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REVIEW OF THE INDONESIAN NATIONAL FAMILY PLANNING PROGRAM

REMARKS
OF
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NATIONAL FAMILY PLANNING COORDINATING BOARD
JAKARTA, INDONESIA

and

THOMAS REESE, CHIEF, OFFICE OF POPULATION/USAID
JAKARTA, INDONESIA

BEFORE

THE HOUSE SELECT COMMITTEE ON POPULATION
UNITED STATES HOUSE OF REPRESENTATIVES
APRIL 27, 1978

Jakarta, Indonesia
1979

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ACKNOWLEDGEMENTS

Dr. Haryono and Mr. Reese would like to express their appreciation to Dr. Suwardjono Surjaningrat, Head, BKKBN, for his continued support and encouragement. Dr. J.S. Parsons and the staff of the Bureau for Research and Evaluation, BKKBN, assisted in the preparation of Dr. Haryono's statement. Financial arrangements for the trip to Washington were provided by the U.S.A.I.D.

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REVIEW OF THE INDONESIAN NATIONAL FAMILY PLANNING PROGRAM

The following is the text of the testimony given by Dr. Haryono Suyono, Deputy III of the BKKBN, and Mr. Thomas Reese, Chief, Office of Population/USAID, Jakarta to the House Select Committee (of the Unites States House of Representatives) on Population on April 27, 1978.

Ladies and Gentlemen:

It is indeed a very great honor for me today to appear before this House Select Committee on Population as a representative of the Indonesian Family Planning Program. Thank you very much for your kind invitation and for the opportunity to describe for you our efforts to reduce national fertility and to contribute to the building of a just and prosperous society for our people.

I would like to briefly describe for you the evolution of our program, its present strategy and its objectives for the future. Before I do I would like to share with you several basic facts:

– Indonesian's population is currently estimated to be between 135 to 138 million people, making our country the fifth most populous country in the world.

– Approximately 65% of the total population is crowded into the Island of Java, which representing only 7% of the total land area of our 3,400 mile long archipelago, is about the size of the state of Louisiana.

– Over 30% of the people are illiterate, more than 60% are employed in agriculture and the estimated per capita GNP is between $150 - $200 per year, less than a well paid factory worker in America earns in a week.

– Despite the absence of significant improvements in socio-economic conditions for the mass of the people, the Indonesian Family Planning Program has achieved a total of over 9 million new acceptors of contraception in the 8 short leaders in signing the United Nations Declaration on Population. In February of the following year, an Ad Hoc Committee recommended establishment of a National Family Planning Program whose first priority would be contraceptive distribution in Java and Bali. A semi-government National Family Planning Institute was established which gradually assumed full responsibility for the provision of contraceptive services on these two most populous islands. By mid-1970 a Presidential Decree transformed the Institute into a fully Government Agency - The BKKBN or National Family Planning Coordinating Board - which is responsible directly to the President and is fully responsible for all family planning activities.

The BKKBN has its own budget, up from U.S.$ 4.6 million in 1970 (of which about 70% was foreign donor supplied) to U.S.$38.8 million in 1977 (of which 46% originated from foreign donors), and staff at the provincial and regency level.

The main functions of the BKKBN are formally defined as coordination, planning,

of family planning activities, both public and private. Its authority for overseeing these activities stems largely from its budgetary control over all family planning matters. The BKKBN itself does not directly provide contraceptive services to the public. Instead, it coordinates the work of various "implementing units" who manage the day-to-day activities of the family planning program, such as conducting information and motivational campaigns and the actual provision of contraceptive services. These implementing units consist of Government Ministries, such as the Ministries of Health, Information, Education and Culture, Social Affairs, Religion, etc., and other Government bodies, such as the Armed Forces Family Planning Institute, and private associations, including the Indonesian Planned Parenthood Association, the Muslim Association and the Indonesian Council of Churches. Complementing these units are the BKKBN's staff of fieldworkers which in 1977 numbered more than 7,000. The fieldworkers, located only on Java and Bali, are directly responsible for face-to face motivational work, for recruiting new acceptors, for supervision of various acceptor group activities, and for providing a major logistical link for contraceptive resupply between the clinic and pill and condom users.

