REPORT OF THE JOINT INDONESIA - JAPAN EVALUATION MISSION ON

THE NATIONAL FAMILY PLANNING PROGRAM IN INDONESIA

JAKARTA, FEBRUARY - MARCH 1985

PREFACE

In February and March 1985 a joint Japan - Indonesian Mission evaluated the Japan's contribution to the Indonesian National Family Planning Program. The Mission examined the strategies, methods, and results of this program in broad outlines. The mission also examined the contribution of the Japan technical cooperation during the last eight years to the program carried out by National Family Planning Coordinating Board (BKKBN). In this regards the mission reviewed several workplans and projects such as Media Production Centre, Jakarta Urban Family Planning Project and Condom Factory. In accordance to its purpose of evaluation the Mission has also looked into possible areas of future cooperation between the Indonesian Government and the Japanese Government.

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The Mission wiishes to express its sincere appreciation to the Chairman, Senior Staff and all members of the BKKBN for their full cooperation and openess during the many discussions held.

In addition the Mission expresses thanks to the staff of the Provincial BKKBN DKI Jakarta for giving information on the Jakarta Urban Family Planning Project during the discussion.

The Mission is grateful for the support received from the staff of the Japanese Embassy, Jakarta,

Last but not least the Mission is most appreciate for the support and assistance provided by Government official and personnel from the BKKBN and the "participant" in the program who generously made available information on all aspects of National Family Planning Program during the field visits. The views expressed in this report are those of members of the Joint Evaluation Team and do not necessarily reflect those of the Government of Indonesia and the Government of the Japan.

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I. SUMMARY AND RECOMENDATION

1. Indonesia, a Republik consisting of 13,677 islands, is facing with serious population problems caused by (i) a high rate of natural increase (above 2%); (ii) a high fertility rate (CBR above 30); (iii) a high dependency ratio (about 41% are in the 0 - 14 age group); (iv) an uneven distribution and density of population (62% living on Java Who's area is only 7% of all Indonesia); (v) high illiteracy rate (about 28% over 10 years).

2. The National Family Planning Program has made considerable achievement during its 15 years of existence. The achievement of the targets set for the three PELITAS exceeded more than 100%. In the course of these years, this program with a strong political commitment, community participation and intersectoral aprroach, this making family planning became a key component of the National Development program for better quality of life, a just, modern and welfare society.

3. At the end of 1984 the current users is about 15 million or about 60% of eligible couples, the current users consist of 27,8% of IUD, 54,2% of Pill, 4,4% of Condom, 10,6% of injection and 3% others method (e.g. Sterilization)

4. The target set for REPELITA IV (1984/1985 - 1988/1989) are about 25 million new acceptors and 17,3 million current users or about 65% of eligible couple. To achieve those targets, the main activities directed to strengthening and developing contraceptive services, IEC, man power development and training, logistics, research and development, evaluation and monitoring and other supportive activities.

5. The Integrated FP Program or beyond family planning program, that is the activities integrated into the existing program of other development sectors through the implementing units and community organization such as integration of FP with health services, nutrition program income generating , agricultural, trade and cooperation education, woman etc.

6. The field worker (PLKB) is a key person in the implementation of the FP program at the "grass roots" level or at the village and subvillage level. Is the present stage of the program the field worker is expected to motivate the people to accept the family planning and to guide the community towards institutionalizing of happy, prosperous small family norms (NKKBS) through community channels.

7. BKKBN is anticipating signifant growth of man power directly in support for the family planning and allied to the program. The anticipated growth in BKKBN salaried staff would increase from 23.000 to 53.000 at the end of PELITA IV with the largest increasing being for the FP field workers. The complementary to

RECOMMENDATION

The Mission recommends :

1. That technical cooperation and the financial assistance through the government of Japan should be directed to the procurement of the necessary equipment for evaluation and monitoring of the family planning program during PELITA IV (Fourth Five Year Development Plan).

2. That the Government of the Japan considers financial assistance to BKKBN during REPELITA IV from 1985/1986 onwards, assistance to build a Biomedical Family Planning Study Centre for studying side effect, complication of contraception and raw material for contraceptive production. The purpose of the centre is to enhance the quality of FP service.

3. That the BKKBN may consider giving priority to the formulation of comprehensive project documents at an early stage in order to substantiate future technological cooperation and financial assistance to the family planning program by the Japanese Government during REPELITA IV and beyond.

II. DEMOGRAPHIC SITUATION AND PROBLEMS

Indonesia is the world's largest archipelago extending between two oceans, Indian and Pasific Ocean. It has a land area of 1,919,443 sq kms (735,354 sq miles) and its 13,677 islands tretch 5152 km (3200 miles) from East to west and 1770 kms (1100 miles) from North to South.

A. POPULATION SIZE.

The 1985 year and population is estimated 165 million. The Government anticipated a population growth rate, between now and the year 2000 of 2% to 1% percent annually, which means that the population will growth to 210 million in 2000.

B. POPULATION GROWTH.

The absolute growth of the population was from about 61 million in 1930 to over 147,5 million in 1980 with intercensal annual growth rates of 1,5 percent to 1961, 21 percent from 1961-1971 and 2,32 percent from 1971-1980.
The most recent increase problem, despite the successful implementation of the national Family Planning program, is caused by a substantial increase in the proportion of young

married couples in combination with a decrease of mortality rates. The population growth rate 1980-1984 is estimated 2 percent and job opportunities can hardly keep face with such growth, much less improve on social welfare basis.

C. POPULATION DISTRIBUTION.

The distribution of population among the islands in Indonesia varies greatly and difference in density are threetened. The result of the 1980 Population Census showed that 62% of the population live in Java and Madur, whose area is only 7% of the total area, so that population density in Java was about 700 per sq km. The population live in Sumatra 19% with 25% area, 4,5% in Kalimantan with 28% area, 7% in Sulawesi with 10% area and 7,5% in other island with 30% area. The uneven distribution and density of population caused environment disturbance particularly in Java.

D. AGE STRUCTURE.

The 1980 census revealed for the first time a substantial reduction of children age 0 - 14 years, the percentage in 1971 being 44.0 and in 1980 was 40.9, the lowest percentage revealed in D.I. Yogyakarta (35:2), East Java (36.5), DKI Jakarta (39.0) and Central Java (39.7). In West Java the percentage of children age 0 - 14 years (42.2) was above the national level.

E. LABOR FORCE.

Indonesian population have a relatively young age structure, where the largest, proportion of population consist of persons under 20. In 1981 the labor force estimated 58.5 million, and in 1986 projection will increase to 65,4 million, in 1991 to 709 million, in 1996 to 77,5 million and in 2001 to 84,1 million. The need for a rapid increase in work opportunities will be pressing in the future decade.

F. POPULATION QUALITY.

Education and literacy are vehicles both for enhancing the opportunities as well as population quality for achieving and sustaining social welfare objective. Evidence from a number of countries indicates a substantial causal relationship between the level of education and the general economic development.

The pattern of change in education attainment over the intercensal period 1971-1980 for population aged 10 and above revealed that in 1971 about 40 percent of all youths and adults over ten years of age had never attended school; by 1980 the proportion had declined to 28 percent. How ever, most of the gain

among those who completed primary school level. Thus, while substantially greater numbers of children were entering school in 1980, it is apparent that most of them do not remain in the system long enough to complete the full primary course.

Secondary education is still relatively rare in Indonesia; current net enrollment rates are about 65 and 38 percent respectively for junior and senior levels, and only about ten percent of the adult population has completed secondary school.

Academy and university is very rare in Indonesia; in 1971 and 1980 only about 0.3 and 0,5 million respectively or less than 0.5 percent of adult population have completed academics and universities. Most of the scholar work in public sectors, only a few them work for research and development, so that there is the constraint for technological delelopment and modern industrialization.

III. THE INDONESIAN NATIONAL FAMILY PLANNING PROGRAM

A. HISTORY OF FP PROGRAM

The first government if Indonesia following independence had a pro-natalist population at that time (approximately 70 Million) and its geographic expanse, political, and foreign policy goals, demographic expansion was considered essential. However, the concept of family planning began to be disseminated in Indonesia through the Indonesia Planned Parenthood Association (IPPA) in the 1950's. Through a series of clinics which were ostensibly offering maternal child health services, family planning information and services were made available. Consequently, from its inception family planning was integrated with health services, in this case MCH. Because of the prevailing political climate, however, services were only selectively available, and resupply was at times unreliable.

In 1967 IPPA sought to obtain political support and commitment for its expanding family planning effort from the New Order Government under President Soeharto. The IPPA Congress of 1967 reported that based upon feedback it had received the concept of family planning was now well accepted by the people of Indonesia, and issued a recomendation to the Government to investigate the possibilities of organizing a national family planning program. The IPPA conference and resultant recommendations were timely in that they coincided with President Soeharto's signing, along with 29 other heads of state in 1967, the World Leaderss Declaration on Population where the president pledged his political commitment to Indonesia's then fledgling family planning program. As a result, a blue ribbon investigative commission was formed by the Minister for Social Welfare in 1968 to assess the potetial of elevating IPPA's family planning activities to become a national program with full government support. The commissions mandate : to establish an institute or government body that could develop a national family planning program that would allow the people to realize their fertility reguation aspiration; and which would coordinate all type of inputs and assistance to the national program.

That mandate was realized on October 18, 1968 with the formation of the National Institute for Family Planning (LKBN). The LKBN continued IPPA's work of making family planning information and service better available to the people. As a semi government agency LKBN was able to utilize existing government service delivery channels more effectively, especially through the government hospital and clinic network.

However, as a semi-government institute influence to adequately coordinate the FP program, and was only envisioned by the blue ribbon population commission as an interim body. Base on experience gained between 1968 and 1970, plans were

being made to strengthen this institute administrative period goals and objectives of the national FP program were also being more clearly delineated.
The social welfare goal meant that the family planning program was viewed as more than just contraceptive service delivery. Hence, it should be integrated with more than just the Department of Health's program, and extend to program in other governmental departments, such as the Department of Agriculture, Religion, Information, Transmigration etc. Organizationaly, it was decided that a non-departmental or non- ministerial level body responsible directly to the president should be established to coordinate the program. The result was the formation of BKKBN in 1970 until now to coordinate the implementation of a family planning program whose activities would be integrated into the activites of existing governmental, non-governmental, and community program.

B. THE FAMILY PLANNING OBJECTIVES

Various state have set up diverse goals or objectives of family planning, such as health objective, human right objectives, population control and development objectives.

In Indonesia, the Guidelines of State Policy (GBHN) adopted by the People's Consultative Assembly (MPR) in March 1983 emphasized the goals and objective of the family planning is as follows:

"The national family planning program has a twin objectives, namely, to promote mother and child welfare and to realize the happy and prosperous small family norm, thereby, laying the ground work for attaining a prosperous society through fertility control and population growth control.

So that the goals objectives of FP in Indonesia concerns with the health objectives, population control, fertility control and development objectives to attain a prorperous society.

The objective of FP can further be specified as follows.

a. Controlling fertility to the extent that the rate (Crude Birth Rate-CBR) further down from 44 in 1971 per thousand to 22 per thousand in 1990.

b. Increasing the number of active FP acceptors or current users by heightening society's sense of resposibility, sense of commitment and willing ness to voluntarily participate in the program, in performing this effort proper consideration should be given to religious and cultural value.

c. Intensifying effort to improve mother and child welfare, increase life expectancy, bringdown mortality rate of children under five and induce a decline in maternal mortality rate.

d. Increasing society's level of awareness of the population problems which lead to acceptance and practice of the happy and prosperous small family norm.

e. Increasing active involvement of woman and young generation in the organization, management and implementation of the national family planning program.

C. POLICY AND STRATEGY

The National Family Planning Program has a program strategy which forms the basis for developing activities in the field. It deals with the national family planning program as an integral part of the national development program, political commitment, participation of the community, BKKBN's function as a coordinating body, and the decentralization of management.

1. The National Family Planning Program as an Integral Part of National Development Program.

National development is in essence the development of the Indonesian persons in his entirety and the development of the Indonesian community. The development of the Indonesian community as a whole include all aspects of the life of the population, materially as well as spiritually. Development in the material and spiritual sector is the joint responsibility of the government and the community. The way that these two sectors cooperate in the context of the National Family Planning Program to work toward a prosperous society is shown in Figure 1.

Development efforts, which at first emphasized the material aspect, especially in the economic sector, have been extended to include spiritual aspect, and in the social sector the aspect of the national and family planning is included.

The National Family Planning Program, which is one of Indonesia's development program, has become an integral part of the development of an individual in his entirety. Consequently, the success of this program will have a positive influence on the other aspects of development and vice versa. There fore, in carrying out the national family planning program we must involve the whole community, including government agencies as well as other institutions of the community in order to guarantee the success the program.

2. Participation of The Community

In executing the national family planning program, the government is fully aware of the fact that it's not easy to get people to accept the program. Bearing this in mind, the government since the New Order are has taken steps to have the community participate from the very beginning, and make them conscious

of the urgency of carrying out the national family planning program. Therefore,the initiative taken by the government should be continued until such a time when the national family planning program and its problem have become entirely the responsibility of the community itself.

The transfer of responsibility of the national family planning program into the hands of the community itself must be exercised as soon as possible, because it constitutes a factor which is very decisive in realizing the aim of the national family planning program; namely the creation of happy and prosperious small families. The tranfer of responsibility of the community starts with the participation of the community in forming acceptors groups or clubs with various names, such as "PPKBD", "SKB", "Apsari", "Ibu Halimah", etc. The existence of these acceptors groups indicates that the executian of the program has started to be performed by community itself at the level of the desa (Village) or dukuh (sub village).

It is necessary to continue this transfer of responsibility via groups or clubs as previously described so that it does not stop at a particular group or club, but rather it is extended as far as the smallest unit if the community (families); so that individuals themselves will be able to meet their own needs, such as in buying contraceptives. Throughout the transferal process the government assumes the role of a guardian protector.

3. Functional Coordinator

In soliciting community participation, functional coordination is necessary to direct the program's allocation of funds and facilitties. The execution of the national family planning program needs a coordinating body, aimed at organizing all kinds of disciplines and resources, which have a mutual interest in over coming population problems.

BKKBN's role as a coordinating agency is a functional one, in that each government agency or community institution involved in executing programs dealing with family planning, performs them in accordance with its function and capacity under BKKBN coordination.

Every executing unit, or executor, beginning with the central level down to the district and willage level, performs the operations agreed upon with technical operational guidance by the local BKKBN and directives from

regional management. Furthermore, in carrying out its coordinating task, the BKKBN has the performance of the population and family planning program.

4. Decentralization of Management

In carrying out the national family planning program at the Province, Redency/Municipality (Kabupaten/Kotamdya), and district (kecamatan) levels, the BKKBN is given authority to design methods of promoting family planning in accordance with local situations and conditions while still following the general guidelines and regulations that have been approved nationally. This is necessary, bearing in mind situational and cultural characteristics which need to be recognized in carrying out the population and family planning program of each region. Each province, Regency/Municipality, and District is encouraged to propose activities and projects which are in accordance with local conditions. This decentralization of management has encouraged every program executor in the BKKBN to create innovative ideas which will improve conditions in their regions and by developing all kinds of activities, the success of family planning has been very heartening. We can also observe the developmet of leadership skills and individual talents as efforts are made to achieve the targets nationally agreed upon at the annual RAKERNAS (National Conferene) of the national family planning program.

5. Priorities of Program Execution

The execution of family planning programs is based upon certain priorities, especially those connected with the size of the population, density of the population, readiness of institutions, complete preparedness of the community, and appropriate use of limited resources (funds and facilities). Based on these matters, the following phased operational regions :

- Java Bali : The Jaava-Bali region covers the province of Jakarta, West Java, Central Java, Yogyakarta, East Java and Bali. The Java-Bali region was the first area (beginning in 1970), where the national family planning program was intensively executed.

- Outer Islands I : The Outer Islands I region covers the following provinces : Aceh, North Sumatera, West Sumatera, South Sumatera, Lampung, West Kalimantan, South Kalimantan, South Sulawesi, North Sulawesi and West Nusa Tenggara.
The Outer Islands I program joined the national program in 1974 under the Pelita III.

- Outer Islands II : The region of Outer Island consists of eleven province : Riau, Jambi, Central Kalimantan, East Kalimantan, Bengkulu, South East Sulawesi, Central Sulawesi, Maluku, East Nusa Tenggara, Irian Jaya and Timor Timur. The region joined the program in 1979, starting with the Pelita III program.

The regions for meeting the priorities is executing the program will be changed in the comming years, and whill be based on program achievement rather than geographical areas. Program achievement consists of the following five phase areas.

Phase I Area : This refers to area where the number of active acceptors is less than 15% of PUS (Pasangan Usia Subur = Eligible couple). The emphasis of activities will be to recruit new family planning acceptors.

Phase II Area : This refers to areas where aaactive acceptors comprise 15% - 35% of the existing PUS. There areas will focus their activities on maintaining, building up and guiding family planning acceptors. At this stage, dynamic activities within communities are starting to arise, such as the establishment of family planning post and damily planning clubs.

Phase III Area : These are areas where active family planning acceptors are 35 - 55% of the existing PUS. Such areas have acceptors groups in the village, and show other indications of performing a more important role in managing the program. In these situations, dynamic efforts of the community that lead toward fulfilling family can be seen. Often, acceptor groups are well developed and the emphasis of activities is on institutionalization.

Phase IV Area : Area where 55 - 75% of eligible couple are practising FP. These areas are considerably advance and other beyond family planning program can be introduced to improve the quality of life.

Phase V Area : Area where greater than 75% of eligible couples pratise family planning. These areas are ready to assume full responsibility for the FP program.

