Indonesia: Basic Health and Food Programme

Ex-post evaluation

OECD sector	12240/Basic Nutrition	
BMZ project ID	1993 65 321	
Project-executing agency	Republic of Indonesia, represented by the Ministry of Health	
Consultant	Saniplan, German Agency for Hygiene and Medicine Ltd., DECON	
Year of ex-post evaluation	**2005**	
	Project appraisal (planned)	**Ex-post evaluation (actual)**
Start of implementation	4th quarter 1993	4th quarter 1993
Period of implementation	66 months	105 months
Investment costs	EUR 126.8 million	EUR 84.7 million
Counterpart contribution	EUR 33.9 million	EUR 10.0 million
Financing, of which Financial Cooperation (FC) funds	EUR 15.3 million	EUR 14.8 million
Other institutions/donors involved	World Bank: EUR 77.6 million	World Bank: EUR 59.9 million
Performance rating	3	
• Significance/Relevance	3	
• Effectiveness	3	
• Efficiency	3	

Brief Description, Overall Objectives and Project Objectives with Indicators

The project cofinanced with the World Bank comprised measures to improve basic health services in 5 eastern provinces of Indonesia (West Java, Central Java, West Timor [Nusa Tengarra Timur - NTT], Moluku and Papua). The main components of the programme were training basic health personnel, building and renovating health centres, fitting them out with medical equipment, instruments and consumables and strengthening management capacity in the health ministry at central level. The FC contribution entailed finance for medical equipment, instruments, consumables, teaching and office material and consultancy services.

The overall objective of the project was to make a contribution to improving the state of health of mothers, infants and children in the programme region. The programme objectives were the ongoing provision of 10% of the total population in the programme regions with basic health services, particularly in mother and child care and imparting healthy nutrition practices.

During the programme appraisal, the following indicators were set for the overall programme: utilization of the basic health services, such as number of treated patients and assisted births; percentage of immunized children; number and type of information campaigns carried out and

the quantity of iodized salt sold. The definitive specification of the indicators and the exact ascertainment of the context (quantification) was to be carried out in the monitoring and evaluation (M+E) system to be implemented under the oversight of the World Bank. Owing to the lack of cooperation by the Indonesian Ministry of Health (MOH) in this field, however, this system was never introduced as the World Bank critically notes in its Implementation Completion Report 2001. For lack of a baseline scenario, the World Bank evaluation report had already been confined to a general review of the health sector changes in the 5 provinces.

Together with the health ministry, the following indicators were stipulated in 1998 for the FC component, without quantitative targets, however: i) tetanus vaccination rate amongst women, ii) percentage of births assisted by specialist medical staff, iii) measles and tetanus vaccination rate amongst children, iv) percentage of underweight children under 5, v) number of doctors and midwives and vi) number of health centres with standard equipment.

Project Design/Major Deviations from Original Project Planning and Main Causes

The overall programme, Third Community Health and Nutrition Programme (CHN3), was conceived as a parallel finance project with the World Bank. Its financing comprises approx. 71%, FC more than 17% and the Indonesian government about 12% of total costs. The World Bank loan was reduced by US$ 20 million due to political unrest on several islands and the resultant diminished absorption capacity of the programme. In addition, the health ministry contribution was heavily curtailed due to the Asian economic crisis (and the resultant depreciation of the Indonesian rupiah). The FC component was cut back as well after the final inspection by EUR 0.5 to EUR 14.8 million and these funds were reprogrammed for other projects.

The CHN3 was divided into two components. The first was aimed at setting up and developing public health services at provincial level, the second at institution building in the health ministry and attached institutions at central level. The measures at provincial level comprised training medical personnel including midwives in public health services as well as healthy nutrition, building regional administrative capacity, developing infrastructure in the health sector and equipping health centres. The second component centred on improving management capabilities in the MOH to set up an efficient central administration and on establishing a health information system to record key indicators.

