



Project Completion Report

PCR: INO 28074

Family Health and Nutrition Project (Loan 1471-INO) in Indonesia

June 2005

Asian Development Bank

CURRENCY EQUIVALENTS

Currency Unit	–	Rupiah (Rp)	
		At Appraisal (30 August 1996)	At Project Completion (31 December 2003)
Rp1.00	=	\$0.000427	\$1.00
\$1.00	=	Rp2,341	Rp8,480

ABBREVIATIONS

ADB	–	Asian Development Bank
BKKBN	–	Badan Koordinasi Keluarga Berencana Nasional (National Family Planning Coordinating Board)
BME	–	benefit monitoring and evaluation
EA	–	executing agency
FHC	–	family health card
FHN	–	family health and nutrition
HIS	–	health information system
IDA	–	iron deficiency anemia
IEC	–	information, education, and communication
MOH	–	Ministry of Health
MOU	–	memorandum of understanding
NGO	–	nongovernment organization
PMO	–	project management office
SSN	–	social safety net

GLOSSARY

adat	–	Customary law
dana sehat	–	Community health financing schemes
INPRES desa	–	Less-developed village
tertingal		
kardazi	–	Family nutrition awareness

NOTES

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

CONTENTS

	Page
BASIC DATA	iii
MAP	ix
I. PROJECT DESCRIPTION	1
II. EVALUATION OF DESIGN AND IMPLEMENTATION	2
A. Relevance of Design and Formulation	2
B. Project Outputs	2
C. Project Cost	5
D. Disbursements	6
E. Project Schedule	6
F. Implementation Arrangements	6
G. Conditions and Covenants	7
H. Consultant Recruitment and Procurement	7
I. Performance of Consultants, Contractors, and Suppliers	8
J. Performance of the Borrower and the Executing Agency	9
K. Performance of the Asian Development Bank	9
III. EVALUATION OF PERFORMANCE	9
A. Relevance	9
B. Efficacy in Achievement of Purpose	10
C. Efficiency in Achievement of Outputs and Purpose	11
D. Preliminary Assessment of Sustainability	12
E. Environmental, Sociocultural, and Other Impacts	12
IV. OVERALL ASSESSMENT AND RECOMMENDATIONS	12
A. Overall Assessment	12
B. Lessons Learned	13
C. Recommendations	14
APPENDIXES	
1. Project Framework	15
2. List of Civil Works Completed by Province	22
3. Summary of Project Commodities	23
4. Revision in Loan Allocations	25
5. Project Cost by Component	27
6. Sources of Funds for Project Costs	28
7. Project Implementation Schedule	29
8. Status of Compliance with Loan Covenants	30

BASIC DATA

A. Loan Identification

1.	Country	Indonesia
2.	Loan Number	1471
3.	Project Title	Family Health and Nutrition Project
4.	Borrower	Government of Indonesia
5.	Executing Agency	Ministry of Health, in cooperation with National Family Planning Coordinating Board (BKKBN)
6.	Amount of Loan	\$45.0 million
7.	Project Completion Report Number	PCR: 896

B. Loan Data

1.	Appraisal	
	– Date Started	10 June 1996
	– Date Completed	29 June 1996
2.	Loan Negotiations	
	– Date Started	20 August 1996
	– Date Completed	27 August 1996
3.	Date of Board Approval	27 September 1996
4.	Date of Loan Agreement	6 November 1996
5.	Date of Loan Effectiveness	
	– In Loan Agreement	26 December 1996
	– Actual	16 January 1997
	– Number of Extensions	None
6.	Closing Date	
	– In Loan Agreement	30 September 2002
	– Actual	30 June 2004
	– Number of Extensions	One
7.	Terms of Loan	
	– Interest Rate	Pool-based variable lending rate (LIBOR-based)
	– Maturity (number of years)	25 years
	– Grace Period (number of years)	5 years
8.	Terms of Relending	Not applicable
	– Interest Rate	
	– Maturity (number of years)	
	– Grace Period (number of years)	
	– Second-Step Borrower	

9. Disbursements

a. Dates

Initial Disbursement	Final Disbursement	Time Interval
2 June 1997	30 June 2004	84 months
Effective Date	Original Closing Date	Time Interval
16 January 1997	30 September 2002	68 months
Effective Date	Revised Closing Date	Time Interval
16 January 1997	30 June 2004	89 months

b. Amount (\$'000)

