Partners in Population and Development (PPD)
A South-South Initiative
Permanent Observer at the United Nations

COUNTRY REPORT

INDONESIA

South-South Collaboration
in
Capacity Development

Lesson Learnt from
Successful Interventions

Chapter I
INTRODUCTION

A. Background

Indonesia presents a unique case for the study of family planning/reproductive health strategies and approaches. When the country started its family planning/reproductive health program in early 1970s, the country was very poor. As the world's largest archipelago, peopled by a culturally and linguistically diverse but predominantly Muslim population, it was a setting generally considered, by many countries in the developing world, unlikely to allow a family planning/reproductive health program to succeed.

Remarkably, in just about two decades, Indonesia's family planning/reproductive health program had beaten the odds, when most of standard criteria used to evaluate such a program, it would have seen that the Indonesia's family planning/reproductive health program have been **very successful**. For example, when the program started, for the average Indonesian woman the Total Fertility Rate was 5.6, that number is now 2.6 (Indonesian Demographic Health Survey of 2002).

However, even at the beginning of the program, it did not **only** apply demographic thinking and measures for its progress. It also thought about culture and cultural change. The program set an extremely important goal - a basic change in the **attitudes** of the people. It is expressed as the development of a new behavioral norm for all Indonesians to believe **that a Small, Happy, and Prosperous Family** is desirable, this has been currently improved **to Quality Family is desirable.**

The features that made the family planning/reproductive health program successful likewise bring out useful lessons. These are:

- **Coordination.** The program is structured differently than most. The National Family Planning Coordinating (BKKBN) coordinates the activity of others, but does not implement the program. This is done by a large number of agencies both govern-ment and non government ones.
- **Political Commitment.** Demonstrated at the highest to the lowest levels of the government administration; this has generated wide national and international support to the program.
- **Clear-Cut Policy Making.** The program has allowed the creative and effective integration and coordination of efforts by agencies from the government and from the private sectors.
- **Support of Key Leaders**. Has mobilized the active participation of leaders of the Muslim, Christian and other religions.
- **Organization Dynamism.** Has developed an extensive and well-established organizational and structural system for program execution.

- **Community Participation**. Has involved millions of committed women volunteers and community-based organizations, which has evolved into a community **ownership** of the program. This, together with the involvement of the private sectors, has enabled the program to have a well-established system for nation-wide contraceptive distribution.
- **New Value Promotion.** The Program has helped attain the norm of Small, Happy and Prosperous Family currently improved into Quality Family among the Indonesian families

The vision of a new partnership in population took form at the 1994 ICPD with formation of the Partners in Population and Development: A South-South Initiative (PPD). It is **an inter-governmental alliance of developing countries**, whose **mission is to assist each other** to successfully address the reproductive health-including family planning and HIV/AIDS-population and development issues. It always seeks to expand and improve collaboration among developing countries in the field of family planning/reproductive health under the broad population and development objectives of the ICPD Program of Action. The establishment of Partners in Population and Development constitutes a global alliance of South-South Countries' resources aimed at accelerating the achievement of ICPD goals.

Within this framework, South-South collaboration is defined as the exchange of expertise, knowledge, informational products between individuals and organizations from developing countries, disregarding the origin of funds financing these activities. Each Partners country will strengthen institutional capacity to undertake program exchange or sharing of activities and initiated a number of trainings and consultative programs aimed at improving human and institutional capacity development, and encourage long-term country cooperation arrangements. The capacity is defined as **the ability of individuals, organizations and systems, including networks of organizations, to perform in support of their development objectives.**

However, there are several issues which are still pending in the agenda of the alliance. The unfinished agenda will, to a large extent, hamper the alliance's efforts to support the achievement of the above goals. The issues, among others include less access to quality reproductive health services, high maternal mortality rate, a high prevalence of HIV/AIDS, gender inequality and inequity, etc.

The alliance fully perceives that these challenges cannot be addressed in a sustainable manner unless the member countries work together to develop a human-centered perspective of development. Collaborating among member countries is a more effective and efficient way of addressing the reproductive health, population and development agenda, because countries could learn from each other's experiences of both policy and programmatic level.

As a key element of the Indonesia's Government policy in the enhancement of South-South Cooperation, Indonesia has started sharing its experiences with other countries in the field of population, family planning/reproductive health in early 1980s. The **National Family Planning Coordinating Board or BKKBN** through its International Training Program or **ITP** began to collaborate with other developing countries by receiving foreign family planning/reproductive

health professionals, policy makers, program managers and implementers, etc on a structured-study program rather than on ad hoc basis. As of February 2005 Indonesia has collaborated with 93 developing countries and hosted not less than **4,200 visitors**.

In this context of the alliance, BKKBN has developed its international sharing of experiences applying **an integrated capacity development approach-** a combination of four modalities - Observation Study Tour, Internship, Technical Assistance and Overseas Educational program as part of internal human resources development- on the basis of **a long-term bilateral arrangement.** This report of capacity development documentation will cover all program of the Indonesian collaboration, but for the sake of evaluation, it will focus on the collaboration that has been done with **Bangladesh and three African countries – Tanzania, Malawi and Ghana**.

B. Goal, Purpose and Objective

Goal

To contribute to build the capacity of member countries to accelerate the achievement of the ICPD and Millennium Development Goals by aligning member countries health system with successful interventions and practices in legislation, policies, human resource management, program design and implementation, and financial schemes of reproductive health services – including family planning and HIV/AIDS–, involving the different players that define and participate the national agendas, from governmental to grassroots stakeholders with media and civil societies in between.

Purpose

To contribute in improving the sexual and reproductive health– including family planning and HIV/AIDS- especially for poor people, in developing countries as a key component of their comprehensive human-centered development.

Objective

1. To identify the developing countries' successful intervention and practices for addressing the reproductive health– including family planning and HIV/AIDS, population and development issues.
2. To facilitate the design of member countries' plans to accelerate the achievement of the ICPD and MDG goals.
3. To facilitate the implementation of the member countries' plans for accelerating the achievement of ICPD and MDG goals following a collaborative learning process among them.

C. Data gathering

1. Nature of data and information

To determine the impact of the collaboration to the capacity development either in the provider or in the recipient both institution and individual, a set of data and information will be gathered

from the two categories of collaboration stakeholders (provider or recipient country). There are two sources of data and information to study the integrated approach on capacity development, which Indonesia collaborated with not less than 93 countries, but this report will only include data and information on the Indonesian collaboration with the Islamic Republic of Bangladesh and a group of three African countries (Tanzania, Malawi and Ghana).

2. Sampling

2.1 Primary data.

The primary data is only collected to study the impact of this collaboration on the capacity development by case to provider institution and individual. The sampling procedure uses the purposive homogenous sampling based on study cases. Data collection methods include distribution of questionnaires to the selected respondents of cases followed by a focus group discussion (FGD).

2.1.1 Observation Study Tour (OST)

As of its inception, the BKKBN International Training program has hosted 292 batches of OST participated by 4,159 people from 93 countries. Out of 292 batches, 19 (nineteen) batches of OST comprising 15 batches with Bangladesh, 1 each with Tanzania, Malawi and Ghana and 1 jointly attended by the countries were organized under special arrangement. The total number of participants were **392** Bangladeshi, **18** Tanzanians, **16** Malawians and **15** Ghanaians. There were 579 Bangladeshi, 99 Tanzanians, 30 Malawians and 46 Ghanaians participating in other OSTs.

BKKBN as the provider country of collaboration has its core stakeholders from both government and non government institutions at national, provincial and district level.

National level

The Government institutions included among others BKKBN, Ministry of Health, State Ministry of Women Empowerment, Ministry of Religious Affairs, while NGOs are among others YKB (Kusuma Buana Foundation), PKBI (Indonesian Planned Parenthood Association), Muhammadiyah, NU (Nahdlatul Ulama) – which are Islamic institutions. Persons involved from these institutions were assigned either as presenters during class sessions or field observation facilitators or workshop. In total, the OST program involved at least **10 professionals** (session topic specialists) and around **15 support staff** in every OST program. Of twenty-five stakeholders, there will be 6 (six) persons taken as study respondents. They consist of 4 government institution personnel (3 BKKBN, 1 Ministry of Health) and 2 (two) non-government institutions.

Provincial level

The institutions involved among others Provincial BKKBN, Local Government Province, Office of Health, PKK (Movement for Family Welfare), Religious institution, PKBI, Youth organization. The personnel who participated in the capacity development were professionals

from these institutions, government bureaucrats. In total, in every OST program, there were up to around 20 people participating in the OST implementation. Of these people, there will be 8 (eight) persons taken as study respondents. They comprise 5 personnel from government institutions (5 BKKBN and 1 Office of Provincial Health), and 3 from non government institutions comprising one each from PKK (Women Movement fro Prosperous Family), Islamic Council of Ulama and PKBI (Indonesian Planned Parenthood Association).

District and Sub-District level

The institutions involved are District BKKBN, Local Government Province, District, Sub-District and Village), Offices of Health (Province and District), PKK (Movement for Family Welfare), Religious institution, PKBI, Youth organization. The personnel who participated in the capacity development were among others professionals from those institutions, government bureaucrats, FP Fieldworker and Supervisors, Volunteers, Community leaders, village government personnel, medical doctor, midwife, nurse and volunteers. In total, in every OST program, there were up to around 30 people participating in the OST implementation. Of these people, there will be 8 (eight) persons taken as study respondents. They comprise 6 personnel from government institutions (4 BKKBN and 2 Office of District and Sub-District government) and 2 from non government institutions comprising one each from PKK (Women Movement fro Prosperous Family), Islamic Boarding School.

Sample area

All OST programs had the field observation sites in 17 provinces in Java and Bali and outer islands such as North Sumatra, West Sumatea, West Kalimantan, South Sulawesi and West Nusa Tenggara, etc.

However, for the study of the Indonesia's collaboration with Bangladesh, Tanzania, Malawi and Ghana, the sample area is elected based on the most frequent province organizing the OST field observation. Of 19 batches of the OSTs for Bangladesh, Tanzania, Malawi and Ghana, 9 (nine) OSTs took Yogyakarta province for the field observation site, 5 (five) OSTs used East Java province, while the remaining 5 were done in West Java province. Then, Yogyakarta province will be taken as the study sample area. In total, there will be 22 respondents taken for the study of OST case.

2.1.2 Internship

Unlike a normal OST, the internship program spent up to two days at national level. The remaining duration (almost three months) was spent at provincial level for Indonesian language study for about one month, while almost two months were spent in sub-district and village levels.

National level

BKKBN personnel mostly from the International Training Program (ITP) briefed the interns about the internship program process and the national family planning program policies. Administrative and logistics were also oriented at national level. In addition, the ITP personnel monitored the internship program implementation and progress made regularly by making visits to participants and the provincial and district BKKBN. There were at approximately 8 personnel involved in managing the internship program. Of these people, there will be 2 personnel from BKKBN taken as the study respondents.

Provincial level

There was about 10 BKKBN staff directly involved in managing the internship program. Their jobs were providing technical briefing on program technical matters such as IEC, Reporting and Recording, Community Participation, etc, monitoring the implementation regularly at village (together with District BKKBN staff) and progress made as well as problems faced by participants and solved. Of these personnel, there will be 4 personnel from BKKBN taken as the study respondents.

