

## Ex Post-Evaluation Brief

### INDONESIA: Cooperation reconstruction aid for district health care services in Aceh/North Sumatra



<b>Sector</b>	12230 Infrastructure in the area of basic healthcare	
<b>Programme/Client</b>	Cooperation reconstruction aid for district health-care services in Aceh/North Sumatra, BMZ No. 2005 65 671*	
<b>Programme executing agency</b>	Bureau of Rehabilitation and Reconstruction (BRR)	
<b>Year of sample/ex post evaluation report: 2013/2013</b>		
	Appraisal (planned)	Ex post-evaluation (actual)
<b>Investment costs (total)</b>	EUR 15 million	EUR 19.5 million
<b>Counterpart contribution (company)</b>	EUR 1 million	EUR 5.5 million
<b>Funding, of which budget funds (BMZ)</b>	EUR 14 million EUR 14 million	EUR 14 million EUR 14 million

\* random sample 2013

**Short description:** The programme attends to reconstruct and improve the health care services in the province of Nanggroe Aceh Darussalam (NAD, Aceh province, North Sumatra). The programme regions comprises six eastern coastal and four central mountain districts of the province. These districts have suffered from the Tsunami catastrophe (coastal areas) and/or from the armed conflict that has been going on for 30 years between the central government and the rebel organization GAM (movement to free Aceh). The programme focused on restoring basic health care facilities so that they can provide health care services to meet the needs of the population.

**Objectives:** The rehabilitation and restoration of destroyed basic health care facilities was intended to create the requirements for providing an adequate level of health care services - in cooperation with the project contribution of the GIZ (German Society for International Cooperation) - and to increase the utilisation of these public facilities (programme objective). It was hoped that this will improve the health care situation and contribute to preventing an imbalance between the areas affected by the Tsunami and the armed conflicts (overall development impact). The latter were hardly supported by external donors at that time. Around 7% of the existing infrastructure for basic health care in the districts was part of the programme. **Target group** of the programme was the entire population of the programme area / catchment area of the health care facilities, however especially the generally poor families living in rural areas.

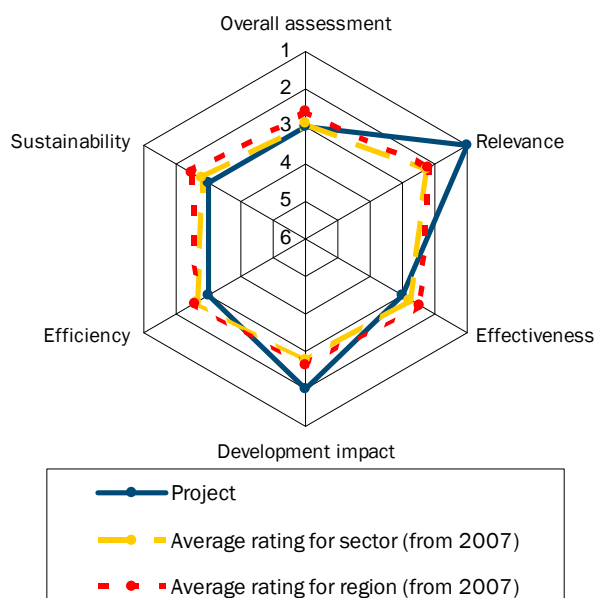
#### Overall rating: 3 (satisfactory)

The programme is rated as satisfactory.

#### Points to note:

- Broad target group approach to prevent regional imbalances (inclusion of armed-conflict and Tsunami regions).
- Rapid implementation of the emergency aid partly caused a reduced utilisation of the financed infrastructure (efficiency).
- Local capacity to take action in very remote regions was achieved by including a local NGO in the project. This also allowed intensive involvement by the respective municipalities.

#### Rating by DAC criteria



## **GENERAL CONDITIONS AND STATUS OF THE PROGRAMME**

The province of Aceh has been the victim of a twin catastrophe - a 30-year civil war for Aceh's independence and the Tsunami in late 2004. The reconstruction was supported by German development cooperation. This also included the above-mentioned FC programme, which was designed as fast-to-implement emergency aid and was financed via so-called "Tsunami aid".

## **EVALUATION SUMMARY**

Overall rating: 3. The project is rated as satisfactory.