The Government's initial involvement in family planning activities was focused on the Islands of Java and Bali where population pressure was greatest. In order to make widespread family planning services available as quickly as possible, the Ministry of Health's existing health services infrastructure was utilized. Simultaneously, new health clinics were constructed, vehicles were procured and dispatched to the field, motivational campaigns were launched and health personnel throughout Java and Bali were trained in the provision of information, motivation and contraceptive services. Like many other early programs elsewhere in the region, the family planning effort developed initially as a clinic oriented program in which potential acceptors were required to come to fixed

Although the clinic based program [illegible] ful in increasing the annual number of new acceptors from a little over 50,000 in 1969-70 to almost 1.5 million in 1974-75, the ability of the program to consistently achieve such results was called into question. First, it was becoming apparent that, if a new tact were not taken, new acceptances would likely "plateau out" similar to what had occurred in other large programs. The reserve of already highly or marginally receptive couples was being rapidly depleted, leaving in its wake a more resistant hard-core group which was less willing to overcome the frictions of distance, cost, and relative indifference to obtain contraceptive services from distant clinics. Second, new acceptors were increasingly selecting the pill and condom (from 54% pill and 3% condom in 1971-72 to 69% pill and 19% condom in 1974-75).

This suggested that resupply of large numbers of existing users scattered over a wide area was to become increasingly difficult and could not be easily surmounted by the fixed clinic approach. Third, given the magnitude of eligible couples to be reached (estimated to be about 14 million for Java and Bali in 1974) and the number of villages to be served (approximately 22,000), it would not be possible to provide an official program presence sufficient to reach and recruit more resistant couples nor to resupply and reinforce the motivation to continue contracepting of those already recruited into the program. Fourth, as additional provinces were added to the BKKBN's responsibility (10 in 1974 and the remaining 11 in 1979) and as it became evident that the program's administrative structure that emerged for Java and Bali could not be replicated in 21 additional provinces without severely taxing the program's financial resources, a new service delivery system would have to be devised. Finally, the program had set for itself the ambitious goal of reducing national fertility 50% by the turn of the century. This implied that not only excessive fertility had to be

be universally adopted. Given the low levels of socio-economic development characteristic of the country, it was unlikely that the perceived and actual value of children to the individual could be substantially lessened without simultaneously attacking those environmental conditions which encourage higher than replacement fertility.

As the program passed through its early infancy, two major program objectives emerged. First, primary emphasis was to be placed on making family planning a village rather than clinic oriented activity. Furthermore, primary responsibility for managing and implementing a program of fertility limitation, including motivating, recruiting and maintaining family planning acceptors, was to be transferred from the Government to the people and their communities.

The second objective was to gradually broaden the scope of family planning from its more narrow birth prevention realm to more positive objectives of promoting overall family welfare by linking family planning with the general development program of the Government.

The strategy for achieving these objectives is twofold. On the one hand, the family planning program is endeavoring to build an institutional capability at the community level for assuming family planning program functions and responsibilities. On the other hand, the family planning program is striving to work more closely with various government ministries to systematically overcome existing environmental constraints to permanent practice of fertility limitation and acceptance of small family norm. In addition, the BKKBN has begun to explore possibilities for directly linking an increased allocation of development funds and activities to community achievements in gaining some measure of control over its own fertility and in achieving this through the creation and strengthening of a community supported family planning institution.

The Java-Bali approach takes as its basic model the highly successful *banjar* system

hamlet closely knit by common economic, social, religious and ceremonial interests. During monthly meetings of the male heads of houshold, community related issues such as irrigation, taxes, disputes and religious and temple festivals, are discussed and resolved through group consensus. Recently family planning issues have been successfully introduced as topics for community deliberation and increasing responsibility has been placed on the hamlet administrative structure for managing its own family planning effort. For example, each head of household is required to report publicly the family planning and pregnancy status of every married woman of reproductive age in his household. *Banjar* registers are compiled listing all eligible couples, their location in the hamlet, their use of contraception and information on their receipt of pill and condom resupplies. The actual provision of resupplies has become largely a *banjar* responsibility and constitutes an additional activity of the monthly meeting. Maps of the *banjar* are drawn which identify every household according to its eligibility for and use of contraception by method, and these are prominantly displayed in the hamlet meeting hall.

