, Nahdatul Ulama, etc.) to work with USAID on implementation of the strategy.
- The national coverage and credibility of these partner organizations (IBI, etc.).
- The flexibility and willingness of USAID's technical assistance partners (STARH, MSH, KuIS) to reorient their programs, budgets and personnel resources (to the extent possible within the terms of their cooperative agreements) to support the family planning graduation strategy.

V. MANAGEMENT AND FUNDING CONSIDERATIONS

A. Funding

Funding requirements for the duration of the family planning graduation strategy are shown below:

Table 2: Proposed Population Budget, FY 2004-2008 (in $000)

Component	FY 04	FY 05	FY 06	FY 07	FY 08
Phased Graduation	6,750	5,300	0	0	0
Private Sector Enhancement					
Advocacy					
Quality					
Management Information		0	0	0	0

Transition	950	2,400	3,300	2,100	
Basic Human Services					0
Total	7,700	7,700	3,300	2,100	0

The specific distribution of population funding for the "Phased Graduation" components shown above has not yet been determined, but will be provided in the following order of precedence (i.e., from higher to lower levels of funding):

1. Private sector enhancement
2. Advocacy
3. Quality
4. Management information

The Mission will determine specific allocation levels for these interventions over the next several months

B. Mission Staffing

One direct-hire FTE PHN Officer will be responsible for overall direction of the health sector portion of the country assistance program. One FTE FSN and one FTE TAACS through 2008 will assist this person in the technical oversight and management of the family planning graduation strategy as well as the integrated maternal and neonatal health activities.

C. Partners

USAID will continue to work with the STARH team and MSH, whose cooperative agreements expire in 2006 and 2005, respectively. The STARH agreement will be extended for a year to September 30, 2006.

USAID will work with the Health Communication Partnership to provide technical assistance to the Coalition for a Healthy Indonesia (KuIS) until 2008.

USAID will develop additional assistance arrangements to implement the maternal/neonatal health and child survival components of its Basic Human Services Strategy. Assistance instruments and/or grants developed for that purpose will be used to support selected family planning components of district-level, integrated health service packages.

D. Other Donor Collaboration

USAID will coordinate closely with the following donors, all of which are working in areas that will complement USAID efforts during the graduation period:

- UNFPA is supporting the **advocacy** activities of the Asian Forum of Parliamentarians

on Population and Development (AFPPD).

- The Asian Development Bank (ADB) is assisting the Indonesian Government in developing **decentralized health services**, with a focus on 50 districts in seven provinces.

- Australian Aid (AusAid) is supporting an HIV/AIDS prevention and care project and a Healthy Mothers/Healthy Babies program in NTT and NTB provinces.

- UNICEF is cooperating with AusAid in a Safe Motherhood program in four provinces of West Java, Banten, Maluku and Papua.

- The World Bank is supporting four Centers of Excellence for Voluntary Sterilization. STARH personnel will provide limited technical advice to the Bank and BKKBN in support of this activity through 2004.

Over the course of the graduation strategy, USAID will encourage these and other donors to focus their assistance resources on critical needs of the Indonesian program that the Agency will no longer be able to support.

ANNEXES

A. Abbreviations

ADB	Asian Development Bank
AFPPD	Asian Forum of Parliamentarians on Population and Development
ARH	Adolescent Reproductive Health
BKKBN	*Dadan Koordinasi Keluarga Berencana Nasional* (National Family Planning Coordinating Board
BP3K	Family Planning Standards and Guidelines
CPR	Contraceptive Prevalence Rate
DAU	General Allocation Grant
Depkes	Ministry of Health
EWRRS	Early Warning and Rapid Response System
FBO	Faith Based Organization
FP	Family Planning
FSN	Foreign Service National
GOI	Government of Indonesia
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
IBI	The Indonesian Midwives Association
IDHS	Indonesian Demographic and Health Survey
IDI	The Indonesian Medical Association
IUD	Intra Uterine Device
KuIS	Coalition for a Healthy Indonesia
KOWANI	Indonesian Women's Congress

MCH	Maternal and Child Health
MIS	Management Information System
MMR	Maternal Mortality Ratio
MOH	Ministry of Health
MSH	Management Sciences for Health
NCTN	National Clinical Training Network
NGO	Non Government Organization
NU	Nahdatul Ulama
PHN	Public Health and Nutrition
PKBI	*Perkumpulan Keluarga Berencana Indonesia* (Indonesian Planned Parenthood Association)
PKMI	The Indonesian Association for Permanent Contraception
POGI	Indonesian Association of Obstetricians and Gynecologists
RH	Reproductive Health
STARH	Sustaining Technical Achievement in Reproductive Health
TAACS	Technical Adviser in AIDS and Child Survival
TAG	Technical Advisory Group
TFR	Total Fertility Rate
USAID	United States Agency for International Development
VS	Voluntary Sterilization
YBP	Yayasan Bina Pustaka

B. Contacts (Not included, for Mission only)

C. Documents Reviewed (Not included, for Mission only)