### Relevance

At the time of the programme planning, directly in the aftermath of the Tsunami and the settlement of the 30-year conflict for the independence of the province, the reconstruction of the basic health care infrastructure was the declared focus of the Indonesian-German cooperation. This focus was also in line with the "*Master Plan for the Rehabilitation and Reconstruction of Aceh and Nias*" formulated by the Indonesian government, which served as the road-map for the reconstruction. Today, health care is no longer a focus of the cooperation. The coordination with other donors took place through the Bureau of Rehabilitation and Reconstruction (BRR), although hardly any other donors were active in the mountain regions at that time.

The programme conceived with a concept to be detailed during implementation, responded successfully to the pressure to act caused by the emergency situation, thereby enabling the first measures to be undertaken rapidly. Locations and type of infrastructure were selected (relatively quickly) at the start of the implementation, in cooperation with national government authorities and a consultant. The measures focused on rehabilitation and new construction at existing locations. During the implementation, the consultant acted in tandem with a national NGO, which enabled direct cooperation with the municipalities in the difficult-to-access regions. The province and district authorities confined themselves mainly to a formal coordination of the measures. In the emergency situation they did not have the capacities to assume a leading role in the implementation.

The grouping of the programme region into districts directly affected by the Tsunami and/or the armed insurgency was very useful to ensure a balanced redevelopment of the destroyed infrastructure. It was also very sensible not to distinguish between population groups within the districts (former rebel fighters and their opponents or those people directly affected by the Tsunami and people not directly affected). This approach promoted the balance between population groups and was aligned to the very fragile, emergency situation and the correspondingly defined dual goals of reconstructing the infrastructure and reducing conflict.

The chain of effects on which the concept is based was basically correct: the availability of qualitatively well equipped health centres leads to better acceptance and thus to the use of the health services, which in turn results in an improvement in the health of the population. Moreover, taking into account regions affected by the Tsunami and the civil war was also intended to contribute to the respective balance between the regions. The profound selection of locations was a lower priority given the need to act rapidly. A trade-off was made in this regard between fast implementation and reliable estimation of future requirements.

**Sub-Rating: 1 (excellent)**

Effectiveness

The following indicators were used to rate the **programme objective (1)**, improvement and more intensive use of the health care infrastructure in NAD province. These indicators are primarily based on the results of on-site inspections (22 of the 106 FC programme locations were visited unannounced):

<b>1a</b>	Appropriate utilisation of the health care centres	<i>The utilisation of the financed infrastructure varies between mountain and coastal region. The latter exhibit a considerably higher level of utilisation, which can be regarded as appropriate (around 60% utilisation). In the mountain regions, however, only around 25% of the centres are utilised intensively; one-third of the centres visited during the ex post evaluation were closed (sometimes temporarily). The indicator is considered to be <b>satisfied</b> for the coastal regions and <b>not satisfied</b> for the mountain regions.</i>
<b>1b</b>	84% of births are supported by medical personnel	<i>According to regional statistics, around 92% of births in the programme districts are now supported by medical personnel (average for NAD province: 88%). The indicator is considered to be <b>satisfied</b>.</i>
<b>1c</b>	At least one medical check-up is conducted for 95% of all pregnancies.	<i>At least one medical check-up was conducted for 96% of the pregnancies in the programme districts in 2012 (NAD average: 94%). In 2006 this figure was 91% (NAD: 92%). Overall, the indicator is considered to be <b>satisfied</b>.</i>

At the time of the programme appraisal, no indicators were defined for the rating of the **programme purpose (2)**, compensating for differences in the provision of health care services between districts affected by the Tsunami and those not affected by it. The following indicators were used for the rating in the ex post evaluation:

<b>2a</b>	Infrastructure density	<ul style="list-style-type: none"> <li>- <i>Mountain districts: between 38 and 57 larger health care centres are available per 100,000 inhabitants (INH). In addition, there are between 43 and 94 birth stations.</i></li> <li>- <i>Coastal districts: between 8 and 24 larger health care centres are available per 100,000 inhabitants. In addition, there are between 24 and 66 birth stations.</i></li> </ul>
-----------	------------------------	--

		<i>As a result, there is no indication that mountain regions are disadvantaged.</i>
<b>2b</b>	Density of medically trained personnel	<i>Almost no difference is perceptible between mountain and coastal regions in the case of medically trained personnel (doctors/dentists, midwives, nurses, lab personnel) per 1000 inhabitants (derived from the catchment area of the respective health care centres): on average, the centres are staffed with around 4 medically trained personnel per 1000 inhabitants.</i>
<b>2c</b>	Distribution of FC financing (Puskesmas/Pustu) to mountain/coastal regions	<i>The FC financing per inhabitant (2005) in the mountain regions is around twice as high as in the notably more densely populated coastal regions, where several other donors also provided support. This ratio is an approximate reflection of the existing infrastructure density and thus points to a distribution of the FC assistance to achieve a balanced outcome.</i>

Overall, a good achievement of the programme objective is expected. However, the overall result is substantially downgraded due to the unsatisfactory utilisation of the infrastructure in the mountain regions, which made up around 40% of the expenditure for infrastructure. But what needs to be taken into account here is the lower population density, which results in lower utilisation – provided the health care stations are reasonably accessible.