The FC contribution was only part of the first component and concentrated on finance for medical equipment (23% of FC funds), instruments (15%), equipment (14%), consumables (8%), teaching and office materials (31%) and consultancy services (9%). It was an open-ended programme so that only a specimen list of equipment was drawn up in the appraisal report, which was repeatedly amended during implementation. Samples to monitor the application of funds were periodically taken by the procurement consultant and documented in his reports. An external evaluation of delivery instalments and their use was carried out twice. We can certify that the FC project made proper use of the funds overall.

The main target group were women and children as well as the basic health personnel involved in implementing the programme measures in the rural areas with a majority of poor population groups.

There were some considerable delays in the CHN3 as compared with the original time schedule. The envisaged adjustments in personnel and institutional processes in the complex programme approach proved to be very difficult. Added to this was political unrest on three of the five islands of (Maluku, Papua and NTT), as well as the Asian economic crisis, which affected Indonesia particularly badly and repeatedly set back programme implementation and

hampered cooperation with the central planning units. Due to the difficult experience with the MOH (including the failure to set up the scheduled M+E system), greater emphasis was shifted during implementation to the regional component and more budget and manpower planning responsibilities accordingly transferred to the provinces. Altogether, approx. 2/3 of the programme budget was disbursed for measures at provincial level. As, however, the provincial personnel were not trained to deal with international tendering procedures and additional complicated consultancy procedures proved necessary amongst the administrative levels there were long delays in procurement activities in the first years that also affected the FC component, which was prolonged altogether by more than 3 years and not completed until September 2002.

Key Results of Impact Analysis and Performance Rating

The public health service in the Indonesian health sector has continuously expanded over the last few decades and has built up a comparatively closely-knit basic health system. This consists of district hospitals, community health services (puskesmas) and subordinate village health services (pustu) as well as village maternity clinics (polindes). The percentage of the government budget for primary health care rose accordingly from 20% in the early nineties to over 30% toward the end of the decade. Altogether, though, at 5.4% of the national budget (2005) health sector spending is very small by regional standards. The envisaged decentralization in the health sector has made slow progress only and is not coordinated. The public health service is very inefficient in allocating, using and managing resources. The reason is poor planning, lack of budget finance and dysfunctional communication between central and provincial levels. The community health services, for example, are directly under the auspices of the district administration, that is, they do not have budgets of their own and major decisions are taken by the districts or centrally in the provincial capital. So the managers of the community health services have hardly any leeway for making decisions and there is a dislocation between planning and needs. Another major deficit is insufficient servicing. There is practically no preventive maintenance. Funds available are usually spent on procuring more consumables. The high personnel turnover for lack of incentive and motivation systems and the poor training of some medical specialist staff also contribute to inefficiency.

The promotion of the health sector in Indonesia has been a priority of development assistance from the World Bank since the seventies with predecessor programmes concentrating on improving physical infrastructure. UNICEF and GTZ have also been actively engaged in the health sector for many years. The poorer provinces of Indonesia, which are included in the programme region, will remain dependent on support from outside for some time as neither the provinces nor central government can provide an adequate investment budget. Income from patient fees are far from adequate to meet overheads and investment costs in the poor provinces in particular.

Aiming to strengthen localized administrative capacity, train basic health personnel and fit out local health stations with basic medical equipment, the programme thus intervened at the right point. As already pointed out, however, the programme suffered from the lack of decision-making powers and restricted capacities of the local administrative apparatus and the institutional weakness of the executing agency, the health ministry, which could not be offset by the World Bank's capacity building measures, either. Other impediments to programme implementation were the economic crisis of 1997/1998, which greatly curtailed the financial scope for the health sector and jeopardized the procurement of sufficient consumables, and the political unrest on the islands of Maluku and Papua. Medical and radio equipment was stolen and destroyed in Maluku. The estimated damage for the overall programme amounted to EUR 800,000 at the time of the final inspection in 2003. All programme measures were then broken off and the local management unit in Maluku was closed.

