



Grant Assistance Report

Project Number: 39184
December 2005

Proposed Grant Assistance
Indonesia: Supporting Community Health Care
Initiatives in Nanggroe Aceh Darussalam
(Financed by the Japan Fund for Poverty Reduction)

Asian Development Bank

CURRENCY EQUIVALENTS

(as of 15 December 2005)

Currency Unit	-	rupiah
Rp1	=	\$0.000102
\$1.00	=	Rp9,780.00

ABBREVIATIONS

ADB	–	Asian Development Bank
ARI	–	acute respiratory infection
BAPPEDA	–	Badan Perencanaan Pembangunan Daerah (Regional Development Planning Agency)
BAPPENAS	–	Badan Perencanaan Pembangunan Nasional (National Development Planning Agency)
CBO	–	community-based organization
DHS	–	decentralized health service
EA	–	executing agency
ETESP	–	Earthquake and Tsunami Emergency Support Project
HKI	–	Helen Keller International
IA	–	implementing agency
IDP	–	internally displaced person
JFPR	–	Japan Fund for Poverty Reduction
MCH	–	maternal and child health
MOF	–	Ministry of Finance
MOH	–	Ministry of Health
NGO	–	nongovernment organization
PHO	–	provincial health office
PMO	–	project management office
PKK	–	Pembinaan Kesejahteraan Keluarga (Family Welfare Movement)
SEAMEO/TROPMED	–	Southeast Asian Ministers of Education Organization/ Tropical Medicine Regional Center for Community Nutrition
SC	–	steering committee
SOE	–	statement of expenditures
UNFPA	–	United Nations Population Fund
UNICEF	–	United Nations Children’s Fund
WFP	–	World Food Program
WHO	–	World Health Organization

NOTES

- (i) The fiscal year of the Government end on 31 December.
- (ii) In this report, “\$” refers to US dollars.

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INDONESIA

SUPPORTING COMMUNITY HEALTH CARE INITIATIVES IN NANGGROE ACEH DARUSSALAM



- Project Area
- National Capital
- Provincial Capital
- District Capital
- City Government
- Subdistrict Capital
- National Road
- Provincial Road
- Railway
- Port
- International/Domestic Airport
- River
- District Boundary
- Provincial Boundary
- International Boundary

Boundaries are not necessarily authoritative.

JAPAN FUND FOR POVERTY REDUCTION (JFPR)

JFPR Grant Proposal

I. Basic Data	
Name of Proposed Activity	Supporting Community Health Care Initiatives in Nanggroe Aceh Darussalam
Country	Indonesia
Grant Amount Requested	\$2,000,000
Regional Grant	<input type="radio"/> Yes / <input checked="" type="radio"/> No
Grant Type	<input type="radio"/> Project / <input checked="" type="radio"/> Capacity building

II. Grant Development Objective(s) and Expected Key Performance Indicators

<p>Grant Development Objectives (GDO): The goal of the proposed JFPR Project is to help reduce the suffering of the population in Nanggroe Aceh Darussalam (Aceh) from malnutrition, illness, disability, and preventable death. The overall objective of the proposed Project is to increase awareness and self-help capacity for better health and nutrition of vulnerable groups, including internally displaced persons (IDPs) living in camps and with host families. The Project will respond to emerging needs during the rehabilitation phase. The Project aims to complement and reinforce health, nutrition, and food aid programs implemented by the United Nations Children's Fund (UNICEF), World Food Program (WFP), World Health Organization (WHO), United Nations Population Fund (UNFPA), and Helen Keller International (HKI).</p>
<p>Expected Key Performance Indicators:</p> <ul style="list-style-type: none"> (i) Increased awareness of communities about major diseases such as malaria, diarrhea, acute respiratory infections, and malnutrition, especially among groups at risk such as pregnant and lactating women and children under the age of 5 years; (ii) Reduced prevalence of malaria and diarrhea in children under 5 and pregnant women; (iii) Reduced number of infants with low birth weight and children with low weight for age (moderate and severe underweight in children under 5); and (iv) Establishment of a community-based growth monitoring system.

III. Grant Categories of Expenditure, Amounts, and Percentage of Expenditures

Category	Amount of Grant Allocated in \$	Percentage of Expenditures
1. Equipment and Supplies	583,000	29
2. Training, Workshops, Seminars, and Public Campaigns	666,700	33
3. Consulting Services	395,000	20
4. Grant Management and Coordination	140,400	7
5. Monitoring, Evaluation, and Audit	34,500	2
6. Contingencies	180,400	9
TOTAL	2,000,000	100
Incremental Cost	50,000	

JAPAN FUND FOR POVERTY REDUCTION

JFPR Grant Proposal Background Information

A. Other Data	
Date of Submission of Application	May 2005
Project Officer	Karin Schelzig Bloom, Poverty Reduction Specialist (Social Development)
Project Officer's Division, E-mail, Phone	Social Sectors Division (SESS) kschelzig@adb.org tel:+632-632-5947
Other Staff Who Will Need Access to Edit/Review the Report	Karima Saleh, Senior Health Economist, SESS Margaret Clare P. Anosan, Administrative Assistant
Sector	Health, nutrition, and social protection
Subsectors	Nutrition, other health and social services
Themes	Inclusive social development, gender and development
Subthemes	Other vulnerable groups, gender equity in capabilities
Targeting Classification	Targeted intervention
Name of Associated ADB-Financed Operation(s)	Decentralized Health Services (DHS) Project Earthquake and Tsunami Emergency Support Project (ETESP)
Executing Agency	Ministry of Health (MOH), Secretariat General
Grant Implementing Agency(ies)	Dr. T. Marwan Nusri Provincial Health Office (PHO) Jl. Arakindo 3 Banda Aceh, Aceh Tel: 0651-41623-22298