Category	Original Allocation	Last Revised Allocation^a	Amount Canceled^b	Net Amount Available	Amount Disbursed	Undisbursed Balance^c
1 Civil Works	1,568.0	681.0	887.0	681.0	497.0	184.0
1A MOH	1,169.0	582.0	587.0	582.0	435.0	147.0
1B BKKBN	399.0	99.0	300.0	99.0	62.0	37.0
2 Equipment and Vehicles	10,765.0	7,349.0	3,416.0	7,349.0	7,194.0	155.0
2A MOH	9,139.0	5,798.0	3,341.0	5,798.0	5,561.0	237.0
2B BKKBN	1,626.0	1,551.0	75.0	1,551.0	1,633.0	(82.0)
3 IEC and Materials	5,463.0	5,097.0	366.0	5,097.0	4,758.0	339.0
3A MOH	2,360.0	3,271.0	(911.0)	3,271.0	3,604.0	(333.0)
3B BKKBN	3,102.0	1,826.0	1,276.0	1,826.0	1,154.0	672.0
4 Consulting Services	4,360.0	2,502.0	1,858.0	2,502.0	2,254.0	248.0
4A MOH	4,323.0	2,487.0	1,836.0	2,487.0	2,251.0	236.0
4B BKKBN	37.0	15.0	22.0	15.0	3.0	12.0
5 Research Studies (MOH)	583.0	333.0	250.0	333.0	460.0	(127.0)
6 Training and Fellowships	5,316.0	7,395.0	(2,079.0)	7,395.0	4,876.0	2,519.0
6A MOH	1,979.0	2,377.0	(398.0)	2,377.0	1,749.0	628.0
6B BKKBN	943.0	1,200.0	(257.0)	1,200.0	858.0	342.0
6C Village Mobilization	2,394.0	3,818.0	(1,424.0)	3,818.0	2,269.0	1,549.0
7 Workshops and Seminars	2,037.0	4,322.0	(2,285.0)	4,322.0	3,108.0	1,214.0
7A MOH	1,483.0	4,305.0	(2,822.0)	4,305.0	3,093.0	1,212.0
7B BKKBN	554.0	17.0	537.0	17.0	15.0	2.0

8	Project Implementation Support	2,938.0	2,906.0	32.0	2,906.0	3,117.0	(211.0)
9	Interest and Commitment Charges	8,980.0	6,480.0	2,500.0	6,480.0	5,392.0	1,088.0
10	Unallocated	2,990.0	0.0	2,990.0	0.0	0.0	0.0
	Total	45,000.0	37,065.0	7,935.0	37,065.0	31,656.0	5,409.0

^a After second partial cancellation dated 12 December 2003.

^b Includes first partial cancellation dated 26 June 2000.

^c As of loan closing date of 30 June 2004.

BKKBN = National Family Planning Coordinating Board; MOH = Ministry of Health.

10. Local Costs (Financed)

– Amount	\$17.2 million
– Percent of Local Costs	44%
– Percent of Total Cost	32%

C. Project Data

1. Project Cost (\$ million)

Cost	Appraisal Estimate	Actual
Foreign Exchange Cost	26.2	14.5
Local Currency Cost	18.7	17.2
Total	45.0	31.7

Note: Total may not add due to rounding.

2. Financing Plan (\$ million)

Source	Appraisal Estimate			Actual		
	Foreign	Local	Total	Foreign	Local	Total
ADB	26.2	18.7	45.0	14.5	17.2	31.7
Government of Indonesia	0.0	30.0	30.0	0.0	21.8	21.8
Total	26.2	48.7	75.0	14.5	39.0	53.5

ADB = Asian Development Bank.