District and Sub-district level

There were approximately 15 personnel directly involved in the management of the internship program. They mainly comprised sub-district government, village head, fieldworker and fieldworker supervisor, volunteers (cadres) community leaders and PKK. Their tasks were among others to implement and monitor the implementation of internship regularly at village and check progress made by the participants. Of these personnel, there will be 5 people taken as the study respondents comprising 4 BKKBN personnel and 1 Sub-district government staff.

Sample area

The study takes Yogyakarta province because all the internship programs were took place in Yogyakarta province. In total, there will be 11 respondents for the study of internship case.

2.1.3 . Technical Assistance

As described earlier, there were 29 Family Planning/reproductive health program experts trained in 'How to Be a More Effective Short-Term Consultant". They were recruited from national and provincial level of BKKBN and its Non Government partner institutions. Of 29 short-term consultants, 20 persons were from national level and the remaining 9 were from provincial level. Viewed from the institution of origin, there were 24 BKKBN personnel (government) and 5 NGO's ones. They have been assigned in at least 17 countries in Africa, Asia and the Pacific regions. Under UNFPA financial support, BKKBN assigned 2 (two) short-term consultants **Tanzania** helping the Tanzanian Family Planning program strengthen its **Community Based Distribution** (CBD) and **IEC** programs, while another 2 (two) experts were sent on a short term consulting services to Malawi on **Management Information System** (MIS) for family planning program.

Sample area

There will be 4 respondents of this case. They comprise 2 from State Ministry of Women Empowerment and 2 from BKKBN and the **sample area** is national level because most of the consultants work at national institutions

2.1.4 . Overseas Educational program

As a part of the capacity development of the family planning/reproductive program, BKKBN includes a short-term overseas training program in population, family planning, reproductive health and related matters for program manpower at various levels as part of its human resource development. For the last ten years, BKKBN has sent program manpower on overseas training programs to a number of developing countries Thailand, Bangladesh, Pakistan, India, Egypt, Iran, Philippines, China, etc. There have been 1,995 persons sent on overseas programs since 1995. However, not less than 88 persons, of which 78 were BKKBN personnel and 10 its partner institutions' personnel attended training program in other developing countries in 2004. They attended courses among others on population and family planning, Advocacy and IEC, Women Empowerment and Gender, ARH Counseling, Project Management, Data Analysis, Micro/small credit management, etc.

Sample area

In 2004, BKKBN sent a total of 88 people to participate in the short term overseas training program. For this study, there will be 34 ex-short term trainees from national level selected as the respondents

2.2 Secondary data

The secondary data are collected from the official documents such as project reports, project consultant's reports, a study particularly done by the third party to measure the project impact as well as participant/short-term consultant's reports. This data and information on Observation Study Tour (OST), Internship and Technical Assistance participated in by all participants and particularly those from Bangladesh, Tanzania, Malawi and Ghana is used to measure the collaboration impact to recipient countries' institutional and individual capacity development.

Observation-Study Tour.

The **Bangladesh** institutions included were among others Ministry of Health (MOH), District Government, District Health and Family Planning Office, and Upazila. The persons involved were among others high level officials of MOH, District Commissioner, District Health and Family Planning Officer, Upazila team consisting of Upazila Chairman, Medical Officer, Family Planning Supervisor and Community leader.

The **Tanzanian** institutions and individuals included were among others MOH, Ministry of Planning, UMATI (TPPF), District Governments, Community Based Distribution (CBD). It

sent multi-sector district-level team, who are selected from MOH; NGO CBD project coordinators; planning and information specialists from the MOH and Ministry of Planning; community development, women's affairs and children's affairs and local administrators.

The **Malawian** institutions included were among others MOH, Regional and District government and Traditional Authority. Persons involved comprised village head, head of Traditional Authority, ward councilor, religious leaders, health assistant, district health education officer, regional MCH/FP coordinator, information officer, community development officer.

While **Ghanaian** institutions included were among others District Government and Sub-district Government. Personnel involved among others consisted of sub-district-level team plus supporting personnel from district level. They were selected from among: health worker, chief/community leaders, regional leaders, social or community development workers. District personnel included District Chief Executives and District Administrative Officers.

Internship

Three African countries (Tanzania, Malawi and Ghana) sent 12 personnel from their family planning/ reproductive health programs (4 persons each). Tanzania assigned District MCH Coordinator, CBD Coordinator, Rural Medical Aid and District Health Officer; Malawi sent District MCH/FP Supervisor, Community Health Nurse, Community Development Assistant and Home craft Worker; while Ghana included Public/Community Health Nurse, CBD Supervisor and CBD Agents.

Technical Assistance

Of the above three African countries, only Tanzania and Malawi benefited from the Technical Assistance program. Tanzania required the technical assistant to help it develop IEC materials and to improve its existing community-based distribution to be community based development. Malawi asked the consultant to assist it in developing FP/RF Management Information System. In each country, the consultants spent 1 month to work with National Family Planning Unit of the Ministry of Health.

3. Analysis

The data and information collected are grouped by case (OST, Internship, TA and Overseas Training). The data on these cases will be classified and analyzed to determine the impact to provider and recipient institution and individual.

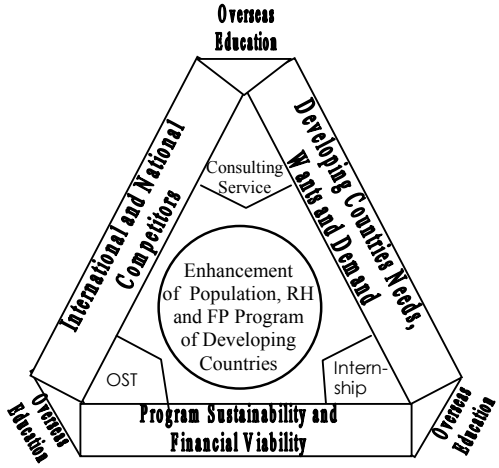
Except **Overseas Educational program**, in which the stakeholders only include the provider collaboration (BKKBN), data collected for the first three cases (OST, Internship and TA) include provider country institution and individual, the recipient country institution and individual. For the latter, the data and information will be taken from the evaluation, which had

been done at the midterm of, and the end of the implementation of the collaboration as the secondary data.

Chapter II
THE INDONESIAN EXPERIENCE: AN INTEGRATED APPROACH OF CAPACITY DEVELOPMENT IN THE COLLABORATION AMONG DEVELOPING COUNTRIES

A. The Conceptual Framework

It combines 4 modalities comprising 2 (two) training programs; i.e. Observation Study Tour (OST) and Internship, and 1 (one) Consulting Service program or Technical Assistance (TA) plus Overseas Educational program, the latter among others aims at supporting the implementation of the OST, Internship and the TA. The relationship of the four elements of integrated approach of capacity development is illustrated in the following chart:



The capacity development aims at improving knowledge and skills of the participants to enable them to contribute to the enhancement of population, reproductive health and family planning program of developing countries.

The three elements inside the triangle – the Observation Study Tour, Internship and Consulting Service (Technical Assistance) are done in and by, the provider country. The first two elements will result in improving the participants' knowledge and skills, while the third element is provided for helping the participants to speed up the implementation of the lessons learned in their country. They will create a synergic impact to the participants' improvement of knowledge and skills for the enhancement of population, reproductive health and family planning program of their country.In making the three elements work effectively, an assessment of the country's needs, wants, and demand should be firstly done. This assessment will be of great importance for designing the collaboration program and materials by taking a comparative advantage with the international and national competitors. In addition to that, the sending country should run another overseas training program to have potential persons, who can help the country promote its population, reproductive health and family planning programs. At the final end, this integrated and systemic approach of capacity development the program aims to make the program sustainable and financially viable.

B. Nature of the Program

1. The Observation Study Tour (OST)

The **OST** is a learning process, which is neither a normal study tour nor a traditional training program. Rather, an OST is hybrid combining structured observation of selected elements of the family planning/reproductive health program (Indonesian) with intellectual study of the observed events

The concept of an OST for international collaboration for family planning/reproductive health capacity development began in 1987. It was developed out of dissatisfaction with the type of inter-country visit or 'tour' in which one or a group of people from one country visit another, meet with a few officials, and perhaps make a brief field trip/visit to observe some aspects of the family planning/reproductive health program in operation. It was felt, such a program usually **did not** result in the visitors or the people visit **learning enough** to make such a trip worthwhile.

The OST does not have the same purposes as a training program. The basic objective of any OST is to help participants to think in depth, from a new perspective, about their own situation, as a result of having seen a different approach (Indonesia's) and having discussed what they observed with Indonesia and with each other. In other words, an OST strongly encourages participants to come up with creative ideas to improve their own program. It comprises 3 interrelated parts:

- A relatively brief **orientation,** providing participants with an overview of the country's family planning/reproductive health policies and main program activities including cross-cutting issues. This part takes approximately 30% of the whole OST duration.
- **Field observation** in one or two field sites, focuses mainly on the grassroots level during which participants observe some of the integrated community-financed family planning/reproductive health services and program management forums such as grassroots-level evaluation and planning meetings, and other events. Opportunities are provided for open dialogue with program staff at all levels, community leaders, volunteers, etc. Each day ends with a **consolidation** session to assist participants to better understand the program both the **tangibles** and the **intangibles** and to start **developing ideas** to improve their own country family planning/reproductive health activities. These field visits are, by far, the largest part (60%) of an OST.
- **A final workshop,** which represents about 10% of the OST duration, aims to further assist participants to reconstruct their class room and field experience and consolidate their ideas in a **Generic Plan of Action** for what they will do on return home. In the Generic Plan of Action, the participants, if felt needed may propose for 2 (additional) assistances to follow up the Plan of Action. The first is an **Internship program** for the field program workers/personnel who assisted the trained personnel to accelerate the implementation and to improve the country family planning/reproductive health program. The second is **Technical Assistance** from host country aiming to help them not only apply the Plan of Action, but also develop systems required to enhance the program.

The OST program's substances are divided into **2 (two) major groups** of contents.

The first is given in the **Orientation Part**. They will include: **I) General policies** and main family planning/reproductive health programs; **II) Specific information** as referred to the OST topic, which consists of 13 topics: 1) Advocacy of Family Planning/Reproductive Health Program for National and Local Decision Makers; 2) From Subsidized to Self-Reliance Family Planning/ Reproductive Health Program: Developing a Strategic Social Marketing Program; 3) Quality Improvement Program in Family Planning/Reproductive Health Services; 4) Youth First, A Multi Sector Adolescent Reproductive Health Program: Formal and Non-Formal Educational Approaches; 5) Safe Mother-hood and Maternal Surveillance Program; 6) Empowering Women thorough Multi-Approaches for Quality Family: A Social, Economic and Cultural Intervention; 7) A Frontline Management Information System in Family Planning/Reproductive Health Program; 8) Developing a Strategic Partnership with Religious Institutions and Leaders in the Family Planning/Reproductive Health Program; 9) Strategic Communication Program for Family Planning/Reproductive Health Program, Including RTI, HIV/AIDS, Maternal Health and ARH: Developing A Social Communication Network; 10) Reducing Maternal Mortality Rate (MMR) through Gender Mainstreaming in Family Planning/Reproductive Health Program: The Indonesian Case,; 11) Strategic Leadership and Management for FP/RH Program: A Learning Organization Approach; 12) Developing A Grass-root-Based Family Planning/Reproductive Health Program: A Demand and Supply Perspective, and 13) Enhancing Commodity Security; and **III) Cross-cutting issues**, which strongly support the first two substances.

The second group of content is provided at the **Field Observation**. The content is related to how policies and major programs planned at central level are translated into operational activities. They will cover information on program managerial aspects, manpower and linkage to other population and development programs as well as role of local government and community and influential leaders, etc.