B. Details of the Proposed Grant

1. Description of the Components, Monitorable Deliverables/Outcomes, and Implementation Timetable

Component A	
Component Name	Capacity Building of Health Promoters for Improved Health and Nutrition Status
Cost (\$)	1,102,200
Component Description	Main interventions will focus on strengthening the capacity of health providers (nutritionists, nurses, midwives) for health and nutrition promotion. This component will (i) assess the appropriateness of existing training modules on health and nutrition promotion, prepare additional modules where necessary, and identify culturally sound communication strategies for improving health and nutrition status; (ii) build a cadre of trainers and conduct refresher training for nutritionists (Nutrition Academy in Banda Aceh); and (iii) train provincial health staff, especially in satellite health posts (including nurses and midwives) on growth monitoring in children under the age of 5 years, identification of groups at risk such as pregnant and lactating women, and prevention and case management of diarrheal diseases, malaria, and acute respiratory infections (ARI). In addition, teachers in public and religious schools and religious leaders will be trained on health promotion (prevention of malnutrition, diarrheal

	diseases, ARI, and malaria). This component will also conduct health and nutrition education for school-age children and will complement (a) UNICEF's relief and rehabilitation efforts on strengthening the nutrition and maternal and child health (MCH) response capacity of the provincial health office (PHO); (b) WHO's interventions on strengthening the treatment of severely malnourished children; (c) WFP's program support for MCH, which provides distribution of highly fortified foods to children aged 1-5 years, pregnant and lactating women in IDP camps, and food support to unaccompanied and separated children; (d) HKI's micronutrient support on sprinkles, vitamin A, and zinc for IDP camps and IDPs in host families; (e) UNICEF's interventions on MCH; and (f) WFP's work on food for education, which will provide food for teachers training.
Monitorable Deliverables/Outputs	(i) Training modules revised and reproduced; (ii) Number of nutritionists, midwives, and nurses trained on health and nutrition promotion; (iii) Awareness raised for the prevention of major diseases among religious leaders and school-age children; and (iv) Number of motorcycles, radios, treated bed nets, and micronutrient supplies distributed.
Implementation of Major Activities: Number of months for grant activities	18
Component B	
Component Name	Supporting Communities' Self-Help Capacity for Improved Health and Nutrition Status
Cost (\$)	542,500
Component Description	This component will develop self-help capacity of the affected population, including IDPs living in camps and with host families to identify at-risk cases and make informed decisions about health care and timely referral. Health promoters trained under component A will support community mobilization by (i) promoting the health of women's and youth groups; (ii) identifying community leaders and religious leaders to select health volunteers for social mobilization for the prevention of malnutrition, diarrheal diseases, ARI, and malaria; (iii) training mothers on growth monitoring, maternal nutrition, and personal hygiene; (iv) conducting leadership training for religious leaders, focusing on preventive health measures and hygiene promotion; (v) training women's groups (PKK), youth organizations, and traditional birth attendants on health promotion, including early detection of diarrhea, malaria, ARI, and malnutrition; (vi) building interpersonal communication and counseling skills for improved health through community-based peer education, especially for vulnerable groups such as households headed by singles; (vii) developing and implementing community-based growth monitoring; (viii) organizing distribution of bed nets for malaria prevention, zinc, and oral rehydration salt for treating diarrheal diseases; (ix) conducting community-based health promotion and distribution of oral rehydration salt and micronutrients for at-risk groups such as pregnant women, school girls, and children under 5; (x) launching bed net promotion, distribution, and monitoring targeted at pregnant women and children under 5; (xi) preparing culturally sound public health and nutrition promotion campaigns through radio and traditional story telling (<i>hikayat</i>); and (xii) public information on services available through the Project.

	This component will reinforce the implementation of WFP's supplementary food rations for children below 5 years of age and for pregnant and lactating mothers, and the provision of school snacks. In addition, it will support UNICEF's MCH program and HKI's provision of micronutrient supplements (sprinkles) to children under 5, distribution of vitamin A capsules as part of the measles immunization program to all children aged 6 months to 5 years and lactating women, and zinc treatment for diarrhea.
Monitorable Deliverables/Outputs	(i) Number of mothers trained on growth monitoring and maternal nutrition; (ii) Number of women's groups and youth organizations trained on health promotion and counseling skills for improved health and nutrition; (iii) Implemented community-based growth monitoring; and (iv) Number of personal hygiene kits distributed.
Implementation of Major Activities: Number of months for grant activities	18
Component C	
Component Name	Grant Management, Monitoring, Evaluation, and Audit
Cost (\$)	174,900
Component Description	The component will support project planning and implementation at the provincial level; and administration, technical assistance, procurement and financial audits, project monitoring, and impact assessment coordinated by the Family Health and Nutrition Division of the PHO in Banda Aceh. Staff of the Decentralized Health Services (DHS) Project will assist in procurement and financial management. The proposal is to establish an independent monitoring and impact evaluation of project interventions such as post-training evaluations. Audits will be conducted by external independent auditors.
Monitorable Deliverables/Outputs	(i) Quarterly progress reports; (ii) Annual project review report; (iii) Monthly financial reports; (iv) Random performance audit, spot audit, completion and post-completion audits; (v) Evaluation report and baseline study; and (vi) Final project completion report.
Implementation of Major Activities: Number of months for grant activities	18