In short, the Family Planning Program on Bali has succeeded to a large extent in making the individual practice of family planning a community issue for which the community assumes increasing responsibility.

For a variety of reasons, however, it is unlikely that the Bali experience can be completely replicated on Java. For one, Bali is predominantly Hindu where as Java is Muslim. The roles and responsibilities of the individual and the community are quite different under each. Stemming in part from this is the fact that the Javanese hamlet is much less closely knit either in terms of kinship or other interests. Monthly community meetings such as those occurring on Bali rarely occur in Javanese hamlets. In addition, Bali is geographically more compact and culturally more homogeneous than Java. As a consequence innovations on the order of the

Despite these obvious differences, though, the BKKBN has embarked on a large scale program to develop a similar sense of community involvement in and commitment to family planning on Java as is found on Bali. The first step is achieving this is through the program's provision of contraceptive resupplies to those already using the pill and the condom. Village contraceptive distribution centers (VCDC) have been created in most of the villages on Java. The *Pos KB*, or family planning post, is usually manned by a village volunteer, such as a member of the headman's staff, his wife or by another acceptor, and pill and condom resupplies are made directly available from village sources rather than solely from the more remote clinics. Each month fieldworkers bring supplies from the clinics to the VCDCs. They also assist the family planning volunteer in maintaining the list of current users who obtain resupplies from the post, noting down the names of acceptors who have not returnned so that a follow-up visit can be made by the midwife or fieldworker, and fill out monthly reporting forms for the BKKBN National Headquarters. The village volunteer may distribute supplies directly to users in the village, often by means of a monthly meeting of all acceptors. During such meetings remotivation by clinic staff is provided, and special courses, such as nutrition or sewing, or other social activities, such as the ubiquitous lottery, are held. In some cases the Post serves simply as a resupply link to hamlet level acceptor groups. These groups have sprung up in order to make resupplies even more convenient by eliminating the need regular trips to the supply depot.

The *Pos KB* and hamlet acceptor groups have become the basic building blocks upon which the BKKBN expects to create a community awareness of the importance and benefits of fertility limitation while at the same time developing a capability for managing its own family planning activities. However, the Post represents only acceptors, and its functions, although beginning to broaden out into more "beyond family planning" activities, are still limited primarily to contraceptive resupply and logistics reporting. In only a few areas do members of the acceptor group actively work to motivate and recruit others in the community. Furthermore, the range of non-family planning activities undertaken, such as various economic cooperatives, rice and money saving programs, and handicraft industries, is limited and is restricted primarily to members of the group itself. In short, the acceptor groups are just beginning to be community supported institution which are widely recognized as a tangible community assest contributing to an improvement in the quality of life for everyone.

Whereas on Java and Bali the BKKBN has been able to maintain a strong official program presence at the village and hamlet levels through the fieldworkers and has been able to directly guide the development of community participation in family planning activities, a similar presence is not possible on the Outer Islands where fieldworkers are not employed. The program has, therefore, had to find an alternative approach for reaching the village and for directly transferring program responsibility to non-program personnel.

The approach settled upon involves vesting full program responsibility by the Government as its coordinator of all developmental programs in his jurisdiction. The *Camat*, or sub-district leader, thus becomes the focal point for ensuring that communities themselves become involved in and ultimately take over complete management of family planning activities. In order to ensure that the *Camat* is capable of executing his family planning duties effectively and competently, the BKKBN has begun a massive step-by-step training program in each of the 10 Outer Island provinces. Trainning is now being provided by the BKKBN Central Headquarters to a provincial level team composed

staff. This team in turn conducts training for a similar group at each administrative level. In short, the BKKBN expects to use its training program not only as an educational tool but also as a mechanism for securing the commitment of the entire provincial administrative structure in the implementation and management of community family planning programs. Thus, compared with Java and Bali where family planning program implementation has been primarily the responsibility of the various implementing units under the overall direction of the BKKBN, in the Outer Islands this responsibility will rest more squarely in the formal provincial administrative structure and on the communities themselves.