These two groups of content are again provided in the **workshop part**, in the form of clarification of unclear issues of family planning/reproductive health found in the first two parts of OST.

The OST is the most interesting modality offered by BKKBN to international participants from developing countries. It applies a marketing concept, which uses regular publications (training program brochure and annual leaflet), newsletters, telephone communication and currently includes website.

An OST duration ranges from 10 days to 3 weeks. A scheduled OST is designed for two to three weeks depending upon its substances. A Non-scheduled OST is the one that is designed for a tailor-made program for which the duration usually ranges from 3 to ten days.

As of May 2005, there have been **4,259** professionals, policy makers, program managers and implementers, staff of international organizations from **93** mainly developing countries in various types of OST programs. Also recorded among others were more than 360 foreign dignitaries, including presidents, ambassadors, prime ministers, cabinet ministers and top officials of international donor agencies who took part in a number of selected OSTs.

The majority of the OST participants benefited from the fellowships provided by donor agencies, such as UNFPA, USAID, World Bank, UDP, ADB, UNDP, UNICEF, UNESCO, WHO, JICA, JOICFP, Pathfinder Fund, SAGRIC, Dutch Government, etc. Though there is no fixed financial figure of the OST program to serve those participants, it is estimated that the programs have spent an amount of US$19,110.200.

2. Internship

The internship is a learning process, which applies the most common **way of learning** on how to perform a managerial task or set of tasks of family planning/reproductive health program by observing someone else who is already competent in the context of apprenticeship arrangement.

It began in 1994, when BKKBN responded to requests from some countries, mostly African countries, who sent their family planning/reproductive health programs' personnel to participate in an **OST** in Indonesia. Their request was to arrange a special program for their field staff (Family Planning Fieldworker Supervisors and Family Planning Field workers) to learn from their peers in Indonesia.

The internship program is designed to enable an individual from the sending country to observe and learn from a peer – a person in a very similar position in Indonesia. In essence, the intern spends a period of time with the peer, observing the process of management and service procedure and discussing family planning/ reproductive health issues. Through direct experiences and socialization, the intern has an opportunity to understand intricate and intangible work processes. This approach might be participated in by personnel at various positions in central, provincial, district and village level.

The internship includes an initial month of Indonesian language training combined with family planning/reproductive health program orientation. This language training is to provide the basic essentials to live in a village environment and to work as Indonesian family planning/reproductive health program field workers. In the second month, they observe and discuss each element of the field worker's jobs in the framework of field level family planning/reproductive health program operational mechanisms. In the final month, they practice these jobs, with the Indonesian field worker guiding them linguistically and technically. Included in this final month is the development of a Plan of Action for them to follow up after returning home to improve their family planning/ reproductive health program.

As of 1999, there has been eight countries participating in the internship program with a total of 56 participants. They were Kenya, Ethiopia, Ghana, Malawi, Tanzania, Uganda, Vietnam and Philippines.

Funded by the government of the Netherlands and Japan through UNFPA, the internship program's budget totals to US$315,150.

3. Technical Assistance

The Technical Assistance (TA) offered under this framework is slightly different from that of a normal TA. Like an internship program, a TA is provided to countries who have sent their staff or personnel to participate in an OST in Indonesia and required a service of Indonesian TA to accelerate the implementation of the Plan of Action they developed during their participation in an OST.

The TA program began in 1992 in response to the request from some developing countries, particularly to help them execute the Action Plan that their country fellows developed during their participation in OST or Internship program in Indonesia.

The Indonesian TAs can be called upon by the interested countries to assist, both with the countries' program and with the follow-up of implementation of the Action Plans designed during OSTs or Internship. The TAs are selected from the BKKBN and its Partner institutions' experts, who do not only have **academic skill**; but they are also equipped with considerably wide **experiences** in the management of Indonesia's population, family planning/reproductive health program. They are people who work day in and day out on the implementation of an aspect of a national population, family planning/reproductive health program. They know what works and what does not. This knowledge can be extremely helpful for other countries that have been considered as having less developed population, family planning/reproductive health programs. These countries would like to have the best practice to help them determine how best to plan and implement activities and to achieve their objectives without repeating the same mistakes Indonesia has made.

Perhaps the most useful way in which technical assistance can be provided for one country is to relate the assistance to the various operational and support systems of which virtually all programs comprise. For example, all family planning/ reproductive health programs contain units in one country responsible for personnel, training, IEC, contraceptive services, etc. The experienced personnel from a unit from one country can help the equivalent unit in another country to assess what it does and to explore possible improvement in managing community participation, that are much better developed in some countries' programs than in others. The Indonesian type of technical assistance has another de facto objective: the consultants often returns to their own Indonesian national program having learned new ideas, which they are then able to apply.

Before a TA is assigned in other country, he/she was to undergo a training program entitled **How to Become a Better Short-Term Consultant.** The training consists of six distinct elements, as follows:

1) A two-week computer training courseto ensure that the selected individuals are able to competently use various computer programs;
2) A one-month specialized English language training, focusing on the written communications and reports required from consultants;
3) A ten-day short-term consultant skills training. This was done in cooperation with the Johns Hopkins University/Population Communication Service (JHU/PCS), USA to equip the selected individuals with the acquired new skills in:
   - Establishing collaborative relationships,
   - Solving problems so they stay solved,
   - Building capacity to solve technical/programmatic problems and develop relationship,
   - Develop client commitment to act.

   These new skills gained after going through a multi-phase training activity that parallel to the consultancy process. These phases are:
   - Entry and contracting,
   - Data collection and analysis/diagnosis,
   - Conceptualization
   - Presentation and deciding to act
   - Implementation,
   - Report writing
   - Oral presentations, and
   - Extension, follow-up or termination
4) A real mentored consultancy outside Indonesia**.** This phase was done in cooperation with NUFPA Country Support Team (CST), Bangkok. The participants went together with UNFPA CST consultants to other country to perform consultancies for that country's family planning/reproductive health program funded by UNFPA project. The UNFPA CST consultant served as mentor during this period, helping them to hone consultancy skills. The duration ranged from one to two weeks.
5) A real mentored consultancy for each individual in Indonesia aimed at solving a problem in the Indonesian family planning/reproductive health program. These consultancies addressed some of the more intractable issues faced by the program, such as the difficulties of reaching urban slums, coastal areas, or other isolated rural people. To the extent feasible, the mentored consultancy experience during their international experience could be used to solve the equivalent issues.

The issues or topics that the TA programs cover, range from overall program design to narrower focuses on IEC planning, contraceptive delivery, contraceptive supply, FP/RH training, reporting and recording, logistics system, community participation, FP/RH management, and management information system. Often, as mentioned, BKKBN experts are requested to provide technical advice to the implementation of the Action Plans designed by country participants during their OST in Indonesia. The short-term consultancy duration ranges from one to three months.

Currently, BKKBN has 29 experts for TA programs. These experts have assisted at least 17 countries in Asia, the Pacific, and Africa, such as; Bangladesh, Nepal, Laos, Papua New Guinea, the Philippines, Vietnam, Solomon Islands, Ethiopia and Tanzania. These consultancy services took place from 1992 to 2005.

The total budget used for this program is estimated at US$515,000, which was provided by the Governments of Netherlands, Japan through UNFPA and the World Bank.

4. Overseas Education

In responding to family planning program needs, BKKBN began an overseas education program, which included degree and non-degree programs by the end of 1970s. These programs have been done intensively since the middle of 1980s. They aim at improving managerial and technical skills of middle managers of family planning/reproductive health program on population, family planning, reproductive health and related fields. They are a part of BKKBN capacity building to support the Indonesian family planning/reproductive health program enhancement and at the same time improving the quality of BKKBN international collaboration.

This program is managed by the BKKBN Center for International Training and Collaboration. The Center intensively and regularly communicates with the potential training institutions, especially in developing countries to look for the latest information on the training programs they organize for international participants in the field of population, family planning, reproductive health and related matters. A list of training priority is then developed and updated regularly as per the family planning/reproductive health program's need. Internally, the Center, based on the BKKBN Human Resources Development Program, identifies and selects the candidates from BKKBN and its partner institutions throughout the country using the criteria set.

Based on the list, BKKBN sent its potential and partner institutions' staff for a short-term training program in other countries.

There are several subjects on population, family planning, reproductive health and related fields prioritized for BKKBN overseas short-term training program ranging from technical matters to general topics in these fields. For example, the following are topics attended in the last ten years: population and FP/RH; Communication, Advocacy & IEC, Contraceptive Logistics

System; Women & Gender in RH program; ARH Counseling Skills; Decentralized Pop and FP/RH program; Data Analysis for Family Welfare; Prevention and Control of STD and HIV/AIDS; Project Cycle Management; Community Involvement in Small Scale Industry Micro Credit; FP/RH research; FP/RH Quality Care; Rural Development and Poverty Alleviation; Reporting and Recording System in FP/RH; Safe Motherhood in FP program; Male Participation; and Marketing Training.

There have been 248 Masters, 12 PhDs and 1,929 non-degree graduates of family planning program policy makers, managers, workers both from BKKBN and its partner institutions participating in the BKKBN overseas education respectively. They were sent to USA, UK, France, Netherlands, Australia, New Zealand, Japan, Egypt, Thailand, China, India, the Philippines, Australia and other countries in Asia.

Sources of funds for this program were ADB, World Bank, UNFPA, USAID, Aus-AID, the Government of Netherlands, etc. The total budget for non-degree program was estimated at US$11,574,000, while for degree programs Indonesia has approximately spent an amount ofUS$13,128,000.

For the OST, Technical Assistance and Internship programs, Indonesia has also provided a counterpart budget, which was estimated at US$4,200,000.

C. The Management

There is a series of measures taken to design and implement the integrated capacity development approach both in the recipient country and provider country (Indonesia). The Observation Study Tour (OST) is the core program of the approach; the next two programs (technical assistance and internship) will supplement the acceleration of OST follow up activities, while the last element is a part of the provider country human resources development. There are two ways of promoting the integrated capacity development approach:

1. The Multilateral program

The multilateral programs, which are supposed to be attended by multi-countries are offered to the interested countries thorough the ITP marketing system using both printed media such as leaflets, brochures, international magazines and electronic media such as website. The OST, which is the main program of this approach, is designed on scheduled multilateral basis. Any country is open to join this OST. In addition, through this marketing system, BKKBN also offers the unscheduled OSTs or tailor-made ones, which are normally arranged on a bilateral basis.

2. The Bilateral program

The bilateral program is usually planned for a long-term period to give significant impact to the recipient country's family planning/reproductive health program. This program is managed thorough the following steps:

a. Develop a MOU or another document of equal value

This is done to enable the country to arrange a long-term bilateral FP/RH program for manpower development. There should be a need and demand for collaboration, which to a large extent will describe a mutual benefit for both provider and recipient country in enhancing the national family planning/reproductive health program. The commitment for collaboration should be made in an official document such as a Memorandum of Under-standing or a Statement of Need for Collaboration.