The programme's best outputs were achieved at provincial level in training and equipping health personnel. Before the start of programme implementation there were considerable deficits especially in the rural areas of Indonesia in pre-natal care, imparting healthy nutrition and infant care. Three training academies were therefore set up during CHN3 (NTT, Papua, Maluku) and well over 1500 health workers, midwives and doctors were trained in different subjects. The individual provinces were closely involved in planning and organizing the training so that abilities were also imparted for the subsequent planning of training programmes. Besides health personnel training, the provinces benefited from fitting out approx. 500 community health services (puskesmas) with basic medical equipment, the provision of over 1,800 midwives with a kit and some with solar lamps and walkie-talkies financed by FC. As a result, basic medical care for pregnant women and children in particular was stepped up substantially in the programme region.

This component has limited sustainability, however. On the one hand, staff changed repeatedly both in the administration and amongst medical personnel (primarily in remote health services) so that know-how acquired in training was lost again. On the other, due to lack of upkeep only approx. 85% of the financed equipment was still being put to proper use at the time of the final inspection in 2003. Sustainable use of the technically sophisticated solar equipment in particular, which, however, accounted for less than 1.5% of the total budget, cannot therefore be assured. Current information on the condition and servicing of units is not available as a systematic monitoring in the field would have been inordinately costly. Based on the situation on the final inspection, however, we gauge that more than half of the equipment is still in appropriate use.

The measures in institution building at central level, in which FC was not involved and which were largely implemented separately from the measures at provincial level, were less successful. Above all, the establishment of an information system for collecting key health indicators was unsuccessful. As a consequence, the planned M+E system was not set up and no specific programme data was recorded. By virtue of the improved cooperation with the MOH in the course of implementation and the successful training measures at university level, this component was judged as just about 'satisfactory' by the World Bank, which also rated the overall project as 'satisfactory'.

The following data provide indications of the impacts of the overall project on improving health status in the five programme provinces:

- Pre-natal care and births assisted by medical personnel have risen in all provinces. Checkups are now attended by 90% of the women in three provinces. Only in Maluku (67%) and Papua (87%) have these percentages not been reached, although the figures for these two islands originate from an older survey and are therefore not comparable. The demand for midwifery by medical personnel has also risen sharply, although at 49% (West Java) to 67% (Central Java) the figures are well below those for preventive checkups. The figures for Papua and Maluku in turn stem from an older survey and are lower.
- Infant mortality has accordingly dropped sharply in all provinces since the programme appraisal. According to the last health survey in 2005, it has halved from 76 to 38 per 1,000 births in Maluku. In the whole programme region, it now ranges between 34 and 53 per 1,000 births after 65 and 90 at the time of the project appraisal.
- Vaccinations of pregnant women and children went up a lot on all five islands during the programme term. The TT2 vaccinations of pregnant women against infant tetanus range between 41% (20%) and 86% (70%) and DPT1 child vaccinations (diphtheria, whooping cough, tetanus), between 81% (55%) and 100% (96%).
- The physician to patient ratio has also improved slightly to presently 7,700 (Maluku) and 16,000 (NTT) of inhabitants per doctor after almost 20,000 inhabitants per physician in NTT.

Despite the implementation problems outlined and the insecure political climate, the overall programme has therefore made a major contribution to reducing infant mortality and improving pre-natal care. The changes in women's behaviour in pregnancy and birth as well as the higher number of vaccinations give grounds to infer an enhanced health awareness, which is essential for a sustainable improvement in health care. On the basis of the training carried out, we surmise that the essentials of healthy nutrition were imparted during visits to the health centres even though no data is available. Where recorded, the indicators on programme objectives achievement by the FC component attest to a clear improvement. Altogether, the FC component has made a plausible contribution to the overall success of the CHN3. Judging by the data presented, the overall objective of the project as a whole was attained.

The population in the project region can be classified as predominantly poor to very poor and benefited directly from the project. Furthermore, the project also aimed above all at improving the health status of women and children, which was achieved by equipping community health services and midwives and by training midwives and health personnel. The training measures, moreover, principally benefited women as personnel in the local public health services. The project did not envisage any particular participatory elements at target-group level. Environmental aspects did not figure in the programme design and environmental aspects did not arise as the basic health facilities were small in scale and the consumption of medical items was confined to the essential minimum.