3. Cost Breakdown by Project Components (\$ million)

Component	At Appraisal			At Completion		
	Foreign	Local	Total	Foreign	Local	Total
A. Family Partnership for Health						
1. Assist Families to Identify their Needs	0.1	3.8	4.0	0.6	6.7	7.3
2. IEC Dissemination	1.6	3.7	5.3	0.1	3.3	3.4
3. Family and Community Resource Mobilization	2.0	5.4	7.4	0.3	6.4	6.8
Subtotal	3.7	12.9	16.6	1.1	16.4	17.5
B. Improving the Quality of Health Services						
1. Reorient Service Providers	1.5	7.6	9.1	1.7	4.5	6.2
2. Develop Integrated Delivery System	3.9	3.6	7.4	0.3	6.0	6.3
3. Improve Technical Skills of Service Providers	4.1	2.9	7.0	2.0	3.7	5.6
4. Equipment and Drugs	2.1	6.4	8.5	0.8	5.9	6.7
Subtotal	11.5	20.5	32.0	4.7	20.0	24.7
C. Project Monitoring, Evaluation, and Research	0.3	1.8	2.1	0.2	0.6	0.8
D. Project Implementation Support	0.3	3.3	3.5	3.1	0.4	3.5
Total Base Cost	15.8	38.5	54.2	9.1	37.4	46.5
Taxes and Duties	0.0	2.7	2.7	0.0	1.6	1.6
Contingencies	1.5	7.7	9.2	0.0	0.0	0.0
Interest During Construction	8.8	0.0	8.9	5.4	0.0	5.4
Total Project Cost	26.0	48.9	75.0	14.5	39.0	53.5

IEC = information, education, and communication.

Note: Total may not add due to rounding.

4. Project Schedule

Item	Appraisal Estimate	Actual
Date of Contract with Consultants		
Central Technical Team (CTT)	February 1997	27 February 1998
Central Task Force (CTF) and Training Support Group (TSG)	June 1997	November 1998
Health Information System (HIS)	June 1997	December 1998
Management Consultant/Executive Secretary	February 1997	May 1997
Midterm Review Consultant	April 1999	April 1999
Central Project Coordinator	May 1999	December 1999
Civil Works		
Date of Award of Contract	September 1997	31 October 1997
Date of Completion of Civil Works	June 2002	February 2003
Equipment and Supplies		
Date of First Procurement	February 1997	2 July 1997
Date of Last Procurement	June 2002	30 June 2003
Date of Completion of Equipment Installation	September 2002	October 2003
Other Milestones		
First National Workshop	March 1997	September 1998
Design/Production of Training Packages	May 1997	January 1998
Engagement of CD consultants	May 1997	October 1997
Preparation HIS (needs, prototype)	June 1997	April 1998
Self-survey	November 1997	January 1998
Benchmark survey	November 1997	January 1998
Midterm evaluation	March 2000	May 1999
Second national workshop	March 2000	May 1999
BME activities	December 1997	November 1998
Final evaluation	June 2001	June 2003
Final national workshop	June 2001	June 2003

5. Project Performance Report Ratings

Implementation Period	Ratings	
	Development Implementation	Objectives Progress
(i) From 16 January 1997 to 30 November 1998	Highly Satisfactory	Highly Satisfactory
(ii) From 1 December 1998 to 28 February 2001	Satisfactory	Satisfactory
(iii) From 1 March 2001 to 31 May 2001	Satisfactory	Highly Satisfactory
(iv) From 1 June 2001 to 30 June 2004	Satisfactory	Satisfactory

D. Data on Asian Development Bank Missions

Name of Mission	Date	No. of Persons	No. of Person-Days	Specialization of Members ^a
Inception	18 to 28 November 1997	1	13	a
Midterm Review	20 April to 14 May 1999	4	79	b,e,g
Loan Review	1 to 11 February 2000	1	11	b
Loan Review	28 May to 8 June 2001	2	21	b,i
Loan Review	1 to 15 November 2001	1	15	b
Loan Review	2 to 19 June 2002	1	9	b
Loan Review	9 to 20 June 2003	2	16	c,f
Special Loan Review	11 to 17 November 2003	2	14	d,h
Project Completion Review ^b	18 to 29 April 2005	3	30	c,h,i

^a a = Health Specialist, b = Senior Social Sectors Specialist, c = Social Protection Specialist, d = Project Administration Unit Head, e = Young Professional, f = Controller/IRM, g = Associate Project Analyst, h = Assistant Project Analyst, i = Consultant.

^b The Project Completion Report was prepared by B. Lochmann, Social Protection Specialist/Mission Leader and R. A. Apolonio, Assistant Project Analyst.

INDONESIA
HEALTH AND NUTRITION SECTOR DEVELOPMENT PROGRAM
 (as completed)



I. PROJECT DESCRIPTION

1. When the Government of Indonesia requested support from the Asian Development Bank (ADB) for a project on family health and nutrition (FHN)¹ in 1994, the access of the rural poor to basic health care services was inadequate. A national survey in 1992 revealed that, among the poorest 20% of the population in rural areas, 56% of those falling ill did not visit health care providers because of inadequate access and high costs of transportation and drugs. The infant mortality rate (IMR) was estimated at 56 per 1,000 live births² and the maternal mortality ratio (MMR) at 390 per 100,000 live births. Forty-eight percent of children suffered from malnutrition in 1993 and iron deficiency anemia (IDA) was the most prevalent nutritional deficiency. About 63% of pregnant women and 55% of preschool children suffered from IDA.