The ultimate success of family planning in Indonesia depends on the development of an individual and community commitment to the practice of fertility limitation and acceptance of a small family norm.

In order to broaden the appeal of fertility limitation while at the same time assisting the Government's developmental effort to improve the quality of life of the people, the BKKBN in cooperation with other Minitries of the Government, will soon begin to employ its program personnel and its community level infrastructure to address what it considers to be five basic needs of all Indonesians. These include health, education, employment, income generation and the status of women.

The health needs of the country, especially in terms of infant and childhood morbidity and mortality, maternal and child nutrition and primary health care, are particularly pressing and greatly influence the level of family planning acceptability. A new project entitled the Small, Healthy Family Project, which has already received substantial funding from one international donor agency and which is promised additional funding from other donors, including AID, will utilize the family planning fieldworkers and community acceptor groups to institute a graduated project which will be by the mothers themselves participating in acceptor groups and under the supervision of the fieldworkers and the Ministry of Health personnel.

Periodic weighing of infants and children under the age of five and simplified recording procedures will help the mothers identify those children whose weight gain is faltering, long before the permanent effects of malnutrition have taken hold. A community and health clinic program of supplementary feedings will ensure that normal weight gain is restored or, in the case of other disorders, such as TB and intestinal parasites, that referral is made to appropriate health personnel for prompt treatment. The monthly weighing sessions which will bring together all young children in the community will enable health personnel to more easily conduct immunization drives.

As community participation in these preliminary health and family planning activities increases and as better coverage of all classes of people is achieved, a community health volunteer will be trained to provide primary health care, especially oral rehydration in cases of severe diarrhea, a major killer of young children in Indonesia, and to identify more severe diseases to be referred to the health center.

Other health projects will be undertaken as the community gains experience with these more basic interventions. A primary objective is to the transformation of the health system from a passive one to an active one. Included is a community health insurance scheme, already in operation in some portions of Central Java, in which each member of the community contributes according to his means to a plan which provides free or subsidized medicines, transportation to health facilities and at least partial hospitalization coverage.

As improvements are registered in the provision of health care and in the acceptance of responsibility for managing the community's

inputs which address other basic needs. Included are the contruction of additional classroom facilities, partial support of tuition and other school fees for the children of poor families, encouragement of handicraft industries and other productive activities, such as cooperatives and credit unions, and especially activities which increase the utilization of female labor.

Having explained about our organization, progress to date and ambitious plans for the future I would like to say a few words about AID assistance to the National Family Planning Program. AID and the BKKBN have known each other for almost a decade. We are friends and it can be confidently said the relationship is one of trust and mutual respect.

The AID financed support to Indonesia is substantial and Mr. Reese has the facts and figurers. But there is more here than just financial support, there is a spiritual and moral support for our efforts to which a price tag cannot be attached. I believe we have had such a relationship because the AID staff – from Mission Director to Population Officers – has always been willing to listen and to learn, to stay in step with the Indonesian pace. They have quickly come to understand, for example, the Javanese "yes". We Javanese are polite and desire harmonious relationships. Thus, we have what we call three Javanese yeses. The first level yes means no. The second level yes means maybe. The third level yes means yes. I am sure you appreciate, Mr. Chairman, how confusing this can be to Americans.

AID has worked closely with us to identify problems and constraints, then seek local solutions, AID has not attempted to bring to Indonesia ready made programs designed in far away places such as Washington, New York or Geneva. Programs that are often totally inappropriate for large scale replication in the LDC setting. Together AID and the BKKBN developed a research and development program in which the planning services to our people. With the resources of the BKKBN–AID research and development project and local initiatives, we developed the Village Family Planning System. The System we now see as not only a means to the small family norm, but a new frontier of development opportunity.

