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USAID / INDONESIA

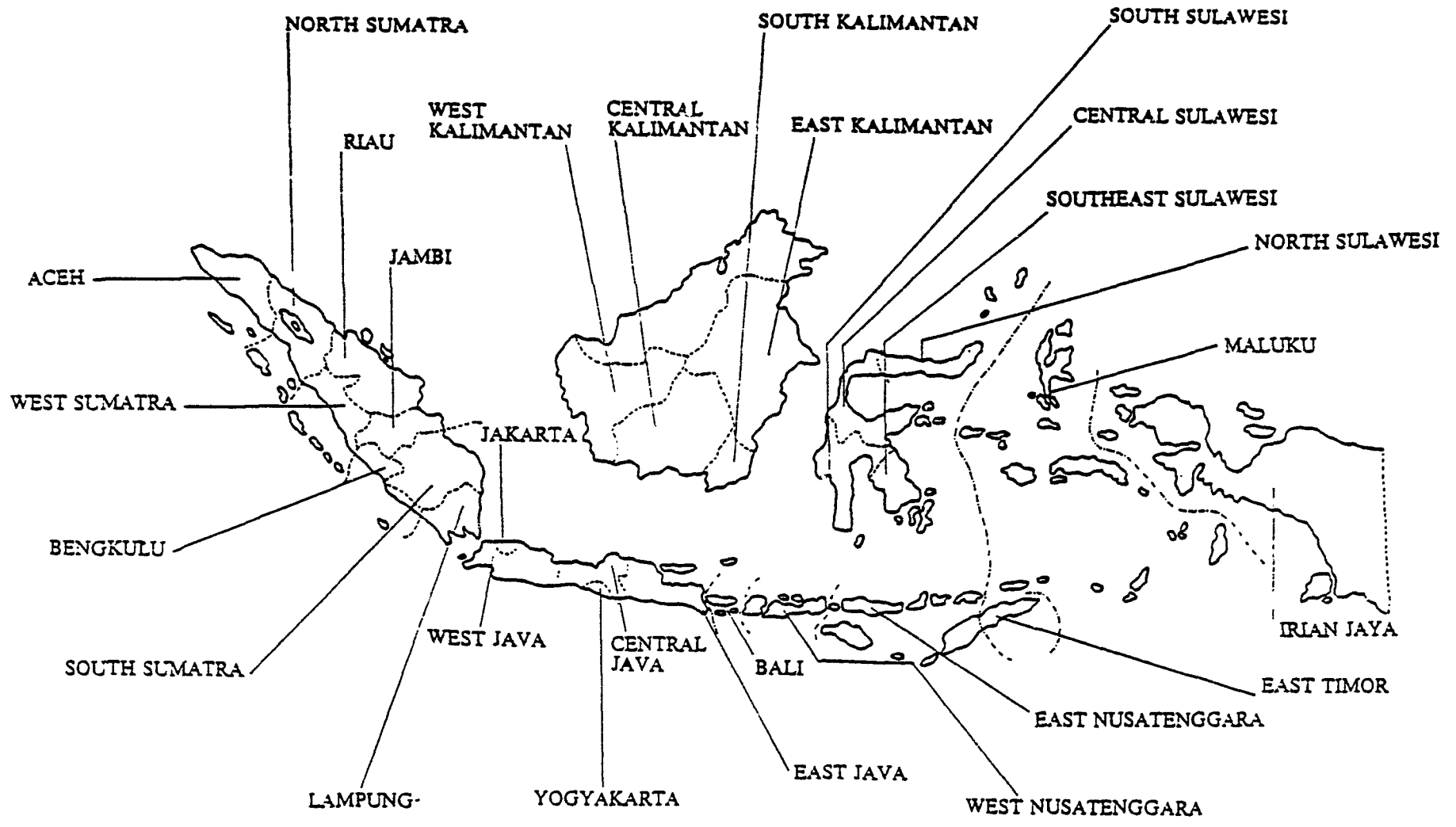
**OFFICE
OF
POPULATION AND HEALTH**

STRATEGIC PLAN

1989 - 1994

INTRODUCTION

A brief description of the organization of this document is necessary to direct readers to material which may be of interest based on the level of detailed technical information the reader desires. The first chapter is the most important part of the document and presents the details of the USAID/Indonesia population and health sector strategy for the years 1989 to 1994. The chapter includes the rationale for the focus of the strategy, the strategy's goals and objectives, the planning assumptions used and a delineation of the strategy itself. Chapters 2 and 3 present information and analyses that are essential background to the strategy. Chapter 2 includes a brief overview of the fertility and mortality/morbidity patterns in Indonesia and information on the organization of health and family planning services, including a discussion of issues that are particularly important in the areas of policy, personnel and finance. Chapter 3 presents the Government of Indonesia's policies and priorities in the health and population sectors. Chapter 4 briefly reviews current projects in the USAID/Indonesia health and population portfolio. The annexes describe current USAID/Indonesia program strategy and AID's worldwide strategy for development assistance in health and population.



REPUBLIC OF INDONESIA

GLOSSARY

APBD I	-	Provincial Routine and Development Budget
APBD II	-	District Routine and Development Budget
APBN	-	Central Routine and Development Budget
ARI	-	Acute Respiratory Infections
AsKeS	-	Civil Servant Health Insurance Program
BAPPEDA	-	Regional Planning Boards
BKKBN	-	National Family Planning Coordinating Board
BUPATI	-	Administrator of the District Level
BAPPENAS	-	National Development Planning Board
BANJAR	-	Smallest rural administrative unit in Bali
BCG	-	Tuberculosis vaccine
CAMAT	-	Administrator of the Sub-district Level
CDSS	-	Country Development Strategy Statement
CHIPPS	-	Comprehensive Health Improvement Project - Province Specific
CS	-	Child Survival
DEPKES	-	Department of Health
DepDaGri	-	Department of Home Affairs
DepDikBud	-	Department of Education and Culture
DIK	-	Routine budget
DIP	-	Development budget
DESA	-	Village
DPR	-	People's Consultative Assembly
DINAS KESEHATAN	-	Ministry of Home Affairs Provincial Health Service

DUKM	-	A government-sponsored health insurance program for private sector employees financed through employer contributions
DPT	-	Diphtheria, Pertussis and Tetanus Vaccine
DDC	-	Diarrheal Disease Control
EPI	-	Expanded Program on Immunization
FKM	-	Faculty of Public Health
FPDS II	-	Family Planning Development and Services II Project
FPH	-	Faculties of Public Health Project
GBHN	-	Broad Guidelines for State Policy
GDP	-	Gross Domestic Product
GOI	-	Government of Indonesia
HHS	-	Household Health Survey
HMO	-	Health Maintenance Organization
HSF	-	Health Sector Financing Project
HST	-	Health Sector Transition Project
HTRD	-	Health Training Research and Development Project
IFY	-	Indonesian Fiscal Year
IMR	-	Infant Mortality Rate
InPres	-	Special Presidential Program
IMM	-	Immunization
KB/Kes	-	Integrated Health and Family Planning Strategy
KLH	-	Ministry for Population and Environment
Kadinkes Tingkat I	-	Department of Home Affairs, Head of Provincial Health Officer
Kadinkes Tingkat II (Dokabu)	-	Department of Home Affairs, Head of District Health Officer
KanDep	-	Department of Health District Office

KanWilKes	-	Department of Health, Provincial Office
KABUPATEN		District/Regency
KECAMATAN	-	Sub-district
KEPALA DESA	-	Village Chief
KADER	-	Village and subvillage volunteer health and nutrition workers
LKMD	-	Village Community Resilience Institution
LNG	-	Liquified Natural Gas
MCH	-	Maternal and Child Health
MOH	-	Ministry of Health
NICPS	-	National Indonesian Contraceptive Prevalence Survey
ORS	-	Oral Rehydration Solution
ORT	-	Oral Rehydration Therapy
PKK		Family Welfare Organization
PKMD		Village Community Health Development
PLKB	-	Family Planning Field Worker
PPKBD		Village Contraceptive Distribution Center
PPLKB		Family Planning Field Worker Supervisor
Pos Penimbangan	-	Village Weighing Post
Pos Imunisasi	-	Village Immunization Post
PosYanDu	-	Integrated village health services post
PusKesMas		Sub-district health center
PUSAT	-	National Level

PANCASILA	-	Indonesia's National Philosophy of: 1. Belief in One Supreme God 2. Just and Humane Outlook 3. Indivisibility of Indonesia 4. Democracy Wisely Implemented by Deliberations With the Governed 5. Social Justice for all Indonesians
PSFP	-	Private Sector Family Planning Project
PosKB	-	Village Contraceptive Distribution Center
RP3JPK	-	Long Range Plan for Health
RaKerKesNas	-	Annual National Health Conference
RaKerNas KB	-	Annual National Family Planning Conference
REPELITA	-	Five Year Development Plan
REPELITA V	-	Fifth Five Year Development Plan (1989-1994)
SKN	-	Indonesia's National Health System
SUPAS	-	GOI Intercensal Survey
TBC	-	Tuberculosis
TBA	-	Traditional Birth Attendant
UPGK	-	Family Nutrition Improvement Program
UUD 45	-	Undang-Undang Dasar 1945 (State Constitutional 1945)
VFP/MCW	-	Village Family Planning/Mother Child Welfare Project

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**1. USAID OFFICE OF POPULATION AND HEALTH STRATEGIC PLAN
INDONESIA - A NATION IN TRANSITION
HEALTH AND POPULATION SECTORS IN TRANSITION**

1.1 INTRODUCTION

The document presents the USAID/Jakarta Office of Population and Health (O/PH) strategic plan for the period 1989-1994. It is a statement of USAID's population and health development assistance goals and objectives and the means to reach them. The strategic plan will guide project development and provide a framework for all O/PH activities. The strategy is based upon USAID's view of current and future trends in the health and population sectors, a view which has been developed with and is shared by our Indonesian colleagues. The strategy aims to assist the Government of Indonesia to forge a public-private partnership that can confront the immediate and pressing problems facing both sectors, and will prepare the institutions, infrastructure and human resources to address the challenges of the year 2000 and beyond.

For Indonesia, the 1990s will be a transition decade. Repelita V is the final five year plan in the country's first long range planning period (1969-1994). Repelita VI (1994-1999), the first five year plan in the second long range planning cycle, will see the "take-off" period that is expected to propel Indonesia into the ranks of the Newly Industrializing Countries (NIC). Experience from other countries has demonstrated that the transition from Developing to NIC status is usually accompanied by dramatic economic, social, demographic and epidemiologic changes. As Indonesia undergoes a similar transition, it is expected that similar changes will occur here. The impending changes and immediate concerns facing the health and population sectors have been considered in formulating this strategy document.

1.2 INDONESIA, NOW AND THEN - A VIEW OF THE FUTURE

The development of the strategic plan has been based upon two interrelated analyses. The first is a thorough analysis of the current status of the health and population sectors and is presented in Chapter 2. The second analysis uses economic, demographic and epidemiologic trends to create a scenario for the year 2000 and is presented in Chapter 1. The two analyses represent the USAID O/PH view of future trends in the health and population sectors. The view is presented from three perspectives - economic, demographic and epidemiologic. The view presents things as they are now, as we expect they will be in the year 2000, and the transformations that we expect in each area as Indonesia moves from a Developing to Newly Industrializing Country.

1.2.1 The Economic Perspective

Current Status

Indonesia's economic adjustment program has been instrumental in shielding the economy from the deleterious effects of the two external shocks of 1986 - the fall in world oil prices and the devaluation of the US dollar. As a result, Gross Domestic Product (GDP) growth has been sustained at 4% per year (TABLE 1). The cost, however, has been expanded external borrowing, an onerous debt service burden, and severe public sector budget austerity which has been relaxed to some extent in 1989/90. The Oil/Liquified Natural Gas (LNG) sector remains the mainstay of the economy, although its percentage of total GDP has declined in recent years.

TABLE 1: Selected Economic Indicators Current and Projected for the Year 2000

	<u>Current</u>	<u>Projected (2000)</u>
Percent GDP Growth	4%	5%
Percent GDP Growth (non-oil)	4.5%	5.9%
Percent share GDP		
Oil/LNG/Mining	20.2%	10.5%
Agriculture	23.7%	19.9%
Manufacturing	9.1%	14.4%
Services	40.4%	47.2%
Debt Service Ratio	40.0%	15.0%
Total Public Investment (% GDP)	9.9%	9.4%

Source: Indonesia: Adjustment, Growth and Sustainable Development, World Bank, 1988

The Year 2000

Indonesia is projected to experience real annual growth of 4-5% until the year 2000. Most of this will come from the non-oil economy, expected to grow by 5-6% per year. With favorable trade and investment policies, non-oil exports should grow by 6-7% per annum, with manufactured goods accounting for 70% of the increment in non-oil exports. The Oil and Agriculture sectors will contract by a third, while Manufacturing and Services will expand by more than 20%. The expected rapid expansion of non-oil exports should considerably alleviate the debt service during the next ten years. Massive infusions of public sector spending are considered unlikely. Public investment, as percent of GDP, is expected to decline from current levels.

Transitional Trends

Repelita V and VI will witness a marked trend toward industrialization. Next to agriculture, manufacturing will be the largest individual sector of the economy and the primary engine for economic growth. Major institutional changes will accompany industrialization. The trade policy reforms begun in 1985/86 will be accelerated to open markets and create a more favorable environment for export. Further enterprise deregulation and privatization will allow the private sector to operate more freely in all areas, even in some areas which were once exclusively in the public domain. Financial and capital markets will be further deregulated and opened to foreign investment to generate the financing for the manufacturing and export growth. As the debt service burden lessens, there should be relaxation of the 1980s public sector budget austerity.

1.2.2 The Demographic Perspective

Current Status

Indonesia's aggressive national family planning program has produced dramatic reductions in fertility since 1970. Nearly half of the population at risk is presently using a contraceptive (TABLE 2). The base of the population pyramid contracted for the first time in 1985, as the percentage of the age group less than five years of age fell to 13%. Indonesia is still a rural, agrarian society with only 26% of the population living in cities. Fertility is still too high to support the government's economic development program. High fertility from the early 1970s has produced a 60 million person labor force that is expanding by 2.3% per year. At current levels of fertility, that figure will not decrease substantially in the immediate future.

TABLE 2: Selected Demographic Indicators Current and Projected for the Year 2000

	<u>Current</u>	<u>Projected (2000)</u>
Total Population (millions)	175.2	216
Crude Birth Rate	30	18
Total Fertility Rate	3.3	2.1
Rate of Natural Increase	2.1%	1.3%
Contraceptive Prevalence	48%	65%
% Population <5 years of age	13%	10%
WRA* as % total population	25%	27%
Urban as % total population	26%	40%
Labor force (millions)	60	83
% Growth in Labor force	2.3	2.2

*WRA - Women of Reproductive Age

Source: Repelita V Document, 1989; SKN, 1984; NICPS, 1987; SUPAS, 1985.

The Year 2000

Fertility should fall even more dramatically by the year 2000 given the government's continued strong commitment to the family planning program. Although absolute population size will increase to 216 million, Indonesia should be approaching replacement levels of fertility by the year 2000. Fewer births will cause further contraction of the population pyramid. Ominously, however, the number of Women of Reproductive Age (WRA) will increase to 27% of total population. The urban population will expand substantially reaching 40% of the total population. The labor force will expand by 40% reaching 83 million by 2000.

Transitional Trends

Indonesia will be an aging and urbanizing society by the year 2000. The rapid decline in fertility experienced in the 1970s and 1980s will accelerate during the 1990s. Substantial urban migration is expected as the rural population abandons farming for jobs in the manufacturing and services sector, which will inevitably congregate in and around urban sectors. The 25 - 29 years age group will be the largest segment of the population. This will have implications in two areas. First the increase in the WRA will create the potential for another baby boom unless the family planning program continues to receive vigorous support. Secondly, labor force expansion will continue to outstrip job creation over the next eleven years, taxing the economy's ability to provide this group with productive employment. Solutions to this problem will have implications for Indonesia's competitiveness on world markets, political stability and growth at home.

1.2.3 The Epidemiologic Perspective

Current Status

Deaths among mothers, infants and children still constitute the majority of all mortality in Indonesia. Infants and children alone account for 44% of all mortality, most of that caused by infectious diseases and perinatal events (TABLE 3). Infant mortality has been halved in the last 20 years, but the current level of 70/1,000 live births is still substantially higher than Indonesia's neighbors in the Association of Southeast Asian Nations (ASEAN). Infectious diseases, especially Acute Respiratory Infection (ARI), diarrheal diseases and the Expanded Program for Immunization (EPI) related diseases are the major causes of death in the country. At the present time, Indonesia spends about 2.7% of GDP on the health sector of which the government contributes one third.

TABLE 3: Selected Epidemiologic Indicators Current and Projected for the Year 2000

	<u>Current</u>	<u>Projected (2000)</u>
Infant Mortality Rate (IMR)	70/1,000	45/1,000
Deaths under 5 years (% Total)	44%	30%
Major Cause of Death		
Disease Category	<u>Infectious</u>	<u>Chronic</u>
Causes of Death	<ol style="list-style-type: none"> 1. Perinatal 2. ARI 3. EPI related 4. Diarrheal 	<ol style="list-style-type: none"> 1. Cardiovascular 2. Injuries/Accid 3. Chronic Resp. 4. Neoplasms
Health Expenditures (% GDP)	2.7	5
Govt. Contribution	35%	25%
Private Contribution	65%	75%

Sources: Household Health Survey (HHS), 1986; Repelita V Document, 1989; SKN, 1984 and Bureau of Planning, MOH.

The Year 2000

Declining fertility and continued government commitment to child survival programs will lead to further reductions in the Infant Mortality Rate (IMR) by the year 2000. By that time infants and children should account for about 30% of total mortality, with IMR declining to 45/1,000 live births. As the large birth cohorts of the 1950s and 1960s pass through middle age, they will be exposed to the chronic, non-communicable diseases that are even now assuming greater prominence as major causes of death in Indonesia. By 2000, chronic disease groups, especially neoplasms, chronic respiratory diseases, cardiovascular and circulatory diseases, and accidents and injuries, are projected to surpass communicable diseases as the major causes of morbidity and mortality. Because of the less conventional and effective strategies available to prevent non-communicable diseases and the high costs of treating them, the percentage of GDP allocated for health will have to increase dramatically. It is projected that 5% of GDP will be needed to address the health problems at the turn of the century as compared to 2.71% now.

Transitional Trends

Economic development will be the most important driving force for the health of Indonesia's citizens. However, the same economic development in the presence of the urbanization and demographic trends mentioned above, will present major challenges to the health sector.

Previously unrecognized problems caused by environmental, lifestyle and behavioral risk factors secondary to an industrializing society will assume greater prominence. As Indonesia moves from a Developing Country to a NIC, it will undergo a mortality transition in which infectious diseases are replaced by chronic diseases as the major causes of mortality. These will be accompanied by significant economic costs, both in terms of the higher cost of treatment and the impact of chronic diseases upon labor force productivity. Developing the manpower and institutions needed to meet the challenges that the mortality and morbidity transition will present must begin now.

1.3 O/PH GOALS AND OBJECTIVES

USAID's goal is to assist the Government of Indonesia (GOI) to reduce fertility and the major causes of morbidity and mortality. The specific USAID objectives are consistent with the GOI objectives as stated in its Fifth Five Year Plan (Repelita V, 1989 - 1994), and the National Health System (SKN) targets for the year 2000.

MORTALITY REDUCTION OBJECTIVES

- (1) Reduce infant mortality rates to 49.8/1000 live births in 1994 and 45/1000 live births by 2000.
- (2) Reduce child mortality rates to 6.5/1000 children ages 1-4 in 1994.
- (3) Reduce maternal mortality rates by to 3.4/1,000 live births in 1994.

FERTILITY REDUCTION OBJECTIVES

- (1) Increase the prevalence of effective contraceptive use to 52.4 percent in 1994 and 65 percent by 2000.
- (2) Reduce the Total Fertility Rate to 3.0 per woman of reproductive age in 1994 and to 2.1 by 2000.

INSTITUTIONAL DEVELOPMENT OBJECTIVES

- (1) Develop the information systems and data bases necessary to measure the magnitude and intensity of current and emerging causes of morbidity and mortality on a national basis.
- (2) Develop the human and institutional resources necessary to address the emerging causes of morbidity and mortality which will likely be most prevalent by 2000.

1.4 PLANNING ASSUMPTIONS FOR EXTERNAL ASSISTANCE

External aid will continue to play a central role in supporting Indonesia's economic adjustment program. In the short term there is a strong case for continued special assistance to support the adjustment in the balance of payments and the budget. In the long term there will probably be continued availability of sufficient external assistance at concessional rates to meet Indonesia's development needs.

USAID will probably not be one of the central actors in the provision of development aid. Forecasts indicate that USAID development assistance to Indonesia will not increase in real terms during the 1990s. Funds for health and population activities will reflect USAID's general resource picture. Because of the expected severe limitations on funding for population and health, USAID technical assistance will probably be directed toward developmental activities rather than providing any recurrent budget support for geographic program expansion. Because of staffing reductions, more efficient intensive ways will have to be found to disburse, administer and monitor the use of those funds. The organizational chart for O/PH is presented in FIGURE 1.

1.5 POLICY AGENDA

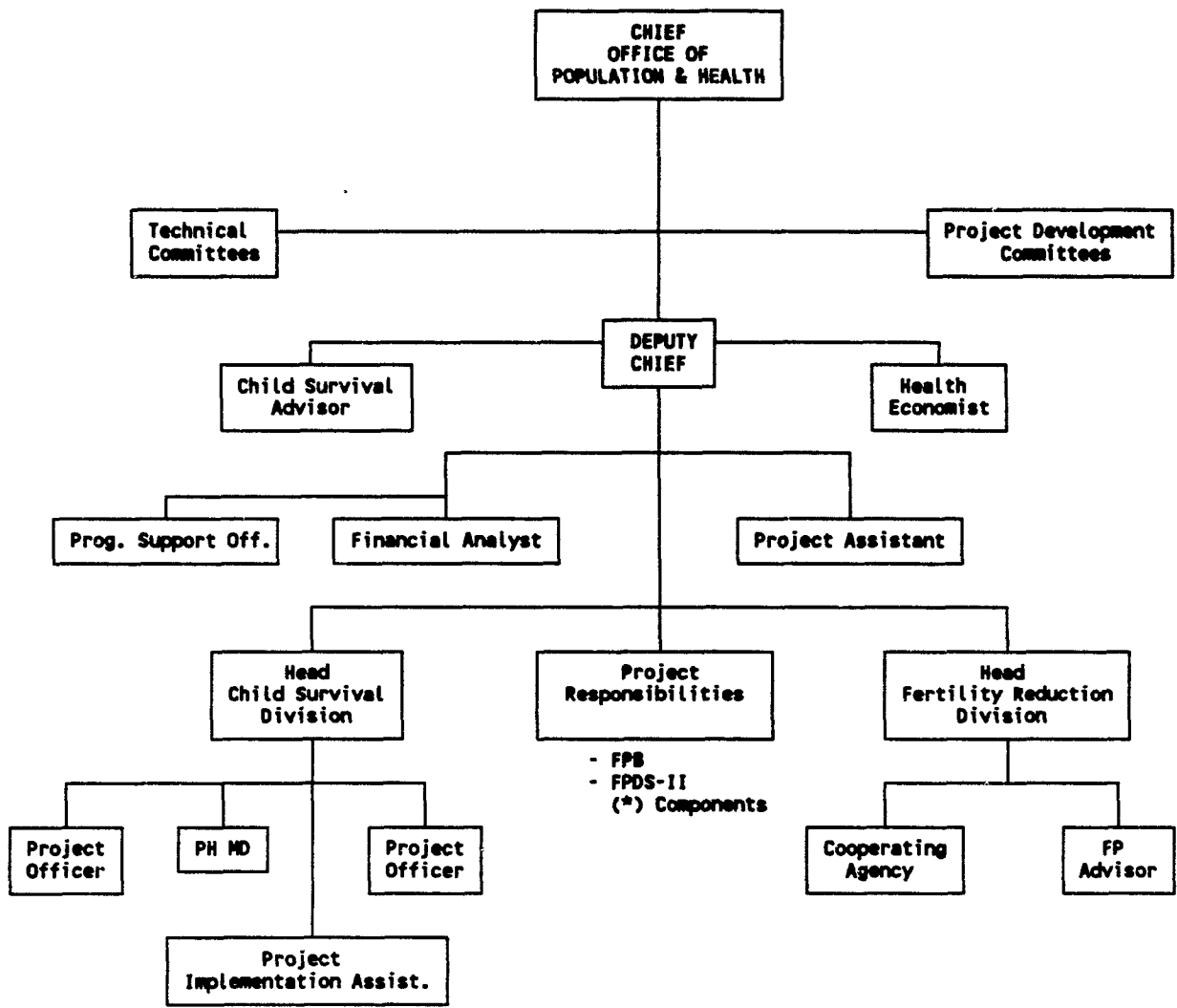
The demographic and health objectives described above are indicators of the impact of the government's commitment of physical resources and political will to fertility and mortality reduction programs over the last two decades. However, as the challenges of the next decade materialize, several critical policy issues will have to be addressed. The satisfactory resolution of these issues will, to a large extent, determine the GOI's success in facing the upcoming challenges. USAID will join the GOI in addressing the following major policy issues during the planning period covered by this strategy.

1.5.1 Public-Private Sector Partnership

During the prosperous years of the 1970s, economic planners thought that government could and should provide for the entire health and family planning needs of the population. The realities of the 80s have rendered that notion untenable. It is now acknowledged government policy in Indonesia to enlist the private sector as a partner in development. The parameters of that partnership must be defined for each sector. A partnership implies that each partner must contribute unique and complementary skills in a mutually reinforcing fashion to achieve a desired end. The public sector should do what it does best, the private sector should do what it does best, and they should do it in a mutually complementary manner.