6. "Panca Karya", a Strategy for Program Intensification.

In line with program implementation intensification in response to the challenges of the 1980's, a strategy was developed at the 1982 National Conference called "Panca Karya". The five subjects mentioned in the "Panca Karya" (five worktarget) are as follows :

- Woman under the age of 30, or with less than two children should plan a maximum of two children. First births should be delayed to age 20 by postponing marriage and birth planning.

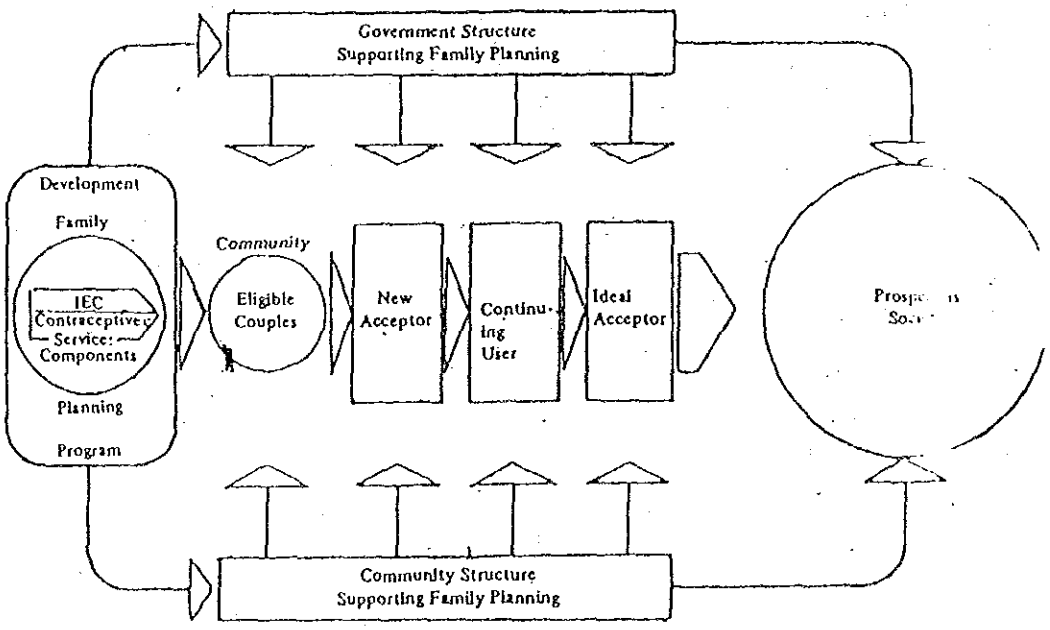
- Woman over age 30, and those with three or more children should plan no additional children and should be offered the best means of fertility regulation.

- An increased emphasis on youth, to encourage teenagers to postpone marriage and first pregnancy by creating activities which deemphasize marriage and children as the only means of providing recognition and personal security, is needed, along with better programs of health and nutrition for children, especially those under 5 years of age. It is hoped that future generations will adopt a new way of life that focuses on education, and access to greater livelihood opportunities.

- In areas with higher rates of contraceptive use, education, basic health service, and income generating activities are needed to help physically institutionalize the social benefits of family planning which allow woman to participate more fully as productive community members. These social benefits will lead to favorable economic events which eventually should become culturallylinked to practising family planning.

- Institutionalize and internalize family planning as an accepted community norm by assisting communities in assuming moral responsibility for the care of the aged, a responsibility which normally necessitates a couple's reliance on many children.

System Approach of the National Family Planning Program



D. ORGANIZATION AND STRUCTURE

The National Family Planning Co-ordination Board has been structured and organized to reach the goals, objectives and targets as set forward above. A basic principle has been to channel a vertical programme efficiently to village and household level and to have this programme reinforced and supported at all level of administration by all sections of the Government. Thus the function of a National Co-ordination Board is to assist in ensuring (as much as possible) "horizontal integration" among sectors at all level would be successfuly introduced at the house hold level to sustain private and voluntary decisions to reduce fertility.

Given this background and the continued political support for a successful family planning programme the BKKBN has establised through close colloboration with the civil administration a village field worker and logistical apparatus which allows information and contraceptive support reach the village and household level efficiently and uninterruptedly. This apparatus also allows and encourages cross-sectoral linkages for example in health, religion, education and agriculture. Since this network has been based on "two-way" communication information and co-ordination with the village level field work provides essential ingredients to the well established planning and monitoring activities for the Family Planning Programme.

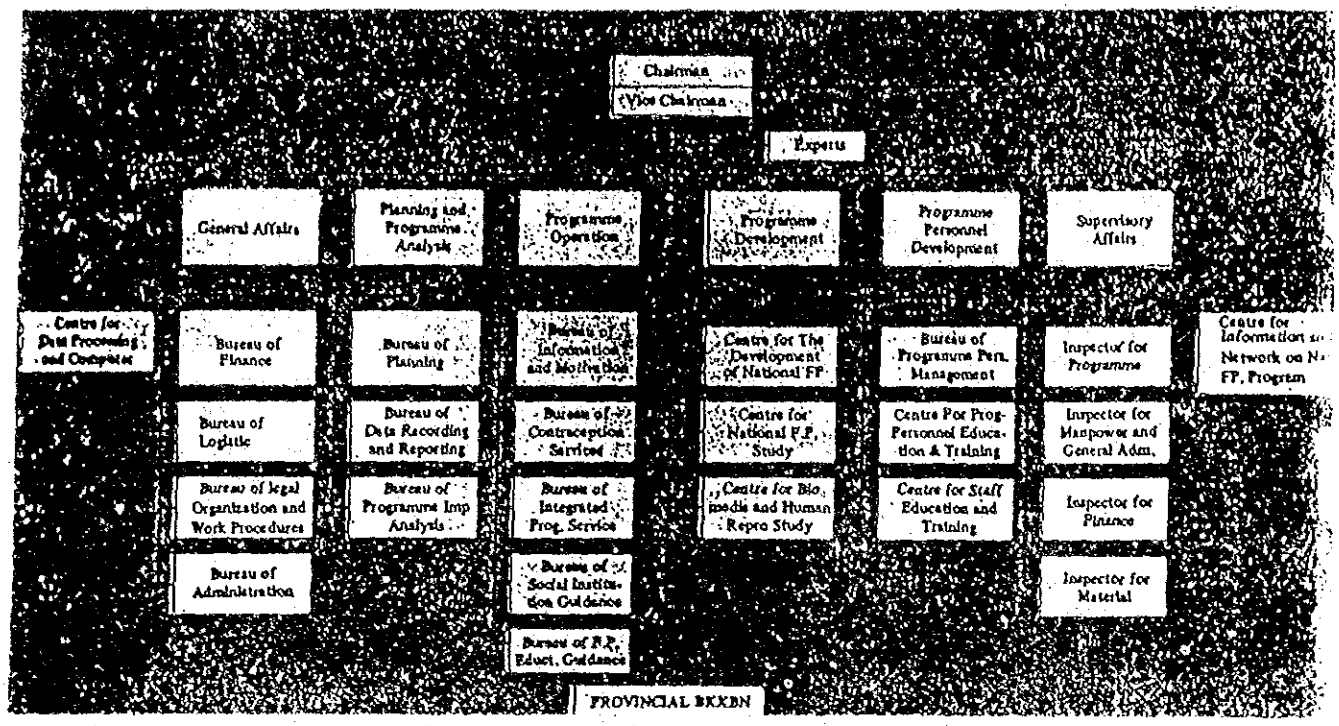
As the Family Planning Program expands and intensifies to reach the challanging targets for Repelita IV care will be taken to ensure that appropriate modification in the structure and organization of BKKBN and its linkages to other Ministries and sectors will be, and lead to efficient and effective results.

Since the organization and structure of BKKBN is a component in a set of pre-conditions to facilitate the country to reach reduced fertility rate it may be essential to monitor the following main features.

First ,support should be given to provincial, regency and field level consistent with the racent re-organization of the central level of BKKBN with conscious attention to reducing the "bureaucratic aspect" of strengthened organization. Strengthening of key managerial issues (discusses below) will be needed.

Second , attention will have to focus on the amount levels of functions a BKKBN field worker can be expected to perform, including cross-sectoral support

to technical fields. Of particular concern will be the increasingly joint functional work in the health and agricultural sectors. To these ends the amount and level of technical material which may be introduced through the family planning programme must be carefully considered and within the skill level of the BKKBN field worker.



E. IEC ACTIVITIES

The Information, Education and Communication (IEC) activities aim to encourage the public to understand and follow the family planning program. The indicated purpose is family and community welfare through the acceptance of the small, happy and properous family norm. The approaches taken in the last decade include mass information group meetings, and individual face-to-face communication.

IEC activities follow three different froms, all of which are "target oriented". Those directed to the masses use the mass media, with the community at large as its target. Those aimed at the group level involve meeting with pre-selected targets. The third form is face-to-face eccounters, where field workers, family planning motivators, and village contraception distribution center personnel (valunteers) "PPKBD" go from door to door to contact individuals.

Mass-media channels includer radio and television, film, newspaper, family planning information mobile units (Mupen KB), traditional media (through folk art), and publications. The RRI (Radio Republik Indonesia) reserves time for radio and television broadcasts on population and family planning through special integrated program such as newsreels puppet and three dimensional puppet plays, and broadcasts depicting village life.

The information mobile units show films to villagers on the way to happy and prosperous families. These films are effective in conveying information and providing motivation.

Newspaper play an important role in opinion formation by disseminating information to the general public through articles based on press conferences, on the spot observations, andpress broadcasts Family Planning mobile units were used for IEC activities at the beginning of Pelita II in order to bridge the gaps between mass, group, and face to face encounters. They were also strengthening the communication of field activities. These activities which are informative and entertaining in character are especially used to reach the community in remote rural areas. Various types of group activities such as seminars and orientation weeks are also carried out in order to reach community leaders and special target audiences. Other efforts seek to motivate certain groups in the community that need special attention, such as religious groups and minority communities. Finally, there is the more intimate and private approach of face-to-face meetings through door to door family visits, and visits with community leaders in the village. This face-to-face approach is also meant to stimulate the formation of local acceptor groups.

F. CONTRACEPTIVE SERVICE.

Contraceptive service are meant to help establish new family planning behaviour by upgrading the quality of services, by increasing the number of contraceptive methods available, and by enlarging the number of services sites in both clnical and nonclinical settings, all with simple procedures and effektive, inexpensive contraceptive devices. This model is pursued by offering contraceptive services at multiple sites : through (a) clinical services in hospitals, family planning clinics, Mobile Family Planning Teams (TKBK); and (b) non-clinical services by family planning field-workers, private doctors, private midwives, PPKBD (Village Contraceptive Distribution Centers) and commercial channels.

From the very beginning of the program contraceptive services were provided in large part through clinics. With the rapid development of the program, the number of clinics also increased. At the present time, there are 7,064 family planning clinics spread throughout Indonesia, in particular throughout Java and Bali. These are operated by the Development of Health, the Armed Forces Implementing Units, other government institutuins, or private organization. The contraceptive devides available are the pill, IUD, condom, injection and other methods; these are of fered by clinic personnel including doctors, midwives, and auxiliary midwives.

Since the availability of clinics is still limited, mobile Family Planning Tams (TKBK) are organized consisting of doctors on midwives and fieldworkers. These teams visit areas that are remote from family planning clinics, where they

provide services to users and instruct propective users in the use of contraceptive devices. One team is stationed at a Community Health Centre (Puskesmas) to which a Family Planning clinic is attached. The mobile team work is coordinated with the sub-district information team, the fieldworkers, the "Camat" staff, including village heads, and village organizations. These support the work to gain new family planning acceptors and to offer the best services possible to current users.

Besides the family planning clinics and the mobile teams, contraceptive service are also offered at hospitals. Activities include general information on family planning, individual motivation and guidance, assistance in selecting a contraceptive method - for example, at the postpartum visit - and further care. Different kinds of contraceptive devices are available, but users are encouraged to acceps the most effective ones, namely the IUD, the pill and injections. At some specific places, operations for male or female acceptor are also available as the need arises.

In addition to its function as a place where reliable services are available, the hospital family planning program functions as a refferal and training site. Technical medical research may also be carried out in the framework of developing new contraceptive methods.

G. INTEGRATED FP PROGRAM

Integration is defined as consolidation and linkage of activities from two or more programs that are mutually supportive in reaching a common target group to achieve a similar goal. The dynamic s of integration start by merging activities from different programs in a phased manner, adding on as needed to ultimately provide comprejensive and complete development service as required by the target group. Integrated programs are expected to produce optimal results efficiently and effectively, hence require coordination and synchronization of target groups, location, time and services with the provision of funds. This means integration in all aspect of program planning, implemntation, supervition, motivation, evaluation, and training so that seemingly disparate and diverse sectoral characteristics of each activity will coverge at the community level.

The Indonesia Family Planning Program constitutes an integrated part of the national development strategy with broad objectives to control population growth, promote mother and child selfare, and institute the small, properous, and happy family norm. The broadened mandate of the family planning program extends, the refore, beyond the demographic objectives related to fertility control to promote family welfare and improved quality of life. Such a broadened mandate cannot be achieved single-handedly. Hence, integration is not a strategic policy option for BKKBN, but

an absolute necessity as the government seeks total mobilization of all available resources in pursuing development objectives. The question is not whether to integrate family planning with other development services; or whether to integrate other development services with family planning. The question is, instead, how to integrate these services so as to maximize scarse resources, infrastructure, and manpower in order to achieve optimum results.

As has been noted previously, family planning has been viewed as an integrated health service since its inception, and has been integrated into the existing programs of other development sectors through the family planning program of the implementing units. Once the BKKBN had developed a village besed service delivery infrastructure other service were integrated with that delivery mechanism.

1. Integration of Family Planning and Health Services

Family Planning in this context has always been at integrated service. When the concept of family planning was first being tested by IPPA in the 1950's, it was offered as one of a host maternal/child health services aimed at reducing infant and maternal mortality.

When family planning was first introduced by the LKBN in 1968 it was offered as an integrated health service through existing government health centres. And when family planning service were first disseminated widely in a phased implementation manner throughout the provinces of Java-Bali, Outer Island I, and Outer Islands II, it was offered as an integrated health service through existing government health centers.

The rationale and logic behind this first phase of integrated service delivery is simple. The hallmark of the Ministry of Health's service delivery strategy since the First Five Year Development Plan has been the establishment of hospital s at the rengency level and health centers at the district level to serveas service delivery points for medical and public health service. These clinics are all staffed by physicians, midwives, nurses, and other trained medical and public health workers. All had exixting maternal child health program aimed at reducing maternal and infant mortality. Referring back to the definition of integrated services i.e the consolidation and linkage of activites from two programs that are mutually supprotive in reaching a common target to achieve a similar goal, amore natural union for integrated service delivery could not be found. The clinical infrastructure already existed, trained manpower were available and in place; the only massing element was logistical supply of contraceptives and reated informaion.

However, in an effort to bring family planning services closer to the people, BKKBN extended its service delivery

infrastructuredown to the village level through its community based family planning service program. Now BKKBN possessed a service delivery infrastructure that extended from the Health Center to 60,000 villages in the country. BKKBN had the manpower at the village level consisting of village Contraceptive DistributionCenters (VCDC) in each village staffed by volunteers and managed by village organized accpetor groups. BKKBN fieldworkers, one for every three villages, supervised the VCDC and provided the critical linkage between the VCDC and the district health centr. Possessing limited service outreach at the village level, te Department of Health was eager to utilize BKKBN' village family planning program infrastructure. The result was the Integrated Family Planning Nutrition Program.

2. Integrated Family Planning Nutrition Program

In accordance with BKKBN's expanded mandate for promoting maternal-child welfare, nutrition service were integrated with community based family planning program in 1978 in the provinces of Java and Bali where contraceptive prevalence has surpassed 35%. The trial of malnutrition, diarrhea, and infectious disease synergistically weakens children in the 0 - 5 age group leaving them susceptible to opportunistic infections that can result in severe morbidity and mortality. The rationale behind this program is monthly community based nuttritional surveillance of under 5 children, a health education program based on results of weighing, diarrheal disese control using oral rehydration, provision of vitamin A to children less than 5 years of age, ferrous sulfare for pregnant and lactating women, and supplementary feeding. The program is community based : Nutrition caders, mst of whom are drawn from village acceptor groups, are trained to weigh children and deliver health education messages.

Family Planning fieldworkers assist with cader training, supervise and resupply weighing posts, and provide vital linkages between village weighing post and district level health centres for referral and reporting.

3. Integrated Program for the Small, Prosperous, and Happy Family.

The Integrated Family Planning Nutrition Program has been in operation fox six years, has reached all six provinces of Java and Bali, and 10 provinces in Outer Islands I. By 1984 the program was operating in 22,249 villages with BKKBN support. In Maret 1984, agreement was reached between BKKBN and the Department of Health to incorporate additional program elements into the integrated Nutrition Family Planning program which would

have greater impact upon maternal/child health and family welfare. This new program, which is being pilot terted East Java Province, is called the Integrated Project for the Small, Properous, and happy family. They new program elements, all of which are totally integrated into exixting community based nutrition family planning program are :

- Immunization of children under 5 years of age with BCG, DPT, Polio, and measles; and immunization of pregnant woman with tetanus toxoid vaccine.

- Maternal and Child Health : pre-natal care to identify and follow-up high risk pregnancies, complete tetanus immunization coverage for woman of reproductive age, extension of delivery care by trained personnel for high risk pregnancies, and quartely visits for lactating women.

- Management of Diarrhea : promoting home based ORS and oralyte solutions in accordance with MOH guidlines.