The roll call of United State's personnel with a keen interest in our population efforts is a long one and I need not list the names here. I would, however, be remiss if I didn't mention the previous USAID Mission Director Richard Cashin and the current Director Thomas C. Niblock. I must, of course, mention Dr. Ravenholt who – although he does not effect the quiet, retiring Javanese style - has been an inspiration to us. We deeply appreciate his support and awareness of our efforts, his often expressed sense of urgency to, as he says, "drive the program."

Finally I want to repeat that the task ahead looms large and the family planning program is beginning to navigate largely uncharted waters - waters beyond family planning, a voyage which we hope AID will continue to share with us. There exists a strong national determination to meet the basic needs of the people and to do so in such a way that the resolve of the people to limit ther fertility, for their own good as well as that of the nation as a whole, is strengthened; and communities gradually assume greater responsibility for directing the future course of their lives, including their own program of fertility limitation.

Ladies and Gentlemen, Indonesia has made great progress in solving its population program. We have a long to go yet and a great deal more needs to be accomplished before we can permanently remove the spectres of famine, malnutrition, ignorance and poverty. However, with the continued and generous assistance of countries such as the United States, we will be better equipped to resolve our own problems and to contribute our share to the stability of the world order and to the productivity and well-being of all mankind.

REMARKS
OF
THOMAS H. REESE III
CHIEF, OFFICE OF POPULATION
USAID / JAKARTA

BEFORE

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this opportunity to appear before them to discuss the USAID assistance to the Indonesian National Family Planning Program.

From FY-1968 to FY-1977 AID has provided $44 million of assistance (including a $7.3 million loan) to the Indonesian family planning program. This assistance has included vehicles, medical equipment, short- and long-term training, contraceptives such as condoms, IUDs and oral contraceptives, plus local currency support for family planning research and development activities.

I believe the USAID assistance has been well utilized. Various U.S. auditors from the GAO, IGA, AG and IIS have audited the USAID population support to Indonesia and reported favorably on the administration and management of USAID's population assistance efforts.

USAID has provided 250 jeeps in order to facilitate province-to-village transportation. We have provided medical equipment such as IUD insertion kits for the clinic program. Short- and long-term population training has been provided abroad for 387 participants. Dr. Haryono is a former AID participant, having received a Ph.D. from the University of Chicago in 1972.

USAID has provided contraceptives, especially oral contraseptives, known as OCs, and through FY-1977 we have ordered and delivered almost two hundred million OCs to Indonesia. We believe it is essential to keep ample supplies of OCs on stock in-country - at least a year's supply - in order to encourage liberal distribution. In the early days Jarrett Clinton, USAID's first Population Officer, noted a tendency of Ministry of Health (MOH) officials to hoard scarce supplies. This tendency he called the "Cookie Jar Phenomenon." When the cookie jar is full, you tend to be liberal with the cookies. You hand them out. You partake of them. But as the supply dwindles them away. Save them for tomorrow.

To break this hoarding tendency we found in the early days that it was necessary to demonstrate ample supplies were available in order to move the OCs out of Jakarta and into the provinces, from the provinces to the counties, from the counties to the clinics. At each step in the supply line we found people, people used to scarcity as a way of life, tended to hoard the OCs - just in case. Thus, it was necessary to continually push the OCs through the system until each level had its reserve and field personnel were confident that stocks could be replinished. Then and only then would we get the two to three months supply in the clinic that we desired and maximum in OC usage.

I am convinced that if the BKKBN* had not had ample OC supplies, they would not have been able to establish the village OC contraceptive depots. Without ample supplies and the belief that more supplies would be forthcoming, the clinics would not have been willing to stock the village depots.

In another important area, USAID has provided $3.6 million in local costs support - especially for research and development projects. The essential ingredient in the R&D project's success has been the leadership of Dr. Suwardjono, Chairman BKKBN, and Dr. Haryono, and the BKKBN's willingness to experiment and innovate in trying to find better and improved ways of delivering and creating an awareness of family planning methods. The BKKBN-USAID R&D projects provided the BKKBN with the wherewithal to test the high risk, high gain ideas such as the village family project. It supplied the venture capital.