USAID plans to use its development assistance to assist the Ministry of Health (MOH) and the National Family Planning Coordinating Board (BKKBN) to define the parameters of that partnership with their colleagues in the private sector. The major elements of this policy agenda are described below.

FIGURE 1: ORGANIZATIONAL CHART OPH, USAID/JAKARTA



Chief Functions

- Liaison with GOI
- Liaison and Advocacy with USAID & Mission
- Policy
- Strategy Planning
- Project Design
- Overall Program Management

Deputy Chief Functions

- Financial Control
- Office Administration
- Liaison PPS, CM, LA
- Information Data Management
- Oversee Project Implementation
- Oversee Project Evaluation
- Personnel Management
- Contractor Support
- Manage Secretarial Pool
- Oversee Project Development

Division Functions

- Project Implementation
- Project Finance Control
- Project Evaluation
- Project Development

Division Responsibilities

- | | |
|------------|-------------------------|
| Projects: | Modern Management (*) |
| - FPDS-II | Vol. Sterilization(*) |
| Research | Urban Fam. Planning (*) |
| Training | - PSFP (FY 89 start) |
| Village FP | |

- | | | |
|--------------|--------------|---------------|
| - FHI | - PSIP | - CONRAD |
| - DHS | - FPMT | - Pop Council |
| - DOD | - EWPI | - Colombia |
| - Pathfinder | - Georgetown | - AED |

Division Responsibilities:

- Projects:
- EPI
 - VFP/MCH
 - HTRD/CDD
 - HSFP
 - CSP (FY 90)
 - VHP Liaison
 - Vitamin A
 - CHIPPS

+ AID/Coordination:

- REACH
- PRICOR II
- ADDR
- PRITECH
- JHU/Vit.A
- JHU (A)
- AED/Rovita
- VBC

+ AID/Coordination:

- SOMARC
- AVSC
- JHPIEGO
- URC
- FPIA
- Enterprise
- TIPPS
- URC

- (1) Through the Private Sector Family Planning Project, assist BKKBN to explore various options for public-private cooperation in support of its stated policy that 50% of all family planning services will be provided by the private sector by 2000.
- (2) Through the Health Sector Financing Project and Health Sector Transition Project, assist the MOH to enlist the private sector as a partner in health development. In defining the parameters of this partnership, the MOH must carve out a clear, manageable and sustainable role for itself which capitalizes on its unique skills, capacities and mandate; and it must recognize the complementary skills and comparative advantage that the private sector can contribute to the partnership.

The public-private sector partnership issue has been raised to the apex of the policy agenda because it has become eminently clear that the challenges facing the health and population sectors, and their concomitant costs, can only be met if the public and private sector approach them as partners.

1.5.2 Sustainability

It has become clear that the resources which the public and private sector will have to mobilize in the future will be exponentially larger than they are today. Of paramount importance, then, is the issue of sustainability, i.e. to maintain a consistent flow of public and private resources to essential programs which reduce fertility and improve rates of child survival in the short term and to confront the emerging causes of mortality in the future.

Like many developing countries, Indonesia maintains a national public sector network of promotive, preventive, curative and rehabilitative services for the population. A large proportion of that budget is consumed by the hospital and pharmaceutical sectors, severely limiting the government's ability to provide the essential public health services which have an impact on fertility and infant and child mortality. Analyses of health budgets indicate that only 10% of the government's budget for health is allocated for child survival. Yet the record indicates that it has been these programs which have had the greatest return on investment and have been instrumental in reducing fertility and infant and child mortality.

As the public and private sectors determine the parameters of their partnership in the future, it is reasonable to assume that the public sector will remain the provider of first choice for promotive and preventive health services. The challenge is to insure that sufficient resources will be available to fund these programs.

USAID will assist the GOI to achieve long term sustainability of its fertility and mortality reduction programs by encouraging policies which support the following three major reforms:

- (1) improve the operational efficiency of government investments in health and family planning programs by providing the analysis and experimentation needed to demonstrate the feasibility of changing policies to improve efficiency and cost recovery within government programs.
- (2) create a more rational resource allocation policy by developing strategies to shift government expenditures from hospitals and pharmaceuticals to the preventive and promotive programs which have the greatest impact upon reducing fertility and mortality.
- (3) encourage a shift toward the privatization of as many services as possible, especially curative services for which the private sector has demonstrated a willingness and comparative advantage, and to promotive and preventive services where feasible. The development of a pluralistic health insurance industry will be a cornerstone of USAID's privatization strategy.

1.6 PROGRAM ISSUES

The USAID strategy also considers several sectoral and generic programmatic issues which impede sectoral objectives. These are described briefly below.

1.6.1 Sectoral Issues

Child Survival

Epidemiologic data indicate that high rates of infant, child and maternal mortality are the predominant problems facing the health sector at the present time. Hence, child survival remains the predominant programmatic issue facing the health sector, at least in the short term. Continued strong emphasis will be placed upon delivering the promotive and preventive services which have maximum impact upon improving rates of child survival. These will include the Expanded Program in Immunizations, diarrheal disease control programs, nutrition, family planning and maternity care.

USAID's strategy will explore ways to intensify provision of these essential child survival services through both public and private channels. In the public sector, the focus will be upon decentralized planning, financing, delivery and evaluation of child survival programs. In the private sector, the strategy will explore areas of opportunity where private elements can become productively involved in preventive and promotive child survival programs.

Fertility Reduction

Despite the dramatic reductions in fertility experienced since 1970, substantial obstacles impede further dramatic fertility decline. At current growth rates, the population will double in 35 years. With 600,000 to 800,000 women moving into their childbearing years annually, family planning efforts must be intensified just to maintain current levels of contraceptive coverage. Projected future public sector allocations for family planning will be insufficient to even maintain current coverage levels, let alone reach projected targets for 2000. Oral contraceptives are still the most popular contraceptive method. Their proportional contribution must decrease and be replaced by a higher proportion of more effective long term methods if future fertility targets are to be realized.

Continued strong commitment to fertility reduction will remain a hallmark of USAID's strategy. USAID will support BKKBN's efforts to expand private sector participation in the family planning program, consolidate BKKBN's diminished, but still essential role as a provider of family planning services, and support its efforts to accelerate the trend toward the use of more effective, long term contraceptive methods such as Intra Uterine Devices (IUDs), progesterone implants and voluntary sterilization.

1.6.2. Generic Issues

Demand for Services

Achieving the fertility and mortality targets specified in this strategy document will require much higher levels of family planning practice, immunization coverage, ORT use, and maternity care than those which currently exist. Given the relatively high coverage levels that have already been achieved for family planning and preventive health programs, it can be assumed that spontaneous demand for these services is reaching its maximum level.

To achieve the higher service coverage levels mentioned above, greater emphasis and attention must be given to generating demand for these services among target populations. Considerable effort has been expended to improve the availability and accessibility of these services. More attention must now be given to making them more acceptable and desirable. Using modern communications and marketing techniques, the private sector in Indonesia has developed a good track record in generating demand for goods and services. The USAID strategy will take advantage of this expertise to generate demand for preventive health and family planning services.

Human Resources

The success of health and family planning programs is related to the quality of human resources who manage and implement them. Service providers exist in abundance. However, the public health technocrats i.e., the health administrators, statisticians, health educators, demographers, communications specialists, epidemiologists, data analysts, programmers, etc., who must plan, design, supervise, monitor, evaluate and formulate policy for these programs are in short supply. In view of the impending transition in epidemiologic patterns forecast for 2000, expanded roles for personnel will have to be developed and training provided.

Given the critical role that human resources play in successful health and family planning programs, and the current stage of their development in Indonesia, human resource development demands continuous attention and will assume an important role in USAID's strategy to support the population and health sectors in Indonesia.

1.7 PROGRAM STRATEGY

The current strategy remains one of evolution, capitalizing on the successful efforts of the past several decades. It responds to the changing policy environment of the health and population sectors and acknowledges the shortfalls in financial resources likely to continue. The O/PH program strategy consists of four interlinked component strategies:

(1) Encourage greater private sector involvement in financing and delivering health and family planning programs, concentrating on those areas where the private sector has a demonstrated or potential comparative advantage to function efficiently. The components of this strategy are:

- o Develop private sector channels of contraceptive delivery for all contraceptives available through the national family planning program. Both commercial distribution networks and private service providers will be stimulated to provide contraceptive supplies and services.
- o Stimulate development of private sector channels for the delivery of preventive health services (immunizations, ante-natal care, etc.) and encourage the GOI to develop supportive policies in this area.
- o Finance the demand for health and family planning services through pre-paid health insurance schemes which pool risk among the insurers or financers, providers and enrollees to contain costs. Private sector participation will be elicited

both as insurers and providers. Health insurance programs can shift the burden of financing and providing care for significant segments of the population from the government to the private sector, thus freeing government resources for those members of the population in greatest need.

- o Apply modern advertising and marketing principles which have been pioneered in the private sector, to the delivery of mortality and fertility reduction services and concepts in order to generate greater demand, and ultimately increased utilization, of these services and acceptance of these concepts. Private sector agencies will be encouraged to participate in campaigns which market abstract concepts (importance of breastfeeding, delayed age of marriage, or small family size) or tangible services and products (oral rehydration solutions, contraceptives, or immunization) available through either public or private sector channels.

(2) Improve the operational efficiency of public sector mortality and fertility reduction programs. Concentration will be on those areas where the public sector has a demonstrated comparative advantage to provide services efficiently. The components of this strategy are:

- o Continue the efforts made to date in controlling the current major causes of mortality. Consolidate the progress made in the Expanded Program for Immunization (EPI), the Control of Diarrheal Diseases (CDD) program, and the Acute Respiratory Infections (ARI) program. These three programs address the current leading causes of mortality. Support efforts to identify areas of expansion in these programs which will lead to further reductions of other causes of mortality (Hepatitis B, rotavirus vaccines, selected nutrient supplementation). Help the GOI develop national policies on selected diseases of potential importance: Acquired Immune Deficiency Syndrome (AIDS), dengue fever and malaria.
- o Assist in improving the quality and availability of intervention programs which will target mortality related to reproduction, vaccine preventable diseases, respiratory and diarrheal diseases, and accidents and injuries. GOI efforts to bring basic preventive services (immunizations, ante-natal care, nutrition) and selected curative services (case management approach to respiratory and diarrheal diseases) to the whole population through the PosYanDu will receive continuing support.
- o Promote increased use of long term contraceptive methods. Assist BKKBN's efforts to motivate new and current contraceptive acceptors to use long term methods of contraception such as IUDs, progestogen implants, and voluntary sterilization; and to deliver these services through the public sector.

(3) Ensure sustained levels of recurrent financing for fertility and mortality reduction programs. This strategy complements and reinforces the second strategy by addressing the critical issue of sustainability of mortality and fertility reduction programs. The components of this strategy are:

- o Explore ways to reallocate public sector resources away from the hospital and pharmaceutical budget, which together constitute 60% of the public sector health budget and towards mortality and fertility reduction programs.
- o Develop the information base needed by the MOH and BKKBN to demonstrate the benefits of investments into preventive health and family planning programs and enable both agencies to secure proportionately larger central government allocations for health and population.

(4) Develop the human and institutional resources, systems and capacity to manage, operate and sustain health and family planning programs in the public and private sector. The components of this strategy are:

- o Develop the information systems and data base needed to monitor trends in fertility and mortality, and to identify emerging causes of morbidity and mortality.
- o Develop the human resource base needed to confront the immediate and pressing problems in both the health and population sectors, and prepare the human resource and institutional infrastructure to address the emerging challenges Indonesia will face in reducing fertility and mortality by 2000.

1.8 PROJECT DEVELOPMENT STRATEGY

Following the 1984-88 Country Development Strategy Statement (CDSS) period, there were eight active projects in the O/PH portfolio. These projects and their relationship with the O/PH strategy during the 1984-88 CDSS period are shown in FIGURE 1A. During the 1989-93 CDSS period, USAID will experience reductions in the number of full-time staff. The project development strategy for the 1989-93 CDSS period will follow program strategies described above. The project development strategy will:

- (a) consolidate several terminating projects which support USAID's mortality and fertility reduction objectives into comprehensive projects supporting those objectives;

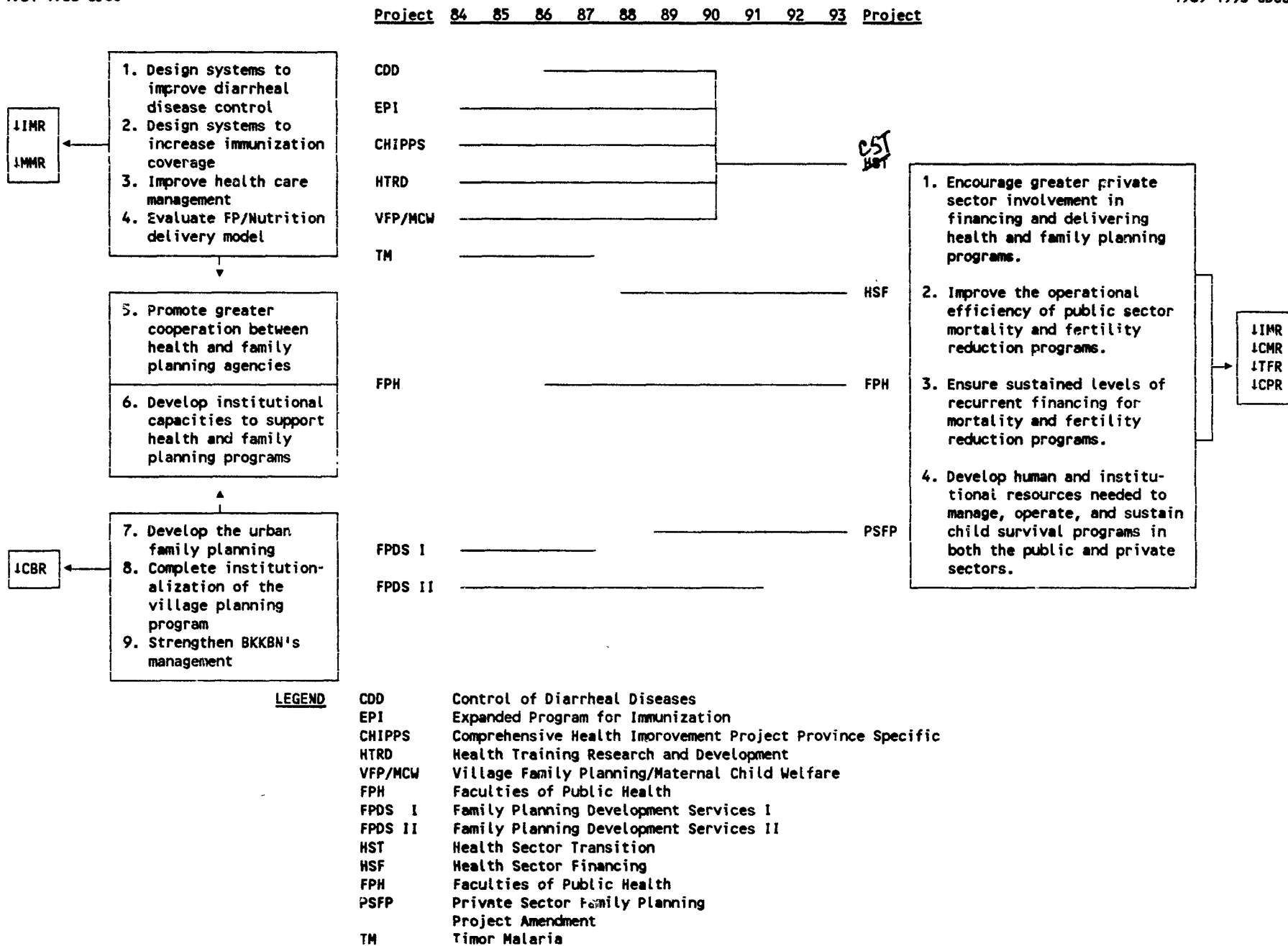
FIGURE 1A: O/PH PORTFOLIO TRANSITION FROM 1984-88 CDSS TO 1989-93 CDSS

OPH Goals
and Objectives
1984-1988 CDSS

OPH Strategy
1984-1988 CDSS

OPH Strategy
1989-1993 CDSS

OPH Goals
and Objectives
1989-1993 CDSS



- (b) reduce the number of projects in the USAID portfolio; and
- (c) develop less staff-intensive methods to manage these projects.

FIGURE 1A illustrates the transition from the 1984-88 O/PH project portfolio to the projected O/PH portfolio at the end of the 1989-93 CDSS. Five projects from the present health portfolio respond directly to the 1984-88 CDSS objective of reducing infant and maternal mortality. Two projects from the Population portfolio respond directly to the 1984-88 CDSS objectives and strategies for reducing fertility. The Faculties of Public Health project will produce human resources to support both the 1984-88 and 1989-93 mortality and fertility reduction objectives.

Five of the current projects in the health portfolio will all terminate in 1989-1990. At that time successful components of these projects will be incorporated into a comprehensive Health Sector Transition Project which will respond to the following components of the USAID 1989-93 strategy: (a) continue efforts to control current major causes of mortality. (b) develop the human resource and information base needed to address the major emerging causes of mortality. (c) apply modern advertising and marketing principles to generate demand for these services; and (d) stimulate development of private sector channels for delivery of preventive health services.

The issue of sustainability of mortality reduction programs supported through the Health Sector Transition Project will be addressed by the Health Sector Financing (HSF) project which began in 1988. The HSF project responds to the following components of the 1989-93 USAID strategy: (a) ensure sustained levels of recurrent financing for mortality reduction programs; and (b) encourage greater private sector involvement in financing health care. The HSF project and the Health Sector Transition Project represent USAID's two major initiatives to achieve its 1989-93 CDSS objectives of reducing infant, child and maternal mortality.

On the fertility reduction side, the current Family Planning Development and Services II project will terminate during the 1989-93 CDSS period. It will overlap and then be replaced by a comprehensive Private Sector Family Planning Project which will respond to the following components of the 1989-93 USAID strategy: (a) promote enhanced use of long-term, effective contraceptive methods; (b) encourage greater private sector involvement in financing and delivering family planning services; and (c) apply social marketing principles to the delivery of fertility reduction programs. The project represents USAID's final major initiative to increase contraceptive prevalence and reduce fertility.

The Faculties of Public Health (FPH) project represents the O/PH's primary initiative to develop human resources for both the health and family planning programs and supports both the USAID's mortality and fertility reduction objectives for the 1989-93 CDSS period. This project will terminate in 1992.

1.9 DEVELOPMENT ASSISTANCE STRATEGY

Since the early 1970s, USAID has provided assistance for activities that expand the coverage and availability of health and family planning services to the rural poor. A case in point is Indonesia's village family planning program, which expanded services outward from Java-Bali into ten provinces of Outer Islands I and selected Outer Islands II, using USAID assistance for routine and development expenditures. During this period USAID was also a major donor contributing to the geographic expansion of Indonesia's health programs, and provided substantial assistance to the Ministry of Health for malaria control, environmental sanitation and communicable disease control.

That era is over and USAID is faced with fewer staff and curtailed budgets. Therefore, the USAID health and population development assistance strategy has been modified accordingly. The new strategy stresses operations research, program design, testing and evaluation, and policy formulation. With limited resources, USAID will attempt to maximize its development impact by taking the lead in funding activities which seek to influence government policy by demonstrating the advantage of introducing certain changes in health and family planning policy and programs. Thus, USAID has concluded that its assistance can be most appropriately used to:

- (1) Conduct careful analyses of problems in the selected program areas corresponding to the USAID's program strategy which impede attainment of the GOI's fertility and mortality reduction objectives.
- (2) Design a variety of possible programmatic solutions.
- (3) Field test on a pilot basis those solutions which exhibit greatest potential in terms of cost effectiveness and impact.
- (4) Refine the most promising delivery systems, programs and strategies from the field test phase, and demonstrate these in a large operational area.
- (5) Evaluate results of large demonstration projects, and communicate findings to GOI decision makers.
- (6) Engage the GOI in policy level discussions regarding the meaning and ramifications of these findings with a view toward formulating policies which will guarantee their institutionalization and lead towards wider scale replication.

The approach described above means a much greater emphasis on supporting the analytical work for policy change, sensitizing policy makers to newly emergent or previously unrecognized problems, developing capacities to recognize and deal with these problems, field testing

solutions to problems, and institutionalizing the ability to carry out such work in the future. Eventually this development work may lead to opportunities for large scale sector support programs to operationalize policy changes which have been instituted. Donors such as the World Bank and the Asian Development Bank are in a better position to provide such program support funds. However, should more resources than expected be available, USAID could also provide sector support programs as a second phase to the policy and development activities which are now anticipated.

An important feature of the new USAID development assistance strategy in the population and health sector is that it involves an increased emphasis on sensitizing the government to the emerging problems brought about by the successes of the past as transitions occur in the demographic and health areas. The strategy builds on the analytical and development capacity of Indonesian institutions, both government and non-government, in order to deal with current and emerging problems. USAID has already begun the process of helping to build this capacity within the BKKBN and within academic institutions involved in the Faculties of Public Health Project. During the new CDSS period, such institution building efforts will be accelerated and broadened to include linkages with private sector organizations, indigenous Private Voluntary Organizations (PVOs) and other institutions which can serve the needs of the MOH and BKKBN. Linkages with US institutions are encouraged to help with this capacity building process, and to meet the need for increased technical assistance and short term internships and training activities.

1.10 CONCLUSION

The linkage between the O/PH CDSS goals and objectives, program strategies, project development strategy, and development assistance strategy form the comprehensive O/PH strategy for the 1989-93 CDSS period and beyond. Through these activities, USAID will continue to be an important influence in the population and health fields in Indonesia despite reduced resources. By careful application of this strategy USAID can leverage relatively broad program and policy impact with these reduced resources. USAID is uniquely positioned to assist the GOI in the innovative areas outlined above because of its long history of development assistance to Indonesia. There are unusually solid relationships that have grown between USAID's Office of Population and Health and the GOI's Ministry of Health and BKKBN through the variety of activities USAID has supported. Finally, there has been a gratifying degree of openness and receptivity to USAID initiatives demonstrated by the GOI. Throughout the coming CDSS period, USAID will remain committed to careful analysis and scrutiny of its strategy and, if warranted, make corrections as needed to assure goals shared by the GOI and USAID can be accomplished in the next five years.

2. HEALTH AND FERTILITY REDUCTION SECTOR REVIEW

2.1 POPULATION GROWTH, FERTILITY AND FAMILY PLANNING IN INDONESIA

2.1.1 Population Size and Growth

Data from the 1971 and 1980 census, the 1985 Intercensal survey (SUPAS), and the 1987 National Indonesian Contraceptive Prevalence Survey (NICPS) conclusively document the dramatic declines in fertility and population growth that have taken place over the past two decades. The average population growth rate for the period 1980-85 was 2.15%, down from 2.32% for the period 1971-80. Even more encouraging was the average growth rate of 1.74% in the five densely populated provinces on the island of Java where 61% of the population resides. The reduction in the population growth rates is reflected in the country's age distribution. By 1985 infants and children accounted for only 13.3% of the population, and the number of children aged 5-9 exceeded the number in the 0-4 age group for the first time.

High fertility during the 1960's and 70's, however, has left Indonesia's age structure skewed toward younger age groups. In 1985, 39% of the population was less than 15 years old. The number of women of childbearing age has increased to 24.9% of the population. Even with the most optimistic projections for fertility decline, this figure will probably reach 27% by the year 2000. Based upon the 1985 SUPAS results, Indonesia's 1988 population is estimated to be 175.2 million. The growth momentum generated by Indonesia's youthful age structure is projected to yield a population of 216 million in 2000, with absolute growth continuing into the 22nd century when the population is anticipated to level off in the range of 338-400 million, despite an aggressive family planning program.

2.1.2 Fertility and Factors Influencing Fertility

Data from the five national population based surveys presented in TABLE 4 graphically demonstrate the striking drop in fertility in recent years. From a level of 5.6 in the late 1960's, Indonesia's Total Fertility Rate (TFR) has fallen to 3.3 in the 1984-87 period. As expected, urban TFR (2.8) was substantially lower than rural levels (3.6), with wide variation among the 27 provinces. The Crude Birth Rate (CBR) has declined from 44/1,000 population in 1971 to 29.8/1,000 in 1985. The Central Bureau of Statistics has estimated further reductions in CBR to 25.3/1000 population for the period 1990-95.

**TABLE 4. Selected Indicators of Fertility from National Survey
Data 1971 - 1987.**

	1971 <u>1/</u>	1976 <u>2/</u>	1980 <u>3/</u>	1985 <u>4/</u>	1987 <u>5/</u>
Total Fertility Rate	5.6	4.6	4.7	4.0	3.3
Crude Birth Rate/1,000	44		36.4	29.8	
Pregnancy Rate (%)		12			6.8
Mean Age of Marriage (Year)	19.3	19.2	20	21.2	
Mean No. of Children Ever Born		3.5			3.4
Median Duration Breastfeeding (Mos.)		19.2			22
Median Period Insusceptibility(Mos.)					9.4

Footnotes:

- 1/ 1971 Population Census
- 2/ 1976 Indonesian Fertility Survey: Java and Bali only.
- 3/ 1980 Population Census
- 4/ 1985 Intercensal Survey (SUPAS)
- 5/ 1987 National Indonesian Contraceptive Prevalence Survey (NICPS)

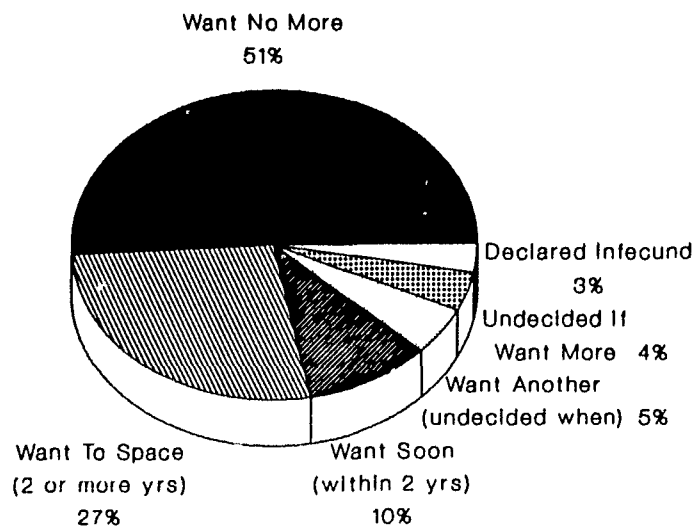
The mean age of marriage has increased to 21.2 years, pregnancy rates have been halved since 1976, and the mean number of children ever born to ever married women is 3.4. The 1987 NICPS quantified the relationship between mean number of children and age of marriage. Women who married at less than 15 years of age had, on average, 4.0 children, while those who married at 25 or above had 2.0.