Applying the key criteria effectiveness, significance, relevance and efficiency, we assess the project as follows:

- Effectiveness: Altogether, the programme objective is rated as achieved since there has been a major increase in pre-natal care, assisted births and a higher vaccination rate. The improvement in other health indicators suggests a higher acceptance of the services provided by public health care, also due to the FC-financed equipment of the health centres. Considering the deficits described in the sustainable use of equipment, we assess overall effectiveness as sufficient (Rating 3).

- Significance and relevance: The project was of developmental relevance at the time of the project appraisal due to the considerable deficits particularly in health care for mothers and children in the programme region. The overall objective of the programme (contribution to improving the health status of mothers, infants and children in the programme region) was attained. A qualification here is that localized units have not been strengthened to the extent intended as these still depend heavily on higher-level administrative units, above all for finance. Communication is still poor, incentives to reduce personnel turnover could not be introduced and no systematic record is kept of relevant data. The subcriterion significance/relevance is rated as sufficient overall (Rating 3).

- Efficiency: Altogether, the implementation period of the project was extended by three years and its was repeatedly adapted in design and scale. Besides the pronounced weakness of the project executing agency, which also caused delays in tendering, the reasons lay in unforeseeable general political and economic problems. On the one hand, this resulted in a much smaller counterpart contribution on the Indonesian side and on the other to long delays in the delivery of equipment. Altogether, the inefficiencies in the existing system could not be remedied despite considerable effort. The scope of the contribution and hence the costs of the overall programme have been much reduced due to the inaccessibility of some islands. Altogether, we gauge the costs as reasonable. Owing to the adverse general climate, we rate overall efficiency as sufficient (Rating 3).

The developmental efficacy of the project is judged as sufficient overall (Rating 3):

General Conclusions and Recommendations

In programmes with large equipment components, sufficient weight must be attached to setting up maintenance services. Attention must be paid to establishing localized servicing, providing adequate budgets and their proper disbursement.

It is crucial to specify realistic indicators for programme objectives with targets after the context has been ascertained. Indicator surveys should be conducted regularly and at reasonable cost by the project executing agency or the localized units, if necessary with assistance from a consultant.

Abbreviations

CHN3	Community Health and Nutrition Project, Phase 3 (World Bank project)
DPT1	Diphtheria, pertussis, tetanus vaccination
FC	Financial Cooperation
M+E	Monitoring and evaluation
MOH	Ministry of Health
NTT	Nusa Tengara Timur (West Timor)
TT2	Tetanus toxoid – vaccination for pregnant women

Legend

Developmentally successful: Ratings 1 to 3	
Rating 1	**Very high or high degree of developmental efficacy**
Rating 2	**Satisfactory developmental efficacy**
Rating 3	**Overall sufficient degree of developmental efficacy**
Developmental failures: Ratings 4 to 6	
Rating 4	**Overall slightly insufficient degree of developmental efficacy**
Rating 5	**Clearly insufficient degree of developmental efficacy**
Rating 6	**The project is a total failure**

Criteria for Evaluating Project Success

The evaluation of the developmental efficacy of a project and its classification during the ex-post evaluation into one of the various levels of success described in more detail below concentrate on the following fundamental questions:

- Are the **project objectives** reached to a sufficient degree (aspect of project **effectiveness**)?
- Does the project generate sufficient **significant developmental effects** (project **relevance** and **significance** measured by the achievement of the overall development-policy objective defined beforehand and its effects in political, institutional, socio-economic and socio-cultural as well as ecological terms)?
- Are the **funds/expenses** that were and are being employed/incurred to reach the objectives **appropriate** and how can the project's microeconomic and macroeconomic impact be measured (aspect of **efficiency** of the project conception)?
- To the extent that undesired **(side) effects** occur, are these tolerable?

We do not treat **sustainability**, a key aspect to consider for project evaluation, as a separate category of evaluation but instead as a cross-cutting element of all four fundamental questions on project success. A project is sustainable if the project-executing agency and/or the target group are able to continue to use the project facilities that have been built for a period of time that is, overall, adequate in economic terms, or to carry on with the project activities on their own and generate positive results after the financial, organisational and/or technical support has come to an end.