- Income Generating : village credit funds and income generating schemes introduced through village weighing posts and local contraceptive acceptor groups. Capital in the form of low interest loans is made available to villages for investmentin income generating schemes. Small loans are also made to mothers bringing children to the village weighing post. The village credit fund constitutes a source of community income obtained from a portion of interest payments which is used for further promotion and expansion of villages level nutrition activities.

- Pancasila : all training programs related to this project have a Pancasila component integrated within their format.

Pancasila, the unifying national philosophy, is considered essential for developing the Indonesia person in his entirety, and the vehicle created by this project is used for deepening and intensifying the Pancasila spirit.

All of the health services in this program are provided by MOH personnel. Using community based distribution infrastructure as its vehicle for reaching the community, this project has carried the concept of integrated health-family planning service to the greatest extent. Results of this program are being closely monitored and assessed by both BKKBN and the MOH to ascertain its potential for further replication. The income generating component is very attrative because of its potential for directly increasing family income and a way to make an integrated program selfsupporting.

In the sense that family planning services have been

integrated into the operational program of other development sectors, family planning/developemtn services have always been integrated in Indonesia. This section will look instead at the development program which have been integrated into family planning programs. The objective of these program are to improve family welfare and quality of life.

4. Family Planning-Income Generating Program

As already discussed in the section on integrated health family planning program, the income generating program is offered through the family planning acceptor groups. BKKBN trains its fieldworkers, staff from related implementing units, and leaders from acceptor groups concerning the fund/loan machanism, interest and principal collection, and financial reporting. Loans are prioritized for FP acceptors and are made by the acceptor groups. The program is viewed as mutually supportive of family planning and income for village FP/Nutrition and health activities which can be used for eventual financial independence of those programs from Government support.

5. Integrated Family Planning-Agriculture-Cooperatives Program

These program have traditionally been implemented individually. Use of resources and achievement of objectives could be maximized through an integrated approach since all program have similar target in rural agrarian families. Accordingly, FP fieldworkers have been trained in rural credit and cooperative schemes related to more efficient production, storage and marketing of agricultural produce, in hopes that this knowledge will be conveyed to FP acceptors and mothers of children being brought to the weighing post. A field manual has already been produced jointly by BKKBN and Department of Agriculture for this purpose, and it is envisioned that the efforts of family planning fieldworkers will complement similar efforts by fieldworkers from both the Department of Agricultural and Cooperatives.

6. Coconut Hybrids Seedlings.

These seedling are being made available to all family planning acceptor in East Java on a trial basis in association with the Integrated Project for a Small, Prosperous, and Happy Family. The coconut seedlings have been made available directly at the behest of the President of Indonesia. Its purpose is to encourage continued family planning acceptance and provide a

resource to family planning acceptors that can be used for income generating and a supplementary nutrional supply. BKKBN, through its community based network in tandem with the Department of Agricultural and Department of Internal Affairs, organized education and training regarding management and care of the coconut seed;ings, chooses the family planning acceptors who will participate (family planning acceptors must be practicing for at least 5 years to be able to participate in the program) monitors distribution, and reports on their utilization by family planning acceptors. Evalation is jointly conducted by the responsible implementing agencies, and in addition to assessing utilization of the coconut seedling, also sppraises intersectoral collaboration at each administrative level. Until now, more than 300,000 seedling have ben distributed through this project.

7. Scholarships for Children of Family Planning Acceptors.

This activity is aimed towards improving livelihood opportunities and quality of life for family planning acceptors while simultaneously encouraging continued family planning acceptance.Scholarships are available or children of persons who have been continuously practicing family planning for 10 years or more. Scholarships are prioritized for family planning acceptors from lower socio-economic backgrounds whose children display exceptional natural talent, diligence and intelligence. The scholarships are aimed at enabling these children to complete their high school educations who under circumstnaces would be unable to achieve that level of educational attainment.

8. Program for Improving the Status of Woman.

This program is an intersectoral effort and a component of program in many governmental departments. Within the context of BKKBN's program, woman are encouraged to improve their educational status, economic status, intrinsic skills, and their contribution to their family's welfare through additional skills training informal education, and capital availability.

H. POPULATION AND FAMILY PLANNING EDUCATION

The objective of those activities are to increase awareness of the young generation toward population problem in relation in accepting the concept of happy, prosperous small family norms.

Various indicators of fertility were shown to be associated with community education, particularly the women's education. Education, by providing basic functional literacy and numaracy, enhances women's status within and outside their immediate family and increases their exposure to the information and ideas disseminated through the mass media and printed material which brings changes in their behaviour including breastfeeding, use of contraception, and fertility.

Advancont in education increases woman's changes to participate in labor force, which in turn create role incomptability and down ward pressure on fertility. Thus, fertility effects of population and Family Planning education would be transmitted through their effects on education attainment of children. This fertility effect, for girls who become eligible to enter school system in 1980, would be realized during 1990 - 2020 when these girls would pass through their reproductive period (15-45 years).

I. TRAINING AND EDUCATION

Iin order to ensure the smooth running and improvement of the national program, skilled manpower for management and field work is needed within the BKKBN itself, as well as within the "implementation units". Upgrading of staff knowledge and skill is carried out through both short and long-term training Basic and refresher courses are attended by service field officials, by IEC officials; by field workers dealing with logistics, reporting and recording; and by evaluation officials, among other. This training is offered at the BKKBN Education dan Training Centers and also at training centers operated by the Department of Health and PKBI. The training covers, in part, work in the field of management, research, demography, IEC, population education, community health, and development sociology.

All training activities are aimed at improving the quality of the program personnel. A few fellowship conducted in abroad.

J. EVALUATION AND MONITORING

The objective of monitoring and evaluation are to provide data on program implemention and result quickly, regularly and reliably. These data and information as the basic for decision making by program managers at the central as well as local level for planning, supervision, control and evaluation of the program.

The activities of evaluation and monitoring consist mainly of data collection, tabulation, abalysis, presentation and

feed back.

Data collection used in evaluation and monitoring process are obtained from the following sources :

a. Routine statistics
b. Observation and supervision reports
c. Survey and census results
d. Vital regristration data.

Tabulation and processing of data at subdistrict, regency, munipality and province levels is carried out by manual, while the majority of the reports received by the Central National of fice are processed by using computers.

The method of analysis being used should be appropriate in terms of purpose of analysis, availability of data and information, and object and scope of aspect being evaluated.

Toward such an analysis, use of the following method are implemented :

a. Simple methods of analysis such as ratios, percentage and trend analysis, this letter needed to get the overview of the direction of the achievement and development of thc Family Planning Program.
b. Simulation method to provide of the overview of the program scenario and then compare it with the actual situation on the field.
c. Multivariate analysis to detect possible association and causal relationship between variables.

The data have been processed, analysis and presented in various forms, are treated through a feedback mechanism, which means every data have been processed sends feedback reports to the reporters and program officials as weel as the implementing units and other interest parties.

K. RESEARCH AND DEVELOPMENT

The need for new information that can be used to initiate and develop program is addressed through research by institutes, universities, hospitals, and other organization. Studies under taken during the 1970's include operational research, basic research, and biomedical investigation, as well as the testing of new approaches through pilot projects.

Operational studies, the results of which can be applied directly in the family planning program, have covered contraception continuation rates, the work patterns of field workers and mobile teams, and the need for recording and reporting.

To obtain basic information that can be used as a foundation for longer range planning, research is carried out

on such topics as knowledge, attitudes, and practice of family planning (KAP).

Developmental projects seek to try out new approaches to program implementation. Such approaches include village family planning and integrated family planning - nutrition of family planning - health care projects.

Biomedical research has investigated the influence of contraception on hormones, and has undertaken experiments with different kinds of IUD's, various brands of the pill, and various injection mathods. This research seeks to obtain valuable infomration about the merits and side effects of contraceptive methods.

The monthly progress of the family planning program is monitored through the recording and reporting system. This is an effort to make simple data available in a speedy and precise way, as a reliable source for decision making by program officials at all levels. In addition, these data are needed for future program planning. This process of recording and reporting is performed every month, and is initiated at the lowest levels with the smallest family planning sites. Topic covered includ number of acceptors and current users by ,ethod and such informational activities as group talks, mobile unit activities and personal home visits.

Supervision and control constitutes a key management task, so that program field aims can be obtained. These aims are organized within the categories of manpower, material, and finances.

L. PROGRAM'S RESULT

Program implementation results that have been achieved so far are as follows. The results are expressed in terms of new FP acceptors, contraceptive continuation rate, current (active) users, CYP and YEP.

1. Number of New Acceptors

Satisfactory results have been obtained by the program in recruiting new acceptors. This is revealed in the increasing number of new acceptors joining the program each year. A total of 1.4 million new acceptor have been recruited during the last year of Pelita I (1973/74). The number of new acceptor became increasingly greater, namely, 2.2 million in the last year of Pelita II (1978/79) and 5.2 million in the last year of Pelita III (1983/84). The number showed that performance in Pelita III was more than twice as better as that in Pelita II. The yearly numbers of new acceptors are listed in Appendix 4 and 5.

Except in the year of the program and in 1971/72 and 1979/80, no major problems have been encountered in achieving the yearly new acceptor targets. Target achievement, in 1971/72 and 1979/80 were around 95 percent. A total of 17.4 million new acceptors have been recruited during Pelita III (1979/1980 - 1983/1984), which was 118.5 percent of the 14.6 million target.

2. New Acceptor Characteristics

Encouraging program results in term of new acceptor are not only reflected quantitatively in their increasing number joining the program each year, but also qualitatively in the trend toward younger and lower parity (number of living children) acceptors. The media age of new acceptors in Java - Bali stood at 29.5 in 1971/72 and went down to 25.03 in 1982/83. For outer islands I the median age figures were 30.18 in 1974/75 and 26.79 in 1982/83. Such a substantial drop in median age definitely works in favor of the effort to bring down fertility. Parity or the number of living children of new acceptors is also on the decline. The Java-Bali median parity was 3.8 in 1971/72 and went down to 2.65 in 1982/83. For Outher Islands I the median parity figures were 4,2 in 1974/75 and 3.1 in 1983/84. A graph showing the development over time in media age and median parity of new acceptors in Java-Bali, particularly those using the pill, IUD, and condom, is presented in Appendix 6.

3. Contraceptive Continuation Rate

To what extent acceptors have been maintained, sustained and reinforced in their motivation can be evaluated by studying the continuation rate (of contraceptive use) data. Results of a modular research held in 1982 revealed satisfactory continuation rates. Continuation rates in Java-Bali (after 12 months of use) were 80.0 percent for the pill, 90,42 percents for IUD and 64.70 percent for the condom. When compared with results of a similar study held in 1976, the 1982 continuation rate figures indicate substantial improvement in contraceptive use. According to the 1976 study, continuation rates after 12 months of use were 64,2 percent for the pill, 89,9 percent for the IUD and 55.8 percent for the condom.

The 1982 study further disclosed continuation rate figures in the Outher Islands that were about the some as those in Java-Bali. It is a apparent from the data in those two studies that the IUD has a higher continuation rate than the pill or the condom.

4. Current Users

As another quantitative measure indicating the quality of acceptance (this latter being, in large part, the result of maintenance, sustainment and reinforcement of motivation by FP workers or the surrounding community) is the number of current users (active users) or the percentage of current users from the number of ELCOs. A substantially increasing number of current users each year may be taken to indicate adequacy of FP acceptance. Service statistics data showed a total 1.7 million current users or 11.11 percent of ELCOs at end of Pelita I (1973/74) The program at the time covered only Java-Bali. Outer Island I become included in the program at the begining of Pelita II and the number of current users went up to 5.5 million or 30.69 percent of ELCOs at the end of this second five year plan (1978/79). The number went further up to 14.4 million or 58.79 percent of ELCOs at the end of Pelita III in March 1984 (the program covered Java-Bali, Outer Islands I and Outer Isands II). The year by year growth in number of current users is presented in Appendix 7 and also in Appendix 8. (See also Appendix 7 a to get an idea of CU percentage from number of ELCO by province). A total of 9.5 million current users was originally planned and set as target for attain ment by the end of Pelita III. This target had later been revised and increased to 12.7 million in the light of the ten year program acceleration. The status of achieveent in current user at the end of Pelita III (on March 31, 1984) was thus 113 percent of this revised target for 151 percent of the original curret user target as written in he Master Book on the Third Five Year Plan). Extraordinary achievements in current users accred in 1982/83 (an increase from 39.13 percent to 48.05 prcet of ELCOs) and in 1983/84 (an increase from 48.05 percent to 58.79 percent of ELCOs). This jump in the number of current users is accounted for by the intensive "FP Safari" campaign in those two years. The contraceptive mix of current users at the end of Pelita III (on March 31, 1984) was : IUD 27.03 percent, PIll 55.35 percent, Condom 4.91 percent, Injectable 9.62 percent and others 3.08 percent. Those figures showed predominance of pill use and relatively little interest in the IUD. The trend toward IUD use is, however, very encouraging. The yearly now acceptor data, especially that in year 1982/83 and 1983/84, showed substantially increasing IUD acceptance, resulting in a sharp percentage increase in the contraceptive mix of new acceptors in favor of the IUD (see graph in Appndix 9) Consequently, the number, of IUD current users was also increasing sharply. Time and consstent efforts to boost IUD accetance, however, are needed for this increase in absolute numbers to reflect itself in a notable percentage

increse in IUD use amog crrent usrs (se graph Appending 10). The increase in IUD use has to proceed at a much faster rate than the increase in use of other methods if a changein the proportion of IUD users among current users is expected to show up. The achievement of 27.03 percent IUD current users at the end of Pelita III was still below the 31.7 percent target that had been set.

5. Couple Years of Protection (CYP) and Years of Effective Protection (YEP)

For the purpose of judging the effectiveness of contraceptive use in the prevention of births, the Current Users data istranslated into Couple Years of Protection (CYP) and Years of Effective Protection (YEP). To take Pelita I as an example, the current users (CU) data at the end of Pelita I (1973/74) which was 1,680,665 could be translated into a CYP of 1,408,100 and YEP of 1,168,723 (YEP = 83 percent of CYP). The effectiveness of protection in the year 1973/74 was thus 69.5 percent (YEP divided by CU). In the same way, the effectiveness of protection at the end of Pelita II in the year 1978/79 could be obtained. With a CU of 5,541,517 at the end of Pelita II (1978/79), a CYP of 4,752,086 and a YEP of 3,944,231 (YEP = 38 percent of CYP) was produced, resulting in an effectiveness of protection of 71,2 percent (YEP/CU).

Effectiveness of protection at the end of Pelita II in the year 1983/84 could be obtained in the some way resulting in the 71.6 percent figure. The computation had been done on the basis of the status in March 1984 with a CU of 14.422.551 a CYP of 12,445,364 and a YEP of 10,329,652. This was quite an increase when compared with the data at the of Pelita II. The above data suggest a tendency of this effectiveness of protection (against pregnancy) to improve over time (from 69,5 percent at the end of Pelita I, to 71.2 percent at the end of Pelita II and further up to 71,6 percent at the end of Pelita III). The development over time of ELCOs, CU, CYP and YEP are presented in the table in appendix 8.

M. PROGRAM INPUTS AND ESTIMATE OF RESOURCES IN PELITA IV

1. Program Input in Three Five Year Development Program (Pelita I - III)

The total amount of the resources channeled through BKKBN, amounted to about $ 649 million, of which Government of Indonesia (GOI) resources amounted to about 58 percent throughout the period PELITA I - III 91969/70 - 1983/84) with the remaining 42 percent coming through

donors.

In both "real" magnitude and percentage terms the GOI has demonstrated high levels of resource support in the National Family Planning Program. Further since a substantial proportion of the foreign assistance were in fact loans, the GOI will have paid directly for over 90 percent of the Family Planning program.

The main donors ti national Family Planning program prior to PELITA IV are USAID Population Program Assistance, World Bank Population Projects, United Nations Fund for Population Activities.

2. The Target in Pelita IV.

The aim of the National Family Planning program is to achieve the happy and prosperous small family planning norms. The demographic target is to reduce the 1971 crude birth rate of 44 perthousand population to accellarate declining to 22 in 1990. The recent CBR is about 32.

The specific program targets in Pelita IV (1984/85 - 1988/89) are to recruit about 22 million of new acceptor, so that can be sustained about 17,3 million of current users or about 65% of eligible couples at the end of PELITA IV.

To achieve those target and objective, the main activities directed to strengthening and developing the contraceptive service, IEC, manpower development and training, logistics, research and development, monitoring and evaluation and other supportive activities.

In case of contraceptive services, the Family Planning clinics at the end of PELITA III 1983/84 were 7064, it would be increased to 10.000 at the of PELITA IV 1988/89.

The Hospital Family Planning service would be increased from 465 to 685. The village contraceptive distribution centers (VCDC) would be increased from 57.440 to 66.000, and Sub-VCDC from 126.900 to about 200.000.

The strengthening of IEC is to replace the 115 mobil units and to expand the facilities for media production centres and publication.

BKKBN is anticipating significant growth manpower directly in support for the BKKBN and allied to the program. The anticipated growth in BKKBN salaried staff would increase from 23,000 to 53,000 at the end of PELITA IV with the largest increasing being for the Family Planning field worker. The unpaid staff of BKKBN in operational manpower group and particularly the large number of community motivators in village which are volunteers would be trained. The complementary to manpower development is the component of training, which for REPELITA IV would indicate that almost 400.000 person would have to receive some kind of Family Planning training and instruction given the fact that about 260,000

persons received this type of training during PELITA III.