2. Financing Plan for Proposed Grant to be Supported by JFPR

Source of Finance	Amount (\$)
JFPR	2,000,000
Government	130,000
Total	2,130,000

3. Genesis

On 26 December 2004 a massive earthquake occurred off the west coast of Sumatra and resulted in the subsequent tsunami flood that affected the Aceh region. Both the earthquake and the subsequent tsunami caused large-scale devastation in at least 13 districts of Aceh and North Sumatra. In the provincial capital Banda Aceh alone, about 300,000 inhabitants were killed and about 513,278 became IDPs in the province. In December 2005, about 100,000 IDPs remain in temporary camps around Banda Aceh, Aceh Besar, and Aceh Barat. More live with host families further inland, which puts a strain on host families and services. After the tsunami disaster, declining health and nutrition status is an increasing concern, especially among women and children. Although medical care is provided to the tsunami-affected population, the current disease pattern in IDP camps shows high rates of diarrheal diseases, ARI, and malaria, and declining nutrition status in children under the age of 5 years.

Several health indicators show that prior to the disaster, the prevalence of diarrhea, malaria, and malnutrition was already high in all districts,¹ and diarrhea and malaria cause high morbidity and mortality among the population.² In addition, Aceh has high levels of malnutrition,³ both micronutrient malnutrition (vitamin A, iron, iodine, folic acid, zinc) and growth faltering in terms of weight gain and stature attainment. According to 2004 data, 43.5% of pregnant women suffered from anemia. About 50% of the population or 2 million people are at risk of malaria (*plasmodium falciparum*)⁴ in Aceh. In the aftermath of the tsunami disaster, malaria is an increasing threat and contributed substantially to mortality, morbidity, and malnutrition, especially among young children and pregnant women.

Another consequence of the disaster is an almost complete lack of basic social services in the worst-hit districts. Rehabilitating such services is hampered not only by massive destruction and a large number of staff casualties but also by the fragile security situation. Responding to the lack of health infrastructure, the Government has established about 60 temporary health centers or satellite clinics, which serve IDPs and affected communities.

While relief interventions were important in the immediate aftermath of the disaster, they need to be replaced as soon as possible by community-led rehabilitation activities. Such interventions need to apply principles of local participation and give attention to informal social networks. Health and nutrition interventions are very suitable for rebuilding social capital as part of rehabilitation work. Involving community-based organizations (CBOs) such as women's organizations (PKK), youth groups, and public and religious schools in health and nutrition promotion equips individuals with skills to monitor health and nutrition status of groups at risk such as mothers and children.

WHO and UNICEF assist the PHO in Banda Aceh to coordinate health and nutrition emergency activities and identify immediate and medium-term needs. UNICEF carried out a

¹ Case fatality rate (CFR), which is defined as the number of deaths divided by the number of cases expressed as a percentage, is 1.67 for diarrhea and 5.43 for malaria. The prevalence of malnutrition is 24.66 for children under the age of 5 years.

² Diarrhea with 41% and malaria with 29% contribute to the highest mortality in children under the age of 5 years in Aceh.

³ Severe malnutrition (<-3SD weight for age) was found in 3.2% of children under 5 years of age (2003). Pidie district has the highest number of severely malnourished children.

⁴ Aceh Barat and parts of the interior highlands have endemic malaria while Aceh Besar has a risk of epidemic malaria.

rapid nutrition assessment⁵ in 13 districts, provided anthropometric equipment for health centers and micronutrient supplements for 12 districts, and supported growth monitoring at the *posyandu* (district health center) level. WFP supports the distribution of food rations for 790,000 tsunami victims, and provides supplementary feeding to 130,000 children under the age of 5 years and to 55,000 pregnant women through local health posts. It operates institutional feeding programs assisting 8,000 orphans and children in day-care centers and food-for-work programs to support the rehabilitation of housing. UNFPA is providing personal kits for men and women, which include clothes and hygiene products. HKI is supplying micronutrients, vitamin A, and zinc, which are vital nutrients for children under 5 years of age and are proven to reduce mortality. The Oxford Committee for Famine Relief (Oxfam) is providing water and sanitation for IDP camps. Several international and local nongovernment organizations (NGOs), including Mohamediya and Fatiya NU, provide support to special target groups such as women and children affected by the tsunami through psycho-social counseling, feeding programs, water and sanitation activities, and mobile clinics. Most of the foreign-assisted health, nutrition, and food programs are carried out in 13 tsunami-affected districts⁶ in Aceh. Funding for these programs is expected to phase out in 2006.

Given the poor health indicators in Aceh and the risk of epidemics, there is a need to adjust and strengthen health and nutrition promotion activities to respond to the immediate and medium-term needs of affected populations, including IDPs living in camps and with host families. Health and nutrition promotion activities not only are essential for complementing and reinforcing ongoing health and nutrition programs but contribute also to long-term strategy as they enhance people's capacity to make informed health care decisions. The proposed Project will help implement selected health sector strategies outlined in the Government's Disaster Management, Rehabilitation and Reconstruction (DMRR) strategy in terms of capacity building for health promoters and mobilizing communities to enhance their self-help capacity for making informed health care decisions. Given many uncertainties in the rehabilitation and reconstruction process of Aceh, the Project will respond to changing needs and circumstances. The Project will be implemented in Banda Aceh and the three districts of Aceh Besar, Aceh Barat, and Aceh Utara⁷ and will be supported by various stakeholders such as local universities, NGOs, and local communities. The latter will especially be actively involved in project implementation.