Almost 80% of Indonesian babies are breastfed for one year, and 40% for two years. The median duration of breastfeeding is 22 months. By examining data on breastfeeding, post partum amenorrhea and abstinence from mothers who had given birth in the previous 36 months, it was estimated in the 1987 NICPS that the median period of post-natal insusceptibility to pregnancy is 9.4 months. That is, up to nine months after giving birth, more than 50% of mothers are still insusceptible to pregnancy. However, this beneficial effect drops off rapidly, and two years after birth fewer than 10% of mothers remain insusceptible.

2.1.3 Fertility Preferences

The fertility preferences of currently married women sampled in the 1987 NICPS are depicted in FIGURE 2. Half of the respondents are ready to stop childbearing. However, only 43% of the respondents with two children want no more children. The mean number of children desired by ever married women is 3.2. This response correlated closely with the mean number of children ever born, 3.4, as discussed in the previous section. These findings would indicate that the two child norm has not yet been completely internalized and desired family size in Indonesia is still three children.

**FIGURE 2. FERTILITY PREFERENCES
CURRENTLY MARRIED WOMEN 15-49**



The NICPS also looked at future need for family planning. About 41% of currently married women who are not using contraceptives definitely want no more children or want to postpone, but only 13% (about one third of these women) intend to use family planning in the future. Thus, there is a sizeable target audience for intensive education, motivation and service delivery efforts.

2.1.4 Family Planning Knowledge and Use

Knowledge of at least one modern method of family planning is almost universal. The most widely known methods are oral contraceptives (91%), injectable hormones (84%), and the IUD (82%). Most of the women who know a method also know where to obtain it. TABLE 5 indicates that the large majority would use public sources such as government hospitals, health centers, and family planning clinics to obtain their contraceptives.

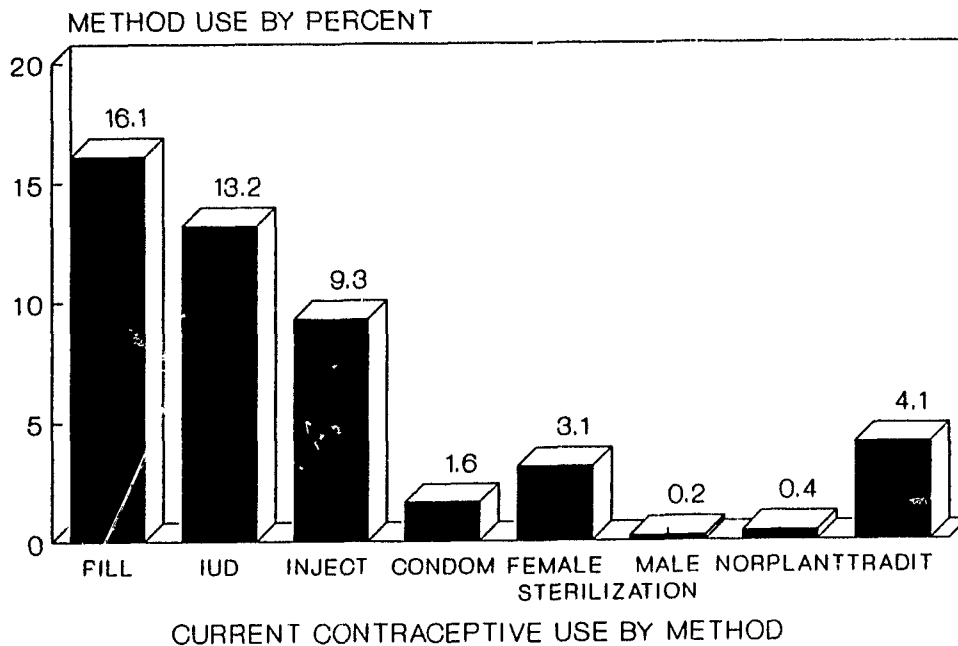
TABLE 5. Percent Distribution of Women Knowing a Method by Source of Supply if They Wanted That Method

Supply Source Named	Contraceptive Method Known						
	Oral Pill	IUD	Injec-table	Condom	Female Ster-ilization	Male Ster-ilization	Norplant
Government Sources	82.3	84.5	83.9	58.0	86.9	83.6	72.8
Private Sources	5.1	6.8	10.8	19.6	5.3	7.1	7.9
Other	9.4	1.1	1.5	2.4	0.1	0.1	1.6
Don't Know	3.2	7.6	3.8	20.0	7.7	9.2	17.7

Source: NICPS 1987

Forty eight percent of currently married women are using contraception in Indonesia; 44% are using modern methods and 4% use traditional methods. The pill (16%), IUD (13%) and injectable hormones (9%) are the most commonly used modern methods. The percent distribution by method is given in FIGURE 3.

**FIGURE 3. CURRENT CONTRACEPTIVE PRACTICE
BY DISTRIBUTION OF CONTRACEPTIVE USE**



SOURCE: NICPS 1987

Contraceptive use is higher in urban areas (54%) than in rural areas (45%). Contraceptive use is reported highest in Java and Bali (51%); the method mix, however, varies considerably by province. The provinces with the highest contraceptive prevalence rates (Yogyakarta and Bali) have the lowest proportion of oral pill users. This illustrates the trend toward more long term family planning methods in provinces with the better established programs.

Comparing data from Java-Bali in TABLE 6, current use of contraception has almost doubled from 26% to 51% in the 11 years between the 1976 Indonesian Fertility Survey (IFS) and the 1987 NICPS. Most of the difference is attributable to increased use of injectable hormones, IUDs and female sterilization.

TABLE 6. Percent of Currently Married Women in Java-Bali Currently Using Contraceptive Methods, 1976 and 1987.

Method	1976 IFS N=7974	1987 NICPS N=7265
Pill	14.9	16.0
IUD	5.6	15.5
Injectable hormones	0.2	10.7
Diaphragm/foam/jelly	0.1	0.0
Condom	1.8	1.8
Female Sterilization	0.3	3.5
Male Sterilization	0.0	0.2
Norplant	-	0.4
Periodic abstinence	0.8	0.1
Withdrawal	0.3	0.7
Other	2.3	1.0
Total Any Method, Java-Bali	26.3	50.9

Sources: Indonesian Fertility Survey, 1976
National Indonesian Contraceptive Prevalence Survey, 1987.

At the present time 80.3% of current users obtain contraceptives from government sources, and 12.4% from private sources. In urban areas, 25.3% of current users obtained methods from private sources. Sixty-four percent of current users obtained their contraceptives free while 36% paid either in whole or in part for their contraceptives. Pill users are most likely to obtain their contraceptives free (84%), followed by IUD (76%) and Norplant (70%). Conversely, 50% or more of condom users, female sterilization acceptors, and injectable users paid for the method or service. These data indicate that there is already a trend toward client financing for contraception. Consumers seem more willing to pay for certain methods. Family planning programs should capitalize upon this trend to elicit greater community financing and thereby improve chances for sustainability for family planning programs.

2.2 MORTALITY AND MORBIDITY

Indonesia is experiencing both an absolute and a relative decline in total mortality. For the period 1971-80 the Crude Death Rate (CDR) averaged 13.2 deaths per 1000 population. Data from the 1985 SUPAS indicate that the crude death rate had fallen to 10.52 for the period 1980-85. Estimates of total annual mortality in 1986 show a decrease by 45% in absolute terms when compared to estimates for 1980. However, age and cause specific mortality have remained relatively constant. Infant and childhood deaths still account for nearly half of all annual deaths, and infectious diseases still comprise the predominant cause of mortality.

Data from the seven province household survey sample in 1986, presented in TABLE 7, show the growing importance of a future mortality transition when chronic diseases will constitute an increasingly larger share of total mortality. These data should be viewed cautiously, however, because of sampling biases which are explained in 2.2.1. Nevertheless, cardiovascular diseases account for nearly 13% of total mortality in this largely rural outer island sample i.e. not Java-Bali, which, if anything is biased toward higher infectious disease mortality. From that sample, chronic diseases (cardiovascular, cancer and respiratory) account for 20% of total mortality. While these data cannot absolutely establish the emergence of chronic diseases as a major health problem in Indonesia at the present time, they indicate the need for closer surveillance and epidemiologic monitoring in the future.

TABLE 7. Cause Specific Mortality, 1986 Household Survey.

<u>Cause:</u>	<u>Percent of Total Deaths:</u>
1. Perinatal Events	7.1
2. Maternal causes	1.5
3. Infectious	46.4
4. Chronic Respiratory	3.4
5. Injuries/Accidents	6.6
6. Cardiovascular	12.7
7. Cancer	3.1
8. Other	19.0

Source: HHS, 1986

However, available data indicate that deaths among infants and children still comprise the bulk of mortality. Indonesia has experienced rapid decline in rates of infant and child mortality over the last two decades. Data from the 1971 Census, the 1980 Census and the 1985 Intercensal Survey document this trend (TABLE 8). Since 1971, the IMR has declined from 135/1,000 live births in 1971 to 70/1,000 live births in 1987. The average annual rate of decline has accelerated in the past five years, from an annual rate of 3.2% during the 1970's to an annual rate of 8.5% during the period 1980-85.

TABLE 8. Infant Mortality Rates in Indonesia 1971-88.

<u>Source</u>	<u>Rate</u>	<u>Rate Reduction (%)</u>	
1971 Census	135/1,000 live births		
1980 Census	98/1,000 live births	1971-80	3.2%
1985 SUPAS	71/1,000 live births	1980-85	8.5%
1987 NICPS	70/1,000 live births		

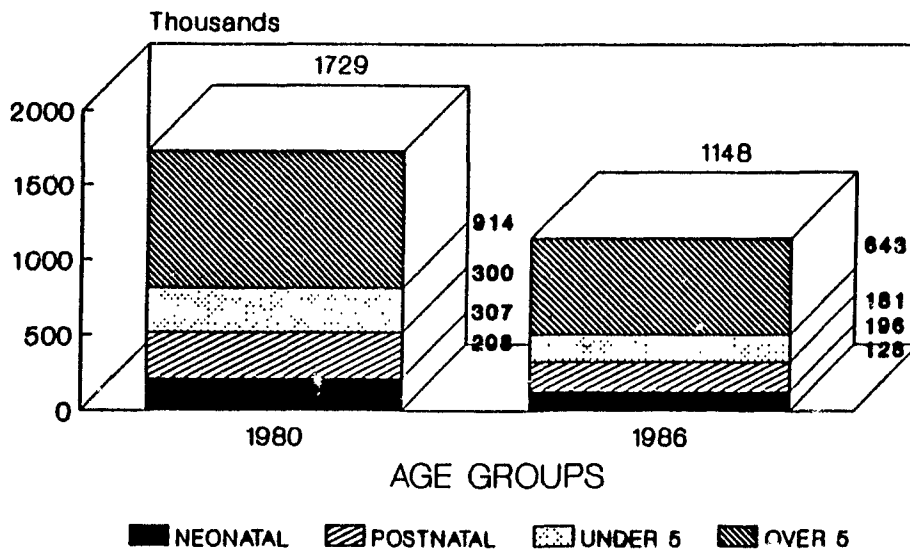
Long range plans for the GOI stipulate a reduction of IMR to 45/1000 live births by the year 2000. Achieving this goal will require average reductions of 4% annually. While this rate may seem achievable in light of the brisk declines in mortality during the 1980's, current economic pressures upon the health and social services delivery infrastructure may make that goal too ambitious. Furthermore, changing patterns in cause of death among infants and children may slow infant mortality declines. Infectious diseases will inevitably account for a smaller proportion of deaths and will be replaced by other causes usually more resistant to reduction through conventional interventions.

At the present time, infant mortality in the East and Southeast Asia region as a whole averages about 45. If Indonesia does achieve its target for reduction in infant mortality by the year 2000, it will only achieve levels which its neighbors had reached in 1985. The geographic and cultural diversity among Indonesia's 27 provinces, and some as yet unexplained widening differentials in IMR among the provinces, will pose an additional challenge to further reduction in IMR.

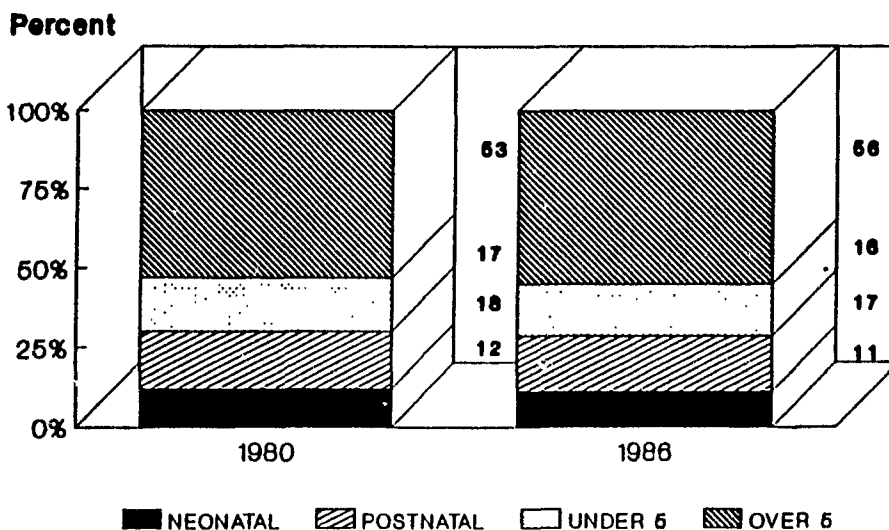
2.2.1 Causes of Infant, Child and Maternal Mortality

Findings from the 1980 and 1986 Household Surveys provide a picture of mortality patterns among infants and children. These data again must be interpreted cautiously. Differences in methodology and sampling make extrapolations and comparisons difficult. The 1980 survey was weighted more heavily in favor of the more populous provinces of Java. The 1986 survey used a seven province sample in which only the Special Administrative Area of Yogyakarta represented the populous provinces of Java. The 1980 survey recorded only the direct causes of death, while the 1986 survey recorded both direct and underlying causality. Despite these limitations, the findings from both surveys provide the most complete picture of causes of death and age at death currently available for Indonesia, and are presented here for illustrative purposes.

**FIGURE 4. NUMBER AND PERCENT MORTALITY
IN SELECTED AGE GROUPS - 1980 AND 1986
IN ACTUAL NUMBERS**



AS A PERCENTAGE



SOURCES: HHS 1980 AND 1986

Although total deaths in all age groups have declined dramatically between these two surveys, the percent deaths in the different age groups presented in FIGURE 4 have remained relatively constant. Deaths among infants and children still account for almost half (44%) of annual mortality in Indonesia. Roughly 66% of all childhood deaths occur in the first year of life; approximately 40% of all infant deaths occur during the first thirty days of life.

TABLE 9 shows that over a quarter of infant deaths are perinatal. More than half of these are attributable to obstetric causes and another quarter are due to growth retardation. This would indicate that fully three quarters of perinatal deaths were potentially preventable with proper antenatal care and birth assistance.

TABLE 9. Causes of Infant and Childhood Deaths in the Seven Province Household Health Survey 1986.

<u>Cause</u>	<u>0-1 Year*</u>	<u>1-4 Years*</u>
1. Perinatal Deaths	26.1%	-
2. Infectious Diseases	57.9%	78.5%
a. EPI Except Polio	19.8%	20.9%
Tetanus	13.6%	2.0%
Measles	5.2%	16.1%
Diphtheria	0.5%	1.0%
Tuberculosis (TBC)	0.1%	1.0%
b. ARI	23.4%	40.2%
c. Diarrheal Diseases	12.8%	22.3%
d. Meningitis	5.2%	4.0%
3. Injuries	2.8%	7.0%
a. Preventable	1.4%	3.2%
b. Non-Preventable	1.4%	3.8%
4. Chronic Respiratory Disease	1.8%	2.4%
5. Nutritional Disorders	1.8%	2.2%
6. Other	9.6%	1.0%

*Refers to the percentage of mortality in the specific age group.
Source: HHS, 1986.

Infectious diseases and their sequelae are by far the most common causes of mortality in both the infant and childhood period, accounting for 57.9% and 78.5% of mortality respectively in these age groups. Acute respiratory infections (most of which are complications from measles), tetanus and diarrheal diseases are the most common causes of death in the infant period following perinatal deaths. During the childhood period, ARI, diarrheal diseases and measles are the three major causes of death, accounting for fully 79% of all mortality in that age group. Despite the impressive progress that has been made in the EPI program, immunizable diseases still cause about one fifth of all infant and child mortality.

Results from the 1986 Household Health Survey (HHS) show the importance of injuries as a cause of infant and child deaths in Indonesia. Injuries are the fourth leading cause of childhood deaths. Poisonings alone account for more infant deaths than diphtheria, pertussis and tuberculosis (TBC) combined.

The emergence of deaths due to perinatal events as a major cause of infant mortality in the 1986 HHS is notable and deserves mention. Perinatal deaths are most often due to hypoxia, asphyxia, abnormal fetal growth and congenital malformations. Conditions which contribute to these causes are maternal health and nutritional status during pregnancy, maternal age, parity, spacing of pregnancies, antenatal care, the type and quality of assistance received during delivery, and sanitary conditions of the place where birth takes place. Other conditions such as anemia, iodine deficiency, malaria and other infectious diseases during pregnancy certainly play a contributory role. Hard data on the direct and underlying causes of perinatal deaths, however, are sparse. Programs aimed at addressing this problem have been sporadic; their results have been inconclusive and their impact negligible. Mounting an effective campaign to reduce perinatal deaths will require a coordinated program of research and service delivery which must combine elements of family planning, antenatal care, nutritional supplementation and safer birthing practices. These programs will be receiving high priority during REPELITA V.

2.2.2 Maternal Mortality

Infant mortality, and to a lesser extent child mortality, are closely related to maternal mortality. The conditions which most profoundly affect perinatal deaths also affect the mortality of mothers. Information on both the magnitude and determinants of maternal mortality remains inadequate. Data from other countries suggest that obstetrical complications from frequent, multiparous pregnancies among nutritionally compromised mothers, as well as the sequelae of septic abortions, are the prominent causes of maternal deaths. These data remain to be confirmed in Indonesia. A precise estimate of the national maternal mortality rate has yet to be made in large part because 80% or more of all deliveries take place in the home and these events are usually not reported.

TABLE 10. Estimated Maternal Mortality Rates in Selected Developing Countries 1980-1987.

Maternal Mortality Rates*	
Indonesia	800
<u>ASEAN</u>	
Malaysia	59
Philippines	80
Singapore	11
Thailand	270
<u>Other Asia</u>	
Bangladesh	600
China	44
India	500
Nepal	850
<u>Africa</u>	
Egypt	80
Nigeria	1500
Somalia	1100

*Per 100,000 live births.

Source: "The State of the World's Children 1989", : UNICEF, Table 7: Women, pp.106-107.

Estimated maternal mortality rates in selected developing countries are shown in TABLE 10. Indonesia ranks highest among its ASEAN neighbors and among the highest in Asia. In view of the dramatic decline in infant mortality in recent years in Indonesia, such a high rate of maternal mortality seems incongruous. Nonetheless, it is clear that women's reproductive health needs to be a primary target for health programs.

2.2.3 Morbidity

Morbidity rates for potentially serious diseases are high in the general population especially among infants and children. The 1986 HHS showed that 16% of infants and 18% of children had been ill the previous month. Mirroring the mortality experience among infants and children, the 1986 HHS found that 44% of all morbidity occurred among the 13% of the population that is less than five years of age. The causes of morbidity shown in TABLE 11 indicate that ARI, diarrhea and skin infections are the major causes of morbidity.

TABLE 11. Causes of Infant and Child Morbidity in Indonesia in 1986

<u>Cause</u>	<u>0-11 Months (in percent)</u>	<u>1-4 Years (in percent)</u>
ARI	42.4	40.6
Diarrhea	15.1	11.4
Skin Infections	12.2	14.5
Bronchitis Asthma + other Respiratory Infections	8.0	7.1
Nervous System Disorders	4.5	6.3
TBC, Diphtheria, Pertussis, Measles	4.2	3.0
Malaria	1.6	4.4
Other Infections	9.4	10.2
Unknown	2.6	2.5
	Total:	Total:
	100	100

Source: HHS, 1986.

2.3 HEALTH AND POPULATION SERVICE DELIVERY

The design and delivery of health and population services in Indonesia is a multi-agency, multi-disciplinary effort. Since the establishment of "The New Order" Government in 1967, primary responsibility for this effort has been delegated to the Ministry of Health and since 1970 to the National Family Planning Coordinating Board. The Ministry of Home Affairs, the Ministry for Population and Environment, the Armed Forces and the private sector also contribute substantially to the delivery of health and population services.

A host of organizational, political, manpower, financial and public health considerations affect how policy decisions are made and how services are delivered. A brief description of these will facilitate an understanding of the health and population sectors.

2.3.1 Organization of Service Delivery at Various Levels

Although contributing a minor portion of health expenditures annually, the public sector health and population infrastructure dominate the delivery of services. Through a complex series of organizational interrelationships at each administrative level as depicted in FIGURE 5, MOH, BKKBN, the Ministry of Home Affairs and to a lesser extent the Ministry for Population and the Environment collaborate to develop policies and strategies, plan activities and services, implement them and monitor their impact.

The Ministries of Health and Home Affairs are the major line agencies with peripheral administrative infrastructures. BKKBN was created by Presidential Decree in 1970 to coordinate population and family planning programs. As such, BKKBN is a non-ministerial agency that is responsible directly to the President and has its own infrastructure at each administrative level. The Ministry for Population and the Environment is a state ministry which coordinates population and environmental policy among BKKBN, MOH and other ministries but has no line authority or infrastructure.

The Ministry of Home Affairs, through the Governor at the provincial level, the Regent at the district level, the subdistrict officer at the sub-district level, and the village chief at the village level, is the predominant Ministry at the peripheral levels. A description of the organizational interactions and responsibilities at each administrative level provides a clearer picture of how health and family planning services are delivered.

Central Level. MOH, BKKBN, and Population and Environment have extensive central organizations (as depicted in FIGURES 6, 7 and 8, respectively) and play the major role in the policy formulation, planning, coordination and supervision of health and family planning services. The Ministry of Home Affairs has only a perfunctory role in health and population at the central level.

Provincial Level. The Provincial Governor is responsible for the activities of all sectors within his administrative and geographic jurisdiction. There are two types of organizational units responsible to the Governor:

- o Autonomous units such as the provincial health office in FIGURE 5, which is a unit of the Ministry of Home Affairs and receives all of its budget from the Provincial Routine and Development Budgets (APBD I).