2. The project goal was to improve the health and nutrition status of the population—in particular poor families in remote rural areas—and to ensure that the improved health status was maintained. The Project had two objectives: (i) to strengthen the quality of health services; and (ii) to increase the capacity of families and rural communities to make informed decisions about health, nutrition, and family planning. The Project comprised four components: (i) family partnership for health;³ (ii) improving the quality of health services; (iii) project monitoring, evaluation, and research; and (iv) project implementation support. About 122,000 poor families in remote villages in 15 districts⁴ were selected, based on a socioeconomic classification by the National Family Planning Coordinating Board (BKKBN), to benefit from the improved health, nutrition, and family services in the provinces of Jambi, Bengkulu, North Sumatra, and South and Central Kalimantan. In each province, three districts with similar demographic and geographic characteristics (such as a large number of poor households and remote areas), were selected. In each village, project activities targeting poor families were organized around groups of 100 families. The Project was classified as a human development intervention. The Ministry of Health (MOH) was the executing agency (EA) and BKKBN was responsible for the implementation of family planning activities. Nongovernment organizations (NGOs) were subcontracted to assist in health promotion activities.

3. The implementation of the Project was affected by two unforeseen occurrences, the Asian financial crisis in 1998 and decentralization in 1999. The social safety net program (SSN), an emergency intervention to mitigate the impact of the crisis, was set up by the Government at the onset of the crisis to support health care delivery to the poor and education assistance and scholarship programs for children. ADB supported the SSN through two program loans, the Social Protection Sector Development Program and the Health and Nutrition Sector Development Program.⁵ The former was a combination of program and project loans to support reforms in the provision of basic social services. It funded specific interventions in education, health, family planning, nutrition, and support to street children. The latter was the successor program, which extended the technical and geographical coverage of the program but did not

¹ ADB. 1996. *Report and Recommendation of the President to the Board of Directors on Proposed Loan to Indonesia for the Family Health and Nutrition Project*. Manila

² In comparison with Thailand (36)

³ The family partnership for health component aimed to help families identify their health needs and enable them to make informed health care decisions.

⁴ North Sumatra (North Tapanuli, South Tapanuli, Nias), Jambi (Batanghari, Sarko Merangin, Bungo Tebo), Bengkulu (North Bengkulu, South Bengkulu, Rejang Lebong), South Kalimantan (Tabalong, Hulu Sungai Utara, Tanah Laut), and Central Kalimantan (Barito Utara, Kotawaringin Barat, Kapuas).

⁵ ADB. 1998. *Report and Recommendation of the President to the Board of Directors on Proposed Loans and Technical Assistance Grants to the Republic of Indonesia for the Social Protection Sector Development Program*. Manila; and ADB. 1999. *Report and Recommendation of the President to the Board of Directors on Proposed Loans and Technical Assistance Grants to the Republic of Indonesia for the Health and Nutrition Sector Development Program*. Manila.

include education components. The program loans were an immediate response to the effect of the crisis. However, the interventions and mechanisms employed for the distribution of benefits as well as the drain on human resources to implement those programs reduced the ability of the EA in project implementation.

II. EVALUATION OF DESIGN AND IMPLEMENTATION

A. Relevance of Design and Formulation

4. The Project's design was relevant to the Government's development objectives and ADB's country strategy. The project design addressed specific targets for economic and human development in the Government's Second Long-Term Development Plan (1994-2019). The health sector strategy of the Sixth Five Year Development Plan (REPELITA VI, 1994-1999) focused especially on improving the quality of health services for the poor through (i) strengthening preventive and health education activities, which reduce maternal, infant, and child mortality and morbidity; (ii) reducing fertility; (iii) improving nutritional status; (iv) increasing the quality, efficiency, and effectiveness of health services and referral systems; and (v) establishing community health funds (*dana sehat*). The health sector strategy complemented the Government's poverty alleviation program for less developed villages in rural areas (*INPRES Desa Tertinggal*), which was launched in 1994.