The logistics activites mainly for contraceptive procurementand distribution, car and motor car repalcement of the old one for operational purpose and equipment for IEC and contraceptives services.

Every year there is about 100 million cycles Pill would be procured and distributed to acceptors, IUD is about 5.5 million pieces, Condom 1.7 million dozen and Injection 8.5 million vials.

3. Estimation of Resources in Pelita IV

In preparation for the Fourth Five year Development 1984/85 - 1988/89 (PELITA IV), BKKBN has been requested by the National Development Planning Board (BAPPENAS) to submit estimates which relates targets to be met with proposed resources for the National Family Planning program is about Rp. 1000 billion or about US $ 945 million or about 250 Billion Yen.

That is about Rp 200 billion every year would be allocated. The main categories of expenditure in PELITA IV are as follows (US $ million).

1. Operational (include IEC contraceptive service and intersectoral program etc)	$ 340
2. Contraceptive supplies	$ 139
3. Salaries	$ 138
4. Monitoring, Evaluation and Research	$ 65
5. Training	$ 62
6. Office supplies	$ 37
7. Construction	$ 19
8. Transportation	$ 13
9. Equipment and supllies	$ 6
10. Administration etc	$ 126
TOTAL	$ 945

The estimated source of resources would allocated from the Government of Indonesia $ 800 million and from the donor agencies $ 145 million.

Estimates for the USAID is about $ 31 million, World Bank $ 50 million (currently in stages of final discussion), UNFPA $ 4 million and Dutch $ 10 million, and the total is about $ 95 million. So that open foreign assistance for $ 50 Million.

N. PROBLEM FACING THE FAMILY PLANNING AND NEEDS ASSESMENT

1. Due to the age structure of the population the number of married couples of fertile age will grow faster than total population. It is estimated that new marrying couples about 1.5 million every year can decrease the prevalence of current users because they are reluctant to assept Family Planning, otherwisw they have completed their ideal family size or accept Family Planning for child spacing.

2. The reduction in fertility as a direct result of the family planning program will therefore only partly effect a reduction in birth rate. To accellare fertility reduction, it needs integrated program with other sectors.

3. In some areas there exist pockets of cultural resistance that may cause problems in the achievement of full community participation, now being one of the challanges of the program, it needs an intensive IEC to change their attitude and behaviour for accepting Family Planning.

4. Due to the advantage of the family planning, it needs a more complex evaluation and monitoring of progress toward reaching objectives and target at national level, provinces, regencies, municipalities and districs. The use of evaluation is to identify the problem and priorities, forcing policy makers and managers to rethink appropriate strategies for planning. The family planning program needs a micro computer for evaluation and monitoring of a more complex data and information at national and provinces as well as at regencies and municipaities.

5. As regards to contraceptive service, there are about 15 million current users, consists mainly of pill, IUD and injection which have also side effects and complications. The budget allocated for contraceptives expenditure is growth past, which the raw material is imported from abroad.
   The family planning program needs a biomedical research center to study the side effect and complication of contraceptive for better quality of services.
   The center can also study the chemical substances for contraceptive's raw materials from domestic supply.

IV. THE JAPAN CONTRIBUTION TO THE INDONESIAN FAMILY PLANNING PROGRAM

The Japanese technical cooperation received from Japan to Indonesian family planning program began in 1977 to March 31, 1985. The assistance was provided for the strengthening of media production centre (MPC) and urban family planning projects.

A. Media Production Centre.

The MPC project began in 1977/1978, the cooperation period is 8 (eight) years from 1977/78 through 1984/85.
The purpose of the project are:

1. To develop and strengthen production of IEC materials and IEC activities.
2. To increase knowledge and skills of service providers through local training.

The evaluation of the project implementation by the end of the project on the 31 March 1985 was follows:

1. The project has been increased the skill IEC staff in the National Family Planning Coordinating Board (BKKBN) and the family planning implementing units.
2. The project has improved cooperation between the BKKBN and the implementing units, especially Ministry of Information.
3. The project has encouraged the development of technological communication instrument for the Populatioan and Family Planning staff.
4. The project has been very effective, especially on the production of prototype information materials such as simple printing media, flipcharts, posters, slide audio and video cassettes.

The production of MPC up to the end of 1984 various have been achieved by the project implementation such as:

1. Video Cassette.
   The video cassette produced by MPC consist of:
   a. 13 titles of soft opera (fragmen) with 30 minutes running time.
   b. 10 titles of comedy opera, which is called "Ria Jenaka" serials.
   c. 7 titles of animation (puppet show) which is called "Si Unyil" serials.
   d. Some titles of documentary video of FP activities.
   e. 3 titles of teaching materials.
   f. Transferring 70 titles of film into video.

2. Audio Cassette.

   A big amount of audio cassette were produced. The cassette

were for radio broadcast and for 7,700 sets of Portable public address system located in Kecamatan (district) through country.

3. As a result of pioneering project of JICA aid, today the MPC in central level is becoming stronger production unit of IEC materials. Beside equipment from JICA and other equipment from World Bank project were installed such as video duplicating system. Provincial MPC also have been installed in 27 provinces. The provincial MPC were procured through World Bamk project and UNFPA aid.

4. The utilization of family planning video has already expanding very rapidly has penetrated to various net-work. The Bureau of Information and Motivation has started cooperation with private transportation company which run 50 intercity buses. The buses are equipped with video monitor to entertained the passengers. The Company has interested in showing family planning programs in the bus. Some negotiations also have been made to use the family planning video programs in other net-works like in the airport terminal, ferry etc.

B. Urban Family Planning Project

The Government of Japan and the Government of Indonesia have cooperated with other in implementing the Jakarta Urban Family Planning project. The duration of the technical cooperation for the project under the Record of Discussion is three years from Januari 28, 1982 to March 31, 1985.

The onjectives of this project is to support the implementation of the Jakarta Urban FP Program in the following specific area :

1. To develop and strengthen production of IEC materials and IEC activities through the MPC;

2. To increase knowledge and skills of service providers through local training.

The Project have been implemented by BKKBN through the following activities :

1. Production of IEC materials in the MPC which is jointly managed with TVRI, RRI (Department of Information) the material produced in the project are :
   a. FP video for broadcasting by TVRI, playing back video nation in public places, hospitals and health centres, as well as mobile information units;
   b. Family Planning for teaching materials;
   c. Audio cassette to be broadcasted by radios and played back in Public Address System located in villages.

To conduct this activities a working group had been set up. The working group conducted regular meeting to discuss the content of IEC materials would be produced. The production of the materials have been done by MPC staff in TVRI, RRI and BKKBN.

2. Training for Family Planning Workers.

Since 1983 the training of IEC have been organized and implemented in Jakarta, The training was implemented by National FP Training Centre and Bureau of Information and Motivation of BKKBN.
Number of persons have been train in 1983/84 are 317 and in 1984/85 are 464, and the total are 781 personnels.

C. Family Planning Program input by JICA

The input from JICA is as follows :

1. Funds Assistance.
The amount in Yen for provision for equipment, consultant assignment and local training are as follows (in thousand Yen).

YEAR	Equipment Provision	Consultant Assignment	Local Training	Total
1977/78	74.514	18.158	-	92.672
1978/79	64.206	12.814	-	77.020
1979/80	87.723	19.955	-	107.678
1980/81	97.486	10.527	-	108.013
1981/82	139.205	26.472	-	165.677
1982/83	123.630	28.949	-	152.579
1983/84	112.792	27.164	10.078	150.034
1984/85	58.644	25.253	11.230	95.127
Total	758.200	169.292	21.308	948.800
Percent	79,91	17,84	2,25	100

The total of project assistance for fiscal year 1977/78 - 1984/85 is 948,800 thousand Yen, which for provision of equipment 758,200 thousand Yen (79,91%), consultant assignment 169.292 (17.84%) and local training 21,308 (2.25%). With exchange rate 1 Yen = Rp.4.03, the total project assistance is Rp.3,823,664,000 or US $ 3,941,897 (1 US $ = Rp.970).

This amount do not include the funds for trainers received in Japan.

2. The number of Consultants Assign, trainess received in Japan and locally training personnel are as follows :

Year	Number of Consultants	Trainess received In Japan	Local Trainees
1977/78	8	0	-
1978/79	5	3	-
1979/80	3	2	-
1980/81	5	4	-
1981/82	9	4	-
1982/83	5	3	-
1983/84	3	0	317
1984/85	3	3	464
Total	41	19	781

The total expert assistance as consultant assignment to the project is 41. The total personnel have been trained is 800, consists of 19 trainess received in Japan and 781 trained locally in Indonesia

D. CONDOM FACTORY.

The Japanese Government contribution to assist the Family Planning in Indonesia mainly construction the condom factory by joint the consortium of Sagami Rubber Industries Co Ltd, Mitsubishi Kakoki Kaisha Ltd, Mitsubishi Corporation and Toyo Menka Kaisha Ltd.

This construction based on the loan agreement from the Japanese Government (Loan OECF No. IP.246) the amount of this loan is Y 2,146,693,920 or about US $ 8,5 million. The main category of the expenditure is for machinary, equipment and expert assistance. The factory is expected to produce condom in 1986 or early 1987.

E. SOME OPTIONS FOR CONSIDERATION BY JAPAN TO ASSIST NATIONAL FAMILY PLANNING PROGRAM IN INDONESIA THROUGH PELITA IV AND BEYOND.

The political commitment exists on the high priority ti reduce the fertility rate and population growth rate as the basic factors for economic growth and better welfare of the Indonesian people.

Based on the evaluation of the Technical Cooperation on Population and Family Planning between Japan and Indonesia, it is felt necessary to continue assistance and further develop in PELITA IV and beyond so that the implementation of the Family Planning program can be accellarated to reduce fertility rate and population growth rate.

There are some options for consideration by Japan to assist the national family planning program in Indonesia for the future :

1. Strengthening the evaluation and monitoring.

   Due to the more complex of evaluation and monitoring of family planning program, the urgent need to provide microcomputer. The existing computer in central BKKBN is overloaded (capacity one megabite). So that only a few data can be processed. It felt that about 20 Bureau in Central BKKBN, 27 provinces and 300 regency/municipality need one or two microcomputer. The computer can also used modern office management. It is a very good option for technological cooperation with Japan, because Japan has very advance in electronic and computer technologis and production.

2. Assistance to build a biomedical family planning study centre for studying side effect, complication and raw material for contraceptive production.

V. CONCLUSION

The National Family Planning in Indonesia facing a serious population problem such as a large size on population, high fertility and growth rate, uneven distribution, younger age structure, higher growth rate of labor force and relatively low population quality.

The National FP Program has made considerable achievements during 15 years of existence, the current users is estimated about 15 million and expecting to bring down the fertility rate. In the course of these years, this program with a strong political commitment, community participation and intersectoral approaches, thus making family planning as the base for better quality of the people in achieving a just, welfare and modern society.

The assesment of technical cooperation between Japan and Indonesia, The assistance has been very effective to support the achievement of the national family planning program. Based on the evaluation of the assistance and the need for increasing cooperation in PELITA IV and beyond some options for consideration by Japan to assist National Family Planning Program in Indonesia such as :

A. Strengthening the evaluation and monitoring
B. Technological cooperation to build Biomedical Family Planning Study Centre.

Appendix 1
Target and Achievement of the Program in Pelita III
1979/1980 – 1983/1984

Region	Original Target		Acceleration Target **		New Acceptors Achievement **			CU Achievement		
	New acceptors	CU	New acceptors	CU	New acceptors	% original target	% acceleration target	CU	% original target	% acceleration target
Jakarta	900,000	545,000	783,661	540,000	1,048,723	116,5	133,8	581,125	106,4	107,6
West Java	3,100,000	1,668,000	2,944,221	2,450,000	4,288,319	138,3	145,7	3,073,311	184,3	125,4
Central Java	3,000,000	1,568,000	3,050,695	2,500,000	3,938,254	131,3	129,1	2,887,867	184,2	115,5
Jogyakarta	300,000	154,000	338,738	296,000	283,951	94,7	83,6	298,327	193,7	100,8
East Timor	2,500,000	3,856,000	2,664,503	3,352,000	2,921,031	116,8	109,6	3,647,336	94,6	108,8
BALI	200,000	228,000	216,874	290,000	233,385	116,7	107,6	288,268	126,4	99,4
WEST BALI	10,000,000	8,000,000	9,998,692	9,428,000	12,713,633	127,1	127,2	10,776,234	134,7	114,3
Outer Islands I	2,900,000	1,200,000	3,704,002	2,806,000	3,748,444	129,3	101,2	3,137,226	261,4	111,8
Outer Islands II	600,000	300,000	956,966	485,000	917,485	152,9	95,9	509,091	169,7	105,0
INDONESIA	13,500,000	9,500,000	14,659,660	12,719,000	17,379,592	128,7	118,5	14,422,551	151,8	113,4

Note : *) Pelita III book
**) Source : BKKBN

Appendix 2

Table 1. Number of PPKBD and Sub-PPKBD.

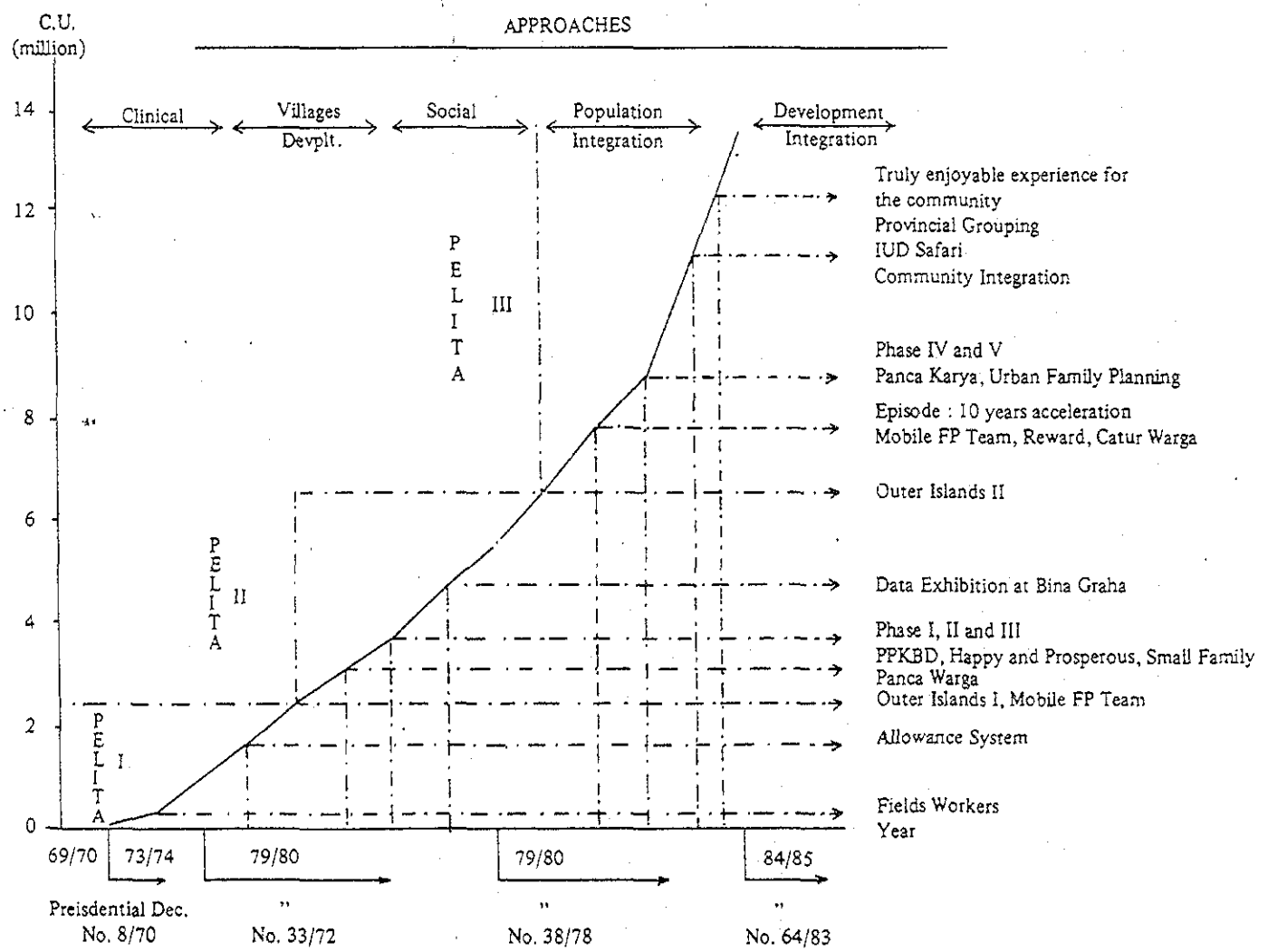
Year	PPKBD	Sub-PPKBD
1977/78	32,900	45,474
1978/79	34,780	55,285
1979/80	49,152	98,783
1980/81	50,204	109,318
1981/82	45,276	121,956
1982/83	53,732	121,980
1983/84	54,100	123,350

Table 1a. Number of FP Clinics and FP Hospitals

Year	FP Clinic	FP Hospital
1969/70	727	6
1970/71	1,465	6
1971/72	1,861	26
1972/73	2,137	26
1973/74	2,236	62
1974/75	3,018	84
1975/76	3,343	112
1976/77	3,620	135
1977/78	3,791	135
1978/79	4,134	135
1979/80	4,796	198
1980/81	5,614	254
1981/82	6,129	324
1982/83	6,586	383
1983/84	7,042	433

Appendix 3

Graph : Policy, Strategy and Organization Trends and Achievement during Pelita I, II and III