Figure 5: Primary GOI Organizational Relationship in the Health and Population Sectors, 1986

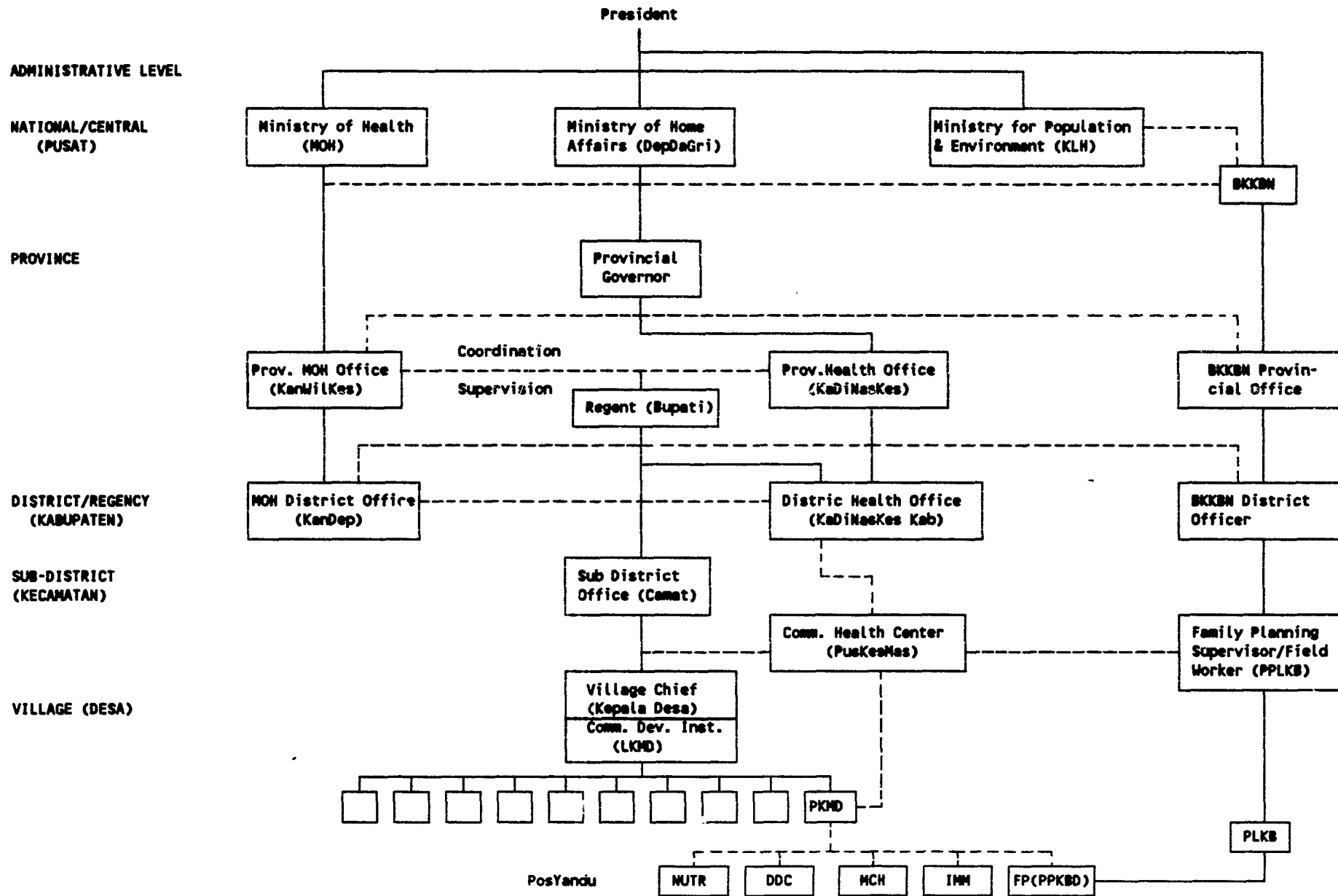


Figure 6: Organizational Structure, Ministry of Health

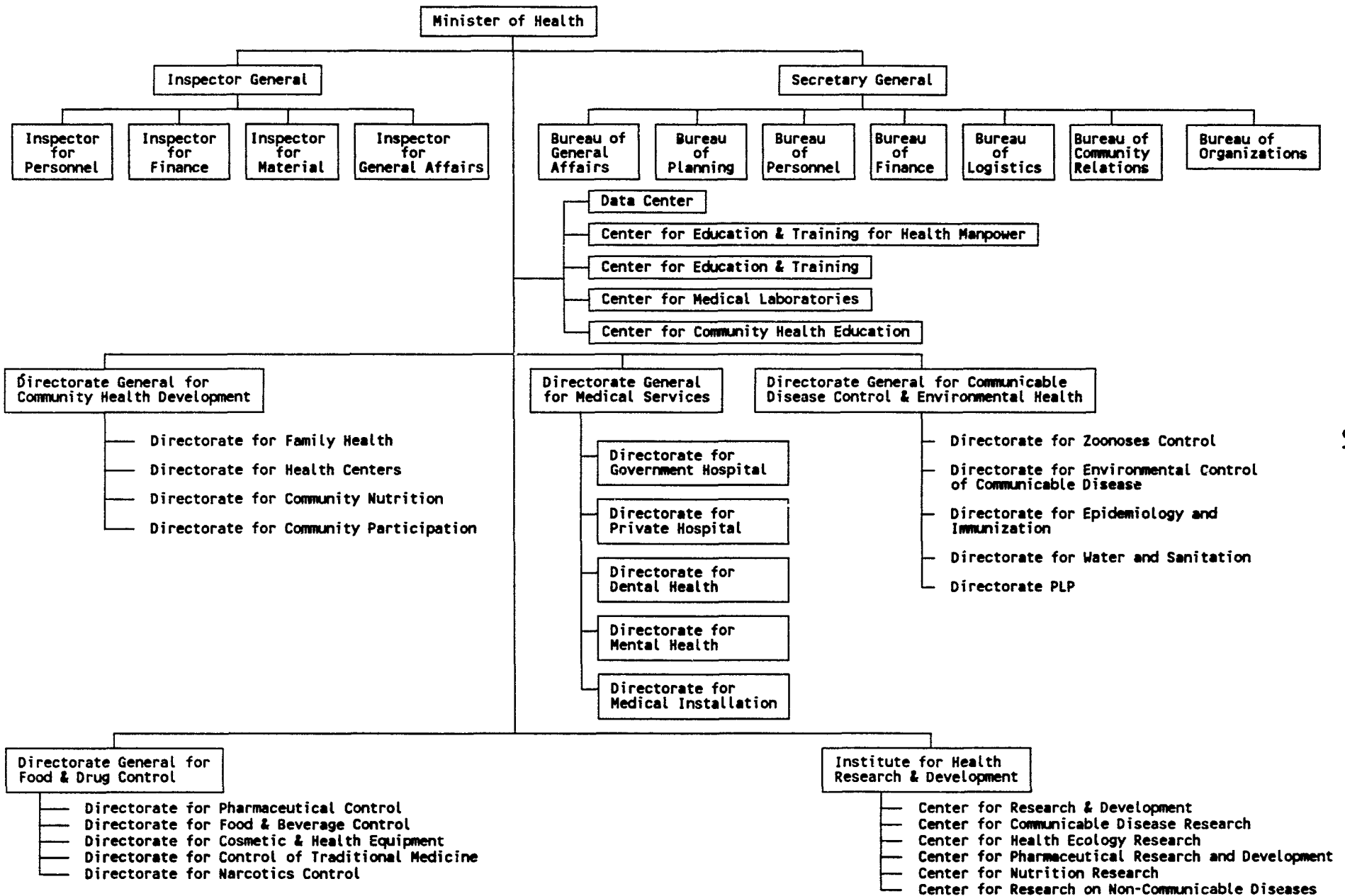


Figure 7: Organizational Structure, BKKBN

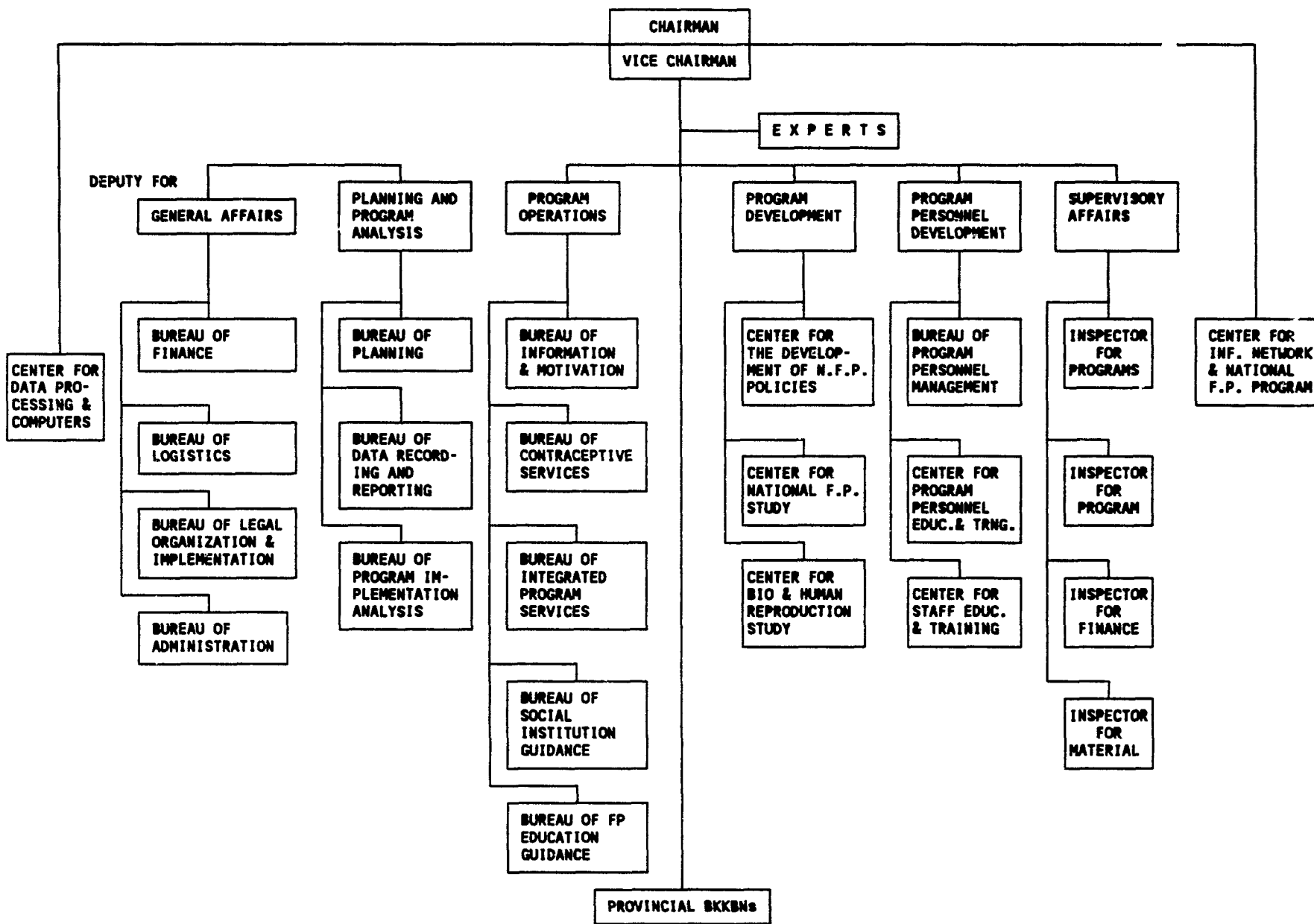
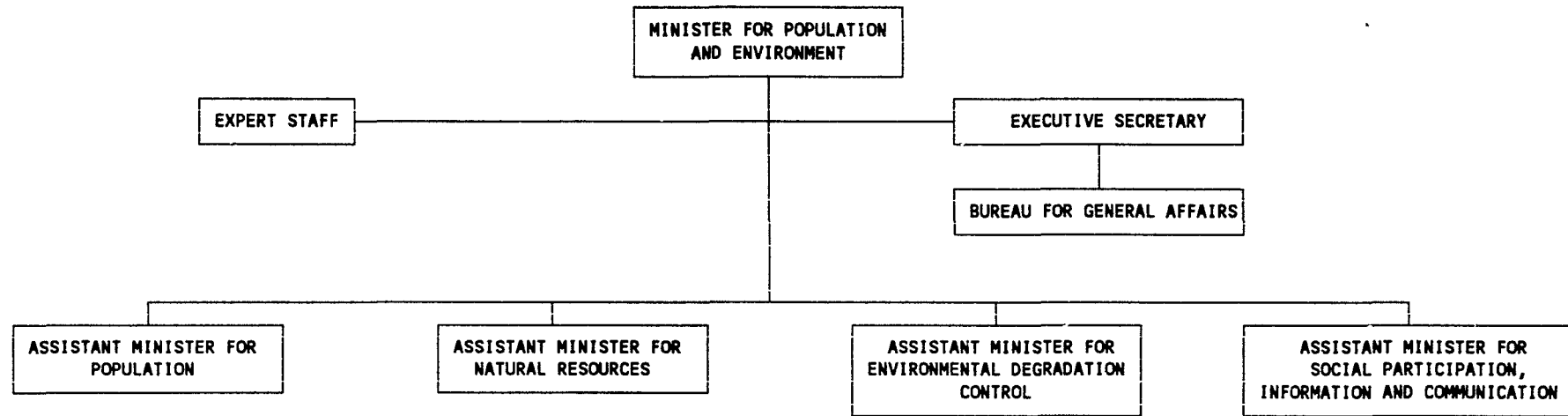


Figure 8: ORGANIZATIONAL STRUCTURE, STATE MINISTRY FOR POPULATION AND ENVIRONMENT



1. Population Dynamics (BANASDUK 1)
2. Population Quality (BANASDUK 2)
3. Social Environment (BANASDUK 3)
4. Population Distribution and Human Settlement (BANASDUK 4)
5. Population Planning (BANASDUK 5)

1. Quality and Function of Environmental Standards (BANASLAM 1)
2. Natural Resources Conservation and Preservation (BANASLAM 2)
3. Natural Resources Utilization (BANASLAM 3)
4. Regional Spatial Planning (BANASLAM 4)

1. Environmental Damage and Pollution Control (BANASDAL 1)
2. Hazardous Substance Control (BANASDAL 2)
3. Environmental Law Enforcement (BANASDAL 3)
4. Environmental Impact Analysis Application (BANASDAL 4)

1. Public Participation (BANASKOM 1)
2. Regional Relation (BANASKOM 2)
3. Environmental Information System and Environmental Accounting (BANASKOM 3)
4. Environmental Skills Development (BANASKOM 4)

- o Vertical units such as the BKKBN provincial office which, although operationally responsible to the Governor, receive only a small portion of their budget from the APBD I. The BKKBN provincial office is organizationally responsible to the central BKKBN, from which it receives policy direction and most of its budget. The MOH is represented by the MOH provincial office at the provincial level. Though nominally subordinate to the Governor, the provincial office is organizationally linked to the MOH central office, from which it receives all of its budget. It is neither a vertical nor an autonomous organizational unit.

The Ministry of Home Affairs' provincial health office is operationally responsible for the delivery of all health and family planning services. The MOH provincial office supervises and coordinates its activities, but has no operational authority or responsibility except in the case of epidemics or natural disasters. The Director of these two provincial offices is the same person, but the staff are separate and independent.

District Level. The organizational interrelationships of this level are similar to those at the provincial level, except that all units are responsible to the Regent. The district health office of the Ministry of Home Affairs has operational responsibility for the implementation of health and family planning services (FIGURE 5). The MOH district office supervises and coordinates the delivery of health services. The BKKBN district office coordinates the delivery of family planning services. The director of both ministries' district offices is the same person. Staff are separate in the large provinces, but the same staff hold both positions in smaller provinces.

Sub-district Level. The Community Health Center (PusKesMas) is the focal point of health and family planning services at this level. Because it is a service delivery site, the PusKesMas has no administrative position within the sub-district organizational structure but is considered an implementing unit. As such, the PusKesMas functions within the Ministry of Home Affairs bureaucracy and its staff are employees of this ministry. However, its budget comes from many sources: the Ministries of Home Affairs and Health, BKKBN and the special presidential

primary health care strategy. It should be noted that all five posts do not exist in every village. The most prevalent is the village contraceptive distribution center because it receives direct financial support and supervision from BKKBN. The other posts receive the bulk of their support from the LKMD whose sole source of revenue is community contributions. The Puskesmas provides technical and commodity support (oral rehydration therapy, vaccines, weighing scales, growth monitoring cards, contraceptives) to the PosYanDu for the delivery of services, but no financial support.

2.3.2 Health and Family Planning Service Delivery Infrastructure

The health and population services delivered through BKKBN, MOH and the Ministry of Home Affairs, are delivered through stationary facilities or a non-clinic oriented community based distribution system. In addition, there is a vigorous private sector operating, especially in health and to an increasing extent in family planning.

Stationary facilities are divided into hospitals and health centers. Since the hospital sector dominates the health services delivery infrastructure down to the district level, consumes more than a third of the public sector budget on health and requires such an enormous allocation of manpower, it requires further elaboration here.

In all of Indonesia there are 1406 hospitals, both public and private, with 111,456 beds (TABLE 12). Hospitals are divided into specialty and general hospitals.

TABLE 12. Total Number of Hospital and Beds by Type, Class and Ownership 1985/86 and 1986/87.

Type of Hospital:	Hospital:		Beds:	
	1985/1986	1986/1987	1985/1986	1986/1987
GENERAL HOSPITALS	686	701	84,254	85,296
MOH/Prov. & Local Gov.	316	324	43,002	44,117
Class A	2	2	2,918	2,854
Class B	16	16	9,396	9,391
Class C	79	84	15,183	15,684
Class D	219	222	15,505	16,188
Defense Ministry	115	115	11,428	11,595
Other Ministry	80	80	8,725	8,012
Private	175	182	21,099	21,572
SPECIALITY HOSPITALS	679	705	26,172	26,160
Ministry of Health	44	44	8,354	8,686
Prov./Local Government	43	42	3,923	3,299
Defense Ministry	24	21	453	444
Other Ministry	10	10	167	161
Private	558	588	13,275	13,570
Total:	1,365	1,406	110,426	111,456

Source: Directorate General for Medical Services, 1987

There are four classes of general hospitals. The Class A hospitals have highly specialized staff and equipment. Class B hospitals have a range of about 10 specialist departments. Most of the medical schools in Indonesia are attached to either Class A or Class B hospitals. Class C hospitals are staff with specialists in the four basic clinical areas: general medicine, general surgery, pediatrics and obstetrics/gynecology. Class D hospitals are staffed only by general practitioners and lack operating theaters, X-ray and laboratory services.

Hospitals in the government sector are operated by the MOH, provincial governments, local governments and other ministries. Of the 63,724 government general hospital beds, only 13% are operated by the MOH, 55% are operated by provincial and local governments, 18% are operated by the Ministry of Defense, and 14% are operated by other ministries.

Private hospitals provide 31% of total hospital beds and 25% of general hospital beds. Most of the bed capacity in the private sector is provided by industrial hospitals such as those run by state enterprises like Pertamina or Tambang Timah, and non-profit charitable and religious hospitals.

For all hospitals the bed/population ratio is 0.65/1000, and for general hospitals it is even lower at about 0.50/1000. Indonesia's level of hospital bed availability ranks it among the lowest of all developing countries regardless of income level, about one quarter of the ASEAN average, and three quarters of the average in low income countries (TABLE 13). There is, of course, great geographical variation in these figures, from a high of 1.86 beds/1000 population in Jakarta to a low of 0.29 beds/1000 population in Lampung, South Sumatera.

TABLE 13. Comparative Hospital Bed Ratios.

	<u>Beds/1000 Population</u>
Indonesia	0.6
Malaysia	2.5
Philippines	2.0
Thailand	1.4
Singapore	5.0
Low income	0.9
Lower middle income	1.3
Upper middle income	2.5
Industrial market economies	10.0

Source: Indonesia: Issues in Health Planning and Budgeting, World Bank 1988

Given Indonesia's abnormally low hospital bed availability rates, hospital utilization is inexplicably low. As can be seen from TABLE 14, bed occupancy rates run about 52% in the aggregate. When one considers that civil servants who have their own health insurance scheme called Asuransi Kesehatan or ASKES, account for more than 30% of all utilization of government health services, utilization among the general population is even lower. These data would indicate that the hospital sector in Indonesia is overbedded relative to demand. Whether the sector is overbedded relative to need is another question. At the present time the reasons for the low utilization of hospital inpatient services are only conjecture. Accessibility, poor quality of service and high cost have been suggested as barriers to higher utilization. It is probably a combination of these factors which ultimately explains the low utilization. However, conclusive evidence has not been presented to confirm these assumptions. Until such evidence exists, it will be difficult to develop public policy to effectively deal with the chronic problems of efficiency and low utilization.

TABLE 14. Hospital Performance in Indonesia, 1985/1986.

Type & Ownership:	Discharges:	Bed Days:	Outpatient:	BOR: %(1)	AV.LOS (days)(2)
A. GENERAL HOSPITALS	2,382,376	16,724,620	36,117,508	53.1	7
MOH/Prov.& Local Gov.	1,390,460	9,217,216	19,553,472	58.3	6
Class A	85,340	801,400	2,017,356	76.9	9
Class B	269,960	2,347,044	4,229,048	67.8	8
Class C	528,216	3,323,696	5,780,396	59.1	6
Class D	506,944	2,745,076	7,526,672	48.4	5
Defense Ministry	226,464	1,893,120	6,311,608	42.2	8
Other Ministry	182,472	1,409,772	4,457,140	43.7	8
Private	582,980	4,204,512	5,795,288	52.1	7
B. SPECIALITY HOSPITALS	373,944	4,962,864	3,561,380	52.1	14
MOH/Local Government(3)	51,976	3,608,964	582,740	79.7	79
Defense Ministry	9,140	38,968	116,040	24.2	4
Other Ministry	3,416	15,152	28,140	23.3	4
Private	309,412	1,299,780	2,834,460	25.9	4

Source: Palekahelu 1986

1. BOR = Bed Occupancy Rate
2. AV.LOS = Average Length of Stay
3. MOH/Local Government Hospitals include chronic care facilities where the average length of stay is quite long.

The sub-district Community Health Centre (PusKesMas) is the government health system's most peripheral, non-hospital clinical facility. It is staffed with professional and non-professional personnel and provides technical/supervisory support for the community based health and family planning system. There are currently 5,340 PusKesMas in Indonesia, each serving on average 32,256 people in a catchment area of 359 square kilometers (Km²). These figures vary greatly among provinces. For example, the average catchment area in Yogyakarta is 31 km² while the catchment area in provinces like East Kalimantan and Irian Jaya is more than 1500 km². Below the PusKesMas are 12,112 satellite health centres (PusKesMas Pembantu) which are stationary facilities staffed on a periodic basis by nurses, midwives or non-professional staff from the PusKesMas. In general there are no full time staff assigned to the satellite health centres.

Two types of facilities comprise the community based infrastructure. BKKBN oversees 63,000 village contraception distribution centres (PPKBD) and 180,000 sub-PPKBD. The MOH oversees 138,786 PosYanDu in 1988, or one PosYanDu per 1,287 population.

TABLE 15 illustrates the trends in infrastructure development that have taken place during Repelita IV and reflects both the MOH's budgetary and policy priorities. Because of the budget crises that have confronted the MOH during the past five years, there has been little or no investment in fixed clinical facilities such as hospitals or PusKesMas. However, the growth of the PosYanDu has been impressive, reflecting the MOH's policy to make that community institution the vanguard of its primary health care program for the rural population.

TABLE 15. Comparison of Health Infrastructure Development During Repelita IV.

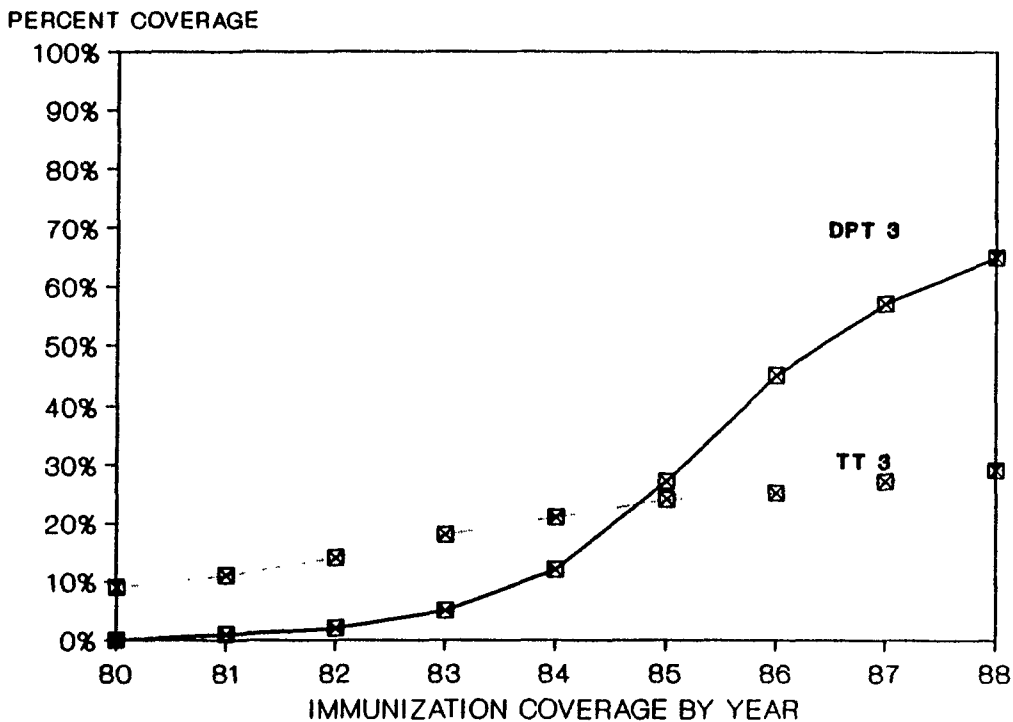
	<u>1984</u>	<u>1988</u>	<u>Percent Change</u>
Hospital	1,367	1,406	+ 2.8%
PusKesMas	5,353	5,340	- 0.2%
Pembantu PusKesMas	13,636	12,112	- 11.2%
Mobile Health Clinics	2,334	2,478	+ 6.2%
PosYandu	90,499	138,786	+ 53.4%

Source: Fifth Five Year Plan, Ministry of Health

Provision of Health Services

Beyond the aggressive expansion of the PosYanDu community service post, the expansion of immunization coverage through the EPI program has been the most outstanding achievement of Repelita IV. Full immunization coverage for infants and pregnant women is depicted graphically in FIGURE 9. At the outset of Repelita IV, full immunization coverage for infants (actually the age group 2-14 months) was quite low with only 12% fully covered. Through aggressive community and social mobilization programs, target screening and identification, and provision of services through the PosYanDu, full immunization coverage began to rise sharply in 1984. All indications point to achievement of the MOH target of 65% full immunization coverage at the end of Repelita IV.

FIGURE 9. PERCENT IMMUNIZATION COVERAGE
INFANTS (DPT3) & PREGNANT WOMEN (TT2)



SOURCE: GEN DIR ODD, MOH, RI

For reasons not yet fully understood, tetanus toxoid immunization (TT2) for pregnant women has lagged far behind delivery of the other EPI vaccines. Although TT2 coverage was already 9% of pregnant women in 1980, improvements since then have been slow. By the end of Repelita IV, total TT2 coverage only reached approximately 30% of pregnant women. Given the substantial contribution of tetanus to neonatal and infant mortality and the proven preventive benefits conferred by the tetanus toxoid vaccine, much more attention must be given to tetanus toxoid immunization coverage.

2.4 LABOR FORCE

The Personnel Bureau, MOH estimates that there are 273,593 employees working in the health sector at the end of Repelita IV. (TABLE 16). This suggests that there has been an increase of over 100,000 employees in the health sector over the last five years. Employees in the health sector are attached to various ministries; consequently it is difficult to determine labor figures accurately. The labor categories where accuracy is most suspect are the Pekarya Kesehatan (Health Workers) and other non-clinical workers, precisely those which have accounted for the bulk of the increase in the labor force according to the figures presented below. However, orders of magnitude give some indication of current health labor, and data for specialists, physicians, nurses, dentists, pharmacists and bachelors of public health labor are probably reasonably accurate.