**Sub-Rating: 3 (satisfactory)**

Efficiency

The programme was implemented rapidly and within the scheduled timeframe of 36 months. This was in part due to extensive use of consulting services and services provided by a local NGO. The consulting costs were around 21% of the total costs or 30% of the FC financing. Added to this are 15% of the infrastructure costs, which cover the NGO's expenses. KfW also established a local office to manage the "Tsunami Emergency Programme", which also strongly promoted the implementation of the programme. Given the emergency situation and pacification process, it was very important to achieve rapid results. The high implementation costs can only be justified with this in mind.

The costs of the investments for the new construction of smaller buildings (Pustu/ Poskesdes) were generally between EUR 25,000 - 30,000 and between EUR 170,000 - 230,000 for larger health care stations (Puskesmas incl. ancillary building). These costs appear rather inexpensive.

The allocation efficiency must be rated differently for the mountain and coastal districts. In the coastal districts, the infrastructure is more intensively utilised, as registered locally, than in the mountain regions, where only 25% of the health care stations visited in the ex post evaluation were more intensively utilised (> 5 patients/day) and one-third of which were closed (sometimes temporarily). This was the case even though no additional locations were

financed through FC, but rather existing (no longer operable) sites were upgraded or replaced. This somewhat low utilisation must be evaluated in connection with the starting situation (objective: fast action) and also in light of the post-conflict situation. The available data for the mountain regions was very sketchy when the programme appraisal was conducted. The pacification of the region also meant that the population became more mobile (better security, rising income, improved roads). This modified way of living calls into question the high infrastructure density of the pre-conflict era. Furthermore, the newly established health insurance "for all" scheme provides patients the opportunity to seek out higher-value levels of service without additional costs. This leads to "voting with your feet"; in other words, stations that don't offer good service are not visited.

The maintenance of infrastructure and equipment is generally deficient. Here too, however, there is a clear differentiation between coastal and mountain regions. For example, the two generators inspected in the mountain regions were out of operation, whereas the two in the coastal region were in operation. Only one of the five established waste incineration facilities in the mountain regions was in operation, whereas all three facilities in the coastal region were still in operation. In some cases, equipment and treatment facilities (for example, birthing chairs, treatment tables, dentist's chairs) had hardly ever or never been used.

In summary, the acceptable production efficiency and the considerably lower allocation efficiency meant that the overall rating was nevertheless satisfactory.

### **Sub-Rating: 3 (satisfactory)**

#### Impact

The overall objective of the programme was to make a contribution to improving the health care situation of the population in the programme region. No indicators were established. Maternal and child mortality figures were used for the rating in the ex post evaluation.

**Maternal mortality** has improved significantly since 2005 (in average NAD). It fell from 224/100,000 live births (2006) to currently 184 (2012). **Child mortality** has fallen markedly during the period as well (from 57 mortalities per 1,000 live births for entire North Sumatra to 11.4 for the province NAD, 2012). The FC program comprises around 7% of the basic infrastructure of the programme area. It can therefore be assumed that the programme has contributed to this improvement – in particular since the geographically important facilities in the mountain regions were included. The introduction of the free-of-charge health insurance for all inhabitants of NAD was just as important; it removed a barrier that was blocking access to the provision of basic health care services.

The second most important programme goal, attaining a balance between the regions affected by the Tsunami and regions affected by the armed conflict, was also addressed during the ex post evaluation. This was ultimately intended to lead to an improvement in the quality of life by, for example, enabling an orderly everyday life and thus preventing the migration of

the population away from mountain regions that had been neglected up until then. Information obtained from on-site surveys and the statistically recorded population trends of the districts were used to evaluate this second primary objective.