The document clarifies the philosophy or background, scope/areas of collaboration, modes of collaborations, distribution of responsibility, and other related issues such as financial arrangements. This document will become the official reference for further collaboration development.

b. Explore a donor or international agency for the project fund

Parallel or prior to the signing of MOU, the recipient country or jointly with the provider country look for potential donor to support the collaboration. In the case of collaboration with the Bangladesh, the Government of Bangladesh got the funding support from USAID, while the collaboration with Tanzania, Malawi and Ghana fund was made available by the Government of Netherlands through UNFPA. This is extremely important for a long-term collaboration due to both recipient and host country's shortage of financial resource.

c. Arrange a high level (decision makers) visit

This is sometimes called a planning visit. The visit will result in training design including curriculum development, requirements of participants (team and individual, type of follow up technical assistance or internship for field level personnel, etc.

d. BKKBN ITP will structure the program and apply a methodology, which uses an interactive participatory learning among equal partners through maximum sharing of experiences based on mutual respect and benefit. ITP trains staff for course management, lectures and facilitators. The latter are recruited from BKKBN and partner institutions. Of great importance is the ITP prepares field sites, which include local resource persons, program technicalities and substances.

e. OST implementation, which is designed in a three-integrated part. The first part is classroom orientation, second part is field observation and third part is the workshop for development of Generic Plan of Action for follow up.

f. Organize an Internship program for field level staff. As described above, ITP can organize an Internship program for field level personnel aimed at accelerating the application of Plan of Action at the field level.

g. Provision of Technical Assistance is done on the basis of the OST participating country's request. This short-term consultancy service is to help the requesting country apply and enrich the Plan of Action developed in Indonesia.

h. Mid-term review aims to review the progress made by the provider country to FP/RH program enhancement and to contribute to the development programs.

i. Final Evaluation, which is held to measure how the collaboration is effective in improving the country's FP/RH program, lessons learned and possible collaboration expansion.

Chapter III
THE COLLABORATION BETWEEN BKKBN AND BANGLADESH, TANZANIA, MALAWI AND GHANA

This long-term collaboration between Indonesia and Bangladesh was the second one. It was based on the evaluation of the first, which took place in 1980 to 1982 during which over 300 of Bangladesh's Thana Family Planning Officers (TFPOs) visited Indonesia to learn about Indonesia's family planning/reproductive health program. It was expected that the TFPOs would return to Bangladesh and implement activities based on some of innovations they observed. An evaluation found that they seemed to have learned useful lessons from their Indonesian experiences, and returned highly motivated. But each one returned to his own Upazila (sub-district), isolated from others who had the same Indonesian experience. As a result, within few months, most retained warm memories of their visit to Indonesia, but they could do little to improve the family planning program.

The evaluation recommended that it would be likely to result in implemented innovations if there were two significant modifications:

- More direct focus on implementation, after they return, of the lessons they learned in Indonesia (rather than thinking as an overseas training activity);
- A critical mass of persons from the same geographical area (rather than just a single individual).

While the collaboration between Indonesia and Tanzania, Malawi and Ghana was not made by chance but a deliberate choice. Indonesia had by then already gained experience with partnerships in population and family planning/reproductive health with a number of Asian countries, but not yet with Africa and perhaps most importantly as there Population Growth Rate, Maternal and Infant Mortality Rate as well as malnutrition were amongst the highest in the world. This fact was the picture in many aspects the same for Indonesia 25-30 years ago, and would probably remain unchanged if the Government had not adopted a set of policies that have proven to bring about results. It is also a fact that Indonesia is still a developing country and plays an important role in the Non Aligned Movement. It also organized the Asia Africa conference in Bandung, making these other developing countries feel close to Indonesia and keen to learn from its experiences, which are still fresh and can be retold by the very persons who implemented these policies that eventually proved to be successful. Therefore, despite the geographical distance that separates the countries from each other, African countries like Tanzania, Malawi and Ghana have been eager to come and observe the Indonesian approaches particularly in the field of population, family planning reproductive health and related matters.

As described above, the most effective sharing experiences through international collaboration for family planning/reproductive health program on capacity development will take the four components of the integrated capacity development: **Observation Study Tour, Internship, Technical Assistance and Overseas Training**. However, the four countries participated in the

capacity development programs according to their own demands and needs. Bangladesh took only OST, Tanzania participated in OST, Internship and received Technical Assistance program, while Malawi and Ghana involved OST and Internship. While Indonesia improved its human resources to support these international collaboration by sending its potential family planning/reproductive health program personnel for a short-term training in other developing countries.

A. Bangladesh

1. The capacity development and process under the Upazila Initiative Project.

a. Background

The capacity development of Bangladeshi Family Planning personnel under the Upazila Initiative project was done through participation in the Observation Study Tour in Indonesia. The OST was designed to benefit from the evaluation of the previous training programs attended by groups of Bangladeshis, which was considered unsuccessful because of a near-absence of follow up. As mentioned, the evaluation recommended two significant modifications:

- More direct focus on implementation, after return, of the lessons learned in Indonesia (rather than thinking of it primarily as an overseas training activity);
- A critical mass of persons from the same geographical area (rather than just a single individual).

With fund support from USAID, the Upazila (later changed to Thana) Initiative Project (UIP) was developed. The project was planned to develop Bangladesh Family Planning program personnel capacity, primarily at Upazila level by **collaborating with Indonesia's Government (BKKBN)** to facilitate a structured learning process of Indonesia's success, as well as to apply the above two critical recommendations made by the evaluation of the previous project, and to involve community leaders as well as family planning program personnel.

Under the terms of this project, teams of Upazila family planning and community leaders would visit Indonesia in **Observation Study Tours** to observe the family planning program, then plan and implement innovative local projects. An outside agency was contracted by USAID to assist in planning and implementation of the project.

From 1987 to 1993, fifteen groups of 24 participants underwent Observation Study Tours (OSTs) in Indonesia, then returned and implemented local-level projects that they had planned in Indonesia.

b. The capacity development process.

The basic design of the capacity development process was as follows:

- Four-person teams of people from four upazilas plus district-and central level support personnel (a total of 24 people per group), were selected by the Bangladesh Government.

Each upazila team comprised two community leaders and two family planning program leaders;

- The Directorate of Family Planning conducted an orientation for the group prior to departure;
- In Indonesia, BKKBN designed and conducted a three-week Observation Study Tour. It comprised a 2 ½-day orientation in Jakarta; field visits in two provinces (primarily at sub-district, village and sub-village levels); and a 3-day workshop to prepare actions plans for implementation when they returned home.

Major contents of the OST curriculum were family planning/reproductive health program policies and main components, program management and leadership as well as approaches, family planning contraceptive services system and logistics, advocacy and IEC, adolescent reproductive health (ARH)-clinic and non-clinical approach, community participation/family empowerment including safe mother-hood, reporting and recording and roles of non government organizations/ community organizations and leaders.

These family planning/reproductive health program and activities were clearly shown in the field visit with an intellectual-structured study observation. To enhance the quality of the field observation and discussion for most activities, the group was divided into four sub-groups, with each going to a different site, each with a central BKKBN facilitator.

While participants were in the field, each day concluded with about a one-hour 'consolidation' session to help them fully understand whatever they observed that day (including the less clear 'intangible' aspects of the program) and to begin to relate the day's observation to the Bangladesh context.

- At the end of the OST, the four Upazila teams prepared action plans with incorporated adaptations of the innovation they observed. The teams were encouraged to be creative, to take their own initiative in developing the best possible plan for their Upazila. Considerable time, technical and logistic assistance was provided to assist the Bangladeshi teams to develop good plans. During this action plan development, considerable input and critical comments were made by BKKBN on the drafts, which assisted the teams to refine these plans.
- Immediately upon return to Bangladesh, during a two-day debriefing the four Upazila teams presented their action plan to Ministry of Health & Directorate of Family Planning (D of FP). The plans were approved, and the teams received the first installment of seed money. They returned home and began to implement their action plans.
- The D of FP, assisted by the contractor, monitored the implementation of these action plans.

- Additional funds (up to a total of $2,000 per Upazila) were provided by the contractor upon receipt and approval of progress reports. Upazilas were required to provide a minimum of 10% of the amount contributed by the project.
- In conjunction with D of FP and with the approval of USAID, the contractor conducted different types of supporting activities to enhance the likelihood of Upazilas' successfully achieving their objectives and sustaining interest.

c. Support activities of capacity development

In addition to the standard project activities described above, irregularly scheduled support activities were also developed. These included among others:

- Visits to Indonesia by high-level teams of Ministry and Directorate officials to observe part of OST and discuss the program with BKKBN officials.
- Visits to Bangladesh by teams of BKKBN central and provincial personnel who had been involved in the implementation of the OSTs, in order to meet with past participants, assess the project's achievements, and explore ideas for improvement of future OSTs.
- A periodic newsletter distributed to all former participants and others, to exchange information about the project in general and action plan implementation in particular, and to sustain participant motivation.
- Workshop of selected district-level and central-level participants to obtain their views of how to improve the Bangladesh family planning program. The major recommendation of the first of these workshops was that Bangladesh should establish a national family planning volunteer program over a ten-year period.
- Workshops of Upazila-level participants to exchange information on action plan implementation, to begin to answer basic implementation questions such as appropriate ELCO (Eligible Couple and to get the better performing Upazilas to motivate others.
- Workshop of FWAs (Family Welfare Assistant) from the project areas to obtain their views on strengthening of project implementation.

A video of the first group's OST, which was used subsequently as a tool for describing this aspect of Upazila Initiative Project to others.

2. Output of capacity development

By the end of the project, when the project's activities shifted completely to Bangladesh, fifteen groups, averaging four Upazilas per group, had undergone an Indonesian **OST.** Including the district and central personnel who accompanied the upazila teams, plus other visitors (e.g., high-level officials, other Upazila Chairmen); **a total of 392** people had directly experienced the Indonesia program through Observation and Study under the Upazila Initiatives Project.

(There were another **579** people from various institutions either government or non-government participating in the OSTs under separate arrangements).

3. Learning gained

The main objective of the Observation Study-Tours was not for the Bangladeshi teams to copy the Indonesian experience, but rather for them to use the opportunity of being abroad, in stimulating environment, within teams from their own community, to be creative and to develop a plan that would succeed in improving the family planning situation in their home Upazila.

Nevertheless, it was only natural that the plans they developed somehow reflected the Indonesian program they observed. The Indonesian family planning/ reproductive health program is very-community-based, and places considerable reliance on organized groups of women at the grass-roots level. And these were the elements of the Indonesian program that were emphasized during OSTs.

Some of the most important ideas inherent in the Indonesian program that were accepted by the Bangladeshi teams were:

- Inter-sector coordination.
- Organized female volunteers at the grass-root level.
- A system of committees that meet regularly to manage the volunteers.
- ELCO mapping.
- Involvement of the political and government infrastructure in the family planning/reproductive health program.
- Different types of volunteers, with varying responsibilities, devoting varying amounts of time.
- No payment for volunteers.
- Volunteers selected initially from among relatively higher-status women.
- Emphasis on motivation for family size and spacing rather than for contraceptives.
- Community responsibility for community-based service points.
- Linking of 'beyond family planning/reproductive health' activities to the level of contraceptive prevalence.
- Rewards only for long-term achievements; a relatively large quantity of inexpensive rewards.

B. Tanzania, Malawi and Ghana.

1. Background.

The Netherlands through UNFPA approved a financial assistance in support of South-South Cooperation between **Indonesia** and a selected number of African countries, which showed their keen interest in this partnership: **Tanzania, Malawi and Ghana**. The possible components of the exchange program are: **Observation Study Tour, Internships and**

Technical Assistance. A delegation composed of two BKKBN personnel (Director of Center Program Manpower Training) and Division chief of Overseas Training) accompanied by UNFPA Consultant for South-South Cooperation visited Ghana, Malawi and Tanzania visited the three countries on an **official mission**.