TABLE 16. Trends in Health Labor Force Repelita III, Repelita IV and Estimated Requirements for Repelita V.

	Repelita III 1984 ^{1/}	Repelita IV 1989 ^{2/}	Repelita V (Est) 1994 ^{3/}
1. Specialists	2,733	1,825	3,575
2. Physicians	7,529	15,532	28,032
3. Dentists	1,292	3,821	5,321
4. Pharmacists		1,777	3,027
5. Bachelors of Public Health	1,219	860	3,500
6. Nurses	44,651	61,775	106,775
7. Paramedic	12,011	22,858	40,358
8. Pekarya Kesehatan (Health Workers)	29,473	56,186	59,186
9. Non Clinical	<u>63,221</u>	<u>108,959</u>	<u>116,459</u>
Total:	162,129	273,593	366,233

Source: Personnel Bureau, MOH

1/ Repelita IV Document

2/ Repelita V Document

3/ Repelita V Document

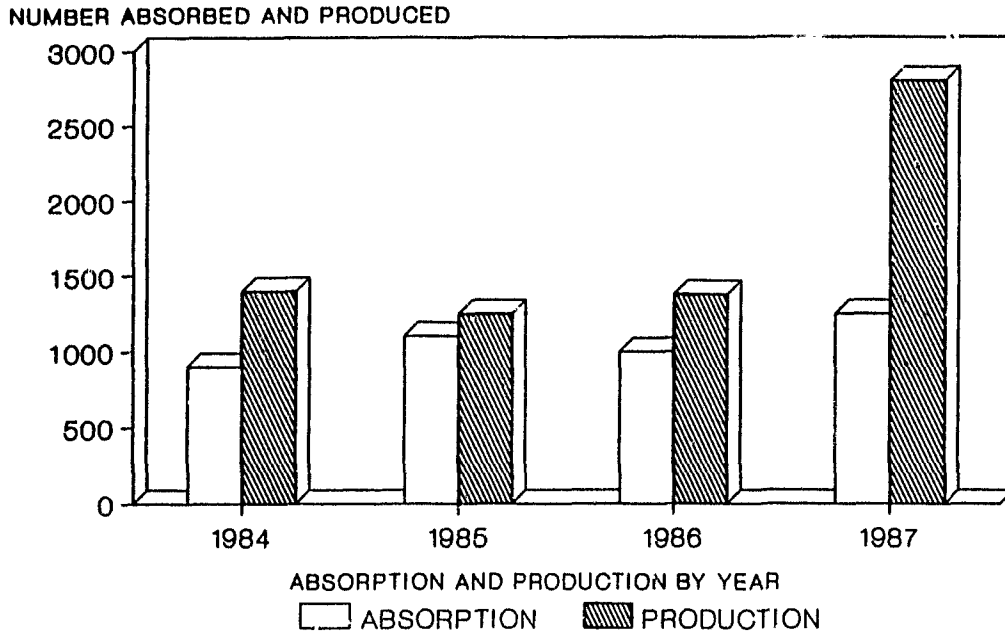
While numbers of physician specialists have decreased, the MOH has been successful in increasing general physicians and dentists through the INPRES program (special President's fund), and thereby has actually exceeded the targets set for Repelita IV. The number of nurses has increased by about 15,000. The decrease in employees with bachelor's degrees in Public Health is a statistical anomaly due to reclassification of that category of labor. In Repelita IV, the category Bachelor of Public Health included all non-physicians and dentists who had a Bachelor's level education in one of the health related fields. Consequently, pharmacists or employees with a bachelor's degree in Biology or Public Health were included in that labor category. In Repelita IV, pharmacists now have been reclassified and the Bachelor in Public Health category primarily contains only employees with bachelor's degrees in Public Health.

As of October 1988, the BKKBN Personnel Bureau reported 38,936 employees, of which about 50% are family planning field workers (18,767). When these data were last recorded in January 1986, BKKBN had 39,500 employees of which 16,800 were family planning field workers. These data indicate that the only new positions that BKKBN has filled over the past two years have been field worker positions. BKKBN has been diligent about filling them, given the essential role that the family planning field worker plays in the national family planning program.

The two major educators of health manpower in Indonesia are the Ministry of Education and Culture and the Ministry of Health. The former educates professionals (physicians, dentists, nurses, pharmacists and graduates with bachelor's degrees in Public Health, allied health, and social and physical sciences) while the latter trains nurses, midwives and other health personnel through academies.

MOH policy requires that, following graduation from medical school, physicians must work in a salaried position within government service or, in limited cases, the private sector before he/she can obtain a license to practice independently. Data from FIGURE 10 illustrate the gap that has developed between the production of physicians and the MOH's absorptive capacity to employ them. Until 1986 about 1,200 - 1,400 physicians were graduated annually, but only about 1,000 of them were able to obtain positions, either as Puskesmas doctors, in the military, in clinical positions in other government departments, in teaching positions in the Ministry of Education and Culture, or in selected clinical positions in the private sector. The remaining 300-400 physicians per year were left with no legal authority to practice medicine. Their alternatives were to move into the medical black market where they function outside of the legally supervised medical system or to give up the practice of medicine to work in another field. In 1987 this gap widened substantially when physician production rose precipitously with nearly 2,000 new physicians unable to be absorbed into the system. As a result of this situation the MOH is now considering policy changes which will allow for more rapid assimilation of new graduates into a legally licensed status.

FIGURE 10. PRODUCTION OF PHYSICIANS AS COMPARED TO ABSORPTIVE CAPACITY



SOURCE: BUREAU OF PLANNING/MOH

The MOH currently operates 379 specialized training institutes to produce health personnel. These training institutes can be broken down into three categories:

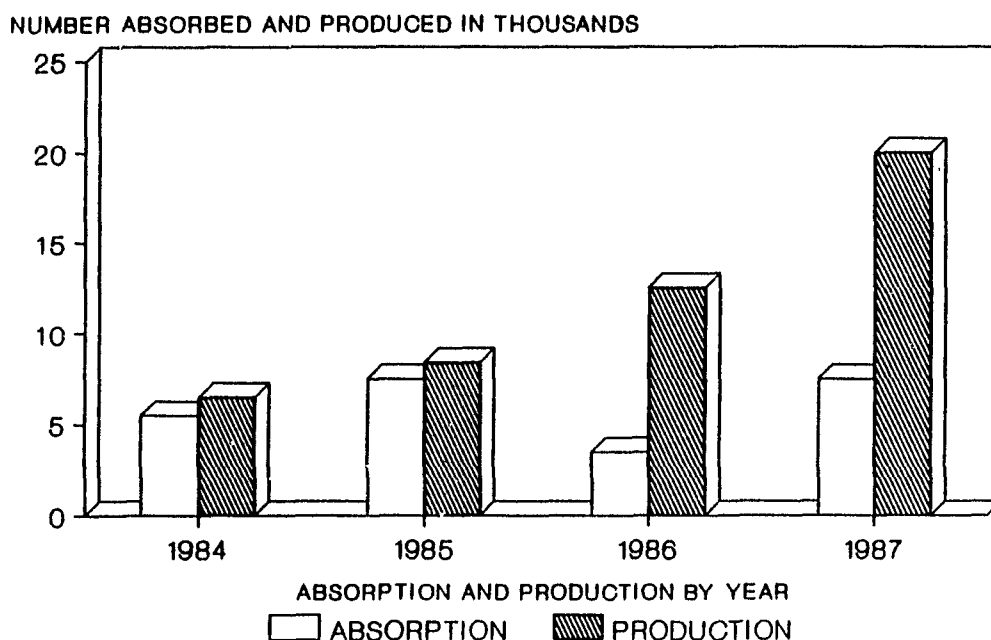
(1) Vocational Schools (280) - Entrants must have a junior high school education. The length of training is three years. Graduates have technical expertise in midwifery, nursing, medical technology, nutrition, sanitation, dental hygiene, and other health skills.

(2) Technical Schools (42) - Entrants must have a senior high school education. The length of training is one year. Graduates have technical expertise similar to graduate of vocational schools.

(3) Academies (57) - Entrants must have a senior high school education. The length of training is three years. There are currently academies for nursing, sanitation, anesthesiology, physiotherapy and medical diagnosis.

The total labor force production target set for nurses during Repelita IV was 58,000 persons. An accelerated program for training specific categories of health personnel was inaugurated in 1984 to assist the MOH in meeting this target. As shown in FIGURE 11, education of nurses has substantially outstripped the MOH's capacity to provide positions for these new graduates. The situation became most acute in 1986, when nearly 11,000 graduates from the MOH's health training institutes could not find jobs in the government service. In response to this emergency, the MOH provided about 7,000 new positions for nurses in 1987, but increased production left about 12,000 new graduates without jobs in that year as well. These nurses are produced exclusively for service within the government health service. When civil service positions are not available for them upon graduation, they have no alternative for legal employment opportunity. Most eventually drift into private practice in the informal sector, i.e. practice without licenses and outside the purview of the MOH. Unless effective policy can be made to deal with this problem, both with physicians and nurses Indonesia will lose an invaluable resource in its battle against reducing infant and child mortality.

FIGURE 11. PRODUCTION OF NURSES AS COMPARED TO ABSORPTIVE CAPACITY



SOURCE: BUREAU OF PLANNING/MOH

2.5 FINANCING HEALTH AND FAMILY PLANNING SERVICES

The pattern of funding government health and family planning services in Indonesia is complex. Through an allocation system, funds are appropriated, obligated, committed, disbursed and finally accounted for annually. The operation of this system has a profound effect upon planning, service delivery and ultimately the government's success in reaching its objectives.

2.5.1 Funding for Health and Family Planning Services

It is difficult to obtain a clear explanation of how funds are allocated for health and family planning in Indonesia, even from persons who work within the system. The most comprehensive review was made by Wheeler (1980) who traced government resource allocation channels in three provinces. It is not the purpose of this paper to reconstruct this system. However, an explanation of terms is necessary to understand its complexity.

Funds for health are derived from 10 major sources as shown below:

Central Government Sources

APBN DIP	Central government development budget
APBN DIK	Central government routine budget
InPres	Special Presidential Grant to regional governments
SDO	Salary subsidy to regional governments
SBBO	Non-salary subsidy to regional hospitals
BLN	Foreign aid

Regional Government Sources

APBD I - DIP	Provincial Health Department Development Budget
APBD I - DIK	Provincial Health Department Routine Budget
APBD II - DIP	District Health Department Development Budget
APBD II - DIK	District Health Department Routine Budget

Funds from the APBN, APBD I and APBD II development (DIP) budgets are used for equipment, materials, land purchase, construction, honoraria and incentives. Funds from the routine (DIK) budgets support recurring costs such as salaries, maintenance, utilities and supplies. Funds from these sources can be used at any administrative level at or below their source. For example, APBN funds are used at the district/municipality level, but APBD II funds are not used at the central level.

InPres are special funds flowing directly from the President. InPres funds are used for drugs, Puskesmas construction and renovation, vehicles, water supply and sanitation. Foreign aid expenditures mirror routine and development expenditures from the three administrative sources. AsKes are the funds the government receives from its civil servants health insurance program.

It is very seldom that any program or activity is financed entirely from one source, or even from one level of government. For most activities, a variety of funding sources is the norm. Even for a given type of input to the same activity, there is typically a multiplicity of funding sources. For example, drugs are provided with funds from APBN routine, APBN development, InPres, AsKes, APBD I routine and APBD II routine budgets.

The variety of funding sources that may contribute to a unit's operation can be seen at its extreme in the case of the Puskesmas, a core unit in the GOI's primary health care system. Original construction costs of the Puskesmas plus vehicles could come from any one of or a combination of InPres, APBN development, APBD I development or APBD II development. Once built, the Puskesmas is owned and managed by the district with a specific budget from the APBD II routine budget. However, that budget covers only a part of the total resources required to operate the Puskesmas: typically, some basic salaries for staff, cost of materials, maintenance and small amounts for travel. Other basic salaries may be included in APBN or APBD I routine budgets, while additional staff costs may appear in APBN development, APBD I development, APBD II development, AsKes or BKKBN.

First-year operating costs of vehicles are provided from InPres, but in subsequent years funds must come from APBD II routine. Drugs could come from any of the sources mentioned above, while contraceptives and drugs to treat their side effects come from BKKBN. While the medical service function of the Puskesmas is funded by APBD II routine, the preventive and promotive functions depend on other budgets, largely the APBD I development budget. With this confusing budgeting system, the Puskesmas is routinely short of funds, or even when funds are available, it may be difficult to utilize them for appropriate service categories.

In comparison to the health budget, government financing of the family planning program is simple. Government funding to BKKBN for the national family planning program comes from only three centralized sources, the APBN DIP, the APBN DIK, and foreign aid. Funds from these sources are disbursed from the central BKKBN to its provincial and district administrative units for all investment and recurrent expenditures incurred by the national family planning program.

2.5.2 Expenditures on Health and Family Planning Services

The complexity of the planning, budgeting and disbursing system for the health sector has made it difficult to estimate exact expenditures on health from the ten sources mentioned above. Without such data it has been impossible for the MOH to determine to which programs the health budget funds could be efficiently allocated. In 1986 the Bureau of Planning MOH made a concerted effort to get a handle on the magnitude and type of expenditures in the Health sector. The data which are presented in the following tables and figures have been collected by

the Health Economics and Policy Analysis Unit of the Bureau of Planning, and represent the most accurate and detailed estimates of expenditures and revenues on health currently available by both the public and private sector.

Data on government expenditures to the family planning program have been obtained from the Planning Bureau, BKKBN. It is interesting to note that data on revenue and expenditures for the family planning program for both the public and private sector are neither as detailed, complete, nor accurate as comparable data for the health sector. As BKKBN moves into its intensive efforts in private sector family planning, this deficiency must be rectified.

Total Rupiah expenditures on health in nominal terms in Indonesia Fiscal Year 1982 (IFY)* by both the public and private sector was Rp. 1,834.4 billion, of which 32% was public sector expenditure and 68% was private sector expenditure. By IFY 1986, the total nominal expenditure had increased to Rp.2,615.9 billion, with public and private sector contributions remaining essentially constant. Nominal expenditures increased by 42% in total funding for the health sector between 1982 and 1986, but because of inflation and other economic factors, there has actually been a 10% decline in real expenditures for the health sector between 1982 and 1986.

Indonesia's total health expenditure as percent of GDP was 2.71% in 1986 as compared to a World Health Organization (WHO) recommended expenditure level of 5% (TABLE 17). The total real per capita GDP on health was only \$7.05 in 1986. Government health expenditures as percent of GDP was 0.95% in 1986 as compared to a WHO recommended expenditure level of 1.2%. When this indicator is compared to Indonesia's ASEAN neighbors, only the Philippines lags behind Indonesia in the percent of government expenditures it allocates for health.

*The Indonesian fiscal year is from April 1 until March 31. IFY 1982, then, covers the twelve month period from April 1, 1982 until March 31, 1983. The Indonesian fiscal year designation will be used throughout the remainder of this discussion.)

TABLE 17. Comparative Ratios of Health Expenditures 1982 and 1986 and with Other ASEAN Countries.

	1982	1986	WHO Recommended
Total Health Expenditure as % GDP	2.93%	2.71%	5%
Per Capita GDP on Health			
<u>Nominal</u> Rp. Rupiah	11,857	15,561	
US.\$ Dollars	17.18	9.49	
<u>Real</u> Rp. Rupiah	13,325	11,636	
US.\$ Dollars	19.31	7.05	
Government Health Expenditure as % GDP			1.2%
Indonesia (1986)	.94%	.95%	
Malaysia (1981)		1.36%	
Philippines (1985)		.63%	
Thailand (1985)		1.20%	
Singapore (1985)		1.78%	

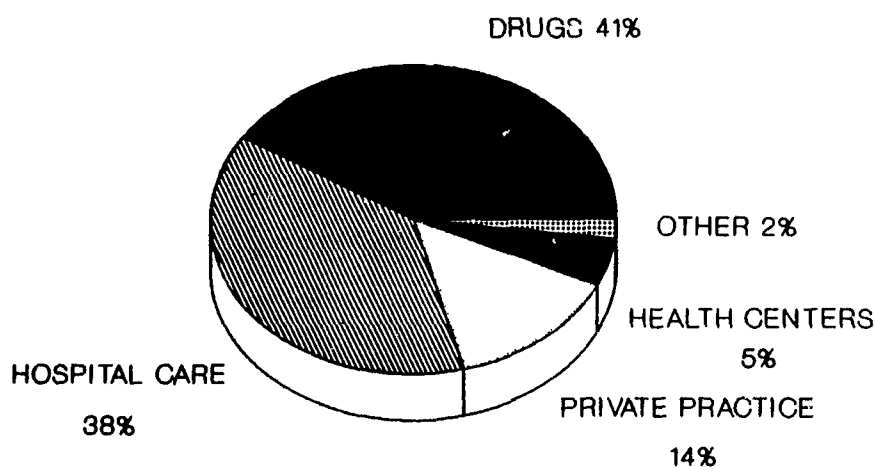
Source: Bureau of Planning, MOH

These figures indicate the inadequate government budgetary allocations for the health sector in Indonesia when compared to other countries. The reasons for Health's low priority among national decision makers are unclear. As the subsequent data will show, budget austerity measures imposed subsequent to the 1986 oil price collapse have been disproportionately borne by the health sector.

An analysis of comparative contributions to MOH budgets from all sources, i.e. central, regional, and foreign aid, is presented in FIGURE 12. Although government expenditures on health in nominal terms have increased from Rp. 586.1 billion in 1982 to Rp. 917.0 billion in 1986, allocations for health in real terms have been constant during that

On the expenditure side, private expenditures are for drugs (41%), hospitals (38%), private practice (14%), and health centers (5%) (FIGURE 15). Not surprisingly, private sector expenditures are almost exclusively for curative care, which does not differ from patterns found in most countries. However, in light of the low total investment into health in Indonesia, strategies must be sought to elicit greater private sector contributions for preventive and promotive health care.

FIGURE 15. DISTRIBUTION OF PRIVATE HEALTH EXPENDITURES: 1985



SOURCE BUREAU OF PLANNING, MOH

On the population side, TABLE 19 shows public sector allocations for family planning since 1979. Allocations to BKKBN rose steadily until 1987, when for the first time BKKBN budget was straightlined coincident with the general decline in government revenues. However, BKKBN's budget was restored again in 1988, when it received another generous increase. When BKKBN's total budget is plotted linearly over time, the budget straightlining in 1987 was only a temporary set back in ever increasing public sector budget allocations for family planning.

TABLE 19. BKKBN Development and Routine Budget Allocation 1979-1988.
(in Billion Rupiah)

Fiscal Year:	Development Budget:	Routine Budget:	Total:
1979/80	11.8	1.2	13.0
1980/81	21.9	4.4	26.3
1981/82	29.6	5.3	34.9
1982/83	39.9	8.5	48.4
1983/84	48.0	11.4	59.4
1984/85	53.4	16.5	69.9
1985/86	55.4	23.4	78.8
1986/87	55.8	33.8	89.6
1987/88	55.1	34.9	90.0
1988/89	65.9	41.6	107.5

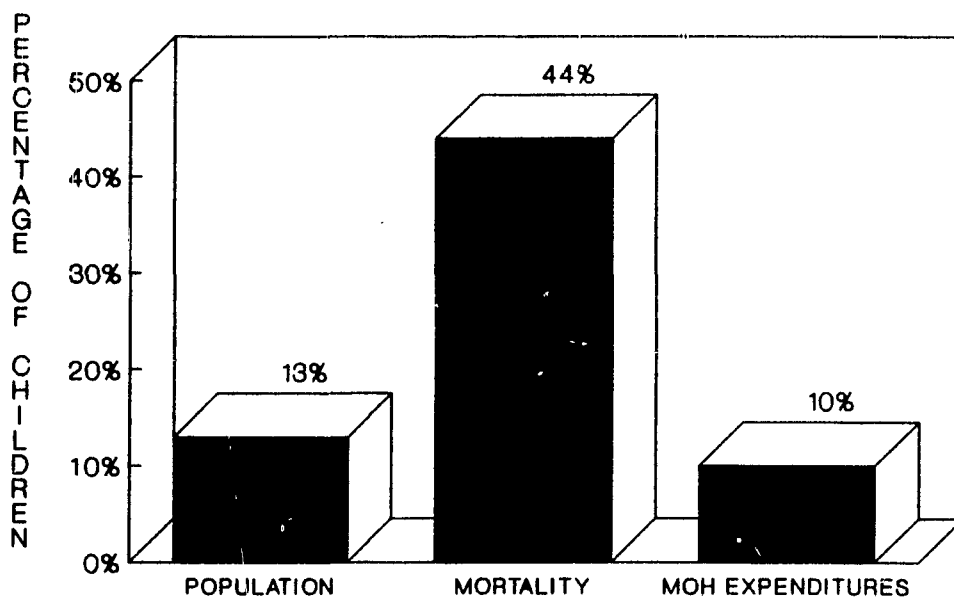
Source: Bureau of Planning, BKKBN.

Of interest here is the different treatment that the health and population sector received subsequent to the 1986 oil price collapse. Whereas the public sector health budget suffered severe reductions and has barely managed to maintain even these reduced budget levels, the family planning budget did not sustain any decline in nominal terms. This treatment gives some indication of the priority each of these sectors maintains among GOI financial planners.

This analysis of the health and population sectors has revealed a picture of declining levels of fertility and mortality in a climate of declining government expenditures on health, sustained government expenditure on family planning and an increasingly active private sector in both areas. Nearly half of all mortality occurs among infants and children, an age group which accounts for only 13% of the population. Hence, an inordinately large proportion of infants and children still die in Indonesia, mostly from preventable causes. Any expenditures for prevention come from the government health budget, which is low by World Health Organization and other ASEAN country standards and accounts for only 35% of all expenditures on health on an annual basis. The issue of utmost importance, then, is the proportion of government expenditures on child survival, specifically those preventive and promotive programs such as EPI, ORT, ante-natal care, clean water and sanitation, nutrition, and so forth, which have been proven to be the most cost effective interventions to reduce infant and child mortality.

In an effort to quantitatively evaluate the MOH's allocative priorities, the Bureau of Planning MOH developed methodologies to calculate the percent of total government expenditures that were allocated directly to those child survival programs mentioned above. Since 1982 the percent of government revenues allocated for child survival hovered at about 10%. FIGURE 16 compares the percent of Indonesia's population who are infants and children, the percent of total deaths this age group accounts for, and the percent of total government revenues which are allocated to the health problems this group suffers, and graphically illustrates the imbalance. This situation leaves only two policy alternatives: (1) government allocative priorities must be redirected toward the problems of mothers, infants and children; and (2) a greater portion of private expenditures must be made for those preventive and promotive services which will impact upon maternal, infant and child mortality. Until either or both of these alternatives are enacted, there does not seem to be any way that current efforts in child survival can be sustained over the long term.

FIGURE 16. DISTRIBUTION OF CHILDREN UNDER FIVE BY POPULATION, MORTALITY AND MOH EXPENDITURES ON SERVICES FOR THEM



SOURCE: BUREAU OF PLANNING, MOH

3. GOI POLICIES AND OBJECTIVES IN THE HEALTH AND FERTILITY REDUCTION SECTORS

3.1 The Health Sector

3.1.1 Policy Context

Indonesia's National Health System (Sistem Kesehatan Nasional - SKN) affirms health as a basic right of every Indonesian citizen and establishes the government, through its Ministry of Health, as the guarantor of that right. Consequently, the SKN directs the government's health system to make health services available to all Indonesian citizens, regardless of their income levels or geographic remoteness, and to direct its activities primarily toward low income groups. The SKN does recognize, however, that government alone cannot meet the total health needs of the Indonesian people. In order to achieve the general objectives of national development and self reliance, the SKN states that health activities must be "integrated, distributed according to needs, acceptable, and accessible ... and carried out with active community participation." Community participation is interpreted broadly to mean community involvement in identifying problems and needs, planning health programs, delivering health services and financing health care. In the delivery and financing of health services, the SKN clearly identifies the private sector within the rubric of community participation and leaves flexibility for developing multiple private and social financing schemes as long as they maintain standards of quality, effectiveness and efficiency.

Based upon the principles contained in the SKN, a Long Range Plan for Health Development was announced by decree of the Minister of Health in 1983. It sets out the policies, strategies and specific objectives in the field of health and population. Five tasks have been identified for special emphasis, in the Long Range Plans:

- o To up-grade and firmly establish efforts in community health;
- o To control and supervise the supply of medicines, drugs and dangerous substances;
- o To develop the full capabilities of health personnel;
- o To improve nutrition and environmental health; and
- o To improve the management of health programs.

TABLE 20 shows the GOI objectives in health and population by 1993/94 and by the year 2000.