Around 25% of the 61 families interviewed in the mountain regions were affected because they were forced to migrate (temporarily). Moreover, almost all the inhabitants suffered under the constant insecurity and considerable restrictions to their freedom of movement. Disputes and events perceived as conflicts have since become rare and most of the people interviewed locally reported that they and their families feel very safe and are able to pursue their livelihoods undisturbed. For example, the population in the programme region has increased by around 10% since 2007 (NAD: 9%). At 7%, the growth in the mountain regions is not quite as strong. If, however, we expand the period under review to include the preceding period from 2005 to 2007, a significant increase in growth is noted for the mountain regions for the period from 2007 to 2012 (2005-2007: 0.8% p.a.; 2007-2012: 1.5% p.a.), while growth in the coastal regions remained largely constant throughout the entire period (around 2% p.a.). This information points to an improvement in the living and working conditions in the mountain regions after peace was declared. The overarching developmental effects are rated good overall.

**Sub-Rating: 2 (good)**

Sustainability

The on-site inspection has shown that the maintenance and servicing of the health care infrastructure is deficient overall and very clearly dependent on the engagement of the respective management. (Limited) amounts for maintenance of the financed infrastructure are always incorporated into the annual budget planning (due to the *on-budget – off-treasury* approach used in the implementation). These amounts are combined with the budget for additional personnel payments (overtime, other extra work). The individual health care stations have discretionary authority to decide how to use these amounts. Due to this discretion, the entire amount is usually paid to the staff as incremental salary and maintenance is severely neglected. This reduces the service life of the financed facilities.

Regarding the future use of the infrastructure, no significant changes are expected – from today's perspective; the degree of utilisation at the lowest service levels may possibly decline slightly. This applies provided the existing health insurance system continues to be maintained. Although this system promotes the use of basic health care services, it also leads to patients increasingly seeking out higher quality facilities in the health care system, to which more competence is attributed. These latter facilities receive higher remuneration from the health insurance for comparable treatments. As a result, lower-level health care stations also refer patients to the higher-level stations when these particular cases do not appear to be "lucrative" for them and even though they are in a position to provide the treatment.

The 2005 peace agreement was the basis for the pacification and "normalisation" of the population's everyday life. Two regular elections have been held since then. After the last election, the provincial government was also transferred to the former rebels, who have since organised themselves as a political party. No relapse into active armed conflict is currently expected. The population – especially in the mountain regions that were comparatively wealthy prior to the conflict - has a clear interest in not allowing the conflict to flare up again.

**Sub-Rating: Sub-rating: 3 (satisfactory)**

## Notes on the methods used to evaluate project success (project rating)

Projects (and programmes) are evaluated on a six-point scale, the criteria being relevance, effectiveness, efficiency and overarching developmental impact. The ratings are also used to arrive at a final assessment of a project's overall developmental efficacy. The scale is as follows:

1	Very good result that clearly exceeds expectations
2	Good result, fully in line with expectations and without any significant shortcomings
3	Satisfactory result – project falls short of expectations but the positive results dominate
4	Unsatisfactory result – significantly below expectations, with negative results dominating despite discernible positive results
5	Clearly inadequate result – despite some positive partial results, the negative results clearly dominate
6	The project has no impact or the situation has actually deteriorated

Ratings 1-3 denote a positive or successful assessment while ratings 4-6 denote a not positive or unsuccessful assessment

### **Sustainability is evaluated according to the following four-point scale:**

Sustainability level 1 (very good sustainability): The developmental efficacy of the project (positive to date) is very likely to continue undiminished or even increase.

Sustainability level 2 (good sustainability): The developmental efficacy of the project (positive to date) is very likely to decline only minimally but remain positive overall. (This is what can normally be expected).

Sustainability level 3 (satisfactory sustainability): The developmental efficacy of the project (positive to date) is very likely to decline significantly but remain positive overall. This rating is also assigned if the sustainability of a project is considered inadequate up to the time of the ex post evaluation but is very likely to evolve positively so that the project will ultimately achieve positive developmental efficacy.

Sustainability level 4 (inadequate sustainability): The developmental efficacy of the project is inadequate up to the time of the ex post evaluation and is very unlikely to improve. This rating is also assigned if the sustainability that has been positively evaluated to date is very likely to deteriorate severely and no longer meet the level 3 criteria.

The overall rating on the six-point scale is compiled from a weighting of all five individual criteria as appropriate to the project in question. Ratings 1-3 of the overall rating denote a "successful" project while ratings 4-6 denote an "unsuccessful" project. It should be noted that a project can generally be considered developmentally "successful" only if the achievement of the project objective ("effectiveness"), the impact on the overall objective ("overarching developmental impact") and the sustainability are rated at least "satisfactory" (rating 3).