4. Sustainability

Capacity building and sustainability are closely related. Component A will focus on building the technical capacity of professional health promoters such as nurses, midwives, and teachers. Component B will help to build capacity for health promotion in communities. In their capacity-building activities, the local governments will implement training modules developed for health and nutrition promotion under the Project. Health promoters trained under the proposed Project will need to be integrated into local governments' health service rehabilitation programs as a precondition for project support.

⁵ Initial results of the UNICEF led nutrition assessment in 13 affected districts in Aceh showed a high percentage of acute malnutrition. About 11.6% of displaced children and 11.4% of nondisplaced children under the age of 5 years suffer acute malnutrition.

⁶ Aceh Barat, Aceh Barat Daya, Aceh Besar, Aceh Jaya, Aceh Selatan, Aceh Timur, Aceh Utara, Bireun, Kota Banda Aceh, Kota Lhokseumawe, Nagan Raya, Pidie, Simeuleu.

⁷ These districts were chosen because they have a high population density and the largest numbers of IDPs. Given the size of the Project, the inclusion of other districts or provinces would have diluted project impacts. The Government has agreed to this geographically focused approach.

5. Participatory Approach

The Project will be implemented through public-civic partnerships. Health and nutrition promotion activities will involve communities, IDPs, and teachers and students in public and Islamic schools.

Primary Beneficiaries and Other Affected Groups and Relevant Description	Other Key Stakeholders and Brief Description
Primary beneficiaries are especially women and children.	The Project will reinforce the implementation of health and nutrition programs by other development partners and closely cooperate with UNICEF, WHO, WFP, and HKI.

6. Coordination

The Japanese Embassy in Jakarta informed the Mission that the Japanese International Cooperation Agency (JICA) and the Japan Bank for International Cooperation (JBIC) will support social infrastructure rehabilitation in Aceh and North Sumatra. The Ministry of Health (MOH), the National Development Planning Agency (BAPPENAS), the Implementation Coordinating Board for Aceh-North Sumatra Rehabilitation and Reconstruction (BKP), and PHO will be key agencies to collaborate with the Asian Development Bank (ADB) throughout project implementation. The Project will complement health and nutrition-related interventions of UNICEF, WFP, WHO, and national and international NGOs.

7. Detailed Cost Table

Please refer to Appendix 1 for the detailed cost estimates, and Appendix 2 for the fund flow arrangement.

C. Linkage to ADB Strategy and ADB-Financed Operations

1. Linkage to ADB Emergency Assistance Plan

The proposed Project aims to complement activities under ADB's Earthquake and Tsunami Emergency Support Project (ETESP), which includes a health component. The ETESP is supporting the reconstruction of Aceh's public health sector by strengthening health care service delivery, especially MCH and health management information systems.

2. Linkage to Specific ADB-Financed Operations

Earthquake and Tsunami Emergency Support Project (ETESP)

Project Name	Earthquake and Tsunami Emergency Support Project (ETESP)
Project Number	G0002
Date of Board Approval	7 April 2005
Grant Amount (\$ million)	290.0

Decentralized Health Services (DHS) Project

Project Name	Decentralized Health Services (DHS) Project
Project Number	Loan 1810-INO
Date of Board Approval	14 December 2000
Loan Amount (\$ million)	75.70

3. Development Objectives of the Associated ADB-Financed Operations

The ETESP includes a health sector component, which will help the Government in the reconstruction and rehabilitation of the health sector in Aceh and North Sumatra. The major objectives are to (i) improve the efficiency of the health care delivery system; and (ii) improve access to basic health care for the population, especially the vulnerable and underserved groups. The ETESP aims to (i) reduce the incidence of communicable diseases, (ii) strengthen public-private partnerships for improved efficiency of health service delivery, and (iii) empower communities for better health. It will cover 10 districts affected by the tsunami disaster.

The objectives of the DHS Project are to (i) strengthen local capacity in health services delivery, including planning and management; (ii) ensure continuous access to quality health and family planning services, particularly by the poor; and (iii) improve quality, cost efficiency, and sustainability of health and family planning services. The DHS Project is implemented in seven provinces one of which is Aceh.

4. Main Components of the Associated ADB-Financed Operations

Earthquake and Tsunami Emergency Support Project (Health Sector Component)

No.	Component Name	Brief Description
1.	Health Service Delivery	1.1 Strengthen primary health care and first referral networks for MCH. 1.2 Design an efficient functioning and rationalized health service delivery network for the province. 1.3. Upgrade and reequip devastated clinics and district hospitals.
2.	Health Financing and Management	2.1 Integrated health planning and budgeting 2.2 District health information system

Decentralized Health Services Project

No.	Component Name	Brief Description
1.	Advocacy and Capacity Building	1.1 Advocacy and information campaigns to local decision makers 1.2 Capacity building including formal training, workshops, and study tours 1.3 Operations research covering performance monitoring and evaluation, health service organization, among others
2.	Health Sector Reforms	2.1 Review of various aspects of the health system 2.2 Support for implementation of locally identified priority reforms
3.	Investments in Health and Family Planning Services	3.1 Financing of clinical and managerial training, consulting services, civil works, equipment, and operational research

D. Implementation of the Proposed Grant

1. Name of the Implementing Agency	PHO in Banda Aceh and, where required, local NGOs
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Please refer to Appendix 2 (Fund Flow Arrangements) and Appendix 3 (Implementation Arrangements).