Appendix 4

New Acceptor
Target and Achievement
1969/70 – 1983/84

Year	New Aceptor Target	New Aceptor Achievement	% of New Aceptor Achievement
1969/1970	100,000	53,103	53.1
1970/1971	125,000	101,059	144.8
1971/1972	550,000	519,330	94.4
1972/1973	1,000,000	1,078,889	107.9
1973/1974	1,250,000	1,396,077	109.5
Pelita I	3,025,000	3,201,458	105.8
1974/1975	1,450,000	1,592,891	109.9
1975/1976	1,600,000	1,966,585	122.9
1976/1977	1,775,000	2,212,790	124.7
1977/1978	1,975,000	2,248,468	113.8
1978/1979	2,200,000	2,215,884	100.7
Pelita II	9,000,000	10,236,618	113.7
1979/1980	2,341,070	2,229,791	95.2
1980/1981	2,677,918	3,051,244	113.9
1981/1982	2,018,109	2,966,897	147.0
1982/1983	3,621,595	3,885,476	107.3
1983/1984	4,002,860	5,246,184	131.1
Pelita III	14,661,552	17,379,592	118.5

Source : BKKBN Pusat

Appendix 5 (continued)

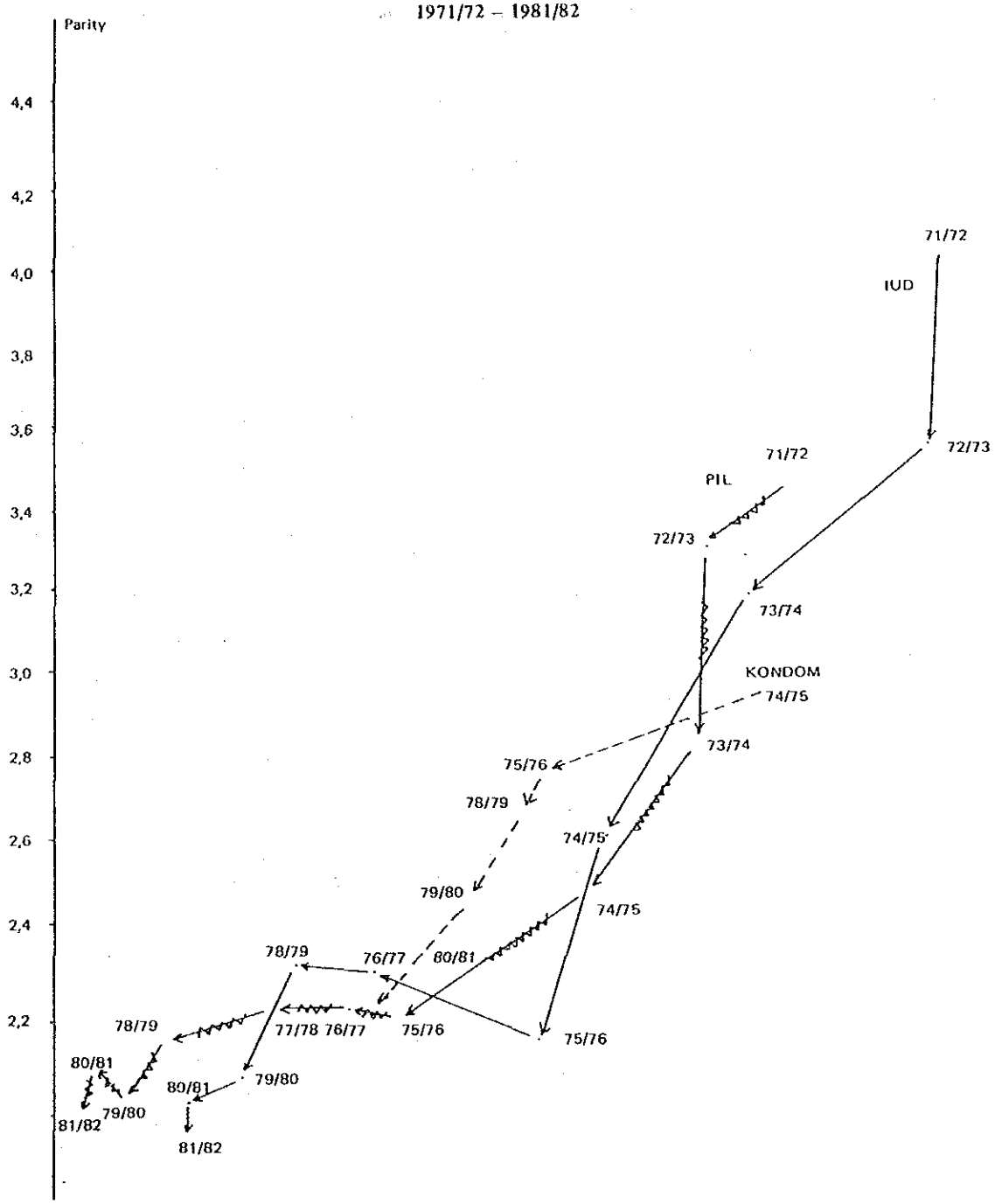
Year	Pill	IUD	Condom	Injectables	Others	TOTAL
Pelita III						
1979/80	1,550,931	398,215	167,701	64,519	48,425	2,229.791
	(69.5%)	(17.9%)	(7.5%)	(2.9%)	(2.2%)	
1980/81	2,120,854	496,846	264,306	112,031	57,207	3,051,244
	(69.5%)	(16.3%)	(8.7%)	(3.7%)	(1.9%)	
1981/82	1,908,551	596,784	165,915	227,731	67,916	2,966,897
	(64.3%)	(20.1%)	(5.6%)	(7.7%)	(2.3%)	
1982/83	2,055,417	893,659	182,618	660,530	93,252	3.885.476
	(52.9%)	(23.0%)	(4.7%)	(17.0%)	(2.4%)	
1983/84	2.316,179	1,424,544	169,524	1.225.984	109.953	5,246.184
	(44,1%)	(27.2%)	(3.2%)	(23.4%)	(2.1%)	

*) Source : BKKBN Pusat

Appendix 5
Number of New Acceptors by Contraceptive Method
in Pelita I, II, and III

Year	Contraceptive Methods					
	PIL	IUD	Condom	Injectables	Others	TOTAL
Pelita I						
1969/1970	14,579	29,040	9,484			53,103
	(27.5%)	(54.6%)	(17.9%)	–	–	
1970/1971	79,768	76,373	24,918	–	–	181,059
	(44.1%)	(42.2%)	(13.7%)	–	–	
1971/72	281,757	212,668	24,905	–	–	519,330
	(54.2%)	(40.9%)	(4.8%)	–	–	
1972/73	607,050	380,253	91,586	–	–	1,078,889
	(56.2%)	(35.2%)	(8.5%)	–	–	
1973/74	857,700	293,171	218,206	–	–	1,369,077
	(62.6%)	(21.4%)	(0.6%)	–	–	
Pelita II						
1974/1975	1,087,760	187,153	301,094	4,283	12,601	1,592,891
	(68.3%)	(11.7%)	(18.9%)	(0.3%)	(0.8%)	
1975/76	1,330,269	251,994	356,282	11,451	16,589	1,966,585
	(67.6%)	(12.8%)	(18.1%)	(0.6%)	(0.8%)	
1976/77	1,481,703	400,234	279,080	27,536	24,237	2,212,780
	(66.9%)	(18.1%)	(12.6%)	(1.2%)	(1.1%)	
1977/78	1,595,544	366,619	201,053	48,460	36,792	2,248,468
	(70.9%)	(16.3%)	(8.9%)	(2.2%)	(1.6%)	
1978/79	1,524,497	405,698	176,880	67,566	41,243	2,215,884
	(68.8%)	(18.3%)	(7.9%)	(3.0%)	(1.9%)	

Appendix 6
Graph : New acceptor age and parity
by method in Java–Bali
1971/72 – 1981/82



Appendix 7
Number of Current Users by Contraceptive Methods
in Pelita I, II, and III

Year	Contraceptives Method					TOTAL
	PILL	IUD	Condom	Injection	Others	
Pelita I						
1969/1970	–	–	–	–	–	–
1970/1971	–	–	–	–	–	–
1971/1972	153,419	202,927	5,323	–	–	366,669
	(43.2%)	(55.3%)	(1.4%)	–	–	(100.0)
1972/1973	456,130	548,492	20,850	–	–	1,025,472
	(44.5%)	(53.5%)	(2.0%)	–	–	(100.0)
1973/1974	865,931	766,191	48,543	–	–	1,680,665
	(51.5%)	(45.6%)	(2.9%)	–	–	(100.0)
Pelita II						
1974/1975	1,463,366	859,397	133,994	3,042	9,683	2,469,472
	(59.3%)	(34.8%)	(5.4%)	(0.1%)	(0.4%)	(100.0)
1975/1976	1,994,364	1,013,419	159,198	11,007	24,317	3,202,305
	(62.3%)	(31.6%)	(4.9%)	(0.3%)	(0.8%)	(100.0)
1976/1977	2,278,838	1,293,889	159,591	32,554	44,108	3,808,890
	(59.8%)	(33.9%)	(4.2%)	(0.9%)	(1.2%)	(100.0)
1977/1978	2,821,623	1,513,633	209,978	60,046	82,443	4,678,723
	(60.2%)	(32.3%)	(4.5%)	(1.3%)	(1.8%)	(100.0)
1978/1979	3,569,587	1,494,153	306,818	58,351	112,608	5,541,517
	(64.4%)	(26.9%)	(5.5%)	(1.1%)	(2.0%)	(100.0)
Pelita III						
1979/1980	4,124,049	1,745,561	409,579	66,552	151,641	6,497,382
	(63.5%)	(26.9%)	(6.3%)	(1.0%)	(2.3%)	(100.0)
1980/1981	4,993,987	2,017,105	477,116	106,775	196,554	7,791,537
	(64.1%)	(25.9%)	(6.1%)	(1.4%)	(2.5%)	(100.0)
1981/1982	5,619,218	2,347,460	505,119	81,234	255,989	8,809,020
	(63.8%)	(26.6%)	(5.7%)	(0.9%)	(2.9%)	(100.0)
1982/1983	6,699,220	2,900,573	606,227	658,468	338,797	11,211,285
	(59.8%)	(25.9%)	(5.4%)	(5.9%)	(3.0%)	(100.0)
1983/1984	7,983,221	3,898,837	708,775	1,387,627	444,111	14,422,551
	(55.4%)	(27.0%)	(4.9%)	(9.6%)	(3.1%)	(100.0)

Appendix 7a.

Target and Achievement of New Acceptors and Current Users
by Province, Year 1983/1984 *

Province	New Acceptors			Current Users	
	TARGET	Achievement	%	Achievement	% against CU
DKI Jakarta	226,630	338,704	149.4	511,125	51.9
West Java	941,116	1,531,175	162.6	3,073,311	62.1
Central Java	748,957	1,060,060	141.5	2,887,867	69,2
D.I. Yogyakarta	102,866	56,726	55.1	298,327	75,0
East Java	851,993	856,974	100.5	3,647,336	71.4
Bali	53,947	51,481	95.4	288,268	73,0
Java - Bali	2,925,509	3,895,120	133.1	10,776,234	66,8
D.I. Aceh	38,562	57,408	148.8	169,693	40.8
North Sumatera	169,048	227,869	134.7	658,261	52.2
West Sumatera	68,268	86,158	126.2	234,449	46.6
South Sumatera	88,484	133,183	150.5	353,433	48.3
Lampung	76,500	142,762	186.6	380,150	46.2
West Nusa Tenggara	125,349	60,304	48.1	231,538	55.1
West Kalimantan	56,947	67,261	118.1	198,674	48.7
South Kalimantan	29,701	49,685	167.2	183,636	52.9
North Sulawesi	39,964	69,339	173.5	206,195	64.3
South Sulawesi	146,683	115,883	79.0	521,197	58.2
Outer Islands I	839,506	1,009,852	120.2	3,137,226	51.2
Riau	30,976	43,095	139.1	69,608	20.2
Jambi	29,808	34,410	115.4	71,628	28.3
Bengkulu	21,621	30,381	140.5	61,994	48.6
East Nusa Tenggara	41,592	72,684	174.7	71,090	19.1
Central Kalimantan	6,803	27,624	406.0	40,302	26.2
East Kalimantan	20,684	31,096	150.3	53,178	26.4
Central Sulawesi	9,890	30,141	304.7	56,952	28.9
South East Sulawesi	17,570	29,202	166.2	34,002	25.4
Maluku	24,601	25,682	104.3	29,038	14.1
Irian Jaya	22,210	12,648	56.9	16,701	8.4
East Timor	12,090	4,249	35.1	4,598	6.0
Outer Island II	237,845	341,212	143.4	509,091	22.5
Indonesia	4,002,860	5,246,184	131.1	14,422,551	58.8

*) Data in March 1984

Source : BKKBN Pusat

Appendix 8

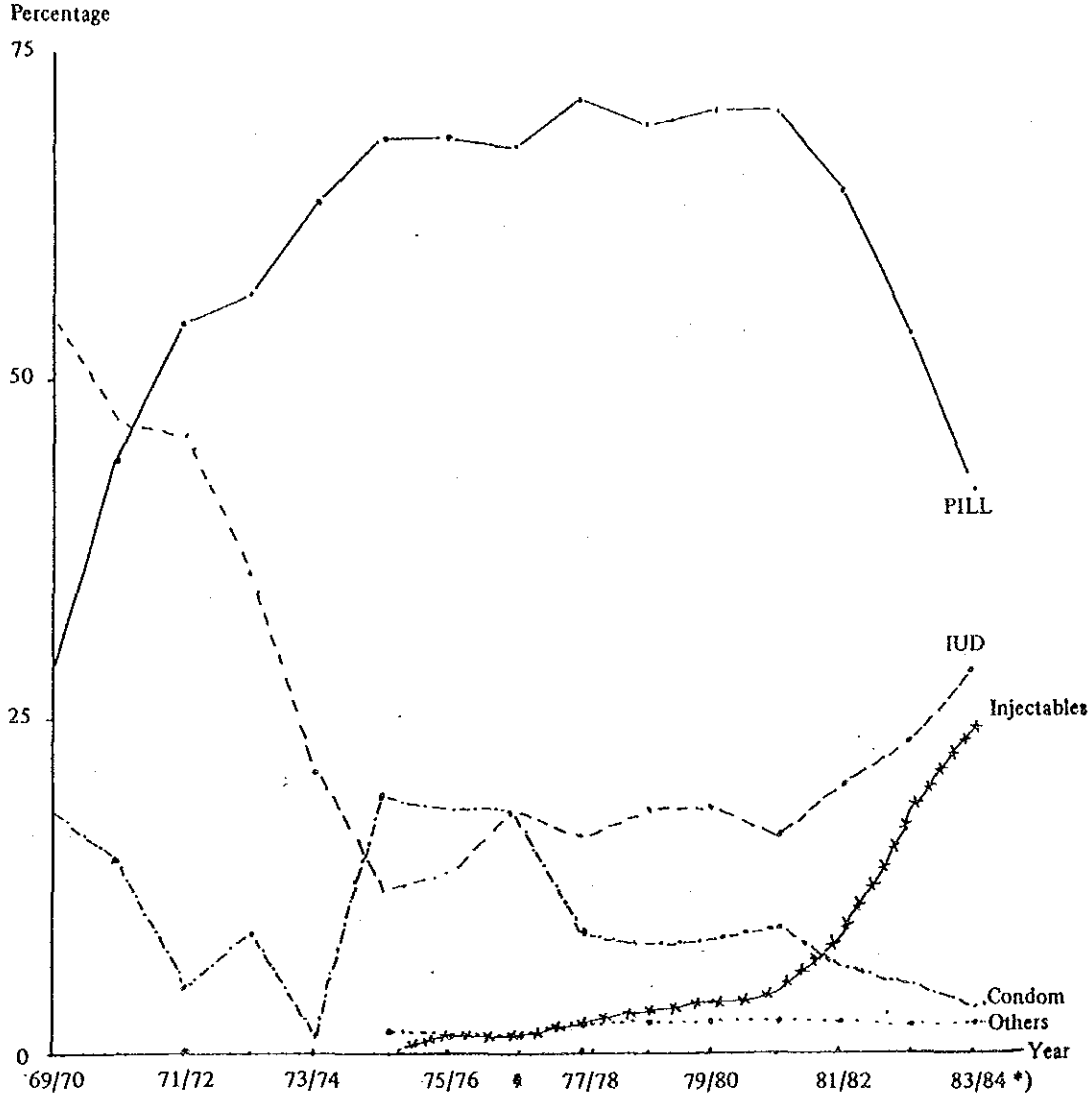
ELCO, CU, CYP and YEP
in Pelita III

Year	ELCO	CU	CYP	YEP	Achievement percentage			
					CU/PUS	CYP/PUS	YEP/PUS	YEP/CU
1971/72	12,974,496	366,669	–	–	2.83	–	–	–
1972/73	13,266,614	1,025,472	732,500	607,975	7.73	5.52	4.58	69.5
1973/74	13,554,863	1,680,665	1,408,100	1,168,723	12.40	10.39	8.62	69.5
1974/75	19,226,742	2,469,472	2,105,500	1,747,565	12.84	10.95	9.09	70.8
1975/76	19,207,554	3,202,305	2,731,095	2,266,809	16.67	14.22	11.80	70.8
1976/77	19,644,822	3,808,890	3,415,255	2,834,662	19.39	17.39	14.43	74.4
1977/78	19,027,864	4,687,723	4,065,108	3,374,040	24.64	21.36	17.73	72.0
1978/79	18,649,616	5,541,517	4,752,086	3,944,231	29.71	25.48	21.15	71.2
1979/80	21,172,652	6,497,382	5,553,153	4,609,117	30.68	26.23	21.77	72.0
1980/81	21,599,234	7,791,537	6,725,242	5,581,951	36.07	31.14	25.84	71.6
1981/82	22,495,560	8,809,020	8,076,204	6,703,249	39.16	35.90	29.80	76.1
1982/83	23,333,008	11,211,285	9,438,112	7,833,633	48.05	40.45	33.57	69.9
1983/84	24,532,728	14,422,551	12,445,364	10.329,652	58.79	50.73	42.11	71.6