The mission objectives were:

- Undertake briefing visits to countries selected for partnership in population/family planning, to explain the proposed strategy, agree on profile participants for Planning OST and ensure appropriate preparations at the local level.
- Ensure the appropriate implication of the UNFPA field network in the establishment and implementation of the partnership programs.

2. Capacity development activities

The process and results of the collaboration can be described as follows:

a. Planning OST

One of the first activities under this collaboration is for planning teams from Ghana, Malawi and Tanzania to participate in an **Observation Study Tour** and a **follow on workshop**. The purpose of the workshop was for each of the three countries to develop plan, in cooperation with BKKBN-ITP, to address one or more problems faced by its family planning program, and to introduce innovations to help solve these problems. Core activities to be used to address these problems included tailor-made Indonesian OSTs, Technical Assistance (TA) in their countries by Indonesian TAs, and a fieldworker internship in Indonesia.

The Planning OST procedure was as follows:

- It was attended by 13 high-level officials - 4 from Tanzania, 4 from Malawi and 3 from Ghana respectively. It comprised a three-day orientation in Jakarta, followed by an eight-day field program observation (in West Java). The orientation provided participants with a general overview of the Indonesian family planning/reproductive health activities. The field program enabled them to observe key elements of this program, primarily at grass-roots level, and to discuss them with villagers, community leaders, volunteers, and program personnel;
- Instead of the normal workshop to end an OST, the workshop for this group focused on planning the details of bi-lateral programs with each country. This workshop began with a summary session about salient features of the Indonesian family planning/ reproductive health program;
- The planning meeting began with a plenary session in which the goals, objectives, and content of the overall activities under this partnership were reviewed. Participants were encouraged first to consider improvements deemed necessary for their country programs, especially in the light of their Indonesian experience. They then were asked to derive the

elements of this partnership programs from strategies and activities needed to achieve those improvements.

- In country groups, participants then prepared draft proposals for collaboration between their countries and Indonesia in the field of family planning and population, aimed at strengthening the problems they had identified.
- The first element of these plans was **Observation Study Tour** for persons from their countries. Five characteristics of these OSTs were addressed – the quantity, type of participants, content, location, and timing. As per OST content, each country team tended to focus on some aspects of the village-level portion of its program. The focuses were not identical, however: for Ghana, the core problem identified was inadequate community involvement in the information system; for Malawi, it was inadequate community-level IEC; and for Tanzania, a more general problem of inadequacy of coverage and quality of volunteer and other grass-root level activities.
- The second and the third element of the plans were **technical assistance** and **internship**, which they developed to help them apply action plans generated in the OSTs.
- A plenary was then convened in which each team (Tanzania, Malawi and Ghana) presented its draft. A discussion followed to assist participants to better define the types of participants they intend to send, in the light of the problems they had identified, as well as to resolve potential scheduling and content problems.
- Each country team conducted a debriefing for relevant officials upon return home.

b. Observation Study Tour (OST)

The three countries had separate tailored-made OSTs due to different content focuses based on the problems faced in individual countries. However, the same procedure was applied.

- Duration was 3 (three) weeks;
- Field sites for the OSTs were determined by BKKBN-ITP. The only characteristics of the field sites identified was that they should essentially be rural, probably one in Java and one outside Java in order to show a range of program development;
- The quantity of participants was 12 per OST per country;
- Each country conducted meetings with participants to prepare their teams and organized follow-up activities immediately prior to and immediately following the OST.
- Each country conducted a least a one-day briefing and a one-day debriefing;

- Each country sent the names and positions of participants at least one month prior to the start date of the OST;
- Basic structure of the OST comprised:
  - 2-3 days orientation in Jakarta
  - 12-14 days field visit to two provinces
  - 3-4 days final workshop
- To reflect the country needs, BKKBN ITP adjusted, to the extent possible, the content for each OST. These modifications did not result in basic changes of the structure or sessions;
- BKKBN ITP designed a basic outline used in preparing their district or sub-district action plans. The outline included sections for description of strategies to be used and a work plan with activities, time line and budget;
- In each country, a mechanism was established to provide technical assistance to teams to implement its action plan.

c. Internship

Each country sent a four-person team comprising Family Planning Fieldworkers and Supervisors to participate in a three-month internship program. The interns spent one month in Indonesian language training, followed by two months sharing experiences with their Indonesian peers. Ghanaian team included 1 Public/Community Health Nurse, 1 CBD Supervisors and 2 CBD Agents; Malawian team consisted of 1 District MCH/FP Supervisor, 1 Community Health Nurse, 1 Community Development Assistant and 1 Home craft Worker; while Tanzanian team 1 District MCH Coordina-tor, 1 CBD Coordinator, 1 Rural Medical Aid and 1 District Health Officer.

d. Technical Assistance

The technical assistance program mission was undertaken by BKKBN. Of the three countries, only Tanzania and Malawi benefited from the consultancy services. The technical assistance mission had two objectives:

- To follow up the past OST participants in order to assist them in the implementation of the plans they developed.
- To assess how to improve future OSTs

3. Output of capacity development

By the end of the project, when the project's activities shifted completely to Tanzania, Malawi and Ghana, **18** Tanzanians, **16** Malawians and **15** Ghanaians had participated in the Indonesian **OSTs.** They comprised central level high ranking staff from Ministry of Health, Ministry of Planning, National program managers, Assistant Head of Family Health Unit, Medical Administrator, Director in Planning Commission, District Chief Executive, District Administrative Officer, District health education officer and sub-district health workers, community/religious leaders, community development personnel, local government administration, etc. There were people from Tanzania, Malawi and Ghana who had undergone

an Indonesia internship. They consisted of District MCH/FP Supervisor, Community Health Nurse, Community Based Development Assistants or coordinator. There were another **97, 30** and **46** people from Tanzania, Malawi and Ghana (government or non-government) who participated in the OSTs under separate arrangements respectively. Tanzania also received consultancy services for one month on IEC design and material development and community based development provided by two Indonesian consultants, while Malawi obtained one-month consultancy services on family planning/reproductive health program management by two consultants of Indonesia.

4. Learning gained

From the reports, field-visits and discussion, it appeared the major learning gained from the collaboration with Indonesia lays in its contribution to the family planning/repro-ductive health programs of the three countries. The learning gained included:

a) family planning/reproductive health program managers and other officials, as well as local leaders (formal and informal) learn **how to bridge** existing socio-cultural gaps between grassroots level communities and the family planning/ reproductive health services, by organizing a high degree of **community participation**;

b) making family planning/reproductive health services accessible to larger numbers of people, by **promoting** the organization of **monthly integrated (village) family planning/health services posts** at community level;

c) teaching family planning/reproductive health program managers and formal leaders **how to involve** formal, religious and socio-cultural leaders in **local** family planning/ reproductive health program activities;

d) increasing the capability of grassroots-level people to deal with their family planning/ reproductive health and related health issues, by **having** the community and its volunteers **take responsibility** for the organization of the monthly integrated family planning/health services post;

e) increasing awareness and knowledge of people at grassroots level on family planning/ reproductive health, by **having** the community **assume responsibility** for and become involved in the organization of the monthly integrated (village) family planning/health services post and data collection;

f) ensuring that **contents** of the family planning/reproductive health and other health services offered are better **adapted to the needs** of the community through the fact that the community and its volunteers are responsible for the organization of the monthly integrated (village) family planning/health services post;

g) increasing the **sustainability** of these grassroots level family planning/reproductive health services through **involvement** of the community, its leaders and volunteer support;

h) increasing the **capability** of the community to **take responsibility** for its problems, initially in the area of family planning/reproductive health, but later in any other field, through

institutionalization of local data-collection, family planning/reproductive health record keeping and analysis; and

i) family planning/reproductive health program managers and community leaders **learn how to mobilize** local resources under conditions of scarcity as an important step toward **self-reliance and program sustainability.**

Chapter IV
IMPACT OF THE COLLABORATION BY RECIPIENT AND PROVIDER PERSPECTIVE

As described in earlier pages, the collaboration or partnership program in the integrated approach to capacity development run with Bangladesh, Tanzania, Malawi and Ghana shall result in mutual benefit. Both recipient and provider country's institutions and individuals involved are expected to gain new experiences that can help them to enhance the family planning/reproductive health in their respective country. In this context, the impact of collaboration will be discussed in two major aspects. The first aspect will be on the country family planning/reproductive health program and the second one on capacity development both in institutional and individual perspective of both recipient and providing country.

In order to determine the impact of the collaboration, the source of data and information include primary and secondary data. Primary data will be used to measure the impact on provider perspective, while the secondary data is used to see the impact on recipient perspective.

A. Impact on Country Program Performance

1. Recipient countries

a. Bangladesh

The outcome of the implementation of lessons learned from the collaboration should be assessed in terms of its output, effect and impacts. More than 90 percent of the participants or alumni reported an increase in the number of female volunteers in their Upazila, an increase in active and committed volunteers and field staff, and improvement in the availability and quality of services. More than 60 percent revealed that the following output had moderately increased or improved: community participation, local management, cooperation among various government departments, field level Management Information System, and quality care. Non-alumnus officials, who were in a position to know about program activities in both participating Upazilas, and the non-participating Upazilas, corroborated these claims of the alumni. Non-alumni reported discernible differences between collaborating participating Upazilas and non-participating Upazilas with respect to program activities and management.

Despite the fact that there was no special study of the collaboration impact the national contraceptive prevalence rate or fertility rates yet, a study of the impact of collaboration (OST) on activities and performance of family planning in Bangladesh showed that it was plausible to conclude that the collaboration contributed to increased program performance at the Upazila level. It was also reported that as of April 1993, the average annual contraceptive prevalence rate in the 166 unions (an administrative unit below Upazila) was recorded at 59% - approximately 15% higher than national average.

b. Tanzania, Malawi and Ghana

Unlike the collaboration with Bangladesh, which took longer, the collaboration with these three African countries was only for two years and was participated in by 18 Tanzanians, 16 Malawians and 15 Ghanaians arranged under separate programs. There were quite a lot of people from these countries who participated in the Indonesian international training program (97 Tanzanian2, 46 Ghanaian2 and 30 Malawians). It was reported that the collaborative effort was discernible in terms of the improvement of community participation in the family planning/reproductive health programs due to concept familiarity to all African countries. However, problems were that few countries had just found how to link, the community participation on the one hand and the family planning/ reproductive health on the other, so that these tended to operate independently from each other. The Indonesian experience had, to some extent, contributed to finding solutions, through community participation, on how the gap between community and family planning/reproductive health programs/services could be bridged.

This was indicated in a few concrete examples of the applicability of the Indonesian experiences in these three African countries' context.

- As these countries have already started programs centered around Community Based Distributors (CBD), the new approaches are in practice integrated into these on going programs, involving a strengthening of the efforts of CBDs through a variety of technics mentioned above;
- The involvement of community-leaders through face-to-face communication is obviously compatible with African socio-cultural conditions, as local leaders and persons of certain age/position are in general still respected and face-to-face communication is still the most popular and wide-spread way of communication in these African countries and in the African continent in general;
- Village level data collection is already being carried out, as this has value for empowering the community to be in charge of its own situation. However, this is not yet generalized and from Indonesia important lessons can be learnt on how to collect village level data in such a way that this data is effectively used for local level family planning/reproductive health program monitoring, implementing and planning, and the system can be sustained from a financial point of view by using volunteers;
- A large scale of volunteers is mandatory for any family planning/reproductive program to have the desired impact and client-centered approach at grass-root level; given the enormous potential in terms of human resources in these countries, lessons from Indonesia can help further explore this area, where it is not easy to achieve success without proper planning.