2. Risks Affecting Grant Implementation

Type of Risk	Brief Description	Measure to Mitigate the Risk
Governance	Problems of corruption	Include good governance and strict financial control. Independent auditing of project funds by external auditors.
Corruption	Causes of corruption and poor governance, associated with lack of transparency	Transparency and audits are ways to mitigate these risks. The Project will adopt the following measures: (i) cash and in-kind assistance under the Project will be checked against suitable identification and verification. All records, receipts, certificates, and other documents related to the cash and in-kind assistance will be properly maintained and made available to ADB at any time; (ii) random performance audits will be conducted to ensure funds have been used properly; (iii) a spot audit will be conducted once during the project implementation period; (iv) completion and postcompletion audits will be conducted to address governance, financial accountability, and transparency; (v) disclosure of information to the public will be provided by posting project inputs on community bulletin boards; (vi) the Project will use ETESP's grievance review and resolution mechanisms. One example would be tracking of funds, procurement and training activities through the web site of e-Aceh.org; and (vii) the Project will explore the feasibility of a hotline that people can use to report fraud and corruption.
Safety	Civil strife and militant actions may occur.	Concluded peace talks and agreement between Government of Indonesia and the Free Aceh Movement (GAM).

3. Incremental ADB Costs

Component	Incremental Bank Cost
Amount requested	\$50,000
Justification	Recruitment of a consultant to prepare the grant implementation manual (GIM). Project implementation support from project officer of Social Sectors Division, Southeast Asia Department (SESS) in Manila.
Type of work to be rendered by ADB	Supervise the preparation of the GIM. Conduct inception and midterm review.

4. Monitoring and Evaluation

Key Performance Indicator	Reporting Mechanism	Plan and Timetable for M&E
Increased awareness and self-help capacity for better health and nutrition of vulnerable groups	Baseline study and rapid assessments funded by the Project	Baseline study and final evaluation
Increased percentage of vulnerable groups utilizing preventive measures, e.g., utilization of bed nets, zinc for diarrheal treatment	Baseline study and rapid assessments funded by the Project	Baseline study and final evaluation

5. Estimated Disbursement Schedule

Fiscal Year (FY)	Amount (\$)
FY2005	800,000
FY2006	1,200,000
Total Disbursements	2,000,000

Appendixes

1. Detailed Cost Estimates
2. Fund Flow Arrangements
3. Implementation Arrangements

COST ESTIMATES TABLES

**Table A1.1: Summary Cost Table
(\$)**

Inputs/Expenditure Category	Component A Capacity Building of Health Promoters for Improved Health and Nutrition Status	Component B Supporting Communities' Self-Help Capacity for Improved Health and Nutrition Status	Component C Grant Management, Monitoring, Evaluation, and Audit	Total (Input)	Percent
1. Equipment and Supplies	423,000	160,000	0	583,000	29
2. Training, Workshops, Seminars, Public Campaigns	284,200	382,500	0	666,700	33
3. Consulting Services	395,000	0	0	395,000	20
4. Grant Management	0	0	140,400	140,400	7
5. Monitoring, Evaluation, and Audit	0	0	34,500	34,500	2
6. Other Inputs	0	0	0	0	0
7. Contingencies (0-10% of total estimated grant fund)	0	0	0	180,400	9
Subtotal JFPR Grant Financed	1,102,200	542,500	174,900	2,000,000	100
Government Contribution	50,000	40,000	40,000	130,000	
Other Aid Agencies' Contributions	0	0	0	0	
Community Contributions	0	0	0	0	
Total Estimated Costs	1,152,200	582,500	214,900	2,130,000	
Incremental Costs			50,000	50,000	

JFPR = Japan Fund for Poverty Reduction.

Source: Asian Development Bank estimates.

Table A1.2: Detailed Cost Estimates
(\$)

Code	Supplies and Services Rendered	Costs				Contributions				
		Unit	Quantity Units	Cost Per Unit	Total	JFPR		Government	Other Donors	Communities
						Amount	Method of Procurement			
Component A: Capacity Building of Health Promoters for Improved Health and Nutrition Status				Subtotal	1,152,200	1,102,200		50,000		
1.1	Equipment and Supplies			Subtotal	423,000	423,000				
1.1.1	Health and nutrition promotion materials	Lump sum for review, development, and printing	1	60,000	60,000	60,000				
1.1.2.	Communication materials	Lump sum for development of radio spots, local stories	1	70,000	70,000	70,000				
1.1.3.	Desktop computer and printer	Per unit	6	2,000	12,000	12,000	DP			
1.1.4.	Software for preparation of materials	Per unit	6	500	3,000	3,000				
1.1.5.	Motorcycle including petrol for staff ^a	Per unit	45	1,000	45,000	45,000	DP			
1.1.6	VHF radio for referral	Per unit	100	100	10,000	10,000	DP			
1.1.7	Impregnated bed nets	Per target group	20,000	6	120,000	120,000	DP			
1.1.8	Micronutrient supplies (iron for anemic pregnant women)	Per target group	12,000	4	48,000	48,000	DP			

DP = direct purchase, JFPR = Japan Fund for Poverty Reduction, VHF = very high frequency.

^a The purchase of motorcycles for health promoters is essential, given the very limited means of any transport and the dispersed location of camps of internally displaced persons.