Source : BKKBN Pusat

Appendix 9

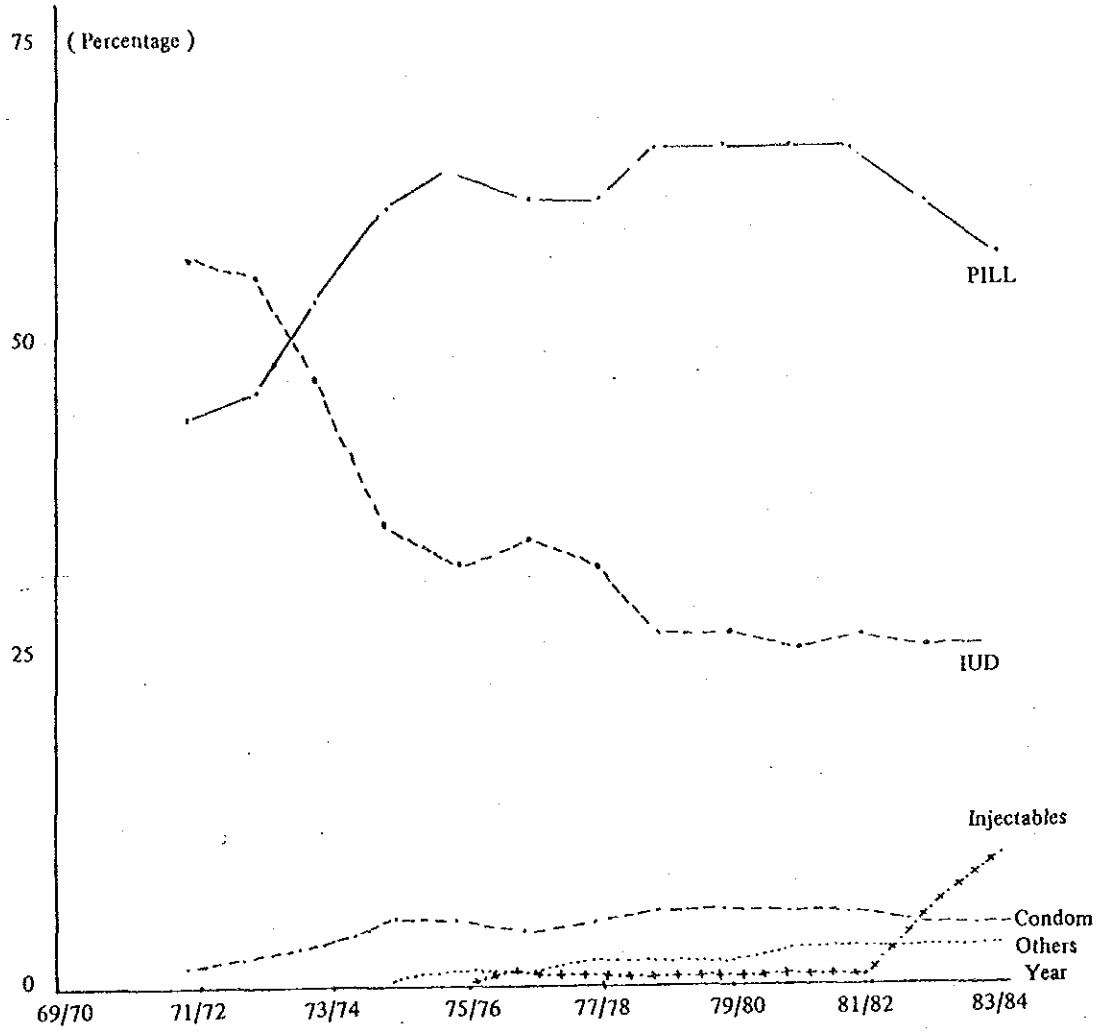
Graph : Percentage of New Acceptors by Contraceptive Method in Pelita I, II, and III

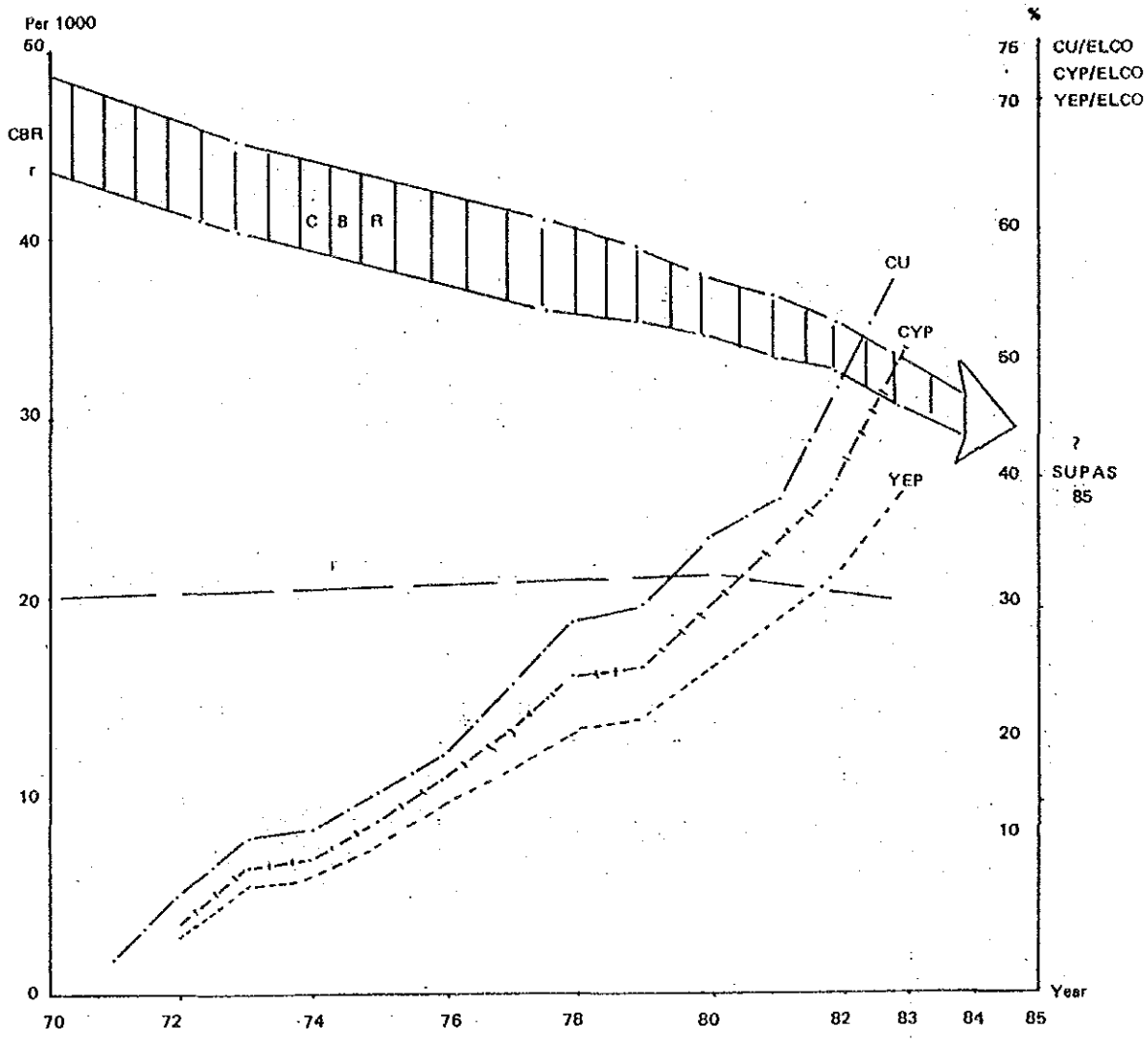


*) Data in January 1984 (feedback)

Appendix 10.

Graph : Percentage of Current Users by Contraceptive Method in Pelita I, II and III





Sketch : Trends in Acceptor Prevalence, CBR and Population Growth in Indonsela in 1970–1983

Appendix 12

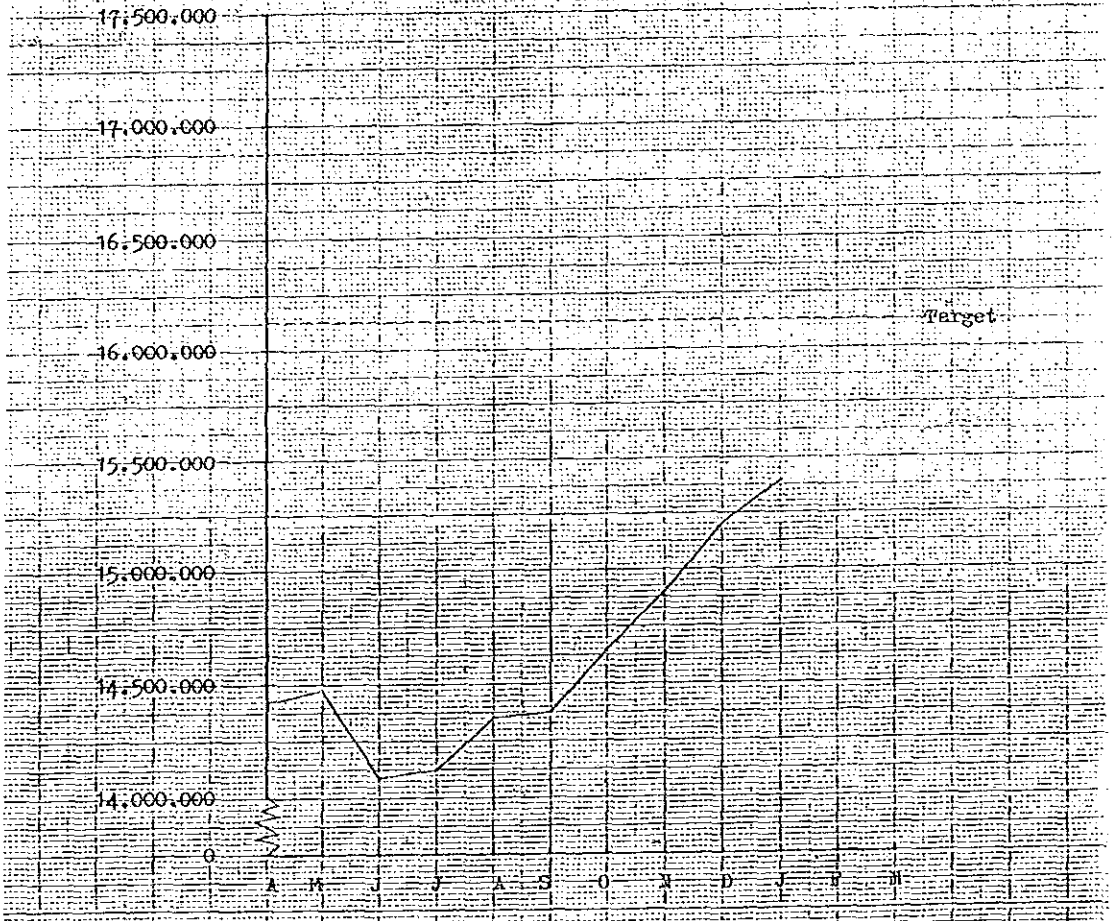
Projection of CU, CYP, YEP in 1982/1983 and CBR, TFR in 1983/1984 by Provinces/Region

Province	ELCO	CU	Mid-Year CYP	YEP	% YEP/ELCO	CBR 83/84		TFR 83/84	
						Low	High	Low	High
DKI Jakarta	1,073,572	444,677	291,294	241,774	22.52	33.9	37.7	4.3	4.9
West Java	4,370,702	2,000,312	1,387,812	1,151,884	26.35	32.6	36.3	4.1	4.7
Central Java	3,968,930	2,212,737	1,983,347	1,646,178	41.48	26.0	28.9	3.3	3.7
D.I. Yogyakarta	423,955	280,683	258,880	214,870	50.68	21.6	24.0	2.7	3.1
East Java	4,527,215	3,174,897	2,815,367	2,336,755	51.62	21.1	23.5	2.7	3.0
B a l i	385,994	257,075	227,876	189,137	49.00	22.4	25.0	2.9	3.2
Java Bali	14,750,368	8,370,381	6,160,619	5,777,314	39.17	26.8	29.9	3.4	3.8
D.I. A c e h	419,023	122,697	69,878	57,999	13.84	37.8	42.1	4.8	5.4
North Sumatera	1,361,877	547,049	312,544	259,412	19.05	35.6	39.7	4.5	5.1
West Sumatera	541,227	181,089	130,373	108,210	19.99	35.2	39.2	4.5	5.0
South Sumatera	734,715	251,614	130,219	108,082	14.71	37.4	41.7	4.8	5.4
L a m p u n g	800,583	311,627	193,949	160,978	20.11	35.2	39.2	4.5	5.0
West Nusa Tenggara	433,783	202,209	136,699	113,460	26.16	32.6	36.3	4.1	4.7
West Kalimantan	392,369	153,314	81,577	67,709	17.26	36.5	40.7	4.6	5.2
South Kalimantan	327,295	142,252	92,615	76,870	23.49	33.9	37.7	4.3	4.9
North Sulawesi	336,164	148,430	109.309	90,726	26.99	32.1	35.8	4.1	4.6
South Sulawesi	952,019	449,421	315,513	261,876	27.51	31.7	35.3	4.0	4.5
Outer Islands I	6,299,055	2,509,702	1,572,272	1,304,986	20.72	34.8	38.7	4.4	5.0
R i a u	321,965	41,660	29,629	24,592	7.64	40.5	45.1	5.2	5.8
J a m b i	237,293	52,079	31,123	25,832	10.89	39.2	43.6	5.0	5.6
B e n g k u l u	126,646	44,138	33,327	27,661	21.84	34.3	38.2	5.4	4.9
East Nusa Tenggara	372,831	38,617	24,199	20,085	5.39	41.8	46.6	5.3	6.0
Central Kalimantan	156,374	29,478	14,653	12,162	7.78	40.5	45.1	5.2	5.8
East Kalimantan	209,629	42,751	27,487	22,814	10.88	39.2	43.6	5.0	5.6
Central Sulawesi	209,391	36,468	20,218	16,781	8.01	40.5	45.1	5.2	5.8
South East Sulawesi	154,944	16,804	8,766	7,276	4.70	41.8	46.6	5.3	6.0
MALUKU	227,331	14,222	10,029	8,324	3.66	42.2	47.0	5.4	6.0
Irian Jaya	180,051	12,835	6,970	5,785	3.21	42.7	47.5	5.4	6.1
East Timor	87,130	2,150	1,459	1,211	1.39	43.6	48.5	5.5	6.2
Outer Island II	2,283,585	331,202	209,860	174,184	7.63	40.5	45.1	5.2	5.8
I n d o n e s i a	23,333,008	11,211,285	8,757,158	7,268,441	31.15	30.4	33.8	3.9	4.3

No.	PROVINCE	NO.REGISTERED CLINICS		NEW ACCEPTORS F.Y. TARGET.	NUMBER OF NEW ACCEPTORS CURRENT MONTH			M.W.R.A. (15-44).	PREVALENCE			Ranking
		REGIS - TERED.	% REPORT THIS MONTH		THIS MONTH	Y.T.D.	% TARGET		ACHIEVEMENT	F.Y. TARGET	ACHIEV / 1000 PUS	
1	2	3	4	5	6	7	8=(7:5)	9	10	11	12=(10:9)	
09	DKI Jakarta	308	97,6	261.618	27.001	254.772	97,3	1.148.860	670.453	648.128	583,6	9
10	West Java	874	94,1	1.100.000	103.836	715.519	65,0	5.022.931	3.233.512	3.493.167	643,8	6
11	Central Java	866	95,3	700.000	61.634	531.169	75,8	4.234.150	3.004.136	3.134.943	709,5	4
12	DI Yogyakarta	146	90,6	60.520	4.453	48.704	80,4	403.608	287.420	312.000	712,1	3
13	East Java	1.503	96,6	974.987	82.375	576.247	59,1	5.175.326	3.776.586	3.817.892	729,7	2
14	B a l i	175	98,2	57.508	3.510	41.396	71,9	401.421	302.217	309.000	752,9	1
	JAVA AND BALI	3.952	96,0	3.154.633	282.809	2.167.807	68,7	16.386.296	11.274.324	11.715.130	688,0	-
01	DI Aceh	176	95,0	73.979	7.458	56.002	75,6	425.286	207.686	214.046	480,3	16
02	North Sumatra	681	95,4	339.075	17.762	175.580	51,7	1.299.730	735.927	837.020	566,2	10
03	West Sumatra	260	98,4	82.350	7.044	75.658	91,8	514.243	269.176	290.000	523,4	15
06	South Sumatra	300	92,4	104.000	14.531	107.438	103,3	753.958	420.309	390.000	557,5	11
08	Lampung	165	69,7	115.789	8.988	108.232	93,4	840.181	458.574	457.196	536,3	13
15	West Nusa Tenggara	147	90,6	133.632	13.860	53.538	40,0	425.444	227.674	249.003	535,1	14
17	West Kalimantan	161	88,8	143.497	10.082	51.726	36,0	617.770	199.399	231.766	477,1	17
19	South Kalimantan	166	94,6	46.000	5.402	46.787	101,7	353.004	211.815	190.000	600,0	8
21	North Sulawesi	151	97,3	65.308	8.422	56.824	87,0	328.747	230.240	257.000	700,4	5
23	South Sulawesi	296	95,3	161.212	14.312	88.045	54,6	908.835	570.859	582.000	628,1	7
	OUTER ISLAND I	2.311	94,2	1.264.042	107.941	819.830	64,8	6.267.398	3.523.659	3.698.031	562,2	-
04	R i a u	138	85,7	63.656	3.921	32.469	51,0	353.933	76.910	101.000	217,3	23
05	J a m b i	117	91,2	45.930	3.567	31.187	67,9	258.113	88.240	97.000	341,9	19
07	Bengkulu	112	92,3	37.502	3.210	24.228	64,9	130.372	71.196	85.934	546,1	12
16	East Nusa Tenggara	141	74,8	78.893	2.704	43.231	54,7	380.187	73.041	98.000	192,1	25
18	Central Kalimantan	145	69,7	20.656	1.062	19.775	95,7	161.032	45.466	60.000	282,3	22
20	East Kalimantan	145	83,2	36.300	3.227	29.138	80,2	205.554	65.002	71.000	316,2	21
22	Central Sulawesi	112	93,7	25.000	2.457	21.193	84,7	205.040	67.956	71.000	331,4	20
24	South East Sulawesi	62	76,8	24.776	1.591	19.680	79,4	133.956	48.243	51.567	360,1	18
25	Maluku	108	73,7	30.000	1.079	21.258	70,8	212.563	41.746	46.000	196,4	24
26	Irian Jaya	94	61,9	23.969	781	17.502	73,0	202.453	22.452	31.000	110,9	26
27	Timor Timur	44	71,4	12.808	391	3.792	29,4	78.523	6.117	13.000	77,9	27
	OUTER ISLAND II	1.218	80,0	399.570	25.590	263.453	65,9	2.321.726	606.369	725.501	261,2	-
	I N D O N E S I A	7.481	92,7	4.819.245	416.340	3.251.090	67,5	24.975.420	15.404.352	16.138.662	616,8	-