5. While conventional public health strategies targeted specific diseases, including childhood diseases, vaccine-preventable diseases, and malnutrition, these interventions had a limited impact on infant and maternal morbidity and mortality rates because of their centralized facility-based approach. The integrated family health approach aims to involve families and communities in preventive, health education, and family planning activities. It involves the establishment of community-based services, especially in remote rural areas. Community mobilization for preventive and health education activities was carried out with nongovernment organizations (NGOs) and community-based organizations (CBOs). By enhancing the capacity of families to make informed health care decisions, the approach aims to increase health care service utilization.

6. The Project was designed as a nationally focused approach but implemented during the transition to decentralization. The project design was relevant at the time of appraisal, but it could have been improved if more targeted activities had been identified to meet the project objectives. For example, the target of reducing high-risk births by 40% by the end of the Project was not appropriate for a project with an implementation period of 5 years. Project strategies were not targeted at strengthening antenatal care and referral services for high-risk pregnancies. Piloting new models to enhance outreach services is essential to increase access to basic health care services for the rural poor but no piloting phase was included in the project design. An assessment of NGOs' availability and technical capacity to undertake such outreach services and health education activities in the project areas would have been beneficial during project design.

B. Project Outputs

7. During the first 3 years, the main project activities focused on community-based health mobilization such as recruiting and training community workers and family health agents and establishing community health councils in villages. After the midterm review, the project focus shifted from a community-based to a facility-based approach, which improved the quality of health services at health centers and village maternity homes by training doctors, nurses, and

midwives in case management of diarrhea, acute respiratory infections, malnutrition, and integrated family health approach for health care providers. As decentralization unfolded in 2000, health care delivery fragmented and the quality of local health care services deteriorated.

8. The Project's investments in training, scholarships, and equipment at health centers were expected to improve the health and nutrition status of the population, maintain healthy diets and lifestyles, and reduce the total fertility rate among poor families⁶ in remote and less developed villages in the five project provinces. The absence of an operational benefit monitoring and evaluation (BME) system and therefore the lack of adequate quantitative data on health and nutrition in the project areas make it difficult to assess improvements in health, nutrition, and family planning status of project beneficiaries. Based on secondary data of the Indonesian Demographic Health Surveys 1994 to 2003, the infant mortality rate was reduced slightly from 50 per 1,000 live births in 1994 to 44 per 1,000 live births in 2003 while during the same period, the under five mortality rate was reduced by almost 50% from 109 per 1,000 to 56 per 1,000. The reduction of childhood diseases in children under 5 years of age remained rather marginal with the exception of diarrheal diseases, which prevalence was reduced from 12.9% in 1994 to 8.2% in 2003. The prevalence of acute respiratory infections decreased from 9.12% in 1994 to 7.7% in 2003. According to the National Socioeconomic Survey (SUSENAS), the nutritional status based on weight-for-age for children under the age of 5 years remained unchanged while protein energy malnutrition for the same age group was reduced from 5.26% in 1997 to 3.43% in 2003.

9. More than 135,888 poor families in 654 largely remote villages benefited from improved access to quality health services. They became more knowledgeable about health care and family planning and better able to make informed decisions. Appendix 1 provides the project framework with details on outputs and targets at project completion. Appendix 2 summarizes the civil works completed under the Project. Appendix 3 provides a summary of commodities purchased under the Project.

10. **Family Partnership for Health, Nutrition, and Family Planning.** The Project did not fully achieve its targets with regard to (i) improving families' ability to identify priority health needs, (ii) increasing contraceptive prevalence, and (iii) mobilizing communities for health and family planning. This was largely due to a lack of technical expertise among provincial and local government health staff to plan and manage these interventions especially community mobilization activities for improved health, nutrition, and family planning.

11. Lack of a coordinating mechanism between MOH and BKKBN adversely affected project implementation with regard to family planning and social mobilization for contraceptive use. BKKBN expanded its national family planning program to project districts but interventions were not adjusted to meet specific project targets for the fertility rate and contraceptive prevalence. The reduction of the total fertility rate was rather marginal from 2.9% in 1994 to 2.6% in 2003.⁷ The utilization of oral contraceptives declined from 76% in 1997 to 52% in 2000, which was a temporary drop due to the impact of Asian financial crisis.⁸ The family planning service availability declined at the health center level which may be also attributed to the overall funding decline of BKKBN family planning and social mobilization activities during the Asian financial crisis.

⁶ Fifty-seven percent of the families covered by the Project are in the lower categories of BKKBN's socioeconomic classification.

⁷ Indonesian Demographic and Health Survey 2003.

⁸ Ibid.