In conclusion: all societies favor programs that give more responsibility to their leaders, that involve the community which is supposed to be the beneficiary of the program and that in the end, result in improving the welfare level of the people.

2. Provider country

There is no special study done to determine the impact of the collaboration in this field to provider's country family planning/reproductive health program especially of provincial or district, which hosted the collaboration field activities such as OST. The information gained during various conferences/meeting with the provincial or district program managers, honestly revealed that at least the opportunity to host the collaboration activities has made the managers and other program personnel strengthen and revitalize the field family planning/reproductive activities, which were to be observed by the international training participants. These efforts have, to some extent contributed to sustain the strategic achievement in family planning/reproductive health in those areas, which is in the long-run have become the model for program sustainability in other areas within the province or district.

Over the last fifteen years, the Indonesian national family planning program has been considered successful in slowing down the population increase. Fertility has declined sharply from 5.6 in the early 70s to 2.6 in 2002-03. Some provinces had even reached aTotal Fertility Rate (TFR) 2.1. The Contraceptive Prevalence Rate (CPR) has reached the level of 60.3 percent. Many successes have been accomplished but there is still much unfinished work for the achievement of a balanced population growth and quality population.

As every country, particularly in the developing world knows Indonesia has been officially appointed by UNFPA Headquarter as one the Four Centers of Excellence in the field of population, family planning, reproductive health due its performance in hosting thousands of professionals, policy and decision makers, program managers and implementers from 93 countries, and selected donor's staff for a study of family planning/reproductive health policies, strategies and approaches.

This new status as a Center of Excellence has contributed to the development of its international and national network of family planning/reproductive health training institutions. At the international level, the Center has a network in the field of population, family planning and reproductive health training and education with a number of esteemed international training institutions such as Johns Hopkins University, Center for Communication Program (CCP) - USA, International Council on Management of Popula-tion Programs (ICOMP) -Malaysia, Nanjing College – China, National Institute of Ministry of Health and Family Welfare (NIHFW) - India, etc.

B. Impact on Capacity Development to Recipient and Provider Country.

1. Recipient country

a. Bangladesh

1) Observation Study Tour (OST)

a) Institution

The impact of collaboration to recipient country's institution capacity development is focused on Upazila – sub district–family planning unit or team including union level community leader and Family Welfare Assistant, though there were some additional participants from district, regional and central level. The first category of participants was the core group, who would work as a team to implement the Action Plan based on the Indonesian experience and made during their OST in Indonesia.

Some of the impacts of OST on Upazila family planning/unit capacity development were indicated in the following skills:

(1) Development of a program action plan. The Upazila family planning/unit has adequate skill in preparing a program action plan as they studied during the OST in Indonesia. The action plans reflected their knowledge about the Indonesian program, their concern about the program in Bangladesh in general and Upazila in particular, and their eagerness for implementing the important elements in their Upazila family planning program;

(1) The Upazila family planning team/unit has created a favorable environment for the program – an environment distinctly different from the environment in the non-OST participating Upazilas;

(2) The Upazila family planning team/unit in cooperation with/under the leadership of local government has successfully generated commitments of government officials, community leaders about the usefulness of OST lessons to be implemented in the entire Upazila area;

(3) The team, together with the local government and community leaders especially those participating in the OSTs, has also substantially increased community participation, involvement of female volunteers, and coordination among the government departments;

(4) The team has also successfully dwindled the opposition to family planning due to religion;

(5) The team members are strongly committed to sustain their cooperative works in enhancing their Upazila family planning program, are widely known in localities as the hardworking and sincere;

(6) A number of Upazilas have undertaken very similar OSTs for other Upazilas family teams/units, instead of visiting Indonesia. In the long-run, it is expected that Bangladesh completely graduated from the Indonesian OSTs will become groups undergo OSTs only within Bangladesh; and

(7) The Upazila family planning team/unit has contributed to convince the Directorate of Family Planning of MOH on its support to implement some lessons learned from Indonesia's OSTs, such as: assignment of local committees with the task of overseeing staff

and volunteer activities, generation of local fund, and increase of the involvement of volunteers in organizing satellite clinics.

- **Individuals**

The individual capacity development due to participation in the OSTs are as follows:

(1) OST participation increased alumni knowledge and Commitment to population and family planning program efforts;

(2) The alumni have self-perception of the importance of community participation in family planning program, the value of involvement by community leaders in local family planning program, the value of involvement by female volunteers, and the importance of political commitment to family planning program by national and local government;

(3) The alumni have considerable skills in increasing participation of community leaders;

(4) The alumni have improved field level MIS (Management Information System);

(5) The alumni, such as Upazila Family Planning Officer (UFPO) have adopted the framework of an action plan learned in Indonesia in local work. The process of implementation of an action plan begins with sensitization of the plan to upazila council for approval; holding a workshop for selected community leaders, and the family planning program staff at upazila office to prepare schedules, assignments and other aspects of implementation; forming local committees or activating the existing committees and forming lower level committees at ward (sub village) and village level, whose members are local level community leaders and service providers; selecting and training female volunteers in how to motivate ELCOs, distribute temporary methods of contraceptives, prepare and use ELCO maps, keep record, and help organize satellite clinic; and actual implementation;

(6) The alumni have also been capable in mobilizing women's groups and youth groups for accelerating family planning program performance;

(7) The alumni have a certain level of advocacy skills to generate commitment of political and government leaders and to benefit from the existing infrastructure;

(8) The alumni have capability to link beyond family activities to the contraceptive use, integration of family planning services with health and nutrition services; and

(9) The alumni's capabilities in motivating ELCOs for the adoption of small families are increased.

c. Tanzania, Malawi and Ghana

1) OST

a) Institution

(1) The Institutions involved in the collaboration were mostly MOH and its branch at district, Central and Local Government, NGO and community leaders. They have been concerned with and improved their capability in expanding the family planning/reproductive health

program to the grass-roots level. They are aware of taking the services of family planning/ reproductive health to the door steps of people to bridge the gap between the health service points and the community as they learned during their Indonesia's OSTs.

(2) The sending institutions, especially health institutions have begun to introduce the modified Indonesia's POSYANDU to their own context in a number of villages. It is called Village Health Day. This is a monthly event, managed and financed by the village people themselves, which has mainly a preventive purpose through health, nutrition and family planning/reproductive health education and motivation, and gives an excellent opportunity for identification of risk cases and ensuring referral to nearest health post, or otherwise, if so required;

(3) CBD (Community-Based Contraceptive Distribution) was found and well establish-ed and expanded to Community Based Development. From Indonesia's OST experience, the managers learned how to select, train and monitor family planning/reproductive health field workers in their work and how their contribution can stimulate voluntarism, leading to viable organization and a certain homogeneity in approach;

(4) The health institutions and its NGO partners are highly concerned about the importance of the volunteer involvement. This was manifest in the increased involvement of community members in the organization of the village-level (Village Health Day) activities and from the involvement of local leaders. As the Indonesian experience indicates, mass involvement of volunteers is necessary to back-up the CBDs in bringing family planning/reproductive health services closer to the community;

(5) The importance of the motivating role of formal leader's e.g. local government is highly perceived by the institutions. The formal leaders who participated in the OST have a high awareness of their motivating role in supporting and encouraging the local people to enhance and sustain family planning/ reproductive health activities;

(6) The confident role and active involvement of non-formal leaders, such as religious leaders, etc is highly recognized by the institutions. As demonstrated in Tanzania, the Ulamas showed themselves very knowledgeable on topics related to family planning/ reproductive health according to interpretations of the Al Qur'an (Islamic Holly Book) and also endorsed the discussions and activities undertaken by the community to popularize family planning/reproductive health concept and services;

(7) The institutions' awareness of the need to mobilize local resources under conditions of scarcity (material, financial and manpower) is something necessary to initiate. This is to some extent successfully shown in Village Health Day as community contribution to the construction of sheds so the Village Health Day could be organized; and

(8) The institutions' confidence, morale, creativity, innovativeness are increased. The good morale and enthusiasm of institutions, family planning/reproductive health program

managers and community leaders are generated and improved, in countries where otherwise conditions would not give much reason for optimism.

b) Individuals

(1) The alumni have plausibly improved their capability in managing the family planning/ reproductive health program in planning, implementing and monitoring the family planning/reproductive health activities using the framework of an action plan they learned in Indonesia's OST;

(2) The alumni, especially district health staff, field worker supervisor have improved the CBD program from only contraceptive distribution post to the Community Based Development of family planning/reproductive health program by expanding its activities to organize Village Health Day;

(3) The alumni have established, in cooperation with local formal and informal leaders, the importance of community participation and recruiting volunteers in village level family planning/reproductive health activities such as Village Health Day;

(4) The alumni have been able to benefit from the key roles of community leaders for the enhancement of family planning/reproductive health program among the people, such as religious leaders as the inter-mediator for Information, Education and Communication between the program managers/implementers and the people;

(5) The alumni, especially program managers, field workers and field supervisors have step by step shifting CBD concept of payment to part-time payment and finally to full volunteerism; and

(6) The alumni, especially Fieldworker and fieldworker supervisor have been familiar with a regular schedules to visit CBD and community leaders to sustain their participation and volunteerism in family planning/reproductive health program.

2) Internship

Internship program was only participated by persons working at district and sub-district level. They came in a team of four personnel comprising health or nursing personnel, field worker supervisor, CBD personnel and local government staff.

a) Institution

The district health institutions have increased concern on the importance of community participation as one of the requisites to accelerate the family planning reproductive health program, coverage, performance and achievement.

(1) The district health institution has improved its capability in expanding the family planning/reproductive health services close to the people by introducing the Village Health Day; and

(2) In cooperation with local government both district and village levels, the district health institution has begun to relinquish its authority to local people by improving CBD concept from distribution of contraceptive to health development and from pay volunteers to half-paid and really voluntarism concept.

b) Individuals

(1) The alumni, especially field worker and field worker supervisor have had regular schedule for visiting CBD personnel, groups of volunteer and community leaders to create and have sustained their commitment to family planning/reproductive health program;

(2) The alumni, especially field worker and field worker supervisor have more confidence to train CBD personnel, volunteers and community leaders about family planning/ reproductive health program and regularly update their knowledge about family planning during their visits;

(3) The alumni, especially CBD personnel are now knowledgeable in managing CBD activities such organization of Village Health Day, record keeping and managing volunteers' activities in family planning/ reproductive health program;

(4) Alumni, especially field worker, field worker supervisor and CBD personnel are now confident in working with the community to do activities by adopting the principles of ten steps of the Indonesian Field Worker working procedures; 1) approach formal leader, 2) approach informal leader, 3) data collection and mapping, 4) commitment building, 5) strengthening of commitment, 6) IEC, 7) develop pioneer group, 8) family planning/reproductive health services to potential acceptors, 9) family planning/reproductive health acceptor maintenance, and 10) recording and reporting.

3) Technical Assistance.