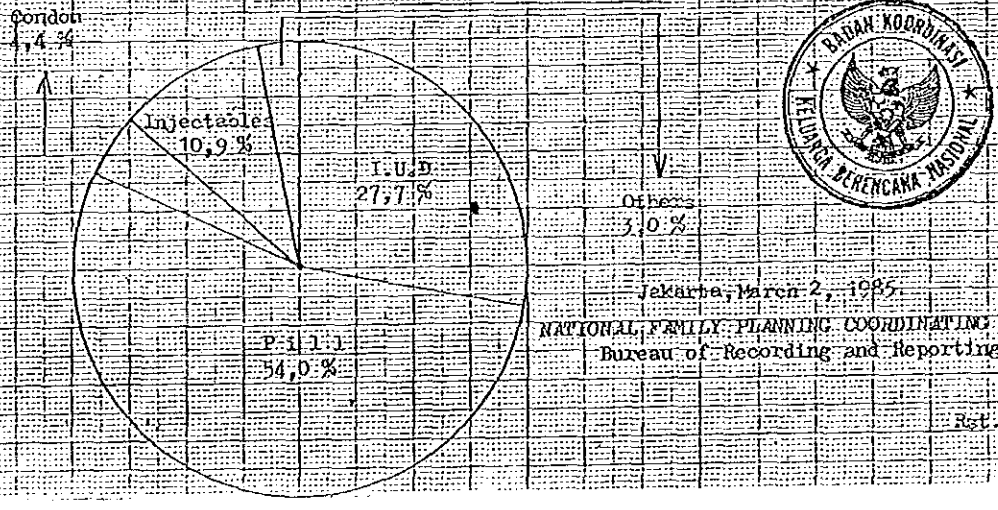
TOTAL NUMBER OF CURRENT USERS BY MONTH

IN INDONESIA 1984/85



THE ESTIMATION OF PREVALENCE RATE BY METHOD

IN INDONESIA JANUARY 1985



Jakarta, March 2, 1985.

NATIONAL FAMILY PLANNING COORDINATING BOARD
Bureau of Recording and Reporting

Rst.

NATIONAL FAMILY PLANNING COORDINATING BOARD
BUREAU OF RECORDING AND REPORTING

MONTHLY STATISTICAL SUMMARY

DATA-DATE : JANUARY 1985

RUN-DATE FEBRUARY 26 1984

YTD = YEAR TO DATE

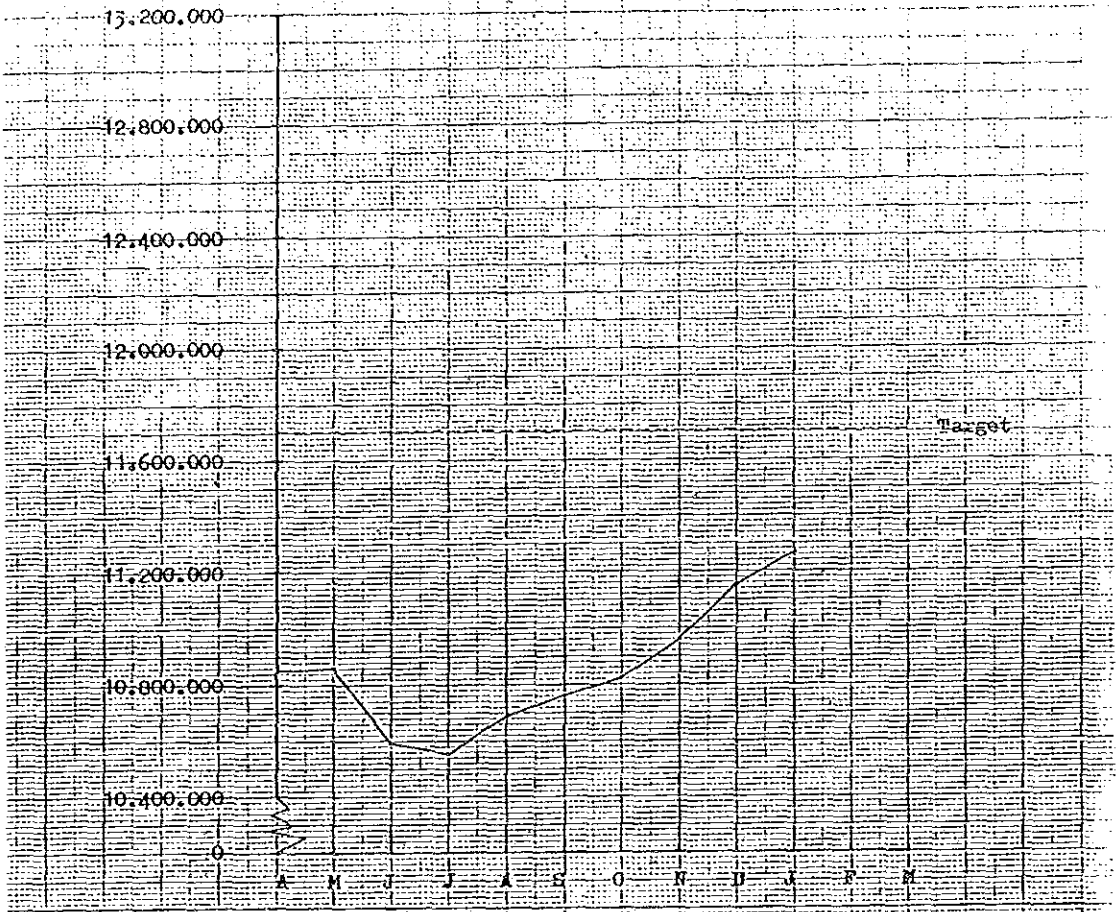
PROVINCE	NO. OF REGISTERED CLINIC: POH	ARM FORCE	OTHR GOVT	PRI VATE	TO-TAL	% RE-PORT	% RE-PORT YTD*	NUMBER OF NEW ACCEPTORS CURRENT MONTH: TOTAL	IUD	%	P I L L	%	CONDOM+ TABVAG	%	INJ	%	OTHERS	%
9 J A K A R T A	243	39	27	79	388	97.6	97.0	27,001	6921	25.6	9703	35.9	628	2.3	9303	34.4	446	1.6
10 EAST JAVA	731	59	31	53	874	94.1	98.4	103,836	15938	15.3	40150	38.6	141	0.1	46696	44.9	911	0.8
11 CENTRAL JAVA	705	55	21	85	866	95.3	95.2	61,634	19453	31.5	20574	33.3	2382	3.8	17097	27.7	2128	3.4
12 YOGYAKARTA	121	7	0	18	146	98.6	97.7	4,453	2188	49.1	477	10.7	335	7.5	887	19.9	566	12.7
13 EAST JAVA	1340	59	24	80	1503	96.6	96.2	82,375	23176	28.1	34777	42.2	4652	5.6	17333	21.0	2437	2.9
14 B A L I	159	4	0	10	175	98.2	97.8	3,510	2223	63.3	608	17.3	208	5.9	352	10.0	119	3.3
T O T A L	3294	225	103	325	3952	96.0	96.7	282,809	69899	24.7	106289	37.5	8346	2.9	91668	32.4	6607	2.3

PROVINCE	ESTIMATED NUMBER OF PREVALANCE THIS MONTH: I.U.D	%	P I L L	%	CONDOM	%	I N J	%	OTHERS	%	T O T A L
9 J A K A R T A	260,426	38.8	211,492	31.5	32,536	4.8	119,022	17.7	46,977	7.0	670,453
10 EAST JAVA	672,093	20.8	1,745,787	53.9	6,024	0.1	749,593	23.1	59,210	1.8	3,233,512
11 CENTRAL JAVA	972,345	32.3	1,493,407	49.7	173,933	5.7	271,721	9.0	92,730	3.0	3,004,136
12 YOGYAKARTA	118,931	41.3	66,852	23.2	55,916	19.4	10,150	3.5	35,571	12.3	287,420
13 EAST JAVA	1,313,126	34.7	2,093,782	55.4	103,044	2.7	163,518	4.3	103,116	2.7	3,776,586
14 B A L I	223,893	74.0	34,396	11.3	19,432	6.4	6,713	2.2	17,783	5.8	302,217
T O T A L	3,561,619	31.5	5,645,716	50.0	390,885	3.4	1,320,717	11.7	355,387	3.1	11,274,324

PROVINCE	P W R A (15-44)	NEW ACCEPTORS: Y T D *	F.Y TARGET	% TAR GET	ANNUALIZED Y T D *	%TARGET	PREVALANCE: FY.TARG.	ACHIEV.	ACH./ 1000 PW
9 J A K A R T A	1,148,800	254,772	261,618	97.3	305,726	116.8	648,128	670,453	583.6
10 EAST JAVA	5,022,931	715,619	1,100,000	65.0	858,622	78.0	3,493,167	3,233,512	643.8
11 CENTRAL JAVA	4,234,150	531,169	700,000	75.8	637,402	91.0	3,134,943	3,004,136	709.5
12 YOGYAKARTA	403,608	48,704	60,520	80.4	58,444	96.5	312,000	287,420	712.1
13 EAST JAVA	5,175,326	576,247	974,987	59.1	691,496	70.9	3,817,892	3,776,586	729.7
14 B A L I	401,421	41,396	57,508	71.9	49,675	86.3	309,000	302,217	752.9
T O T A L	16,386,296	2,167,807	3,154,633	68.7	2601,368	82.4	11,715,130	11,274,324	688.0

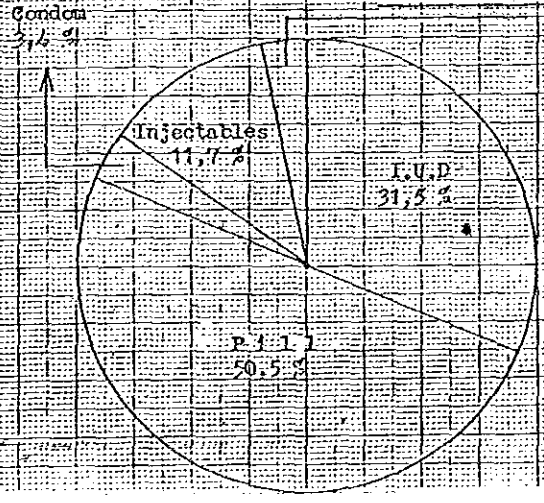
TOTAL NUMBER OF CURRENT USERS BY MONTH

IN JAVA & BALI 1984/85



THE ESTIMATION OF PREVALENCE RATE BY METHOD

IN JAVA & BALI JANUARY 1985



Jakarta, March 2, 1985

NATIONAL FAMILY PLANNING COORDINATING BOARD

Bureau of Recording and Reporting

Rst,

NATIONAL FAMILY PLANNING COORDINATING BOARD
BUREAU OF RECORDING AND REPORTING

MONTHLY STATISTICAL SUMMARY

DATA-DATE : JANUARY 1985

RUN-DATE FEBRUARY 22'1985

YTD = YEAR TO DATE

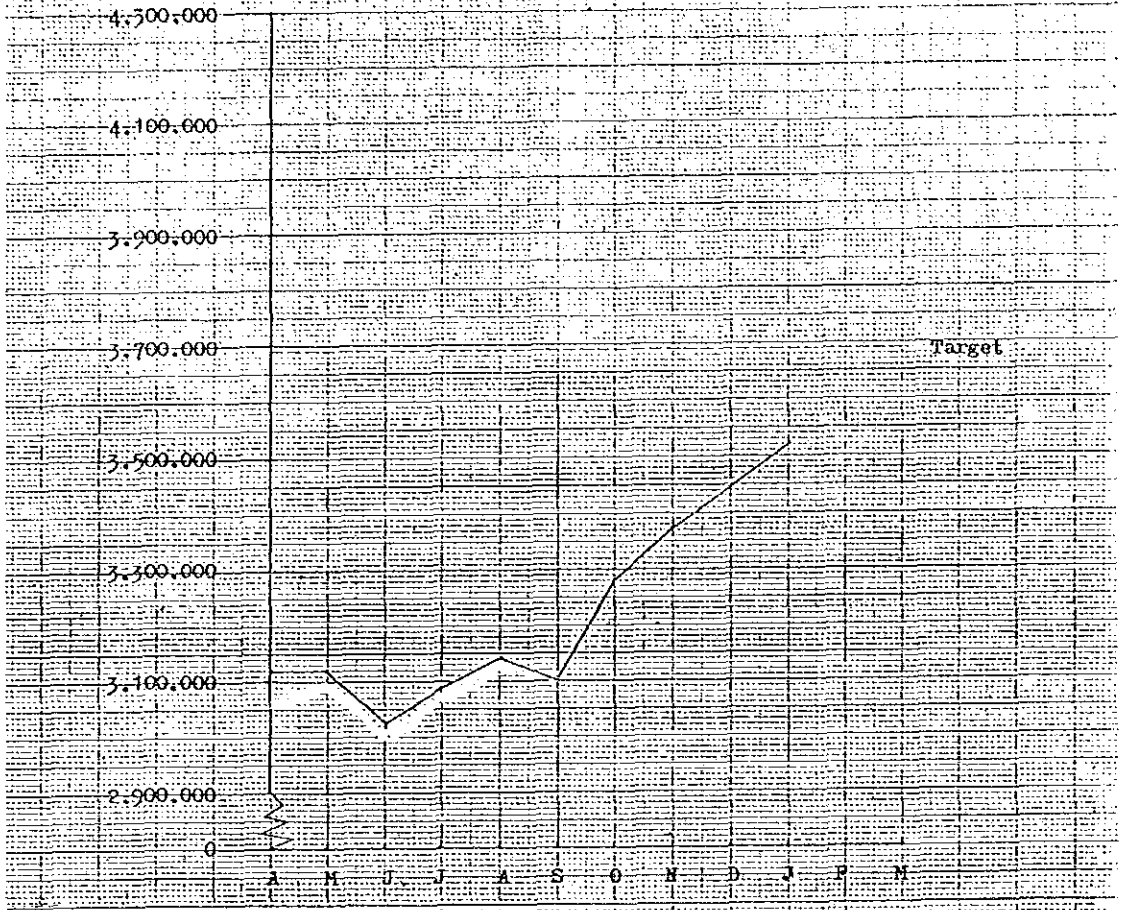
PROVINCE	NO.OF REGISTERED CLINIC POK	ARM FORCE	OTHR GOVT	PRI VATE	TO-TAL	% RE-PORT	% RE-PORT YTD*	NUMBER OF NEW ACCEPTORS CURRENT MONTH TOTAL	IUD	%	P I L L	%	CONDOM+ TABVAG	%	INJ	%	OTHERS	%
1 A C E H	147	17	4	8	176	95.0	90.7	7,458	310	4.1	4824	64.6	268	3.5	2048	27.4	8	0.1
2 NORTH SUMATRA	326	42	43	70	481	95.4	93.8	17,762	3138	17.6	6865	38.6	1692	9.5	5486	30.8	581	3.2
3 WEST SUMATRA	228	14	6	12	260	98.4	97.3	7,044	1406	19.9	3384	48.0	357	5.0	1844	26.1	51	0.7
6 SOUTH SUMATRA	229	21	32	26	308	92.4	94.5	14,531	1840	12.6	9641	66.3	1092	7.5	1755	12.0	203	1.3
8 LAMPUNG	141	6	5	13	165	89.7	88.9	8,988	1538	17.1	5748	63.9	255	2.8	1370	15.2	77	0.8
15 WEST NUSA TENGGAR	111	9	5	22	147	90.6	90.2	13,860	2279	16.4	9459	68.2	143	1.0	1950	14.0	29	0.2
17 WEST KALIMANTAN	137	9	3	12	161	88.8	88.0	10,082	991	9.8	6765	67.0	626	6.2	1661	16.4	39	0.3
19 SOUTH KALIMANTAN	146	11	4	5	166	94.6	94.6	5,482	422	7.6	3916	71.4	141	2.5	981	17.8	22	0.4
21 NORTH SULAWESI	112	13	0	26	151	97.3	96.0	8,422	1589	18.8	2021	23.9	67	0.7	4651	55.2	94	1.1
23 SOUTH SULAWESI	236	30	4	26	296	95.3	95.5	14,312	1134	7.9	9524	66.5	138	0.9	3429	23.9	87	0.6
T O T A L	1813	172	106	220	2311	94.2	93.4	107,941	14649	13.5	62147	57.5	4779	4.4	25175	23.3	1191	1.1