I would like to emphasize that in late 1974 when the first few village depots

* BKKBN = National Family Planning Coordinating Board.

for village family planning. There was also great hesitation to move to the village: What would local formal and informal leaders think? What would religious leaders thinks? What would security officials think? Most important of all, what would the people think? Although viewed as risky, the BKKBN believed that somehow, through some means, the program had to move closer to the village. Again and again there were complaints in the field from program personnel that the clinic was too distant from the people to support the scale of program that was required to make a meaningful impact on the birth rate.

Step-by-step, the village family planning program evolved, dissipating fears and conventional wisdoms until each province on Java and Bali - six in all - had designed their own unique village family planning programs. Currently USAID is assisting the BKKBN in pilot testing the village family planning (VFP) program in the Outer Islands.

It is important to mention that the USAID style of operation is important as roles are sometimes not clearly defined in social development projects where lines of expertise and responsibility are less clear than in engineering or construction projects. Beginning with USAID's first population officer in 1968, the population staff has considered themselves not advisors or consultans to the Indonesian Government, but managers of USAID resources. There is an important difference. We have worked to develop collegial relationships with our BKKBN counterparts in order to:

(1) identify problems;
(2) bring resources to bear to resolve these problems;
(3) utilize AID's comparative advantages in achieving the goals and objectives that the Government of Indonesia has set.

If we are advisors, then we are advisors to the USAID Mission Director, advising him

Within this framework we have never lost sight of the fact that we are working in Indonesia - but not Indonesian. To put it another way we stand on the sidelines, not the playing field - the game is ultimately theirs.

As Dr. Haryono has already mentioned, the National Family Planning Coordinating Board (BKKBN) coordinates Indonesia's family planning efforts. The BKKBN is an independent coordinating body organized in 1970, reporting directly to the President. The BKKBN's family planning progress from 1970 to now is, in fact, remarkable:

- 9 million women recorded as acceptors;
- currently 30% of the eligible couples using family planning in Java and Bali;
- 22% are users country-wide;
- a 15% reduction in the Crude Birth Rate on Java and Bali;
- a 10% reduction in the country's population growth rate from 2.1% to 1.9%;
- a village family planning program consisting of over 20,000 family planning posts and 40,000 sub-village family planning groups on Java and Bali;
- 10 village family planning pilot programs underway in the Outer Islands.

Based on the BKKBN's success to date and results of a 1976 Intercensal Survey, which indicate a significant reduction in birth rates on Java and Bali, the Government of Indonesia's Central Bureau of Statistics is revising its estimate of the population in the year 2000. These projections, although not now officially available, will estimate an Indonesian population of around 200 million people by the year 2000 - a revision downward from the former estimate of 250 million people at the turn of the century. In other words, 50 million people less.

I believe the Indonesian population will eventually stablize at 275-300 million people, not at 600-700 million as frequently cited in early 1970 when the program had just begun.

wich village family planning. The BKKBN is testing the feasibility of utilizing the village family planning system to deliver health and nutrition services. In addition, sub-village family planning groups are expanding into handicrafts and non-formal education activities. We are seeing the transformation of the village family planning program into a village vehicle for development.

Based on my experience, I believe Indonesia has made such remarkable progress in such a short period due to a number of factors:

(1) President Suharto's continual and visible support for the family planning program;

(2) the increasing budget support from the National Development Planning Agency;

(3) the dedication of the BKKBN staff at the Central, provincial and district levels;

(4) the excellent cooperation between the BKKBN and the Ministry of Health in utilizing public health clinics to make available clinical family planning services;

(5) the continued strong support of other Government Ministries such as Information, Religion and Home Affairs; and

(6) the generous and flexible support which AID has been able to provide to the total effort - especially in the area of research, development, innovation and experimentation.

In addition, the BKKBN has adapted a decentralization planning model in which the provinces are allowed to design and implement their own family planning programs. This insures program actions that are harmonious with regional cultural nuances, and takes advantage of a Government administrative structure that extends from the province to the sub-village.

Indonesia has managed and utilized this assistance wisely. Principle donors in the past were AID, IBRD, Japan, UNDP, Ford Foundation and The Population Council.