The Technical Assistance program was undertaken in two countries, Tanzania and Malawi. Despite the fact that there is the absence of evaluation about the consulting services done, the Indonesian Technical Assistant, from the interaction with Tanzanian and Malawian OST participants, the impact the recipient institution (MOH) of the two countries could be concluded as follows:

a) Institution

(1) The MOH, especially Family Planning Unit of Tanzania has an improved IEC program using a multi dimensional and multi channel approach, by which it is currently able to cover various segment potential target audience;

(2) The MOH, especially Family Planning Unit of Tanzania has an improved Community Based Development system, which minimizes payment to CBD volunteers as done before;

(3) The MOH and Population, especially Family Planning Unit has an improved family planning/reproductive health management system using a multi sectoral, private, NGO and

Community approach. The concept introduced with active coordination forum done at national down to regional, district, traditional area and village level with different frequency. The lower the level, the greater the frequency of the coordination forum. This conceptual framework had expanded the existing concept, which only relied on the single Ministry. The concept also introduced the importance of setting operational policies and annual target based on national population policy;

(4) Assisted by the Technical Assistant, the MOH and Population, especially Family Planning Unit has been able to develop a three-year family planning/reproductive health plan.

b) Individuals

(1) The related personnel of MOH and Population personnel have improved their capability in applying the management system, which introduce the concept of alignment with related institutions in addressing the family planning/ reproductive health issues;

(2) The related personnel of MOH and Population are highly aware that this paradigm can only be only achieved by organizing the coordination forum at various level based on partnership system; and

(3) The related personnel of MOH and Population are aware of the importance of setting of annual targets as the yardstick to monitor and evaluate the family planning/ reproductive health program performance.

2. Provider country

a. OST

1) Institution

a) The impact on provider country institutions, which organize the implementation of the collaboration, especially Center for International Training and Collaboration – It is plausible to conclude that the collaboration between Indonesian and Bangladesh and three African countries (Tanzania, Malawi and Ghana) has contributed much to the capacity development of the Center which results in the recognition of and the quality of its international collaboration such as training, networks and technical assistance.

b) The Center has learned much from the experience of conducting OST with Bangladesh, Tanzania, Malawi and Ghana. In early the 1980s, BKKBN had conducted programs for foreign visitors in an ad hoc fashion as per request, with no regular planned curriculum or management procedures guiding this process. Personnel were assigned as needed, without designed continuity. In other words, BKKBN has learned a lot from this collaboration with those countries. It is the learning that shifted the Center from utilizing linear approach to a non-linear one (systemic) when organizing those OSTs.

In the late 1980s, when BKKBN began to officially collaborate with Bangladesh government to improve, particularly the Upazila family planning program of unit/team, BKKBN through its International Training Program commenced:

- To correctly plan its international collaboration programs particularly OST;
- To assign available resources to learn about the interested countries' – including Bangladesh and later Tanzania, Malawi and Ghana – program's needs;
- To develop and continuously update curriculum and teaching/learning materials;
- To visit field sites in advance in order to prepare them for their responsibilities. Technical assistance was provided to obtain additional ideas from an outside observer. The repetition of similar groups due to a long term bilateral collaboration, made evaluation of an OST more meaningful, as the recommendation for improvements.

The most important substantive lessons BKKBN (Center for International Training and Collaboration) learned were:

- Technical focus and the bulk of an OST's time should be devoted to the grass-roots level. This is the strongest element of the Indonesian family planning/reproductive health program, as well as the comparative advantage that BKKBN has compared with family planning/reproductive health departments/institutions/units in other countries;
- Daily Consolidation Sessions – meetings of small groups of participants and their facilitators – are valuable opportunities for participants to consolidate what they have been facilitated. These hour-long sessions help them to be sure they really understood each of the things seen that day, relate each to a more complex and abstract understanding (intangible) of the Indonesian family planning/reproductive health program.
- An OST is a form of international collaboration that is very different from a training program and very different from a study tour. Its keys objective is not for participants to learn a set of knowledge or skills or simply to travel and see another country's program, but rather to open people's minds, to get them to think creatively about improvements in their own program.
- The OST serves as the facilitator for this creativity, providing opportunities to learn about a different (and successful) family planning/reproductive health program, to exchange views with peers from another country, to exchange views with colleagues from home, then apply creative thinking to the development of a real plan that they, will themselves have to implement.

The partner institutions both of Government and Non Government ones at national level, such as MOH, Ministry of Women Empowerment, PKBI (Indonesian Planned Parenthood

Association), YKB (Kusuma Buana Foundation), which provided orientation during the first part of OST program felt that their participation in the OST has resulted in two things:

- Firstly, it improved the institutions' capacity in communicating and interacting with foreign visitors about family planning/reproductive health issues, which their institu-tions dealt with;
- Secondly, their participation in the OST as resource persons, had to some extent has improved the image and reputation of their institutions, which also frequently hosted foreign visitors visiting their institutions for exchange of experiences on issues of family planning/reproductive health related to their competencies.

The provincial and district BKKBN, which hosted the field visit of the OST revealed that the opportunity to host the field visits of an OST, which is the most important part, have improved their capacities in the following aspects:

- Generate and strengthen the partner institutions' support to the family planning/ reproductive health program;
- Improve the local government's perception about the BKKBN family planning/ reproductive health program, which indirectly contribute to increase the positive image and reputation of the province or district and the governments amongst local people;
- Improve access to the local government's leaders, which enable them to generate substantial support for program activities, such as making family planning/ reproductive health program an integral part of the local government strategic development in the context of autonomous government.
- The local partner institutions', especially NGOs' participation in organizing the OST field activities related to their institutions' program has improved their management capacity since they have to well prepare the activities to be observed;
- The non-formal programs organized for OST participants have also improved the BKKBN institutions' - at national, provincial and district level – capacity in designing the OST program a combination of core substances of family planning/reproductive health program with cultural orientation aspect, making the participant know about the family planning/reproductive health program and the country's culture, habits and economy, etc.

2) Individuals

a) The personnel involved in the OST both at national and provincial level improved their knowledge about family planning/reproductive health program and related matters on both tangible and intangible issues;

b) The personnel involved in the OST both at national and provincial/district level have improved their skills in communicating effectively the issues in this field to make the foreign visitors understand the issues comprehensively;

c) The personnel involved in the OST both at national and provincial/district level have enriched their understanding about other countries' family planning/reproductive health program, social cultures, etc, which were helpful to them in their inter-action with foreign visitors;

d) Family Planning Fieldworkers and Supervisors and cadres/volunteers felt the honour to host the OST in their areas as a reward to them and their community due to their success and encouraged them to work harder to sustain the strategic achievement in family planning/reproductive health;

e) The personnel involved in the OST both at national and provincial/district level have an opportunity to practice English and this motivated them to improve their English proficiency for better family planning/reproductive health communication.

f) The personnel involved in the OST both at national and provincial /district level have improved their knowledge about the people's culture, economy, etc and skills in communicating with them to generate the participants' questions to know more about Indonesia.

b. Internship

1) Institutions

a) BKKBN Center for International Training and Collaboration has improved its capacity in designing and managing a longer period of training program for foreign participants in addition to its OST program, which is arranged in a shorter period;

b) BKKBN of provincial and district level have proven to be capable in managing a longer period training program, while managing operational activities of family planning/reproductive health activities at the same time;

c) Having had their colleagues from abroad, stay with and learn from them about what they have been doing, BKKBN of district level have become more confident in strengthening and sustaining the working network at community level and so make the family planning field workers and supervisors more skillful in mobilizing and engaging community in the family planning/reproductive health activities;

d) BKKBN of district level sustains its good access to local government (district and sub-district) and leaders and generate substantial support for family planning/ reproductive health program;

e) Community institutions have become more committed to be actively engaged in community-based family planning/reproductive health activities.

2) Individuals

a) The Family Planning Field Workers and Supervisors feel more confident to work with and sustain good relationships with the community and leaders because the success of local family planning/reproductive health program has made the sub-district and villages used for internship program by their peers from other countries;

b) The Family Planning Field Workers and Supervisors have improved their knowledge on managerial skills in family planning/reproductive and related issues because of their inter-action with their peers;

c) The Family Planning/Reproductive Health cadres or volunteers have improved their confidence and voluntary roles in family planning/reproductive health program due to the comparison with that of the interns' countries family planning program situation;

d) The community leaders refresh their "Gotong Royong" (mutual help) spirits in making community-based development activities, such as family planning/ reproductive health for community members' welfare improvement;

e) The Sub-district and Village heads have improved their commitment to support the community-based or initiated development activities, such as family planning/ reproductive health as the use of their areas for internship program by other people from other countries has granted them for their success in local leadership.

c. Technical Assistance (TA)

A number of BKKBN staff and partner institutions' personnel who were trained for a short-term consultant by the Center for International Training and Collaboration in cooperation with the Johns Hopkins University, Center for Communication Program have been hired by the international donor agency such as UNFPA, USAID, Ford Foundation, World Bank as short-term consultancy services in some developing countries.

Four of them were assigned to Tanzania and Malawi for short-term consultancy services on areas requested by these countries. The consulting programs in other countries have had an impact on both BKKBN and the individual capacity.

1) Institutions

a) BKKBN has improved its capacity in providing consultancy services especially to those that sent their family planning/reproductive health program personnel to Indonesia in OSTs program, since this consulting program has proven to be effective in accelerating and implementation of the recipient countries' family planning/ reproductive health programs;

b) The effectiveness of this TA program has made BKKBN receive requests for short-term consultancy services by some developing countries, such as Vietnam, Nepal, Sri Lanka, etc.

c) BKKBN is currently noted and considered by donor agencies, to have a list of potential consultants for a short-term consultancy work in developing countries on ad hoc basis as done by UNFPA, USAID and World Bank;

d) BKKBN is also considered to have been capable of providing resource persons in international training as done by the National Institute for Health and Family Welfare of Ministry of Health, India (IEC Training) and Nanjing College on Population Program Training Center International (Leadership Training), Partner Secretariat (Leadership Training) and ICOMP for designing the international training program on Strategic Leadership Development, etc.

2) Individuals

a) The TA has contributed to the promotion of the consultant's career in BKKBN. Most of the consultants are echelon II at BKKBN. Two of four consultants sent to Tanzania and Malawi have been promoted to be echelon I; and some of echelon III have been also promoted echelon II;

b) Some of the TA have moved to some International Agency, such as UNFPA on BKKBN approval;

c) Some of the TA have been registered on the list of Country Support Team (CST) of UNFPA and Partners in Population list of consultant;

d) Some of the TA has done consulting work in the country for a number of institutions dealing with family planning/reproductive health.

d. Overseas Education

In the last four years, BKKBN has sent nearly 400 personnel for short-term overseas training programs in a number of developing countries, such India, Bangladesh, China, Thailand, Egypt on population, family planning, reproductive health, adolescent reproductive health, management, etc. This program is done as a part of BKKBN Human Resource Development. This program has brought positive impact to both BKKBN institution and the alumni in improving national family planning program and in managing and implementing the BKKBN international collaboration with developing countries.

1) Institutions

a) BKKBN has improved its capacity in accelerating the family planning/reproductive health program at various levels ranging from to national down to district level;

b) The family planning/reproductive health program and management quality have been plausibly improved due the deployment of alumni in various positions at various levels of BKKBN institution;

c) BKKBN has many choices of assigning its staff in supporting the international collaboration with other friendly developing countries in the field of population, family planning, reproductive health and related issues;

d) Indonesia's status as one of the Four Centers of Excellence in the field of population, family planning, reproductive health and related matters has been strengthened by the availability of professional trained personnel;

e) The BKKBN Center for International Training and Collaboration has benefited from this program, not only as facilitators but also developing the international training materials and publication.