PROVINCE	ESTIMATED NUMBER OF PREVALANCE THIS MONTH I.U.D	%	P I L L	%	CONDOM	%	I N J	%	OTHERS	%	T O T A L
1 A C E H	12,484	6.0	153,037	73.6	16,139	7.7	24,694	11.8	1,332	0.6	207,686
2 NORTH SUMATRA	117,934	16.0	382,085	51.9	124,104	16.8	74,594	10.1	37,210	5.0	735,927
3 WEST SUMATRA	87,747	32.5	132,866	49.3	25,365	9.4	17,318	6.4	5,880	2.1	269,176
6 SOUTH SUMATRA	60,430	14.3	281,663	67.0	46,182	10.9	18,854	4.4	13,180	3.1	420,309
8 LAMPUNG	87,421	18.2	328,541	72.9	11,448	2.5	24,936	5.5	3,228	0.7	450,574
15 WEST NUSA TENGGAR	52,782	23.1	164,888	72.4	2,232	0.9	6,146	2.6	1,626	0.7	227,674
17 WEST KALIMANTAN	16,726	8.3	149,423	74.9	18,290	9.1	12,718	6.3	2,242	1.1	199,399
19 SOUTH KALIMANTAN	14,876	7.0	179,985	84.9	3,173	1.4	11,609	5.4	2,172	1.0	211,815
21 NORTH SULAWESI	75,961	32.9	108,326	47.0	1,718	0.7	38,082	16.5	6,153	2.6	230,240
23 SOUTH SULAWESI	65,571	11.4	454,245	79.5	8,064	1.4	37,028	6.4	5,931	1.0	570,859
T O T A L	586,932	16.6	2,335,059	66.2	256,735	7.2	265,979	7.5	78,954	2.2	3,523,659

PROVINCE	K W R A (15-44)	NEW ACCEPTORS Y T D *	F.Y TARGET	% TAR GET	ANNUALIZED Y T D *	%TARGET	PREVALANCE FY.TARG.	ACHIEV.	ACH./ 1000 KW
1 A C E H	425,286	56,002	73,979	75.6	67,202	90.8	214,046	207,686	488.3
2 NORTH SUMATRA	1,299,730	175,580	339,075	51.7	210,696	62.1	837,020	735,927	566.2
3 WEST SUMATRA	514,243	75,658	82,350	91.8	90,789	110.2	290,000	269,176	523.4
6 SOUTH SUMATRA	753,958	107,438	104,000	103.3	128,925	123.9	390,000	420,309	557.5
8 LAMPUNG	840,181	106,232	115,789	93.4	129,878	112.1	457,196	450,574	536.3
15 WEST NUSA TENGGARA	425,444	53,538	133,632	40.0	64,245	48.0	249,003	227,674	535.1
17 WEST KALIMANTAN	417,910	51,726	143,497	36.0	62,071	43.2	231,766	199,399	477.1
19 SOUTH KALIMANTAN	353,004	46,787	46,000	101.7	56,144	122.0	190,000	211,815	600.0
21 NORTH SULAWESI	328,747	56,824	65,308	87.0	68,188	104.4	257,000	230,240	700.4
23 SOUTH SULAWESI	908,835	88,045	161,212	54.6	105,654	65.5	582,000	570,859	628.1
T O T A L	6,267,398	819,830	1,264,842	64.8	983,796	77.7	3,698,031	3,523,659	562.7

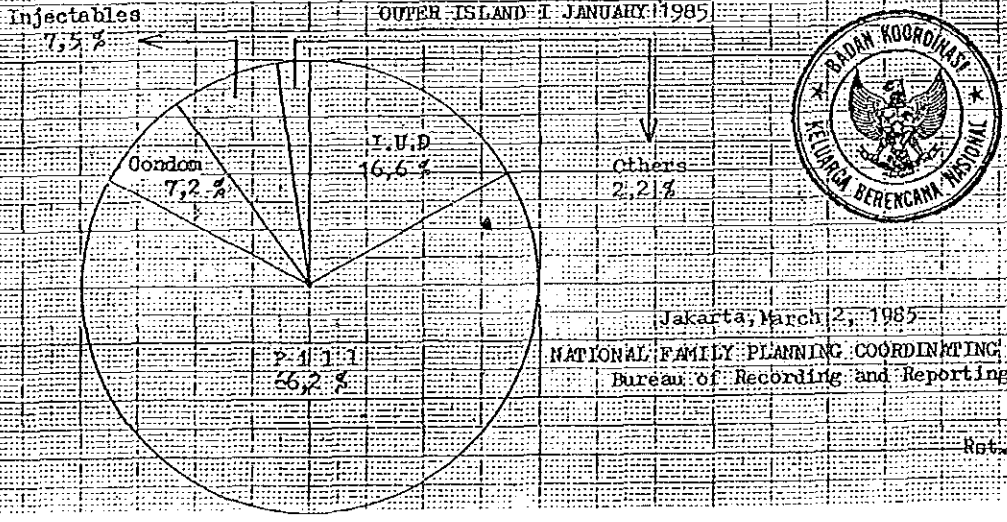
TOTAL NUMBER OF CURRENT USERS BY MONTH

OUTER ISLAND I 1984/85



THE ESTIMATION OF PREVALENCE RATE BY METHOD

OUTER ISLAND I JANUARY 1985



BADAN KOORDINASI KELUARGA BERENCANA NASIONAL

Jakarta, March 2, 1985

NATIONAL FAMILY PLANNING COORDINATING BOARD
Bureau of Recording and Reporting

Rpt.

COORDINATING BOARD

DATA-DATE : JANUARY 1985

YTD = YEAR TO DATE

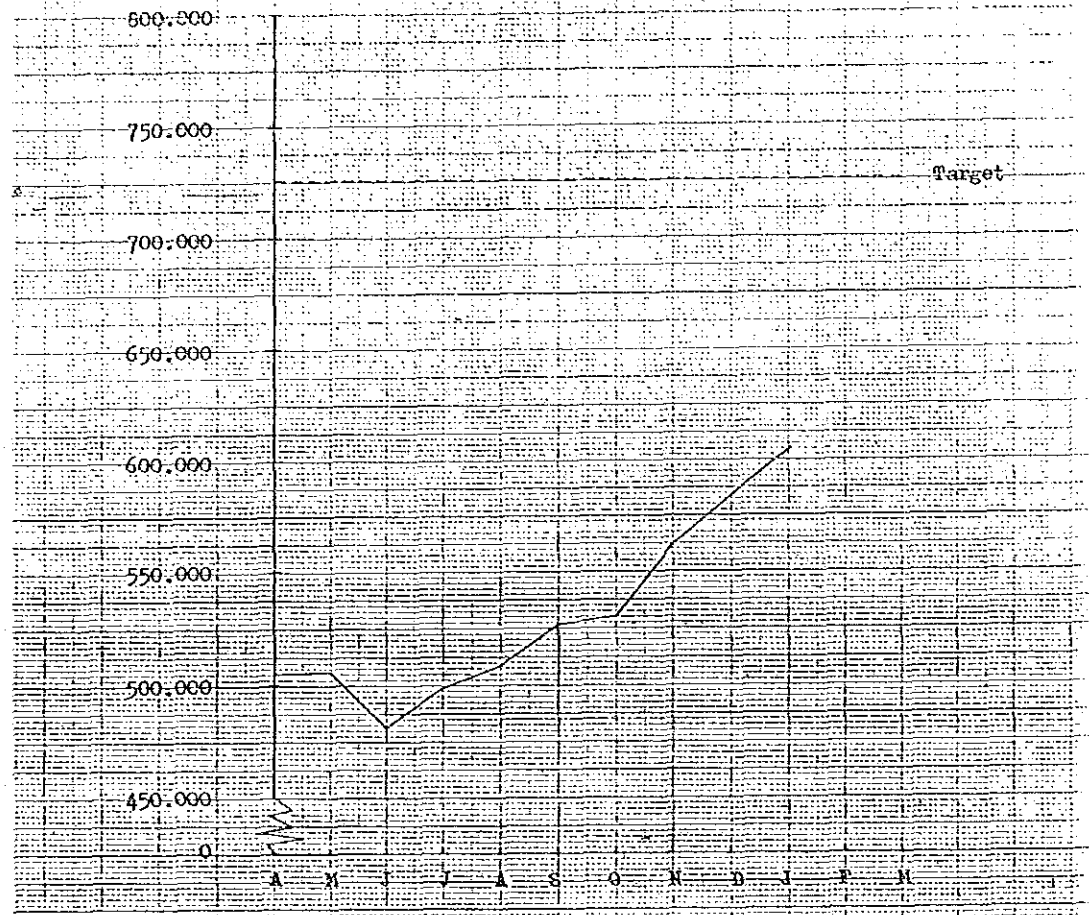
PROVINCE	NO. OF REGISTERED CLINIC ABRI	ARM FORCE	OTHR GOVT	PRI VATE	TO-TAL	% RE-PORT	% RE-PORT YTD*	NUMBER OF NEW ACCEPTORS CURRENT MONTH TOTAL	IUD	%	P I L L	%	CONDOM+ TABVAG	%	INJ	%	OTHERS	%
4 RIAU	107	12	10	9	138	85.7	90.6	3,921	605	15.4	2117	53.9	419	10.6	730	18.6	50	1.2
5 JAMBI	101	7	6	3	117	91.2	92.4	3,567	506	14.1	1978	55.4	104	2.9	962	26.9	17	0.4
7 BENGKULU	101	6	4	2	112	92.3	82.4	3,210	561	17.4	1501	46.7	70	2.1	1025	31.9	53	1.6
16 EAST NUSA TENGGAR	126	4	1	12	141	74.8	83.8	2,704	337	12.4	612	22.6	88	3.2	1618	59.8	49	1.8
18 CENTRAL KALIMANTA	124	8	2	7	145	69.7	84.4	1,862	257	13.8	1066	57.2	27	1.4	502	26.9	10	0.5
20 EAST KALIMANTAN	102	12	10	18	145	83.2	90.9	3,227	558	17.2	1306	40.4	114	3.5	1202	37.2	47	1.4
22 CENTRAL SULAWESI	70	7	1	14	112	93.7	89.6	2,457	337	13.7	1358	55.2	21	0.8	726	29.5	15	0.6
24 SOUTH EAST SULAWE	51	7	2	2	62	76.8	91.7	1,591	330	20.7	1090	68.5	9	0.5	142	8.9	20	1.2
25 M A L U K U	83	10	1	9	108	73.7	89.2	1,879	436	23.2	617	32.8	39	2.0	764	40.6	23	1.2
26 IRIAN JAYA	73	10	2	9	94	61.9	87.6	781	180	23.0	184	23.5	63	8.0	325	41.6	29	3.7
27 EAST TIMOR	39	4	1	0	44	71.4	96.2	391	47	12.0	132	33.7	5	1.2	203	51.9	4	1.0
T O T A L	1007	86	40	85	1218	80.0	89.2	25,590	4154	16.2	11961	46.7	959	3.7	8199	32.0	317	1.2

PROVINCE	ESTIMATED NUMBER OF PREVALANCE THIS MONTH I.U.D	%	P I L L	%	CONDOM	%	I N J	%	OTHERS	%	T O T A L
4 RIAU	13,613	17.6	42,474	55.2	6,879	8.9	10,776	14.0	3,168	4.1	76,910
5 JAMBI	13,804	15.6	57,506	65.1	4,893	5.5	11,240	12.7	797	0.9	88,240
7 BENGKULU	16,369	22.9	40,050	56.2	3,562	5.0	10,353	14.5	862	1.2	71,196
16 EAST NUSA TENGGAR	27,890	31.3	19,179	26.2	2,875	3.9	24,667	33.7	3,430	4.6	73,041
18 CENTRAL KALIMANTA	6,248	13.7	30,721	67.5	1,675	3.6	6,425	14.1	397	0.8	45,466
20 EAST KALIMANTAN	12,988	19.8	33,972	52.2	2,577	3.9	13,280	20.4	2,293	3.5	65,002
22 CENTRAL SULAWESI	12,271	18.0	43,684	64.2	499	0.7	10,187	14.9	1,315	1.9	67,956
24 SOUTH EAST SULAWE	4,590	13.6	36,164	74.9	1,005	2.0	3,706	7.6	778	1.6	48,243
25 M A L U K U	12,876	30.8	15,897	38.0	1,440	3.4	10,178	24.3	1,355	3.2	41,746
26 IRIAN JAYA	7,005	31.1	7,894	35.1	1,221	5.4	4,164	18.5	2,168	9.6	22,452
27 EAST TIMOR	486	7.9	3,477	56.8	130	2.1	1,945	31.7	79	1.2	6,117
T O T A L	125,032	20.6	331,018	54.5	26,756	4.4	106,921	17.6	16,642	2.7	606,369

PROVINCE	W M W A (15-44)	NEW ACCEPTORS Y T D *	F.Y TARGET	% TAR GET	ANNUALIZED Y T D *	%TARGET	PREVALANCE FY.TARG.	ACHIEV.	ACH./ 1000 MW
4 RIAU	353,933	32,469	63,656	51.0	38,962	61.2	101,000	76,910	217.3
5 JAMBI	258,113	31,187	45,930	67.9	37,424	81.4	97,000	88,240	341.9
7 BENGKULU	130,372	24,220	37,502	64.6	29,073	77.5	85,934	71,196	546.1
16 EAST NUSA TENGGARA	380,187	43,231	78,893	54.7	51,877	65.7	98,000	73,041	192.1
18 CENTRAL KALIMANTAN	161,032	19,775	20,656	95.7	23,730	114.8	60,000	45,466	282.3
20 EAST KALIMANTAN	205,554	29,138	36,300	80.2	34,965	96.3	71,000	65,002	316.2
22 CENTRAL SULAWESI	206,040	21,193	25,000	84.7	25,431	101.7	71,000	67,956	331.4
24 SOUTH EAST SULAWES	133,956	19,680	24,776	79.4	23,616	95.3	51,567	48,243	360.1
25 M A L U K U	212,563	21,258	30,000	70.8	25,509	85.0	46,000	41,746	196.4
26 IRIAN JAYA	202,453	17,502	23,969	73.0	21,002	87.6	31,000	22,452	110.9
27 EAST TIMOR	78,923	3,792	12,888	29.4	4,550	35.3	13,000	6,117	77.9
T O T A L	2,321,726	263,453	399,570	65.9	316,143	79.1	725,501	606,369	261.2

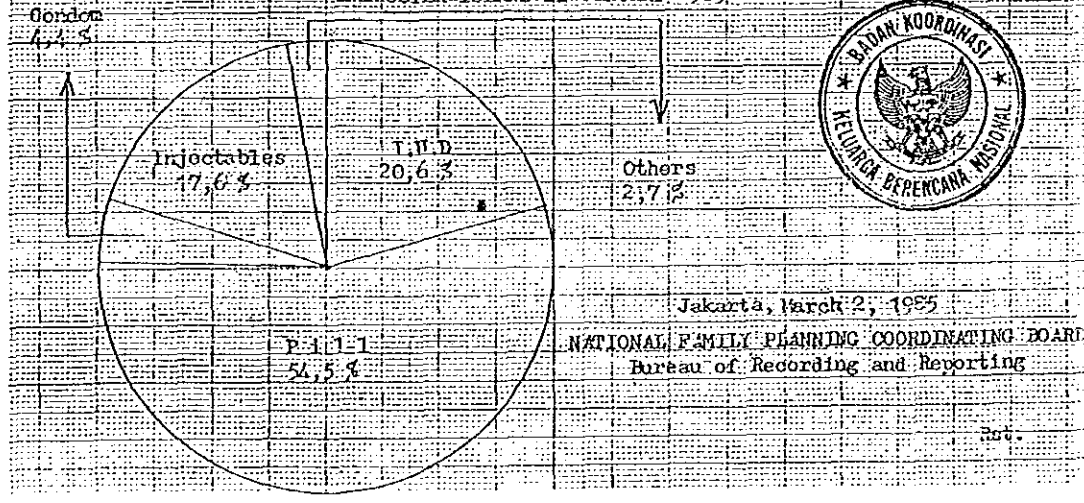
TOTAL NUMBER OF CURRENT USERS BY MONTH

OUTER ISLAND II 1984/85



THE ESTIMATION OF PREVALENCE RATE BY METHOD

OUTER ISLAND II JANUARY 1985



Jakarta, March 2, 1985

NATIONAL FAMILY PLANNING COORDINATING BOARD
Bureau of Recording and Reporting

Ant.

Ⅳ 資　　料

1. インドネシア側プロジェクト評価報告書
2. 討議議事録集
3. 第4次協力期間を中心とする供与機械リスト（1981～1984年度）
4. 国家家族計画調整委員会組織図
5. 国立家族計画医学センター構想にかかる安請書
6. 小槻調整員総合報告書

1. インドネシア側プロジェクト評価報告書