12. The Project supported social mobilization of household members through NGOs and CBOs using the family health card (FHC), which recorded health behavior and household facilities such as water supply. However, the information collected was not shared with health providers and they were therefore not able to respond appropriately to the changing demands of the health care and nutrition interventions. In 1998, the SSN provided access to health services by the use of a special health card (*kartu sehat*).⁹ Poor households were given health cards so they could use health care services, which covered first treatment and referral, basic maternal care, nutritional improvement through food supplementation to undernourished poor families, and immunization. Anecdotal evidence suggests that, with the introduction of the special health card, the use of the FHC declined. About 90% of poor families in the project area received the health card. Given the low education level, especially among poor women¹⁰ in the project target areas, it is doubtful whether the importance of the FHC in making informed health care decisions was fully understood by poor women. The limited availability and technical capacity of NGOs at the district level and the reluctance of departments of health to outsource health education activities to NGOs resulted in rather marginal community empowerment for better health, nutrition, and family planning. It appears in those areas where CBOs and NGOs were strong, family health awareness was improved.

13. Because of the impact of the Asian financial crisis on household incomes from 1998 onwards, group income generation activities became a priority intervention of the Project. At appraisal, income generation schemes were intended to supplement community health financing schemes and to cover costs such as transport and drugs of poor households. However, because of the financial crisis, the income generated was used to purchase food. Another reason for the low achievement of community health financing schemes was the introduction of the special health card, which provided access to free basic health services.

14. **Improving the Quality of Health Services.** The Project upgraded health services in 829 villages and subdistrict health facilities. BKKBN rehabilitated five provincial training centers and 15 district media production centers. Media production centers produced information, education, and communication (IEC) materials, radio and TV spots on health and nutrition promotion and family planning. During the Project Completion Review Mission's visit to Bengkulu and Central Kalimantan, the media production centers were utilized for the production of health promotion videos by the provincial health education department. Equipment and medical supplies (including 10 mobile x-ray units, 74 dental units, and 70 obstetric and gynecological beds) were provided to village and subdistrict health facilities. Twenty-two mobile IEC units were purchased for health education services and 58 mobile health centers and 15 speed boats for outreach services. To strengthen the health information system (HIS), 270 computers were distributed to village health facilities.

15. It could have been expected that staff training, upgrade of health facilities, and the provision of equipment increased health service utilization, however, there was a temporary drop in utilization of village health posts (*posyandu*)¹¹ by children from birth to 5 years of age by 11% between 1997 and 2000 nationwide,¹² which may have been attributed to a lack of community resources to provide meals to children under 5 years at the village health post level during the Asian financial crisis. On the other hand, the utilization of sub-district health centers (*puskesmas*) remained unchanged. Health outcomes for children did not seem to suffer during

⁹ The *kartu sehat* program covered about 25% of the poor population.

¹⁰ The incidence of no formal education among women was 10.6% in North Sumatra, 18.7% in Jambi, 16.6% in Bengkulu, 13.8% in Central Kalimantan, and 15.3% in South Kalimantan.

¹¹ *Posyandu* are monthly local mother-child health clinics which are run by the local community out of their own resources with support of the village midwife.

¹² RAND Cooperation. 2004. *Indonesian Living Standards. Before and After the Financial Crisis*.

the crisis because of the SSN program but there was considerable leakage to the non-poor. Based on data from a national survey¹³ in 2001, 27% of the poor and 70% of the nonpoor used community health centers.

16. The Project partly achieved its targets with regard to (i) strengthened outreach services, (ii) case detection and treatment of priority diseases, and (iii) increased capacity for project management. Outreach services were largely provided by village midwives who received transport (motorcycles) from the Project. Anecdotal evidence suggests that midwives were not able to go to remote areas given their limited physical mobility because of customary law (*adat*), which prohibits unaccompanied women from traveling on their own to other villages. Training on maternal and neonatal care, reproductive health, and malnutrition was organized for health providers and paramedics, but the impact remains unknown since no post-evaluation was carried out. Strengthening case detection and disease management was challenging in the absence of an operational HIS, which was planned as part of the project BME system. Training on data collection and analysis to make informed health care decisions at the village health center level was insufficient due to a lack of trainers and therefore the HIS was not fully established. Following decentralization, there was no guidance from MOH to the district and provincial health offices on where to report such data. Given the upgradation of health services, training, and provision of equipment, it can be assumed that the demand for health services increased.