I believe the USAID assistance to the BKKBN has been effective for a number of reasons. We have been blessed with able, vigorous Mission Directors who took a personal and keen interest in the USAID population assistance program. Both Mr. Cashin, the former Mission Director, and Mr. Niblock, the current Mission Director, have unstintingly supported the program. We have received strong AID/Washington support from Dr. Ravenholt's office as well as from the Asia Bureau. AID/Washington has allowed us flexible guidelines in developing our projects and in managing and administrating project implementation. We were fortunate that Congress has seen fit to provide funds so that USAID/Jakarta projects received adequate funding. If I am not mistaken the population problem is the only one of the key development problems which the Congress and the Administration have approached with the full concern and commitment to do all that could reasonably be done to cope with the problem. We appreciate the fact that we were asked how much money and other resources we could use. We were forced to seek out programs and back innovations. We had more flexibility in the field than in any other program. We had grant rather than loan funds. We were challenged to do our best. Red tape was held to the minimum.

In the past six years in Indonesia I have visited more than 100 villages - most of them with Dr. Haryono. I have two vivid impressions from this extensive field experience.

First, the quality and dedication of the Indonesian officials working in the field program on a day-to-day basis is high. These are the BKKBN and other government

heroes of development. They represent a tremendous resource, a corps of development workers that Indonesia can be proud of, an asset for the future.

Second, the VFP program has demonstrated that the village can be penetrated, that rural people are ready and receptive to development programs. The Indonesian Government is increasingly concerned with rural development activities and there is today a sense of movement to the village.

USAID's total assistance program has dramatically shifted gears the past few years in response to the Congressional Mandate to move from super highways and fertilizer plants to assistance to the rural poor. In addition to population programs, USAID assistance today consists of programs planned and designed to:

- improve village health through sanitation, vector control, child immunization and village nurse training.
- increase food production through agricultural research, rural works and small irrigation systems.
- provide rural electrification to deliver a reliable source of energy in rural areas for increased village productivity.
- experiments with area integrated development projects that focus on farm-to-market roads, irrigation systems, agricultural extension services, cooperatives and personnel skills training.
- and in all these programs expand training to develop leadership. There are now about 500 Indonesian students studying abroad under AID sponsorship. This number will double over the next few years.

As Dr. Haryono has mentioned, the village family planning group will become the focus for expanded development activities. the VFP system. Thus, the Government will not only encourage child spacing and the small family norm, but also simultaneously show concern for family welfare through:

- baby weighing and child growth monitoring.
- immunizations.
- clinic referral.
- sanitation.
- home gardening.
- nutrition education.

During baby weighing and child growth monitoring, family planning workers will identify slow growing children and provide supplemental feedings for undernourished children with meals provided by the family planning cooking classes. The USAID PL-480 Title II program will provide the food for the cooking classes. Thus, USAID family planning and the PL-480 Title II program will link-up in the village to provide support for child spacing and small families and also demonstrate a tangible concern for living children and a means to assist children in healthy growth and development.

Interestingly, as this project develops we see Government of Indonesia planners are forced to coordinate with other development sectors. In weighing and charting child growth, family planning workers must consult with the health staff. In deciding on supplemental feedings, the nutritionist must be brought in. In considering growing village food supplements through home gardens, the agriculture extension workers are consulted. Agriculture extension efforts may require an increase in non-formal education in order to increase village literacy. If home gardens produce a village surplus, then a road is required to move the produce to market, Each step in solving the problem leads to yet another contact with a different developmental sector.

Thus, we are seeing that village family planning - the antithesis of macro planning - catalyzes integrated development. When you

difficult to ignore the other needs and wants of the village - especially those of the children. It is also natural for the villagers to ask: "Where are the other programs? The nutrition programs. The health programs? The education programs?"

I believe Indonesian planners and administrators have gotten the message. I know that to brief other high government officials on village family planning. I believe there is now a new sense of direction. A new journey has begun. It is a long journey, but a noble one. I believe it is a journey that the American people - with their peculiar concern and admiration for people working together to solve their problems and improve their lot - will be proud to have shared in.

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