Source: Asian Development Bank estimates.

Code	Supplies and Services Rendered	Costs				Contributions				
		Unit	Quantity Units	Cost Per Unit	Total	JFPR		Government	Other Donors	Communities
						Amount	Method of Procurement			
1.1.9	Micronutrient supplies (zinc for children 6 months-12 years with severe diarrhoea)	Per target group	50,000	0.50	25,000	25,000	DP			
1.1.10	Iron folate and deworming (adolescent girls 13-18 yrs)	Per target group	30,000	1.00	30,000	30,000	DP			
1.2	Training, Workshops, Seminars, and Public Campaigns			Subtotal	334,200	284,200		50,000		
1.2.1	Training of nutritionists (Nutrition Academy, Banda Aceh)	Per workshop (4 days) for 40 nutritionists	6	6,000	36,000	36,000				
1.2.2	Training of midwives and nurses	Per workshop (3 days)	40	5,000	200,000	150,000		50,000		
1.2.3	Training of traditional midwives	Per workshop (2 days) for 80 midwives	10	4,000	40,000	40,000				
1.2.4	Advocacy seminars for religious leaders	Per seminar (1 day) for 30 religious leaders	16	1,500	24,000	24,000				
1.2.5	Radio campaign for health and nutrition promotion	Per radio broadcast	72	100	7,200	7,200				

Source: Asian Development Bank estimates.

Code	Supplies and Services Rendered	Costs				Contributions				
		Unit	Quantity Units	Cost Per Unit	Total	JFPR		Government	Other Donors	Communities
						Amount	Method of Procurement			
1.2.6	Provincial workshop on effective health and nutrition promotion strategies	Per workshop (3 days)	6	4,500	27,000	27,000				
1.3	Consulting Services			Subtotal	395,000	395,000				
1.3.1	Health promotion training specialists	Per person-month	55	3,000	165,000	165,000	QCBS/Biodata			
1.3.2	Anthropologist	Per person-month	10	3,000	30,000	30,000	QCBS/Biodata			
1.3.3	Community mobilization specialists	Per person-month	50	3,000	150,000	150,000	QCBS/Biodata			
1.3.4	Nutrition epidemiologist	Per person-month	10	5,000	50,000	50,000	QCBS/Biodata			

Source: Asian Development Bank estimates.

Code	Supplies and Services Rendered	Costs				Contributions				
		Unit	Quantity Units	Cost Per Unit	Total	JFPR		Government	Other Donors	Communities
						Amount	Method of Procurement			
Component B: Supporting Communities' Self-Help Capacity for Improved Health and Nutrition Status				Subtotal	582,500	542,500		40,000		
2.1	Equipment and Supplies			Subtotal	160,000	160,000				
2.1.1	Oral rehydration salts (children under 5 years)	Per target group	20,000	0.50	10,000	10,000	DP			
2.1.2	Personal hygiene (soap, towel, tooth brush, etc)	Per target person at satellite clinic	6,000	25.00	150,000	150,000	DP			
2.2	Training, Workshops, Seminars, and Public Campaigns			Subtotal	422,500	382,500		40,000		
2.2.1	Health promotion training for women's groups (PKK) and youth organizations	Per training program (2 days)	1,000	100	100,000	100,000				
2.2.2	Health and nutrition promotion in Islamic schools	Per training session	150	150	22,500	22,500				
2.2.3	Health mobilization campaigns for mothers and children	Per camp/per satellite clinic	1,200	150	180,000	140,000		40,000		

Source: Asian Development Bank estimates.

Code	Supplies and Services Rendered	Costs				Contributions				
		Unit	Quantity Units	Cost Per Unit	Total	JFPR		Government	Other Donors	Communities
						Amount	Method of Procurement			
2.2.4	Health mobilization campaigns for schoolgirls (public schools)	Per school	100	200	20,000	20,000				
2.2.5	Incentives for social mobilization (women)	Per family activity	2,000	50	100,000	100,000				
2.3.	Consulting Services			Subtotal	0	0				
Component C: Grant Management, Monitoring, Evaluation, and Audit				Subtotal	214,900	174,900	40,000			
3.1	Management and Coordination			Subtotal	170,400	140,400	30,000			
3.1.1	Baseline survey and impact assessment	Per survey per camp	6	8,000	48,000	48,000				
3.1.2	Additional staff time (DHS 1) central, provincial level and Directorate of Community Nutrition	monthly	18	2,000	36,000	26,000	10,000			
3.1.3	Project coordination support at provincial health office	monthly	18	3,000	54,000	34,000	20,000			
3.1.4	Operational costs (communication including web site, office space) central, provincial levels	Monthly	18	1,800	32,400	32,400				

Source: Asian Development Bank estimates.

Code	Supplies and Services Rendered	Costs				Contributions				
		Unit	Quantity Units	Cost Per Unit	Total	JFPR		Government	Other Donors	Communities
						Amount	Method of Procurement			
3.2	Monitoring, Evaluation and Audit			Subtotal	44,500	34,500		10,000		
3.1.5	Travel costs for supervision (domestic)	Lum sump for central and provincial staff	20	1,000	20,000	15,000		5,000		
3.2.1	Audit services (bi-annual independent external audits)	Audits	4	5,000	20,000	15,000		5,000		
3.2.2	Quarterly coordination meetings	Meetings	18	250	4,500	4,500				
	Components A to C = Subtotal			Subtotal	1,949,600	1,819,600		130,000		
	Contingency (Maximum 10% of total JFPR Contribution)				180,400	180,400				
	Total Grant Costs			Total	2,130,000	2,000,000		130,000		
4	Incremental Cost Details									
4.1	Recruitment of consultant for preparation of grant implementation manual Project preparation and implementation support from project officer in Manila			50,000	50,000	50,000				
	Total Incremental Costs			50,000	50,000	50,000				

Source: Asian Development Bank estimates.