2) Individuals

a) The alumni feel more confident in performing their jobs and functions;

b) The alumni, to some extent have introduced some innovations of their work scope, quality and environment to give a greater impact to the attainment of their working units' objectives in particular and the family planning/reproductive health program objectives;

c) Some alumni have contributed significantly to the improvement and quality services of the international collaboration, such as development of training materials, facilitation both in class session and field observation;

d) The alumni have improved their communication capability using English language in international forums or gatherings such as international training programs by which they could generate lessons from other countries' experiences;

e) The alumni are potential for promotion in their career in the institutions they work for;

f) The alumni have shown their improved capability as reflected in their suggestions to improve the BKKBN Overseas training program to make it an effective and efficient human resource development program.

Chapter V
POLICY IMPLICATIONS TO RECIPIENT AND PROVIDER COUNTRY PROGRAM

The bilateral collaboration between Indonesia and the recipient countries is done, because of the possible benefit gained during the implementation of the collaboration. The recipient countries, on one hand feel that their collaboration with Indonesia has to some extent contributed to the enhancement of their respective country family planning/reproductive health program in particular and in population program in general. While Indonesia, on the other hand is of the opinion that the collaboration in the field of population, family planning/reproductive health and related issues between and among the developing countries is something necessary to sustain and improve.

A. Recipient Countries

1. Bangladesh

a) In selecting Upazilas for sending persons for OST, preference should be given to the difficult and low performance Upazilas. These Upazilas urgently need special attention and strong interventions, and OST can act as a required intervention to rapidly change the situation there;

b) The Upazila's team size should be increased and should also include a large number of active community leaders, Family Welfare Assistants, and even some educated female volunteers or educated social workers of the locality;

c) The tendency of the directorate (family planning) to frequently transfer the alumnus officials to other Upazila and offices should be avoided. The alumnus officials should be retained in the Upazila from where they conduct OST at least for a few years, e.g. five years. Otherwise, the pace of implementations will slow down;

d) The Upazila chairman, having sufficient influence on local people and the officials, used to act as the 'local guardian' of the family planning program and sustainability contributed to implementation of OST lessons;

e) In order for the implementation of OST lessons to speed up sufficiently, some measure should be taken immediately at the top level of the government to increase involvement of and coordination among the various departments of the government not only at Upazila level but also at higher level;

f) Enhance integration of family planning program with socio economic programs, involve religious leaders on a larger scale, incorporate the useful OST lessons in the national population plan, and more importantly, remove the on-going friction between the Upazila Family Planning Officers and the medical officers prevailing within the program staff;

g) Local level population and health workers may benefit the most. Higher level OST alumni in decision making and administrative positions have an important role to play in creating

and implementing policies supportive of local-level family planning programs, but local level population officers and health workers seem to be doing the most on a day-to-day basis with the lessons they learned from OSTs;

h) Local teams of OST alumni should be kept together as long as possible. The impact of OSTs is reduced if local teams of OST alumni are broken up through transfer or reassignment. This makes it harder to build a core or critical mass of committed and like-minded population workers at the local level;

i) Supportive infrastructure facilitates implementation of OST lessons. The presence of influential and socially-committed local leaders is important to the implementation of program innovations and these leaders should be part of the local team sent for OSTs. But an established programmatic infrastructure is important, too.

2. Tanzania, Malawi and Ghana

Out of the three countries, **Tanzania** and **Malawi** are interested to continue the collaboration or partnership with immediate effect; **Ghana** needs more time, due to its present restructuring exercise, to formulate the contents of the second phase of the collaboration or partnership;

a) **Tanzania**: would like to expand the partnership programs to 2 new districts on Tanzania mainland and Zanzibar. Additional special OSTs are needed for religious leaders of both mainland and Zanzibar. High-level visits for leaders at Ministerial level, in addition to an internship program for Zanzibar and mainland.

A joint Committee of ITP/BKKBN-Alumni will be established, with separate secretariat for mainland and Zanzibar to monitor the implementation and the lessons learned which have been consolidated in an Action Plan, and its replication to other districts, and the whole country in the end;

b) **Malawi**: intends to expand the partnership program to the whole of Blantyre District mid 1997 and a year later to the entire Southern Region. The Government will contribute from local (district level) funds and integrate the innovative approaches into ongoing Community Based Development programs funded by UN, ODA and others. It needs commitment building of high-level Government authorities.

A joint Committee of ITP/BKKBN-Alumni will be established for monitoring of implementation and replication of the lessons learned from Indonesia, which has been consolidated in an Action Plan.

c) **Ghana**: expresses its need of having Indonesian expertise or Technical Assistance to assist the implementation of the Action Plan.

B. Provider Country

a. Central Government level

1) Indonesia's government is determined to propose intensification of collaboration with developing countries in population, family planning, reproductive health;
2) Indonesia's government is determined to play an effective and leadership role in the promotion of South-South and Technical Cooperation among Developing Countries in population, family planning and reproductive health programs and put it into the key element of Indonesia's policies;
3) Indonesia has signed a number of Memorandum of Understanding with some countries (example: China, Egypt, Malaysia, Pakistan, Tunisia, and Vietnam) on the cooperation in the field of population, family planning, reproductive health and related matters, based on which it will endeavor to explore potential funding agencies either individually or jointly with the concerned country;

b. BKKBN/Center for International Training and Collaboration

1) BKKBN, particularly through the Center for International Training and Collaboration has and will sustain its international commitment as part of its function as one of the Four Centers of Excellence in the field of population, family planning and reproductive health;
2) In this connection it will continue strengthening its international networks with international donor agencies, training institutions and give a greater impact to the collaboration at national, regional and international level;
3) The Center for International Training and Collaboration has improved its international training process to systemic learning with quality services approach. The system undertakes the whole process of learning as inter-connected and inter-related parts, which serve the participants with quality services beginning from their arrival up to their departure back to their own countries. In this respect the quality services will provide equal important services not only in substantial aspect or formal learning process but also in non substantial aspects, which to some extent affect learning processes, such as free-program activities to facilitate them to appreciate the Indonesia's ethnical and national cultures;
4) Having a look at potential competitors, the Center also applies progressive marketing of its international trainings and collaboration using a multi-media approach, such as publications, e-mail and website, etc.
5) With regard to training materials, the Center has enriched the existing list with new materials to include the latest information about population, family planning/ reproductive health either of international or national contents;
6) In this connection, BKKBN nominated and developed not less than 6 provinces and 22 districts as leading laboratories for international training program filed sites;

Chapter VI
LESSONS LEARNED

The integrated approach of capacity development in the field of population, family planning/ reproductive health programs applied in the collaboration between Indonesia and other developing countries in general and Bangladesh and three African countries (Tanzania, Malawi and Ghana) in particular has resulted in a number of lessons learned.

1. The conceptual framework of integrated capacity development approach is proven to give a greater impact to institutional and individual capacity of both the recipient and provider's country;
2. The core element of the frame is the Observation Study Tour (OST), which is neither a normal study tour nor a traditional training program. Rather, an OST is a hybrid structure combining observation of the Indonesian program with intellectual study of the elements of the program;
3. An OST does not have the same purposes as a training program. Its basic objective is to help participants to think in depth from a new perspective about their own country situation, as a result of having seen a different approach (Indonesia's) and having discussed what they observed with the Indonesians and other participants. In other words the objective of OST is to come up with creative ideas to their own program, which are developed in a Plan of Action;
4. As OST time is often considered rather short, the second element is to equip the field level personnel who will be involved in the implementation of an Action Plan developed by OST participants with family planning/reproductive health operation systems. The third element of this framework is helpful to assist them to accelerate the application of the Action Plan; while the fourth element will function to support them to speed up the expansion of the lessons learned to other areas;
5. To ensure a substantial impact to a recipient country's family planning /reproductive health program, a bi-lateral collaboration program, which is planned for a long-term seems to be highly effective for at least four reasons:
    - It could create a critical mass in the recipient country, which will much affect the implementation of lessons learned and accelerate the program expansion to other areas;
    - It provides opportunities for each country (recipient and provider) to learn more about the other;
    - It also provides opportunities for the activities to be more focused on a country's real situation and real needs; and
    - It provides opportunities for knowledge of impact.
6. Ideally, the objective of a bi-lateral collaboration program is truly for two countries to share their program experiences;
7. Other modalities of collaboration might be also included. This could include technical training, exchange selected materials and bi-national seminars or other meetings, etc.

8. The basic lesson learned of this collaboration is that any form of international collaboration – is more likely to succeed if there are some arrangements within the recipient country to plan and implement follow up. A major focus on follow up, on some type of extra *push*, will result in the gains from international collaboration being far more likely to be sustained.

Chapter VII
RECOMMENDATIONS

1. All developing countries should view the collaboration in the field of population, family planning/reproductive health among developing countries in general and among South-South countries as a mutually-beneficial sharing of experiences. This basic suggestion to all countries is that such collaboration should always be perceived as a mutual *sharing of experiences,* not as one country *teaching* another;
2. The integrated approach of capacity development, which combines four elements– Observation Study Tour, Internship, Technical Assistance, and Overseas Educational Program with its hierarchical order is a very efficient and effective means for helping people to learn about other country's family planning/reproductive health program experiences;
3. Long-term bi-lateral linkages between two countries are far more beneficial that shorter-term ad hoc arrangements. It is much more effective if done on large-scale, planned, and organized manner rather that on an occasional ad hoc basis. Structured follow up of the initial activities are as important as the activities themselves;
4. As likely to be more difficult or seemingly impossible now for every country, which has scarcity of financial resources, to get donor's support for its international collaboration with other countries, especially to invite people from other countries, the Secretariat of Partners in Population and Development: A South-to-South Initiative could bridge this gap in at least two ways:
5. To assist the interested partners participating country [ies] in finding out the potential donor [s] for its/their international collaboration proposal in the context of South-to-South Cooperation;
6. Based on the participating country's[ies] proposal (s), Secretariat of Partners can develop an Inter-Regional Program with funding from the interested donor [s], in which the Secretariat can function as program manager, who will arrange and manage the inter-country collaboration, such as Global Leadership Program funded by the Bill and Melinda Gates Institute but in different manner by taking recommendation no. 3 into account.

Chapter VIII
CONCLUSION

Indonesia has considerable experience in implementing the developing countries including South-South exchanges in the field of population, family planning/ reproductive health and related matters, such as family planning/reproductive health program capacity development, and in searching for and obtaining means to support these exchanges. Since its inception in 1987, it has hosted not less than 4,200 professionals, policy and decision makers, program managers and workers, as well as selected donor's staff, of whom more than 360 foreign dignitaries which included presidents, prime ministers, cabinet ministers, and top officials of international organizations.

In this connection, the Governments of Bangladesh, Tanzania, Malawi and Ghana have sent their officials and Non Government Organization's personnel totaling to 392 people, 18 people, 16 people and 15 people respectively under a bi-lateral program. In addition, there are hundreds more people from these countries coming to study the Indonesian family planning/ reproductive health program under separate arrangements.

The Center for International Training and Collaboration (as the BKKBN arms for its international cooperation) has a wide range of an international network with esteemed institutions, such as Partners in Population and Development,The Johns Hopkins University, Population Communication Service, ICOMP, NIHFW of India, Nanjing College, etc. in support of its international collaboration with the developing countries in the field of population, family planning/reproductive health and related matters.

The high performance of the Indonesian international collaboration has credited it to be appointed as one of the four Centers of Excellence in the field of population, reproductive health, family planning and related matters by UNFPA.

It has introduced, at least to Bangladesh, Tanzania, Malawi and Ghana an integrated capacity development in family planning/reproductive health program, which seems to have substantial impact not only to family planning/reproductive health institutions and individuals of related persons, but also, as expected to contribute to the enhancement of the family planning/reproductive health program both in recipient and provider country's program.