TABLE 20. GOI Objectives in Health & Population by the End of Repelita V and the Year 2000

	(Estimated Achievement) 1988/1989	(Planned) (1989/1994)	Target Year 2000
* Crude Death Rate (per thousand pop.)	7.9	7.5	n.a.
* Life Expectancy (at birth)	63 yrs.	65 yrs.	68 yrs
* Infant Mortality Rate (per thousand live births)	70	49.8	45
* Child Mortality Rate (1-4 years) (per thousand children under five)	10.6	6.5	n.a.
* Maternal Mortality Rate (per thousand live births)	4.5	3.4	n.a.
* Antenatal care	n.a.	70%	n.a.
* Crude Birth Rate (per thousand population)	26.0-32.0	25.3	18
* Average Annual Population Growth Rate	2.1%	1.9%	n.a.
* Low Birth Weight (< 2.5 kg)	8.2%	7.4%	7%
* Protein Calorie Malnutrition (among under fives)	10.8%	9.5%	n.a.
* Xerophthalmia (among under fives)	0.7%	0.5%	n.a.
* Nutritional Anemia During Pregnancy	55%	40%	35%
* Endemic Goiter	5%	4%	Down 80%
* Incidence Rate of Diarrheal Disease (per thousand population)	350	300	200
* Prevalence Rate of Malaria (Java-Bali) (Outside Java - Bali)	1.0% 4.0%	1.0% 4.0%	n.a. 2%
* Malaria eradication	37.5%	60%	n.a.
- household spraying (mill./year)	4.6%	3.0%	n.a.
- case treatment (mill./year)	-	5.0%	n.a.
* DHF eradication (mill. household/year)			
- trash burning	2.9%	15.8%	n.a.
- selective abatization	9.0	36.0%	n.a.
* Prevalence Rate of Tuberculosis (per thousand population)	-	-	?
* Upper respiratory tract infections			
- no cases seeking treatment in million cases	-	3.5%	n.a.
- health center coverage of households in thousand	-	5.0	n.a.
* Prevalence Rate of Neonatal Tetanus (per thousand live births)	5	3	1
* EPI Coverage for Children Under 14 months	65%	80%	80%
* Tetanus Toxoid 2	30%	80%	n.a.
* Family Nutrition Improvement Program Coverage (Villages)	-	-	65,000
* Qualified Birth Attendants	45%	65%	80%
* Clean Water Supply			
(percent of rural population)	30.5%	60%	n.a.
(percent of urban population)	65.0%	80%	100%
* % Population using latrines	37.5%	60%	n.a.

Sources: Repelita V Document, 1989 and the SKN, 1984.

The data presented in this document show that high levels of fertility and infant, child and maternal mortality are the most serious health problems facing Indonesia today. They emphasize the need for promotive and preventive community health efforts provided through community-based approaches supported by fixed health centers to combat the direct and underlying causes of high fertility and infant, child and maternal mortality.

During Repelitas I-IV, the MOH focused its efforts on developing the human resources and physical infrastructure needed to provide medical and health services to a geographically dispersed population. As was shown in Chapter 2, fixed facilities have been developed throughout the archipelago and the educational infrastructure has been established to provide the professional labor force to staff those facilities.

During Repelita IV, the MOH turned its attention toward developing a community-based infrastructure that more directly addresses the problems of high fertility and infant, child and maternal mortality. The result has been the Integrated Health and Family Planning (KB/Kes) Strategy.

KB/Kes integrates the delivery of the five basic preventive health services considered most effective in reducing fertility and increasing rates of child survival. These services are provided at the village level at the integrated village health services post called the PosYanDu. The organizational position of the PosYanDu vis-a-vis the government's total health and family planning administrative infrastructure was briefly described in Chapter 2. The five services that have been integrated in the PosYanDu are nutrition, maternal/child health, immunization, diarrheal disease control and family planning. The PosYanDu is planned as a community financed and operated unit receiving technical support from the Puskesmas. As such, it operationalizes the concept of community participation as presented in the SKN and as defined in the Long Range Plan.

During Repelita V, the SKN will be developed further to serve as guidelines for the delivery of health services by the Government, the community and the private sector. The Ministry of Health will emphasize the development of leadership as a critical component for introducing the "take off" phase in Repelita VI. In Repelita VI, more stress will be placed on promoting positive changes in the health behaviors of individuals in order to effect improvements in health status in communities as a whole.

As a continuation of Repelita IV, Repelita V will administer its programs on the basis of three premises: employing the public health service delivery approach, encouraging community participation and improving the health referral system.

The MOH is committed to improve quality and efficiency in all aspects of health delivery services by optimizing the capabilities of health personnel, providing standardized services and capitalizing on appropriate technology and the results of research and development studies. All of these will involve other sectors beyond the health sector to meet community needs.

Significant efforts to increase equity in access to health care services is an important aspect of Repelita V. A network of complete health care services will be institutionalized from the households, the community, the PosYanDu and the sub-district health center (PusKesMas). In order to achieve the objectives, the number of sub-district health centers, village health centers and mobile health centers will be increased and their services will be expanded. Hospitals will be upgraded to approved standards of health care services at all levels. The community and the private sector will be encouraged to participate in planning for community health needs. The MOH will provide guidance for the use of effective traditional medicine. Occupational health will receive more attention particularly for the low income and unreached workers.

The development of health personnel capabilities will involve integrated planning in their production, supervision and distribution. Functional positions will be established to enable career advancement. A balanced distribution will be made to cover government and private needs.

The MOH will continue to control pharmaceutical, foodstuffs and harmful chemical procurement, distribution and management. The distribution of essential drugs will be increased to reach deeper into the community. Information, education and communication efforts will be carried out to assure the appropriate and rational use of drugs.

Improving nutritional status will continue to be a primary focus of community health efforts. Minimum nutritional requirements will be established. Families will be encouraged to consume a variety of foods if available resources permit. Intersectoral collaboration and community participation will be encouraged to improve family nutrition.

Environmental health will be emphasized by broadening the scope of basic sanitation to control environmental pollution in industry, in slums and in newly opened areas.

The MOH will reorient the health management system to give more authority and responsibility to the provinces with coordination from the central level. The organizational rearrangement requires improvement in the management capacity of the provincial and district levels. Bottom-up planning will be encouraged in the spirit of a "responsible autonomy."

The development of health science and technology as well as the consideration of medical ethics and health laws will be important issues in Repelita V.

The allocation of limited resources will be carefully planned in order to achieve health development objectives and priorities. Emphasis will be put on efficiency and community resources will be mobilized so that the government subsidy on curative care can be shifted to the preventive care.

3.1.2 MOH Priorities in Health

Within this policy context, the MOH has identified six areas which it perceives as priority areas requiring specific attention in the Repelita V. These are discussed in the following paragraphs.

3.1.2.1 Improvement of Basic Health Services

During Repelita V the MOH plans to increase the number and improve the distribution of practicing midwives and traditional birth attendants (TBAs) in order to achieve 70% antenatal and postnatal coverage of women. To achieve this coverage, the training and placement of about 18,000 midwives in villages throughout Indonesian will be necessary. Improving the coverage of women before, during and after child birth to 70% is expected to reduce the incidence of low birth by 10%. Although not yet documented sufficiently, low birth weight is considered to be a major contributor to perinatal and infant mortality.

The family nutrition improvement program (UPGK) will be expanded through and outside of the PosYanDu. The number of PosYanDu will increase to a ratio of about 1:100 children under five years old. Nutrition services at the PosYanDu include growth monitoring, Vitamin A capsule distribution for children, iron supplements for pregnant and lactating women, food supplementation for families with children under five, oral rehydration therapy and nutrition education. Outside of the PosYanDu, activities will include nutrition counselling, family gardens, iodized oil injections and food consumption monitoring of village based, low income groups.

In the area of environmental health, the MOH plans to develop model villages; increase access to clean water, adequate drainage and sanitary housing; supervise public sanitation, food storage and pesticide management; and monitor the quality of the environment in industrial centers.

The MOH will support school health care with health education and by overseeing basic sanitation facilities at schools in order to encourage healthy living habits.

More attention will be given to geriatric health care at the level of the sub-district health center. The MOH recognizes the need to expand services to this increasingly larger age group.

In order to expand the delivery of basic health services, the number of sub-district health centers will increase from 5,642 to 6,196; the number of health center inpatient beds will increase from 1,067 to 1,350. Mobile health centers will increase from 3,251 to 6,227 and the auxiliary health center ratio to health center will be improved to 1:3-5. In addition to the increased numbers, existing facilities will be renovated and damaged equipment will be replaced.

3.1.2.2 Resource Allocation

The resources available in the health sector are likely to remain static in the near and medium term. The MOH sustained a 48% reduction in its development budget in 1986/87, a 65% reduction in its 1987/88 development budget, and planners expect similar cuts in the future. The overall budget in the sector will increase only marginally in nominal Rupiah terms. It is clear that fewer financial resources will be available to provide the increasing numbers of services that will be needed to reach the MOH objectives for reducing fertility and infant, child and maternal mortality.

Accordingly, MOH planners expect that emphasis must be placed on improving the operational efficiency (production of outputs with the least-cost combination of inputs), allocative efficiency (optimal allocation of resources to various vertical programs within the health budget), and equity efficiency (the optimal distribution of benefits and burdens of the national health services system) of the government's health services in particular, and the delivery of health services in general in Indonesia.

In these planners' view, operational efficiency can be most favorably and quickly affected by improving the labor force's productivity and financial management. Data from the University of Indonesia's functional analysis study (1986) and other research indicate that the productivity of the health labor force is low and personnel are not deployed in accordance with workloads or disease conditions in a particular area. Concurrently, because of inadequate and inefficient financial management, the MOH's ability to actually spend all of the budget allocated to it annually, has been low - only 40-50%. Both low productivity and poor utilization of available budget resources are structural problems not amenable to quick-fix solutions, but are considered to be of primary importance as the resource picture worsens.

The analysis of health sector expenditures in Chapter 2 reveals that expenditures in both the public and private sectors are skewed toward curative and rehabilitative services. Fully 27% of the 1982/83 and 1985 government health budget is allocated for hospital services. If the central government's health administrative costs are subtracted, hospitals claim 75% of the central government's health development budget (Stevens and Doodoh, 1986). MOH planners project that a small diversion from the hospital budget would free up large amounts of funds for preventive services. They are advocating strategies which will allow for favorable internal reallocation of existing government budgets toward preventive- and promotive-oriented line items.

In line with the SKN's mandate to explore the potential for private sector involvement in the financing and delivery of health services, the MOH is studying health financing strategies that would shift the burden of financing health services to the segment of the population that is able to afford them. This strategy would harness the dynamism of the

private sector to deliver and finance health services. Under consideration are various prepaid financing schemes which, through capitated risk sharing approaches, would improve the equity and efficiency of health services.

One program under scrutiny is to develop a health insurance scheme which would help to increase the cost recovery of health facilities. At the same time, the MOH would explore the capacity of communities to participate in such a scheme and thereby contribute to hospital and health center expenses.

3.1.2.3 Community Participation

As the MOH proceeds with the development and deployment of its KB/Kes strategy via the PosYanDu, the community will be requested to contribute more of its resources to support this effort. Active community involvement in and support for the PosYanDu will support the basic goals of self reliance and community cohesiveness that underlie all development planning in Indonesia. In the PosYanDu model, human, material and financial community resources will be the mainstay of operations. Government resources will only be used for monitoring and technical support by Puskesmas staff, and the provision of essential commodities such as immunizations and oral rehydration solution. One of the major challenges facing the government, in its view, is mobilizing greater community support for the PosYanDu program in particular, and for the general provision of health services.

For the PosYanDu program, efforts must be intensified to elicit more active involvement of community leaders, whose support has been shown to be absolutely critical for any community-based activity. Second, PosYanDu activities are heavily dependent upon community volunteers to promote the attendance of target families, deliver educational messages, distribute child survival commodities, and run the PosYanDu through registration, weighing, triage, education and follow-up activities. High attrition rates among these volunteers has been a constant problem plaguing the PosYanDu and its precursors. Strategies will have to be devised to increase their commitment to the program and so increase their longevity of service. Third, local organizations such as the women's family welfare group (PKK) and religious groups will have to be more actively involved. Finally, more community resources in the form of physical facilities and monetary contributions will have to be realized in order to defray the operating costs of integrated health posts throughout the country.

As interpreted by the SKN, community participation also involves increased private and commercial sector activities. In the Indonesian context, entrepreneurial activities, private practice, drug funds, employer-financed health care and insurance schemes are all considered community efforts. The increasing awareness that social marketing, aided by private marketing, communications and survey firms, can promote PosYanDu and positive health seeking behaviors, and contribute to the emphasis on the community as the leading edge of service delivery. To

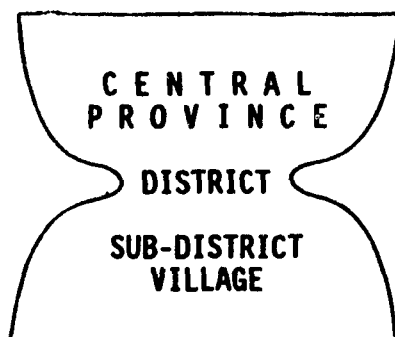
the extent that private enterprise is able to increase the quality and quantity of the services it provides so as to complement MOH activities, community participation advances the government's program aims.

3.1.2.4 Decentralization

During previous Repelitas, the GOI demonstrated a desire and willingness to increase provincial autonomy and self reliance in planning and implementing development programs. Regional planning boards (BAPPEDA) have been strengthened, and larger amounts of both APBN and InPres funds have been channeled directly to the provinces. In order to address the vast social, cultural, economic, topographic and regional differences in Indonesia and the varied disease patterns these create, the MOH has actively followed a provincial decentralization strategy through the CHIPPS Project (Chapter 4) and other efforts. Such strategies are within the guidelines of the basic Principles for Health Development in the SKN which states: "The Central Government will progressively transfer autonomy to the regions ... capability of local governments in health must be strengthened."

Organizational analyses by MOH planners have indicated that decentralization to the provincial level is only a first step in transferring greater autonomy to lower levels of government. They have identified a significant organizational bottleneck at the district level, which they refer to as the "hourglass effect," which hampers service delivery at the peripheral levels (FIGURE 17). In the past, the MOH has directed copious resources toward developing central government infrastructure and capacities, sub-district physical and human resources infrastructure through building Puskesmas and sub-centers and providing health personnel training programs to staff them, and is now devoting resources to building a community-based infrastructure through the PosYanDu. Decentralization efforts in Repelita III and mainly in Repelita IV directed much-needed resources for capacity building to the provincial level. Largely overlooked has been the district level, despite the important role district administrators play in channeling funds to the more peripheral levels and monitoring their activities.

FIGURE 17. Hourglass Effect of Physical and Human Resources Infrastructure Development by MOH



To meet this need, the MOH plans to reorganize central and provincial operations to ensure coordination, integration and synchronization through district and sub-district levels. The planning capacity of district staff will be strengthened with emphasis placed particularly on bottom-up planning. The process will be gradual as lower levels take on more and more responsibility to find solutions to their particular needs.

The central level will continue to provide guidance for this process by improving methods and resources for management and supervision. An integrated health information system will be created to back stop the decision making process at the lower levels.

3.1.2.5 Involvement of the Private Sector

Although the MOH has alluded to the need for greater private sector involvement in the financing and delivery of health services in the priority areas of resources allocation and community participation, private sector involvement as a priority area for DepKes deserves special mention because of its relationship to the GOI's general policy. Emphasis on the private sector is central to GOI policy as the economy prepares for its tinggal landas (take off) in Repelita VI. The economic hardships imposed by falling world prices for Indonesia's mineral and fossil fuel exports have accentuated this need. The GOI is urging all sectors to make greater use of the private sector to achieve Indonesia's development objectives. This policy is expressed in the SKN as given below.

The potential of the community, including the private sector, to participate in health efforts, either as service provider or as service recipient, should be taken into account to defray health costs. If this potential can be directed in such a way that it can alleviate the burden presently borne by the government, then the health budget can be allocated more for promotive and preventive health efforts in the future.

There is a growing awareness among MOH policy makers that the private sector is capable of participating in activities in the financing and delivery of health services. The MOH has the responsibility to coordinate and guide these activities so that they contribute to national development and health objectives. This role as monitor is critical given the potential that increased private sector involvement could increase the price of health care and would in turn decrease access to quality care for low-income families.

In the health financing area, the MOH has assigned priority to the development of pre-paid, managed, health insurance schemes. Several pre-paid medical schemes exist now in large urban areas but are thinly capitalized and unstable. Indemnity or casualty health insurance schemes in the wage-based sector also exist. Changes in tax law will make such

plans more attractive to employers who currently provide care for their employees. A major government sponsored program of health insurance for private sector employees financed through employer contributions (PKTK) is in the early testing stages. Assuring that such plans are oriented towards preventive services and provide adequate levels of care for both workers and their families are priority concerns of the MOH in developing guidance in this sector.

In the area of health service delivery, company-owned facilities have the potential to provide comprehensive care. Several hospitals in Jakarta have contracted exclusive arrangements with factories. Should the Pertamina Oil Company establish a health maintenance organization for its employees, it would serve as an example and its success or failure would have repercussions on a wide number of financing projects.

Private-public sector cooperation in rural areas is seen as holding future possibilities. Plantation-based health schemes and other employee plans can be extended to benefit the whole community. Religious hospital facilities (which constitute 90% of private hospital beds) need to coordinate with public facilities, especially if they are producing more efficient services. The availability of capital, development of managerial capacity, and investments in research and development involve coordination and cooperation between MOH and private sector providers.

3.1.2.6 Quality of Care

Quality of care is a continuing area of concern for the MOH, especially in light of diminishing resources. Little controversy exists regarding the quality of services being delivered. At the PosYanDu level there needs to be improvement and that once improved, quality will need to be maintained.

The massive effort to establish and staff PusKesMas is gradually coming to fruition. The basic integration of nutrition and family planning services is beginning to be replaced by a more comprehensive package of services. Significant deficits in quality persist, however. For example, the use of oral rehydration solution remains inadequate, as physicians still routinely prescribe expensive and inappropriate antibiotics while excessively utilizing intravenous solutions for the clinical treatment of mild dehydration. Physicians and other professional staff do not yet have the public health skills to organize and promote adequate child survival programs in their catchment areas. Immunization coverage varies significantly among geographic areas, with Measles immunization for children and tetanus immunization of pregnant women still markedly low. Hygienic practices and vaccine potency is not yet uniformly high. Parents do not always understand the usefulness of growth monitoring, thereby minimizing the effectiveness of preventive nutritional care. Shortages of essential drugs plague the health system and drugs are often too expensive for the poor when they do reach the market.

Because of the important role the Puskesmas plays in Indonesia's health delivery system, the Puskesmas doctors and their staff are critical to the success of the GOI's health and family planning program. Yet, because of the nature of their training and the way they are deployed, Puskesmas doctors are frequently inadequately prepared for the challenges they face in managing and supervising the clinical and public health program of an entire sub-district. Medical training in Indonesia has a high technology, clinical emphasis. Students are prepared for the specialty training to which most aspire. Although a strong public health component exists in the medical curriculum, it generally pales in most students' eyes in comparison to the prestigious clinical and surgical rotations. Compulsory Puskesmas service is generally viewed as an enforced temporary hiatus needed to fulfill licensing requirements. Medical school training neither adequately prepares physicians for their work in a Puskesmas, nor does it provide the necessary orientation toward preventive medicine and public health.

To improve the performance of Puskesmas physicians, the MOH has proposed on-site in-service training programs. These programs would provide the Puskesmas doctor with the managerial and epidemiologic skills needed to diagnose more adequately a community's needs, and plan Puskesmas clinical and outreach activities appropriate in that community. Simultaneously, medical school public health curricula need reassessment to explore approaches which would inculcate these skills in medical students. The Faculty of Nursing at the University of Indonesia, nursing and midwifery academies elsewhere will be examining their curricula to conform to national health goals and objectives.

Significant improvements in the quality of care can only occur once health personnel and volunteers are trained appropriately for their tasks, are supervised conscientiously to maximize their impact, and have the means at their disposal to provide services to the community. Training programs which are oriented to community health skills (clinical, epidemiological and managerial) remain to be implemented. Adequate monitoring systems which are used by trained supervisors can pinpoint those program aspects which require reinforcement. Many of the above problem areas can only be addressed by decentralized planning. There need to be adequate resources allocated to community health and training programs in professional schools which prepare students to meet the specific challenges they will face.

3.1.2.7 Transfer of Technology

This is a general government policy which will receive greater priority in the future. The MOH would like to adapt certain health technologies for use in Indonesia. Primary among these are the new biomedical technologies for producing pharmaceuticals, vaccines and diagnostics. Also important are industrial technologies to manufacture medical equipment and supplies. The transfer and adaptation of software technologies for research, management and information management are also receiving attention.

3.1.2.8 The Role of Women

The government's policy for health sector development will place more emphasis on the role of women during Repelita V. Plans are underway to improve the knowledge, skills and awareness of women to improve and maintain the health of their family. Training targets will be all women but especially women of reproductive age, pregnant women, those who have children under five years and female workers. Fifty percent of companies which have at least 50% female workers will receive preventive occupational health education. Village health cadres, who are largely female, will be called upon more and more to perform preventive family health services.

To increase the role of women in the health sector, a wide range of activities, including sectors outside of the MOH, will be involved. A multi-media approach will be carried out for information dissemination on health and for the development and distribution of training materials. Health program managers, women's organization members, female workers and female cadres will need to be trained. In order to achieve these goals, collaboration with the PKK will need to be strengthened. It is planned that by the end of Repelita V all women's organizations will have received training in family health, women's health and other matters related to improving the role of women.

3.2 THE POPULATION AND FERTILITY REDUCTION SECTOR

3.2.1 Policy Context

Indonesia's national family planning program has an overall goal of developing a small, happy and prosperous family norm. Many successes have been achieved in the past decade. There has been an increase in the average age at first marriage and a decrease in the absolute number of live births. The crude birth rate decreased from 44/1,000 population in 1971 to 28.7/1,000 in 1988, surpassing the Repelita IV target of 31.02/1,000 population.

The Total Fertility Rate which was 5.6 in 1971 declined to 3.3 by 1988 (TABLE 21). The growth rate declined from 2.32 percent in the period 1971-1980 to 2.15 percent in 1980-1985. The growth rate in 1988 is estimated to be 2.09 percent. At present rates the population will grow from 175.6 million in 1988 to 192.9 million by 1993. The current population of 44.4 million women in the fertile age groups will increase to 50.5 million by 1993.

TABLE 21: Selected Family Planning Current Indicators and Future Targets

	<u>1988</u>	<u>1994</u>
Growth Rate	2.08%	1.9%
Total Fertility Rate	3.3	3.0
Life Expectancy	63 years	65 years
Age at First Marriage for Women	-	22 years
Age at First Marriage for Men	-	25 years
Birth Spacing		One child under five per family
	<u>1989/90</u>	<u>1993/94</u>
New Family Planning Acceptors	4.4 million	4.5 million
Acting Family Planning Participants*	19.0 million	21.5 million
Contraceptive Prevalence	48.96 percent	52.35 percent
Continuing Users (from prevalence)	15.0 million	17.6 million

Source: BKKBN Repelita V document; NICPS, 1987.

*A new BKKBN concept based on BKKBN services statistics; akin to ever use, including acceptors who accept and drop out during a year.

The GOI views rapid population growth as a major constraint in its efforts to achieve national development objectives; hence, the population program is viewed as intrinsic to national development. During Repelita IV the GOI stressed the importance of family planning to other development programs and encouraged its integration with other sectoral activities. Although BKKBN's demographic objective remains of paramount importance, the family and community welfare objectives of the national family planning program received greater prominence in Repelita IV. As in the health sector, community participation is strongly emphasized. BKKBN has been aggressive in testing strategies for shifting greater responsibility for program planning, implementation and management to the community level.

Because of Indonesia's predominantly rural population, BKKBN has focused its efforts on developing a community-based contraceptive distribution system throughout the country. By 1986 there were approximately 180,000 village contraceptive distribution centers in Indonesia, covering nearly every village in the country. Family planning health cadre have been trained to distribute mainly reversible contraceptives like oral pills and condoms to the families in need of family planning among the five or ten-households they have been assigned to oversee. Injectables, contraceptive implants, voluntary sterilization services, and the first cycle of oral pills are obtained through fixed MOH facilities or mobile family planning clinics. The government supplies about 80% of all contraceptives in Indonesia, with the non-governmental and commercial sector supplying the remainder.

3.2.2 BKKBN Objectives in Population and Family Planning

Although widely recognized as one of the most successful national family planning programs in the world, difficult challenges now face BKKBN as it strives to maintain program momentum and improve the quality of its services. Because of the high birth rates of the early 1970s, large new cohorts of women are moving into their reproductive years. Increasing numbers of new acceptors will have to be recruited and continuing acceptors will have to be maintained just to keep contraceptive prevalence constant and prevent escalation in birth rates. Although BKKBN's budget has been spared the draconian reductions experienced by the MOH, it will have to achieve its new and continuing acceptors targets with only modest increase in budget.