17. **Monitoring, Evaluation, and Research.** At appraisal,¹⁴ it was agreed that a BME system would be established, based on systematic surveys at the beginning, midterm, and end of project implementation. No separate baseline survey was conducted for the project target area but data were used from district health profile surveys. It was intended that the BME system would be progressively developed. In the first year, six districts were covered. However, key indicators of the project framework (such as maternal mortality, low birth weight, protein energy malnutrition, IDA, and fertility rate) were not included in the BME and therefore it gave only a limited indication of project implementation. Health staff at district and subdistrict health centers were responsible for collecting data and operating computers but they were not adequately trained. The development of the BME was not pursued after 1998 largely because the implementation of the SSN diverted staff from the Project to SSN implementation and monitoring. With the introduction of decentralization in 1999, districts had no instructions on where to report information to. The Project conducted 14 research studies, which included a policy study on behavioral changes and the development of nutrition indicators, including a healthy family potential index, which is a set of indicators on local behaviors that all families should practice such as drinking clean water or using latrines. While these research studies were important contributions to health policy development on nutrition indicators, other operational research studies on behavioral change for healthy lifestyles were not adequate. Stronger research studies could have strengthened the component on family partnership for health, nutrition, and family planning.

C. Project Cost

18. At appraisal, the project cost was estimated at \$75.0 million, with ADB's share estimated at \$45.0 million (60%) and the Government's share at \$30.0 million (40%). The loan amount was progressively reduced during the portfolio restructuring exercises that were carried out in the wake of the Asian financial crisis. The final loan amount was reduced to \$37.1 million, after two partial cancellations. Appendix 4 provides details on loan allocations per category at

¹³ Ibid.

¹⁴ Memorandum of Understanding of the Loan Appraisal Mission, June 1996, p. 5.

appraisal and at completion. The actual project cost was \$53.5 million (71% of the appraisal estimate), of which ADB financed \$31.7 million (59%) and the Government \$21.8 million (41%).¹⁵ Appendix 5 compares actual project costs by components with project costs at appraisal. Appendix 6 shows sources of funds for project costs at appraisal and at project completion.

D. Disbursements

19. Disbursement was slow in the first 3 years of project implementation because of the fourfold devaluation of the Indonesian rupiah during the Asian financial crisis. In addition, the project consultant team was recruited 13 months after the Project began, which meant there was no plan of operation for more than a year. By the midterm review in April 1999, only 8% disbursement and 25% physical completion had been achieved, although 43% of the Project's scheduled time period had already elapsed. The ADB Midterm Review Mission recommended the recruitment of a project technical advisor. This advisor provided significant leadership to the central technical team (CTT) and improved project disbursements. Disbursements at loan closure totaled \$31.7 million, which included procurement of equipment and vehicles (23% of total loan utilization), IEC materials (15%), training (15%), and fellowships (15%). An imprest account that facilitated initial disbursement was established for the Project. Loan utilization was 85% of the final reduced loan amount of \$37.1 million.

E. Project Schedule

20. ADB approved the Project on 26 September 1996 and the loan was declared effective on 16 January 1997, 1 month later than the target date. ADB approved the Government's request to extend the loan completion date by 15 months (30 September 2002–31 December 2003), to complete planned activities. To accommodate submission and processing of eligible withdrawal applications, the loan account was kept open for another 6 months. The loan was financially closed on 30 June 2004. The first procurement contract was awarded in July 1997, nearly 5 months later than estimated at appraisal. The contract for the project consultant team was awarded in February 1998, 13 months later than estimated. These delays were caused by the limited technical and human resource capacity of MOH to handle procurement activities and the additional work load in managing and implementing the SSN. Appendix 7 presents a detailed project implementation schedule comparing actual achievement with appraisal targets by components.

F. Implementation Arrangements

21. In compliance with the loan agreement, a project steering committee, comprising representatives from MOH, BKKBN, Ministry of Agriculture (MOA), and Ministry of Home Affairs (MOHA), was established at the national level to provide overall technical and administrative guidance for project implementation. At the central level, the Director General of Community Health, MOH, served as project director and a full-time executive secretary was the project coordinator. Coordination and policy guidance was carried out by the intersectoral committee composed of the project director and representatives from MOH, BKKBN, and MOHA. The central project secretariat based at the MOH was to facilitate project coordination between MOH and BKKBN. The project director left 6 months after project inception and the newly appointed project director was not familiar with the objectives of the Project, which delayed implementation. The project coordinator was familiar with project administration but did not have enough technical knowledge to prepare a detailed plan of operations for the central, provincial,

¹⁵ US\$1.00 = Rp8,480 as of 31 December 2003.

and district levels. A technical advisor for the Project was appointed only 3 years after project commencement. At appraisal, the Project did not foresee the establishment of a central project secretariat in BKKBN. It was assumed that BKKBN family planning activities would be planned and implemented by the project secretariat rather than by a separate project secretariat established in BKKBN. There was therefore no joint planning by MOH and BKKBN or integration of family planning related activities at central and local government levels, which was the intention of the Project.