FUND FLOW ARRANGEMENTS

1. A Japan Fund for Poverty Reduction (JFPR) special account will be opened in a commercial bank to be operated by the executing agency (EA) through the project management office (PMO) under statement of expenditures (SOE) procedures. The special account will be established, managed, replenished, and liquidated in accordance with the provisions set forth in ADB's *Loan Disbursement Handbook* (January 2001). The Provincial Health Office, the implementing agency (IA), will prepare budget requirements based on the proposed project activities and submit the budget requirements to the EA. The EA will consolidate all budget requirements and forward them to ADB for fund release. The approved budget will be disbursed to the IA which will maintain a separate JFPR account. The ceiling for the SOE is \$20,000. The ceiling of the imprest account is \$200,000, which is based on estimated expenditures for 6 months. The interest earned on the JFPR imprest account can be used, subject to ADB approval, within the approved total amount of JFPR, and any unutilized interest should be returned to the JFPR fund account maintained at ADB, upon the completion of the JFPR project and before closing the JFPR account. If remittance fees and other bank charges are higher than the interest earned of JFPR imprest account, there is no need to remit the interest to the JFPR account maintained at ADB. The SOE procedure will be used to liquidate/replenish the imprest account. The use of the JFPR account, imprest account, and SOE procedure will be audited annually by independent auditors acceptable to ADB (Appendix 3, para. 4). A separate audit opinion on the use of the JFPR account, imprest account, and SOE procedure should be included in the annual audit reports. Subject to arrangements being worked out with MOF for all tsunami-related assistance, the arrangements proposed here may be revised before project implementation.

2. The ADB disaster and emergency assistance policy provides that, to expedite rehabilitation assistance, ADB's *Guidelines for Procurement* may be flexibly interpreted. In accordance with this flexibility, when the estimated contract cost of procurement of equipment and materials is equivalent of \$500,000 or less, local procedures will be followed, with invitation for bids published in national newspapers, bidding periods of 7 days, and an evaluation time of 15 days. Direct purchase procedures will be adopted for contracts up to \$100,000, with award within 7 days. For small contracts of up to \$30,000, community-based procurement may be allowed, where appropriate, following procedures set out in ADB's *Guide on Community Participation in Procurement*.

3. Consultants will be hired in accordance with ADB's *Guidelines on the Use of Consultants* and other arrangements satisfactory to ADB for engaging domestic consultants. Since the Project will be completed in about 2 years, expeditious selection and fielding of the consultants will be the key issue. Where possible, simplified procedures, including greater delegated authority to the Indonesia Resident Mission, will therefore be adopted. ADB will engage domestic consultants who will provide technical assistance in different areas including health promotion, communication, cultural anthropology, and nutrition. An estimated 125 person-months of domestic consulting services will be required to provide technical guidance to the Project. Training and community empowerment may be contracted to local nongovernment organizations (NGOs), and local academic and research institutions in accordance with competitive selection criteria and procedures acceptable to ADB. Contracted NGOs will have extensive experience in health promotion and social mobilization. A simplified grant implementation manual will be prepared prior to project implementation. The manual will describe implementation details and procurement arrangements.

IMPLEMENTATION ARRANGEMENTS

A. Executing and Implementing Agencies

1. The Secretariat General of the Ministry of Health (MOH)¹ will be the Executing Agency (EA) (Appendix A3). The implementing agencies (IAs) will be the provincial health office (PHO) in Banda Aceh and, where required and available, local nongovernment organizations (NGOs). The project management office (PMO) will be responsible for overall project management at the provincial level. The PMO will be based in the Health Promotion Division of the PHO in Banda Aceh, which will work in close collaboration with the Family Health and Nutrition Division. A central technical team will be constituted in MOH, which will be composed of representatives of the Secretariat General, Center for Health Promotion, Directorate General of Community Health, especially the Directorate of Community Nutrition, the Southeast Asian Ministers of Education Organization Tropical Medicine Regional Center for Community Nutrition (SEAMEO/TROPMED) and university representatives. A provincial steering committee (SC) will be constituted, which will be composed of the PHO, Office for Religious Affairs (Dinas Agama), provincial development planning agency (BAPPEDA), Nutrition Academy, Office of Education (Dinas Pendidikan), and one local community or NGO representative. The SC will meet at least twice a year to discuss the progress of the Project. The SC will monitor the work plan and budget allocations.

2. Health and nutrition promotion activities will be implemented in collaboration with local NGOs, CBOs, religious institutions, and aid agencies working in the health sector. The Project will cooperate with institutions such as SEAMEO/TROPMED, universities, Nutrition Research and Development, which will be engaged to support the development of health and nutrition promotion training materials, the preparation and organization of training courses for health promotion at the provincial and district level.

B. Reporting and Project Monitoring

3. The IAs will provide quarterly progress reports to the EA and the Asian Development Bank (ADB), and other relevant government agencies, i.e., provincial governments and local governments. The quarterly reports will include descriptions and evaluations of project activities implemented during the reporting period. Issues that need to be dealt with to streamline implementation and possible solutions will be included. A project completion report will be prepared by the IAs and submitted to the EA, relevant government agencies, and ADB within 3 months after project completion.