Within this context, BKKBN has identified six policy objectives for Repelita V. These are:

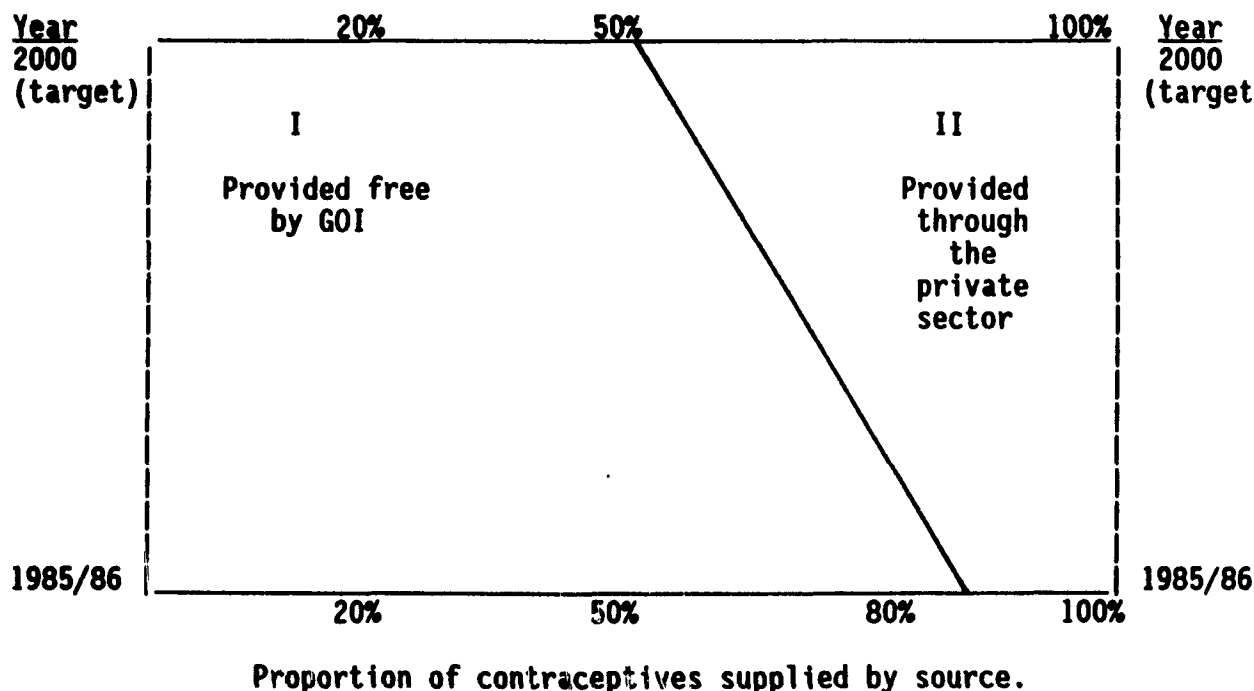
1. To control population growth by reducing birth rates and death rates of mothers, infants and children, and by improving life expectancy rates.
2. To strengthen the front-line infrastructure and to decentralize management from the Regency/Municipality (Kabupaten/Kotamadya) to the District (Kecamatan) level. The District level will be expected to function as the front-line managers of the family planning movement.
3. To promote active participation by communities in the family planning movement. Community participation will be phased in stages until ultimately communities no longer need outside help. The government, however, will continue to oversee services to ensure maximum product safety for the protection of family planning clients.
4. To encourage couples with women less than 30 years old or who have less than two children to have no more than two children. To encourage couples with women who are over 30 years old or who have two or more children not to have any more children.
5. To expand the role of the private sector in family planning services by increasing reliance on private providers, clinics and hospitals.
6. To expand the roles and to increase the status of women by improving their education. It is hoped that this strategy will keep women in school longer and make them more marketable in the modern work force. These factors will in turn promote delayed marriages, delayed first births and well spaced births.

In order to reach these objectives, BKKBN has described several issues which it believes must receive specific attention in Repelita V. These are discussed below.

3.2.2.1 Transition to an Increase in Private Sector Distribution of Contraceptives

It is anticipated that the community, through non-governmental organizations, private providers and the commercial sector, will assume greater responsibility for recruiting family planning acceptors and delivering contraceptive services. BKKBN's targets for this transition are shown in FIGURE 18.

FIGURE 18. Current and Future Proportion of Family Planning Services



Source: BKKBN, Repelita V Document.

The relative quantities of contraceptive supplies by source are graphically represented by the diagonal line. The free contraceptives provided by the GOI (through BKKBN field staff, PosYanDu, PusKesMas, etc.) are shown in area I. This proportion will decrease from 80% to all supplies in 1985/86 to 50% by the year 2000. The proportion of supply originating from private sector sources (commercial retail outlets, private fee-for-service providers and PVOs) will rise from 20% to 50% as shown in area II.

Such a transition will call for numerous program modifications which are still, by and large, in the investigation stage. Delivery questions will be paramount. How can the private sector be encouraged to take on production, quality control and distribution responsibilities? How will BKKBN ensure that demand for commercial products is maintained once free products become less available? Organizationally, what will this transition mean for BKKBN field staff and local volunteers? Clearly, new responsibilities in coordination will require intensified training efforts in planning and management skills. Effective communications will be critical if the shift in consumer demand to the private sector is to be successful. Maintaining effective, continuous use among those women using exclusively private sector sources will challenge those responsible for message development and broadcast strategy. Training/manpower development will not only affect BKKBN internally; BKKBN will also have additional responsibilities for ensuring that high-quality care and appropriate education are available from other organizations and private companies who will become active in the field.

Strategies to effect this transition have tentatively been formulated. The initial family planning delivery system was based in a clinical facility with outreach capacity to the rural areas. Urban areas were then included. Now as a follow on, the BKKBN is introducing its private sector strategy in urban areas. Family planning services in urban areas, particularly the larger cities, are available through a wider range of public and private outlets than in the rural areas, which are served almost entirely by the government family planning program. In urban areas, family planning information and contraceptives are offered through government hospitals, clinics and family planning centers; through private hospitals and clinics; through pharmacies and other commercial channels; and through private physicians and midwives. The challenge facing BKKBN is how to involve more fully all existing and potential service points in providing better quality, urban-style information and services as they attempt to maintain current users, convert acceptors to more effective methods of fertility control, and develop attractive, affordable information and service activities aimed at present non-users. Three approaches have recently been launched under the "Blue Circle" campaign to meet these challenges: the involvement of private health providers; service-oriented information, education and communication campaigns; and product-oriented social marketing.

3.2.2.2 Promotion of More Reliable Long-Term Contraceptive Methods

The oral contraceptive is the predominant method used by continuing family planning acceptors in Indonesia. Its use effectiveness, however, is low in Indonesia; hence, continuation rates, couple years of protection, and protection against pregnancy for couples using this method are compromised. BKKBN has and will continue to emphasize a shift from the the oral pill to more reliable, long-term and more cost-effective methods. This policy becomes even more important in

light of the current economic situation where BKKBN must achieve reductions in fertility at lower cost. The methods that BKKBN believes must be more fully promoted and made available are IUDs, injectable contraceptives, progesterone implants and voluntary sterilization. BKKBN plans to increase the overall contraceptive prevalence and number of current users from 14.9 million in 1989/1990 to 17.4 million by 1993/1994.

3.2.2.3 Improving Quality of Services

A third priority of the BKKBN is to improve the quality of services. Quality of services is considered to be multifaceted. In addition to the provision of a range of contraceptive methods with high medical and technical standards, quality is related to adequacy of supervision, counseling and follow-up of acceptors, and effectiveness of communication and adequacy of the information reaching the clients. Improvements in the quality of services are thought to result in better continuation rates, improved use effectiveness and appropriate method switching. Personnel training will concentrate on the front-line doctors, nurses, midwives and health cadre with plans to train 144,638 of these personnel over the next 5 years.

In line with the private sector initiatives described above, one approach BKKBN is developing to improve the quality of services is to shift emphasis from a community-based group dynamics approach to recruiting new family planning acceptors and ensuring continuing use, to a system based more on individual choice. Such a system would depend on advertizing and other forms of information and education to: 1) convince couples in the childbearing ages that it is in their own best interest to plan their families; 2) encourage them to pay for the contraceptive method of their choice; and 3) inform them that contraceptive methods are available either from public sector service points or from the private sector. It is believed that more discriminating individuals will seek and select services from providers who offer better quality care.

To meet expected growth in demand for services, the number of family planning clinics will increase from about 8,500 in 1989 to 12,000 by 1994 with an emphasis on the establishment of private clinics. Government and private hospitals with family planning services will increase from about 700 in 1989 to 898 in 1994.

Integrated services at the village level will also be given priority with a special emphasis on promoting family planning along with good family nutrition. The village income generating groups (UPPKA) will increase from about 19,000 in 1989 to 55,000 in 1994. Groups of families with children under five years (BKB) will increase activities from 1,000 villages in 1988 to 28,712 villages by the end of Repelita V. The village family planning sustainment posts (PPKBD) will increase from 66,416 in 1989 to 71,780 (or one post per village) by 1994. Likewise the sub-PPKBD will increase from 216,318 in 1989 to 332,000 in 1994. Family planning acceptor groups will increase from 360,000 in 1989 to 996,000 in 1994. Family planning acceptor groups in the Ten-House-Per-Cadre plan has set a target of 1.98 million groups by 1994.

4. CURRENT O/PH PROJECT PORTFOLIO

4.1 HEALTH TRAINING RESEARCH AND DEVELOPMENT PROJECT (497-0273)

USAID Contribution: \$12,450,000 (Grant)
 \$ 1,450,000 (Loan)

Project Agreement Signed: September 1, 1978 (Grant)
 August 12, 1983 (Loan)

PACD: September 30, 1989

4.1.1 Objective:

The core objective of this project is to strengthen the Ministry of Health's (DepKes) institutional capability to plan, implement and evaluate the recruitment, training and management of public health personnel; applied research; and community health education.

In trying to achieve its broad objective, the project was first designed to assist four selected DepKes institutions, emphasizing the need for improved human resource and research capacities. These institutions, which are responsible for different aspects of the health planning function, are: the Bureau of Health Planning (especially as related to the manpower information system); the Bureau of Personnel; the Center for Education and Training of Health Personnel (PusDikLat), charged with in-service training; and the National Institute for Health Research and Development (LitBangKes), especially as related to operations research on health management issues. In line with USAID/Indonesia's increasing emphasis on child survival activities, a Diarrheal Disease Control component was added to the project through a \$3 million amendment signed on August 25, 1986. This effort seeks to reduce high mortality rates from dehydration due to diarrhea, the principal cause of death for children under five in Indonesia (at least 24% of under-five deaths, a total of about 500,000 children per year).

The Project Paper and its Amendment include the following outputs for achievement by the end of the project: (1) the Bureau of Health Planning will have the capability to continue labor force and health planning, and will have improved evaluation capabilities; (2) the number, quality and relevance of research projects will be improved; (3) a more relevant, thorough, widespread and standardized health education system will be in place; and (4) the DepKes' capability to manage and coordinate activities associated with the promotion of Oral Rehydration Therapy will be strengthened.

4.1.2 Current Status:

4.1.2.1 Diarrheal Disease (CDD) Component

Efforts in this component are being focused on promoting mothers' and health providers' acceptance and use of Oral Rehydration Therapy to prevent and treat the symptoms of dehydration. West Java province has been identified as a special intensification area where ORT activities are being promoted, through a program emphasizing education through mass media, communications and social marketing. The program has begun in West Java and was launched in Kabupaten Garut in June 1986 after baseline and marketing design studies were completed there. Early implementation activities included training over 3,500 kaders and retailers about ORT. In addition to social marketing, other project activities include intervention for upgrading epidemiological surveillance, medical education, health worker training, a management information system, and supply management.

In 1987 a strategic plan for a national diarrheal disease control program was developed. Pilot provinces are W. Java, S. Sulawesi and S. Sumatera. Lessons learned in W. Java to date are being applied in the new provinces.

4.1.2.2 Health Planning Component

The mid-term evaluation team (1983) noted the accomplishment of establishing a Manpower Health Planning Unit within the Bureau of Health Planning, but emphasized a critical need for complete and useful job descriptions at all levels of the health system and for a comprehensive management information system (MIS) to assist personnel administration. These activities are well underway, with a manpower information system now being incorporated into a more comprehensive MIS which includes a PusKesMas service statistics data system. The Bureau of Health Planning has now completed the development of a methodology for calculating immediate manpower needs based on present work load in over 8,000 service units. This new methodology has been adopted for nation-wide use. The project also provided technical assistance and local costs for developing the health portion of the Fifth Five Year Development Plan.

4.1.2.3 Health and Training Components

The 1983 evaluation team observed more serious problems with regard to the research component, and made several recommendations for its re-design. Funds for this component have now been expended and it has been effectively closed. The HTRD training component developed some potentially successful interventions, including the formation of a cadre of local management consultants; however, some aspects of the technical training provided were felt to be too theoretical or impractical and not cost-effective according to the February 1986 evaluation of this activity. This component is now being phased out on schedule.

4.2 EXPANDED PROGRAM IN IMMUNIZATION (EPI) PROJECT (497-0253)

USAID Contribution: \$ 9,200,000 (Grant)
 \$12,500,000 (Loan)

GOI Contribution: \$16,500,000

Project Agreement Signed: August 15, 1979 (Grant)

PACD: September 30, 1990

4.2.1 Objective:

To reduce infant and child mortality by expanding the national program of smallpox and tuberculosis (BCG) immunization to cover a larger proportion of the population and include immunization for diphtheria, pertussis, measles and tetanus.

Expected project goals include improving DepKes capabilities for managing immunization programs, increasing local production of high quality vaccines, and strengthening the epidemiological surveillance system for vaccine-preventable diseases. The target population consists of women and children under five living in 76% of all Kecamatan. Anticipated end-of-project outputs include fully immunizing 57% of the targeted child population and 56% of the targeted population of pregnant women nationwide.

4.2.2 Current Status:

In measuring progress toward achieving these project's objective and goals, the 1982 evaluation team noted a number of significant accomplishments: (1) all provinces and Kabupaten/Kotamadya had focal EPI staff; (2) 60% of all Kecamatan had introduced an EPI program against pertussis, diphtheria, TBC and tetanus; (3) vaccine production had expanded to the point where it could meet existing and anticipated program needs; and (4) all Kabupaten and some Kecamatan/Kotamadya had an effective cold chain.

The evaluation also cited some serious problems, however, most notably low coverage rates. The cluster survey showed that 8-33% of the targeted children received two DPT (diphtheria/pertussis/tetanus) and one BCG (tuberculosis) immunization; and 2-22% of targeted women received two tetanus immunizations. The team identified several constraints contributing to these problems and made a number of recommendations for improving the program.

The Internal Program Review completed in May 1986 concluded that "Indonesia's EPI program has made exceptional progress during the last three years," stating that it is approaching Repelita IV targets and, with continued resources, may meet or exceed some of these targets.

It noted particularly the important and increasing involvement of PKK, religious and education leaders in assisting this effort. The major weaknesses cited were in the PosYanDu (health post), where it was observed that poor organization allowed some children to go unimmunized and incidents of unsterile practices to go uncorrected. The joint GOI/WHO/UNICEF/USAID project evaluation completed in December 1986 also noted "remarkable progress" in the program, finding that in surveyed provinces, over 60% of children under 15 months of age had received at least one dose of vaccine and 33% of infants were fully immunized. Major recommendations for improvement included taking better advantage of "missed opportunities" for immunizing children (e.g., during visits for curative care at hospitals), additional and better training (especially in supervision, cold chain maintenance, sterile practices), and improved public education and information activities.

An amendment to this project was signed in August 1987. Activities under the Amendment focus on reducing missed opportunities through better EPI program guidelines and incorporating EPI into clinical facilities; reducing dropouts by modern marketing demand generation techniques; supporting decentralized planning and implementation; and advocating greater GOI contributions to EPI.

4.3 FACULTIES OF PUBLIC HEALTH (497-0348)

USAID Contribution: \$4,000,000 (Grant)
 \$5,000,000 (Loan)

GOI Contribution: \$9,000,000

Project Agreement Signed: July 21, 1986 (Grant)
 July 26, 1985 (Loan)

PALD: June 30, 1992

4.3.1 Objective:

The objectives of this project are to help the GOI produce appropriately trained public health personnel to manage its National Public Health Program and to expand and regionalize public health education and research.

This project is assisting four regional faculties develop the capability to offer diploma, S1 (Bachelor's) and S2 (Master's) degree education in public health: Hasanuddin University in Ujung Pandang, Airlangga University in Surabaya; Diponegoro University in Semarang, and the University of North Sumatra in Medan. Prior to the start of the project, only two universities in Indonesia had Faculties of Public Health, the University of Indonesia in Jakarta and Hasanuddin University in Ujung Pandang.

Project inputs include technical assistance; short-and long-term training for public health faculty members in Indonesia and abroad; library materials, micro-computers, teaching and administrative equipment, and funding for research, policy seminars and pilot demonstration projects.

Four major outputs are anticipated for achievement by the end of the project: (1) establishing four new faculties of public health in Indonesia, each of which will include a minimum teaching staff, expanded library and information resources, and educational, administration and management systems; (2) strengthening the capacity of FKM-UI (Faculty of Public Health - University of Indonesia) as a national resource center for public health; (3) completing research, pilot projects and feasibility studies on region-specific public health programs; and (4) producing 1,120 Bachelor's (S1) and 360 Masters's (S2) graduates in public health.

4.3.2 Current Status:

Project activities were initiated in November 1985. The Central Project Management Unit (PMU) and Local Management Units (LMU) at each participating university have been established, staffed and began operations in January 1986. Faculties have all received their first class of students into the two-year S1 program and existing curricula for S1 programs in public health have been reviewed, with some revision completed. Arrangements were completed with BKKBN to manage applications, English Language training and orientation for long-term overseas training candidates. The provision of core commodities, especially computer equipment, has been completed.

The three programs of study in public health, within the Medical Schools, have now met all criteria for accreditation as Schools of Public Health. It is anticipated that they will be formally accredited in late 1989, which is within the planned target period. Regional and national planning for curricula and research project development is now an accepted procedure and this planning process incorporates representation from several government agencies with broad public health health interests. Technical assistance, largely from national experts, has supported the curricula and research development.

Almost 60 faculty members drawn from all five universities are in full time study at master's or doctoral levels. Twenty-five will return to their teaching responsibilities by July, 1989. A market survey of potential job opportunities for graduates from the four year baccalaureate program revealed considerable employment interest, including in the private sector. Graduates from this four year program in public health are now accredited for entry into the Indonesian Civil Service structure.

A mid-term evaluation was completed in mid-December 1988. This review will be useful in making course corrections for the consolidation phase of this project.

**4.4. COMPREHENSIVE HEALTH IMPROVEMENT PROGRAM-PROVINCE SPECIFIC (CHIPPS)
- PROJECT (497-0325)**

USAID Contribution: \$6,800,000 (Grant)
 \$4,200,000 (Loan)

GOI Contribution: \$9,000,000

Project Agreement Signed: August 27, 1981 (Grant)
 September 30, 1981 (Loan)

PACD: September 30, 1989

4.4.1 Objective:

(1) To strengthen the capacity of provincial health officials to target, manage and evaluate health/nutrition interventions that will improve child and maternal survival, and (2) to contribute to decentralization of health services in the three outer island provinces of Aceh, West Sumatera and East Nusa Tenggara (NTT).

The project carries out its objectives through support for training health personnel and health intervention field trials based on epidemiological data collected and analyzed in the provinces.

By the end of the project, it is anticipated that the participating provinces will have significantly increased the quality and quantity of professional rural health personnel, and the provincial public health system will be better able technically, analytically and managerially to carry out sector programs adapted to the often unique circumstances in these provinces.

4.4.2 Current Status:

The 1984 CHIPPS process review documents early project implementation problems, particularly those resulting from an over-emphasis on loan funds. After the project amendment of 1985 provided additional grant funding for technical assistance and field studies and trials, implementation proceeded rapidly. Early project efforts provided academic and field training to increasing the supply and quality of health personnel, especially nurses, in participating provinces. Later, provincial health officials learned to conduct epidemiological surveys to identify local health problems and plan and carry out interventions to solve them. During the final years of the project, emphasis shifted to strengthening overall health management capabilities at the district level to improve performance of village health posts.

The project has achieved its most impressive results using locally collected and analyzed data to plan and carry out specific health interventions. In doing so, project leaders carried out the CHIPPS

"process" of identifying health problems and designing programs to solve them in all three provinces in different ways. In Aceh, local health officials conducted epidemiological surveys indicating neo-natal tetanus was the leading preventable cause of infant mortality. On the basis of these results, they planned and implemented a series of accelerated immunization efforts, including mass media materials, immunization campaigns, and targeted approaches mobilizing support of religious leaders. In West Sumatera, project officials developed population-based health information reporting systems to help them target supervision efforts and management interventions. In NTT, which lacked both resources and personnel, project leaders mobilized and trained leaders of women's groups to supplement the public health service delivery system.

Some of these activities had significant success; in Aceh, a 1987 survey found a 40% reduction in neo-natal tetanus mortality in the first project intervention area--most of which is attributed to project-supported immunization programs. Further analysis documents that the better data available to health officials in the CHIPPS provinces has also strengthened their hand when negotiating with central level leaders for additional resources. Project officials are now documenting lessons learned in the project to identify policy and planning implications for future projects. To do this, they plan an in-depth evaluation of key issues, including analysis of financial sustainability, effectiveness of training approaches and health information systems.

4.5 VILLAGE FAMILY PLANNING/MOTHER-CHILD WELFARE PROJECT (497-0305)

USAID Contribution: \$14,000,000 (Grant)

GOI Contribution: \$18,150,000

Project Agreement Signed: June 6, 1980

PACD: May 30, 1990

4.5.1 Objective:

The purpose of this project is to reinforce the GOI National Family Planning Program objective of a small, healthy and prosperous family through innovative support for an integrated, community-based family planning/health services delivery program. Specific objectives include decreasing the prevalence of malnutrition and diarrheal disease among children under five while increasing the level of family planning acceptance and continuance.

By the end of the project, it is anticipated that the following will have been accomplished in participant villages: (1) new family planning (FP) acceptors will increase by 15%; (2) the percentage of children under five with protein calorie malnutrition and untreated

diarrhea will decrease by 50% and 90% respectively; and (3) income generating activities will be established for participating villagers. The amended project plan includes meeting the following additional objectives: 1) developing a research agenda for priority topics (e.g., kader incentives, means of increasing mothers' participation); (2) designing and field testing an effective service delivery model, especially one aimed at increasing coverage and efficiency of the PosYanDu (health/FP posts); and (3) institutionalizing the Integrated Family Planning - Health Service Program's (KB/Kes) Integrated Task Force to make policy recommendations on the program to the highest echelons of DepKes and BKKBN.

4.5.2 Current Status:

The rationale of this project is to utilize BKKBN's extensive network of village fieldworkers and FP posts to improve coverage of the DepKes Family Nutrition Improvement Program (UPGK - a services package including distribution of ORS, Vitamin A and iron, monthly weighing and nutritional education), which was previously only available at sub-district health centers. The program began in 1979, focusing on East Java, Bali and West Nusatenggara (NTB); by 1984 the AID program's coverage included 20,000 villages.

Results of the 1982 mid-project evaluation noted the major accomplishment of establishing an integrated family planning/nutritional services delivery system in East Java and Bali. There were a number of constraints, however; village-level participation in project management was limited and little institutionalization had occurred.

Following the evaluation, substantial policy changes and modifications were made, most significantly in establishing the KB/Kes Program as a joint DepKes and BKKBN operation to manage the five priority services of nutrition, family planning, immunization, diarrheal disease management and mother-child health care through the PosYanDu system. At the same time, the Integrated Task Force was established, made up of Directorate chiefs for the five programs, to coordinate inputs and plans and formulate policies for KB/Kes. A number of successful efforts were subsequently made in the project to develop innovations at the local level that are uniquely tailored to the needs of the target areas.

A comprehensive two-year series of evaluation studies began in 1984 to measure overall project impact in East Java and Bali. Results of the studies (completed in September 1986) indicated there were "significant positive changes" during the period 1980-85; for instance, in Bali, the percentage of women who had used contraceptives increased significantly, as did immunization rates and such other practices as use of latrines and piped drinking water. It was difficult to know, however, to what extent these changes resulted from the project as opposed to other factors. More important, evaluation results identified many variables that could be used to improve the program, e.g., the positive

correlation between active PKK participation and mothers' attendance at weighing posts, factors influencing kader effectiveness, accuracy of village-level statistics, etc. The policy implications of these results have been analyzed and used in developing pilot projects and operational studies.

The USAID project amendment (signed August 25, 1986) assists BKKBN and MOH to overcome identified project constraints through supporting further operations research to identify problems (especially in the PosYanDu service delivery, supervision and monitoring systems), design and test solutions and establish a policy framework which will incorporate these results into the KB/Kes service model and, finally, into Repelita V plans. A major thrust of planned activity is to mobilize and strengthen the role of the Integrated Task Force as a policy-formulating body able to assess the implications of project research activities and influence needed policy changes.

4.6 FAMILY PLANNING DEVELOPMENT AND SERVICES II (497-0327)

USAID Contribution: \$19,200,000 (Grant)
 \$17,200,000 (Loan)

GOI Contribution: \$76,866,000

Project Agreement Signed: June 16, 1983 (Grant)
 June 17, 1983 (Loan)

PACD: December 31, 1992

4.6.1 Objective:

To increase the use of all legal types of contraceptive methods in Indonesia from 43% of all married women of reproductive age in December 1982 to 69% in December 1992.

This project was designed as a follow-up to FPDS I (497-0270) and incorporates many of the recommendations of the 1985 evaluation in the already highly successful program. It focuses on the expansion and improvement of family planning services in urban and rural areas and on strengthening BKKBN's management, training and research capabilities. The overall goals and purpose are the same as those of the GOI's national family planning program.

4.6.2 Current Status:

According to BKKBN service records, the original objective of achieving a contraceptive prevalence rate (CPR) of 58% of the targetted population was reached a year ahead of schedule in 1986. However, the recently completed 1987 National Indonesian Contraceptive Prevalence

Survey (NICPS) indicated that contraceptive prevalence was 48 percent at the end of 1987. The project was amended to increase the prevalence to 69 percent prior to obtaining the results of this independent survey.

The purpose and status of the six project components are presented below:

4.6.2.1 Village Family Planning

The 1983-87 phase of AID support for this component aimed at improving contraceptive prevalence in low performing villages in 13 priority provinces. A 1987 independent evaluation of this activity confirmed that this goal had been achieved. It also recommended improving quality of services and investigating ways to improve program sustainability. Utilising funds added to the project in 1987, an operations research project is being conducted in three high prevalence provinces (Jogyakarta, Bali, North Sulawesi) to test cost recovery schemes and ways to improved quality, and small scale pilot self sufficiency projects are being developed in the original priority provinces as well as five new low prevalence projects.

4.6.2.2 Modern Management Technologies

This component seeks to improve BKKBN management capabilities through the provision of modern technologies. Computers, software and training plans are now in place to expand the automated MIS to all provinces. With amendment funds a new mini computer is being purchased which should greatly improve Central BKKBN's capacity to manage its nationwide service statistics and logistics system.

4.6.2.3 Research

This component provides support to measure program progress, test new ways of delivering information and services, and strengthen monitoring and supervision of program operations. This first national contraceptive prevalence survey was conducted in 1987, providing a wealth of information on program evaluation and demographic achievement. In 1988, an independent evaluation recommended that the BKKBN consolidate and improve the quality of its research efforts and that a management and training assessment be conducted. This has recently begun and the BKKBN is reviewing the proposed options. Amendment funds were added to fund additional technical assistance, a 1990 contraceptive prevalence survey, and a grant to the Center for Child Survival to conduct research on family planning-child survival interrelationship.