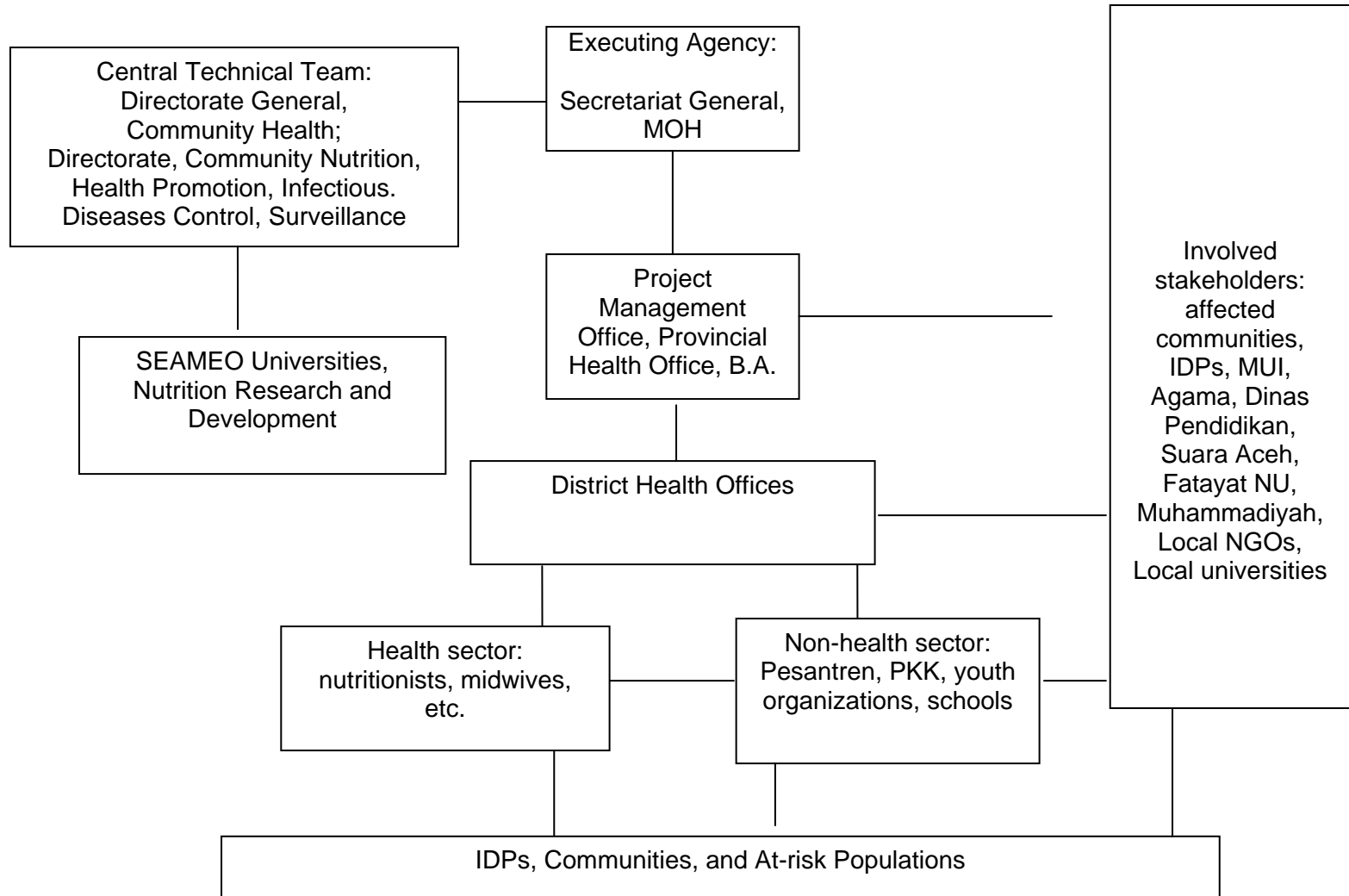
4. ADB will engage an independent auditor to conduct a total of four audits (random performance audit, spot audit, completion audit, and post completion audit) during project implementation. The audit reports, in English, will include a separate audit opinion on the use of the special JFPR account, statement of expenditure procedures, and procurement undertaken. The reports will be submitted to ADB not later than 6 months after the end of the fiscal year to which they relate.

5. Within ADB, a project officer responsible for supervising the implementation of the Project will be assigned to administer it, monitor progress reports, and undertake project supervision missions. The overall administration of the Project and project status reports will be the responsibility of the Social Sectors Division of the Southeast Asia Department, ADB.

¹ ADB. 2000. *Report and Recommendation of the President to the Board of Directors on a Proposed Loan Indonesia for the Decentralized Health Services Project*. Manila.

6. The Project will be implemented over a period of 18 months. The Project will begin in July 2005 and be completed in June 2007. The JFPR implementation arrangements are described in Appendix 2.

Figure A3: JFPR Implementation Arrangements



B.A. = Banda Aceh, IDP = internally displaced person, MOH = Ministry of Health, MUI = Islamic Council of Indonesia, NGO = nongovernment organization, PKK = Pembinaan Kesejahteraan Keluarga, SEAMEO = Southeast Asian Ministers of Education Organization.
Source: Asian Development Bank.