4.6.2.4 Voluntary Sterilization (VS)

This component originally provided support to expand and improve voluntary sterilization services in 13 priority provinces. Training, renovation, medical and non medical supplies were provided on the basis of a needs assessment. With amendment funds, further facility

upgrading is being conducted in the original 13 provinces, as well as selected sites in the 14 Outer Island provinces. In addition, counseling, supervision, and surveillance systems are being strengthened.

4.6.2.5 Training

USAID supports in-country and overseas long and short-term training related to family planning management and technical skills improvement. BKKBN has developed the capacity to manage its own in-country and overseas long-term academic training program, including recruitment and screening of degree candidates, provision of English language training and logistics support. Funds were also utilized to improve the personnel system at BKKBN and to develop a distance learning system (programmed learning with instructional packages) for fieldworkers. Amendment funds were provided for 30 additional U.S. Master degree participants, retraining of all village family planning fieldworkers in self sufficient family planning, new methods of contraception, and their role in the PosYanDu. Funds for refresher training for 2,500 midwives in modern clinical contraception were also provided.

4.6.2.6 Urban Family Planning

This component includes a variety of operational research activities and private sector initiatives, targeted in the 11 largest urban areas of Indonesia, as well as the Social Marketing for Change (SOMARC) effort, supported initially through AID/Washington. SOMARC began marketing condoms through private commercial outlets in three cities in April 1986 and is now expanding to eleven cities. A Blue Circle campaign to promote private sector services for provision of contraceptives was begun 1987 and a Blue Circle Products Campaign was launched by President Soeharto in November 1988. Amendment funds were provided to expand these social marketing activities.

4.7 PRIVATE SECTOR FAMILY PLANNING (497-0355)

USAID Contribution: \$20,000,000 (Grant)
Host Country Contribution: \$21,300,000
Project Agreement Signed: August, 1989 (planned)
PACD: December 31, 1995

4.7.1 Objective:

To expand the availability, quality, sustainability and use of family planning services provided by the private sector.

Although recognized as one of the outstanding programs in the developing world, Indonesia's government-led national family planning program cannot adequately meet the projected 50% increase in family planning users that is required to meet national population goals. The GOI has therefore announced its intention to shift a major part of responsibility for family planning to the private sector to further create and meet demand for quality services. The Private Sector Family Planning Project (PSFPP) will assist the GOI to achieve its family planning self sufficiency goals. It will: (1) create demand for and expand access to private family planning services and supplies through a social marketing program implemented by commercial marketing and distribution networks; (2) greatly expand and improve the network of private fee-for-service providers and non-government organizations delivering family planning services; (3) increase the availability and quality of long term, more cost effective contraceptive methods. These priority areas have been selected because: (1) they are areas which the GOI sees as crucial in its move to privatization, and (2) they build on several years of USAID supported studies and well-evaluated pilot experience which confirm their importance and promise of high potential for success.

By the end of this six year project, it is expected that: (1) the proportion of family planning users who obtain their services from private sector sources will have increased from less than 15% to almost 40%; that a majority would be paying all or part of the costs themselves; and that the expanded networks of self sustaining private and NGO providers will have increased user access to and use of high quality, long-term contraception. Thus, through 20 years of support, AID will have helped Indonesia develop self-sustainable, immensely effective family planning capability.

4.7.2 Current Status:

The PID was approved by AID/W in December, 1988 and the Project Paper will be written in April, 1989. Obligation of funds is expected by August, 1989.

4.8 HEALTH SECTOR FINANCING PROJECT (497-0354)

USAID Contribution:	\$15,000,000 (Grant)
GOI Contribution:	\$ 5,515,000
Project Agreement Signed:	March 12, 1988
PACD:	March 31, 1995

4.8.1 Objective:

The purpose of this project is to develop the institutional and policy context needed to ensure the financial sustainability of child survival programs. By the end of the project, a 35% increase (real terms) in government spending on child survival programs will occur using 1987 as the baseline year. This will be achieved by improving efficiency and cost recovery for services which consume a large share of the Ministry of Health's budget and by redirecting the savings to child survival programs.

4.8.2 Current Status:

1. **Hospital Component:** The project is currently conducting a comprehensive assessment of hospital operations in public and private hospitals in three provinces. This diagnosis will focus upon hospital administration and management, quality of care, fiscal management, and the ability of the populace to afford care at government facilities. The results of the hospital diagnosis will be used to design a program of pragmatic interventions which will result in improved hospital efficiency, greater ability of public hospitals to retain revenues, and reduced government subsidies to government hospitals.

2. **Pharmaceutical Component:** The project is conducting a focussed assessment of the government system for selection procurement, distribution and use of pharmaceuticals in 6 provinces. The results will be used to design a program of pragmatic interventions in the government pharmaceutical system which will foster more rational drug use and enhance the therapeutic benefit of the government's pharmaceutical budget. The objective of this component is to improve the internal allocative efficiency of the pharmaceutical budget, reduce expenditures on antibiotics, and make more funds available for the purchase of vaccines, ORS, and other child survival related pharmaceuticals.

3. **Social Financing:** The project is assisting with the development of capitated prepaid health insurance schemes in both the public and private sector. Public sector programs receiving assistance through the Project are the AsKes program for government employees and the PKTK social insurance program for the wage based sector. In the private sector the project is assisting the Dana Sehat program for the rural population and to set up a health insurance program through its rural cooperatives; and is providing assistance to private insurance companies, providers, and employers to established HMO products based upon the HMO model. Four private groups are currently receiving assistance through the project: a) P.T. Tugu Mandiri Insurance Company, b) Telogorejo Hospital, c) St. Carolus Hospital, and d) P.T. Kalbe Farma pharmaceutical company.

In addition to these components, the HSF is assisting with the development of a Health Economics and Policy Analysis Unit which will monitor the quantity and type of public and private sector revenues and expenditures on Health, and will monitor progress in achieving the end-of-project status.

4.9 HEALTH SECTOR TRANSITION (497-0359)

USAID Contribution: \$25,000,000 (Grant)
Host Country Contribution: \$6,250,000
Project Agreement Signed: June 1990 (planned)
PACD: May 31, 1995 (planned)

4.9.1 Objective:

The objective of this project is to expand and improve the technical and managerial capacity of the government and private sector to plan, implement, monitor and evaluate programs and services directed toward improving the health status of the Indonesian family.

4.9.2 Current Status:

This project is still in its development phase. Activities are expected to begin in June 1990. There are several issues which are shaping this new project and will provide the background to the various project components.

Recent transitions in demographic patterns in Indonesia have alerted program planners that older age groups are emerging as a significant portion of the population and that non-communicable and chronic diseases are of growing importance in these adult age groups. For the present, child survival issues and communicable diseases remain priority targets for health programs. The infant mortality rate has declined but remains high. EPI coverage has increased overall but tetanus coverage for pregnant women remains low. Communicable diseases like diarrheal disease, acute respiratory infections and the EPI preventable diseases like tetanus and measles, are still major contributors to morbidity and mortality in infants and children.

Conditions like chronic hepatitis B virus infection, cardiovascular disease, accidents and injuries, and other occupational and environmental hazards are emerging as important contributors to morbidity and mortality in childhood and adulthood. These factors affecting the health status of families have implications for Indonesia's national development strategy.

Specific objectives of this project will include mortality and morbidity reduction objectives and capacity increase objectives for the MOH, the private sector, communities and families to develop the skills necessary to improve health status.

ANNEX 1

**USAID/INDONESIA COUNTRY DEVELOPMENT
STRATEGY STATEMENT - CDSS¹⁾ 1989-1993**

1.1 Where Indonesia Stands

1.1.1 The Record 1965-89

Indonesia has made remarkable economic and social progress since the change of government in 1965, when the economy was virtually in a shambles. Indonesia's record of economic and social achievements in its first twenty years under Soeharto ranks with the best in the developing world. By 1985 Indonesia has doubled its rice production to achieve a fragile self-sufficiency in rice, cut its total fertility rate by 31%, reduced its population growth rate to almost 2%, and nearly attained universal primary education. Macro-economic performance was also exceptional: between 1983 and 1989 the Government of Indonesia (GOI) undertook an unusually far reaching set of economic policy reforms, generally directed toward deregulation and a stronger market orientation, and away from governmental control.

Indonesia has transformed itself into a modernizing nation with a chance of joining the ranks of Asian success stories within the next fifteen years. It is now near the same point in its economic development as Korea was in the early 1960s, with similar potential for rapid trade-led growth and development if the right policy environment is vigorously pursued. Steps taken during the next five to ten years will be crucial in determining whether Indonesia advances within the coming fifteen years to the point where it no longer requires foreign assistance.

1.1.2 The Challenges

The challenges which lie ahead include:

- Employment: Indonesia must find jobs for the 20 million people who will enter the labor force over the next decade, while protecting its easily depleted natural resource base. Together with incomes, employment is considered by the Mission, the GOI, and most other observer to be the overriding socio-political-economic issue facing Indonesia over the next ten years.

1) This strategy is under review in 1989. Any changes to the Mission strategy will be incorporated when the review process is completed and changes are approved.

- Incomes: Per-capita income is estimated to be below \$400 in 1987 (owing to the 1986 devaluation), a level that puts Indonesia back in the lower income country category. Future projections are for essentially stagnant real per-capita incomes unless Indonesia vigorously seeks to deregulate the economy. Over 40% of the population still live below the IBRD poverty line.

- Social factors: Life expectancy in Indonesia (63 years) is the lowest in ASEAN, while infant mortality rates (70/1000) are still high. The human resource base needs much more development: only 1% of the work force has attended college.

- Reduced revenues: Heavy dependence on oil for government revenues has resulted in a 50% decline in real development budget expenditures, with additional cuts likely. Indonesia's total debt service ratio has more than doubled, to over 37%, and foreign debt stands at over \$43 billion, one of Asia's largest.

The USAID program strategy is tailored to help Indonesia meet the challenges it faces, including longer-term structural adjustments. The current policy environment is receptive. Intelligent advice and a program that is well focussed (even if small relative to the \$3 billion total annual donor aid to Indonesia) may actually make a difference in the course of events.

1.2 USAID Strategy Summary

1.2.1 Strategy Evolution 1946-1988

USAID's early focus on capital transfer and infrastructure evolved in the mid-1970s to a program that emphasized meeting the needs of the rural poor. The 1983-1988 CDSS focused on broad based institution building and support to national programs. It began the present involvement with policy analysis. It broadened the previous focus on agricultural productivity as the main vehicle for growth in the economy to include increasing off-farm employment, improving primary health care, completing the institutionalization of family planning, and accelerating human resources development.

As Indonesia enters a more advanced phase of development with new challenges that involve sector-wide and structural economic issues, the current AID strategy has evolved again. It addresses the employment and incomes problem through an approach that places greater emphasis on sector-wide and macro-economic policy change, promotes the private sector as a major alternative to the public sector, encourages a greater voice and responsibility for a larger constituency, and is concerned with the sustainability of resources (natural resources and environmental management). At the same time, it takes into account continuing problems that cannot be ignored in a balanced long-term development strategy: human resource development, health, and family planning.

1.2.2 The 1989-1993 CDSS

1.2.2.1 One Goal

During the 1989-1993 period, USAID's goal is to improve long-term, sustainable employment and income opportunities through means which promote efficiency and productivity. Rapidly increasing the demand for labor requires major attention to a variety of measures which increase resource efficiency, productivity and mobilization. Similarly, improving labor supply requires qualitative and quantitative improvements in human productivity through education, family planning and child survival.

To address the goal, USAID has developed a strategy based on the 1985 Mission employment study. USAID selected the activities largely on the basis of their contribution to efficiency and productivity in the economy as the most effective support for the long-term employment and incomes goal. For this reason, USAID looks to the significance of the efficiency/productivity impact of an activity rather than its direct near-term employment implications.

1.2.2.2 Four Sub-Goals

The strategy consists of four sub-goals:

1. Supporting a more open, less regulated market and trade oriented economy, both internally and externally.
2. Increasing the sustainability, productivity and efficiency of the agriculture production, processing, distribution and consumption system.
3. Achieving an efficient, high quality human resources development system which effectively links systems outputs to market requirements.
4. Reducing fertility and improving rates of infant and child survival.

Each sub-goal will, in turn, be pursued through selected objectives that fit within the integrated strategy framework.

In addition, USAID will apply new leveraging and management effectiveness criteria to sharpen the choice, design and implementation of activities throughout the portfolio.

Impact: USAID plans to utilize fully the funding sources available: bilateral Development Assistance, PL-480 (Titles I and II), Housing Guarantees (new), and regionally/centrally funded resources. However, AID assistance, by other donors' standards, is small. USAID

hopes to magnify the impact by carefully screening new project or program proposals. It will select those efforts that have high potential for affecting key policy changes, strengthening critically situated institutions or agencies which have the responsibility for major budgetary or policy decisions, replication by the GOI or other donors following key demonstration projects, or leveraging other donors' resources toward the employment-incomes problem.

Management Effectiveness: To make the staff utilization as efficient as the program, USAID will, in addition to the substantive objectives and leveraging criteria, emphasize those projects and programs that have lower staff intensity. Reducing staff intensity will require attention to: expanding the variety of programming modes, limiting the number of projects and management units, improving internal program complementarity, and shifting more responsibility for operational management to the GOI and the independent sector (including both the private sector and non-government organizations) where feasible. USAID will gradually change the mix and deployment of skills, within present staff levels, away from conventional project skills and toward macro economic, policy and budgetary analysis skills.

Programming modes will include DA program assistance as a continuing element of the program, subject to policy and budgetary need and to a positive appraisal of the current effort. Because of the synergy needed between project aid (to identify, analyze, and test policies) and program aid (to support policies in which USAID is confident), both modes of aid are needed to maintain a quality aid program.

The number of projects has come down from 43 in FY 1983 to 31 in FY 88. The strategy, with its unifying goal of employment and income, provides a tighter focus for future investments: it will reduce the number of projects/programs further, to approximately 20, during the current CDSS period.

Internal program complementarity is increasing. Apart from the unified goal, USAID has common themes throughout the portfolio. For example, USAID is supporting private sector activities in health, population, agriculture, and education as well as in our deregulation, trade, and private sector program. In addition, USAID expects a greater integration of PL-480 and Housing Guarantees with DA-funded activities.

ANNEX 2

**AID/WASHINGTON POLICY AND STRATEGIES IN THE HEALTH
AND POPULATION SECTORS**

While the preceding section discussed GOI priorities in the health and population sectors, this section describes the U.S. Agency for International Development's (AID) policies in general, and its specific priorities for health and population assistance. Such a description is essential for establishing the parameters and framework for a more specific country-oriented strategy.

2.1 The AID Strategy for Development Assistance

AID's ultimate goal is a world in which economic growth and development are self-sustaining, basic human needs are being met, and the extremes of poverty have been eliminated (AID, 1985). AID has identified an overall target for economic growth and has established quantitative basic needs levels for achieving this growth. These levels were set with the realization that they can only be reached through the policies and collective efforts of the host country and all donors, AID being only one small part of the development process. The targets are:

- o Economic Growth: Attain an annual real rate of growth of per capita income of not less than 2%, reflected in increases in employment, income and agricultural production.
- o Hunger: Achieve the FAO critical level of calorie intake for 90% of the population in each AID-assisted country, and reduce chronic and severe undernourishment to less than 20% of children less than five years of age.
- o Disease and Early Death: Reduce infant mortality to less than 75/1000 live births, reduce childhood mortality (children 1-4 years of age) to 10/1000, and achieve a level of life expectancy at birth of 60 years.
- o Illiteracy and Lack of Education: Increase primary school enrollment to 90% for boys and girls, with 70% of the age group completing at least four years of schooling; provide skills training compatible with development requirements; and achieve an adult literacy rate of 50% for both men and women.
- o Unmanageable Population Pressures: Enable access for at least 80% of couples to a wide range of acceptable voluntary family planning services, thus enabling them to make their own family planning decisions.

AID has set the year 2000 as a reasonable time frame in which to focus efforts to move toward these levels of achievement, but acknowledges that these targets may not be attainable simultaneously in all countries, nor perhaps within this time frame for all AID-assisted countries. Success in achieving these targets will depend upon the domestic policies of host governments and general donor agency policies. AID also stresses that emphasis must be given to indirect approaches - such as the development of an indigenous private sector to broaden a country's resource base, increasing opportunities for women, and mitigating the negative effects of development on the environment - as well as more direct approaches which may yield results that are sustainable in the long term.

AID believes that all of the countries with which it collaborates have the inherent capability, through sound policies and their own efforts (stimulated by international assistance, trade and investment) to become economically self-reliant and ultimately will be able to meet the basic needs of their own people on a sustained basis, using their own material and human resources. Hence, AID will support long-term development which helps to bring about fundamental and structural changes in economies that will continue to bring improvement in these five areas of basic need.

While AID continues its focus on basic needs, it has changed its way of approaching fundamental development problems. AID seeks to achieve systematic changes in recipient countries that reach far beyond the direct beneficiaries of specific projects. Its concern is with policies, institutions, technologies, free market forces and involvement of the private sector. There are four aspects of AID's policy and strategy:

- o Policy Dialogue: Long-term equitable development depends heavily upon the nature of the domestic policies followed by developing countries. AID, by virtue of its field mission structure and assistance structure, is uniquely positioned to assist with policy analysis and engage recipient countries in policy dialogues.
- o Institutional Development: The principal objective is to develop human resources and use them effectively in sustainable institutions, i.e., structural frameworks that produce results. This may require decentralizing and encouraging greater reliance on private and community efforts rather than only building public institutions.
- o Private Sector: The private sector can play a greater role in delivering the goods and services vital to development. The private sector can become an engine of growth, achieving self-sustainability without requiring continued infusions of public funds. Healthy private sector economies exist in all the countries where AID operates, and where the free play of market forces is allowed to flourish, this sector can contribute substantially to rapid and sustainable development.

- o Technology Research, Development, and Transfer: AID will give priority to developing, transferring and disseminating new technologies. Increasing attention will be given to the commercialization of technologies as a method of sustainable dissemination.

To enhance the impact of AID's assistance, it will:

- o work towards closer cooperation with multilateral development institutions and other donors,
- o encourage recipient countries to take a more active role to assure coordination,
- o more fully integrate the variety of AID resources including development assistance, economic support funds, food aid (PL 480), American schools and hospitals abroad, and disaster assistance, and
- o seek better coordination of these resources with other U.S. Government economic assistance instruments.

2.2 The AID Policy and Strategy for Assistance in the Health Sector

AID's goal in the health sector is to increase life expectancy in AID-assisted countries (AID, 1986b). Reducing infant and child mortality, which account for half of the yearly deaths occurring in most developing countries, is viewed as the most effective and expeditious way to increase life expectancy. AID's specific health sector objectives are to:

- o reduce infant and early childhood morbidity and mortality,
- o reduce maternal mortality,
- o use child survival interventions as the basis for building a more comprehensive health care system over time,
- o ensure that gains made in improving child survival are maintained, and
- o develop new technologies and improved systems for the delivery of child survival services.

2.2.1 Child Survival Strategy

AID has formulated a Child Survival Strategy (USAID, 1986a) to address these objectives. The twin engines of this strategy are immunization and oral rehydration therapy, which can purportedly prevent half of all deaths in children or one quarter of all deaths in the developing world. AID's focus will be on developing a sustained capacity

in each recipient country to provide effectively oral rehydration therapy, immunizations and the two other important child survival interventions, nutrition and birth spacing, to its vulnerable population.

Three aspects of AID's child survival strategy are critical to achieving maximum impact and long-term sustainability. These are:

- o Institutionalization of Services: The existence of an indigenous capacity to manage and deliver child survival services is essential to ensure that children will continue to receive the necessary care.
- o Utilization of the Private Sector: In line with AID's general strategy, efforts should be made to explore opportunities for involvement of the private sector to complement and support public sector programs.
- o Modern Communications Strategies: It is viewed as essential that demand creation, using modern marketing and communication techniques, be incorporated into child survival programming.

AID will use a selected country-specific approach, chosen on the basis of morbidity and mortality rates, coverage levels, and resource indicators, to target resources to countries receiving priority for child survival assistance. Indonesia has been chosen as one of the priority countries.

2.2.2 Secondary AID Health Strategies

AID recognizes the wide variations that exist in morbidity and mortality levels, disease patterns, environmental conditions, economic growth rates, and government policies throughout the world. Among recipient countries, it will thus support other health interventions justified on the basis of particular conditions in host countries. These are:

- o Health Financing: The success of AID child survival programs will, to a large extent, depend upon the host government's financial commitment toward sustaining their recurrent costs. Where government budgets are exceptionally skewed towards curative care and fixed facilities, such commitments will be difficult to achieve unless concerted efforts are made to assure that the necessary resources are available. Accordingly, AID will support appropriate health financing systems that will free up otherwise committed resources, leverage new resources, and allocate scarce existing resources more efficiently toward the support of child survival and other preventive programs.

- o Water and Sanitation: These will be funded mainly from the Economic Support Fund account and through private voluntary organizations where justification can be made that these interventions will have a direct impact on child survival.
- o Vector Control: In areas where vector-borne diseases are major health problems, consideration will be given to support for vector control projects. Efforts will focus on malaria, onchocerciasis, endemic dengue hemorrhagic fever, schistosomiasis, and guinea worm, but AID support will be minimal.

2.3 The AID Policy and Strategy for Assistance in the Population Sector

The objectives of AID's population assistance program are:

- o to enhance the freedom of individuals in developing countries to choose voluntarily the number and spacing of their children, and
- o to encourage population growth consistent with the growth of economic resources and productivity.

Unmanageable population pressures have been recognized as a prominent factor which influence economic growth, the health status of mothers and children, and ultimately, food availability and hunger. Hence, assistance in the population sector is considered integral in attaining AID's general development targets. AID acknowledges the reciprocal links between fertility and population growth on one hand, and general development on the other, and seeks to encourage programs that are mutually reinforcing.

AID policy for population assistance mirrors the general Agency development policy, and can be summarized as follows:

- o to initiate policy-level discussion with host countries to support the development of a clear population policy and institutional reforms which encourage voluntary family planning programs and reduced fertility;
- o to stimulate greater private sector involvement in the delivery of family planning services, especially through commercial retail sales and the social marketing of contraceptives;
- o to foster the involvement of local institutions in population programs and to strengthen their capabilities to deliver family planning services; and
- o to develop new contraceptive technologies and analytical methodologies to determine the impact of rapid population growth on economic progress, and to transfer these technologies to our host country counterparts.

REFERENCES

- AID AID Child Survival Strategy. Washington, D.C.: USAID, 1986a.
- AID AID Health Policy Paper. Draft. Washington, D.C.: USAID, 1986b.
- AID Blueprint for Development: The Strategic Plan of the Agency for International Development. Washington, D.C.: USAID, 1985c.
- Budiarso, Ratna, Outrali M. Comm, and Muchtaruddin, Household Health Survey 1980. Jakarta: Ministry of Health, Health Research and Development Board, 1980
 - Bureau of Finance and Bureau of Planning, MOH
 - Bureau of Planning, BKKBN
 - Central Bureau of Statistics, Survey Penduduk Antar Sensus (SUPAS), 1985
 - Central Bureau of Statistics and UNICEF Jakarta, An Analysis of the situation of Women and Children in Indonesia, August 1984
 - Central Bureau of Statistics, BKKBN, Institute for Resource Development/Westinghouse, National Indonesian Contraceptive Prevalence Survey 1987, draft report, December 1988
 - Central Bureau of Statistics, "Proyeksi Penduduk Indonesia per Propinsi 1985-1995" Seri SUPAS No. 34, February 1988
 - Central Bureau of Statistics, "Proyeksi Penduduk Indonesia 1985-2005 berdasarkan hasil Survei Penduduk Antar Sensus 1985" Seri SUPAS Nomor 33, October 1987
 - Central Bureau of Statistics, "Perkiraan Angka Kelahiran dan Kematian" Hasil Survei Penduduk Antar Sensus 1985 Seri SUPAS Nomor 35, January 1988
 - Central Bureau of Statistics, Indonesian Fertility Survey 1976, Principal Report, Volume 1, Jakarta 1978
 - Chao, Dennis, John A. Ross, and David Piet, Public Expenditure Impact: Education and Health, Indonesian Family Planning. Jakarta: USAID/Indonesia.
 - Government of Indonesia, The Fifth Five Year Development Plan for Health, Jakarta 1988.
 - Ministry of Health, data from the Directorate for Hospitals, December 1985.

- Ministry of Health, Division of Reporting and Evaluation, Center for Health Manpower Education, 1986
- Ministry of Health, Sistem Kesehatan Nasional (National Health System). Jakarta. Government of Indonesia, 1982
- National Family Planning Coordinating Board, The Fifth Five Year Development Plan for Population and Family Planning, 1988
- Palekahelu, Dirk. A Country Profile, Indonesia Jakarta: Ministry of Health, 1986
- Personnel Bureaus, Ministry of Health and BKKBN, 1986
- Stevens Carl, and Arie Doodoh, Increasing the Efficiency of Health Services in Indonesia: A Key Strategy for Child Survival. Paper prepared for USAID/Indonesia Office of Population and Health, September 1986
- USAID/Jakarta 1989-1993 Country Development Strategy Statement
- UNICEF, State of the World's Children, 1989, Oxford University Press
- Wheeler, Mark, Financing Health Services, Development Administration Group, Institute of Local Government Studies, Sectoral Study No. 2 Birmingham, England: University of Birmingham, December 1980.
- World Bank, Expenditure and Financing Issues in the Health Sector in Indonesia. Washington, D.C.: IBRD, 1983.
- World Bank, Indonesia: Adjustment, Growth and Sustainable Development, 1988.
- World Health Organization, "Tables on Global Indicators," 1983.

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