22. At the provincial level, heads of provincial health departments were appointed as provincial project managers responsible for the coordination of project implementation activities at the district level. At the district level, heads of district health services were appointed as project managers responsible for the implementation of project activities at the subdistrict level, which included subcontracting to NGOs. While this delegation of authority was innovative and ahead of decentralization, the lack of technical and administrative guidance from the central level project secretariat made project management difficult, especially at the district level. When the Government started the SSN in 1999, many staff were allocated to the SSN and the Project was understaffed.

G. Conditions and Covenants

23. The sector covenants on the designation of provincial project staff (Schedule 6, paras. 7, 11, 12, 13, 14) were fully complied with. Loan covenants on the intersectoral project coordination committee (Schedule 6, para. 5) and insurance of project facilities (Section 4.09) were not relevant.¹⁶ Most of the loan covenants were not fully complied with because of inadequate supervision, especially during the Asian financial crisis, to ensure timely accomplishment of all project tasks. The main reasons for noncompliance were related to (i) lack of timely fund availability because of late arrival of Government's budget documents, (ii) establishment of provincial steering committees was not possible because the BKKBN deputy district manager was not appointed, (iii) inadequate involvement of local government in project implementation delayed the appointment of district project manager and BKKBN as deputy district project manager substantially, (iv) adequate training of health providers was not sustainable because of the high turnover of health personnel, (v) overseas fellowships and local training were only partly efficient because of the late recruitment of PhD students who were not able to complete their studies, (vi) establishment and operationalization of BME was not achieved because of the late recruitment of consultants and a lack of supervision, and (vii) the recommendations of the midterm review were only partly relevant to meet project objectives. There was also noncompliance with the conditions of the action plan for operational research and studies, related to the lack of coordination between the project secretariat and directorates such as Nutrition and Health Education in MOH in consolidating an action plan for operations research and studies. Appendix 8 gives the status of compliance with loan covenants.

H. Consultant Recruitment and Procurement

24. Consultant recruitment was carried out in accordance with ADB's *Guidelines on the Use of Consultants*. Recruitment of the technical consultant team was delayed by 13 months because MOH was not familiar with ADB's bidding procedures (although project staff had attended project implementation seminars during the early stages of inception). Inputs of international consultants were estimated at 66 person-months and domestic consultants at 647

¹⁶ Loan 926-INO: Second Health and Population Project was completed in December 1995, therefore the Project Coordination Committee could not be continued under FHN Project since loan negotiations were in August 1996. There is no insurance for project facilities in Indonesia.

person-months. During the midterm review, international consultant inputs were reduced from 66 to 36 person-months and domestic consultant inputs from 647 person-months to 645 person-months. International consultants were assigned to (i) develop the plan of operations, (ii) provide technical guidelines for research activities, (iii) prepare community mobilization activities, (iv) identify NGOs and specify their participation in the Project, (v) prepare a training plan for health providers and NGOs, and (vi) design social marketing campaigns for family health activities. Domestic consultants assisted in (i) developing monitoring and evaluation indicators, (ii) providing technical guidance to research studies, (iii) conducting IEC and training modules, (iv) analyzing health insurance schemes and small-scale income generation activities to be included in the Project, (v) establishing quality assurance of health services, and (vi) developing an HIS.

25. Goods and services were procured from loan funds in accordance with ADB's *Guidelines for Procurement*. Modifications were requested by the Borrower, to reflect specific procurement requirements of some provinces.¹⁷ The auditors rendered a qualified opinion because of unsubstantiated payments by the PMO to the CTT consultants.¹⁸ The amounts were relatively small. There was no formal investigation undertaken by the Office of the General Auditor but ADB advised the PMO to take appropriate action and closely pursued findings with the EA, which cooperated in monitoring compliance of participating provinces with audit recommendations. Overpayment of contractors and resource persons due to lack of project supervision by the PMO was reported. The audit report also mentioned that some commodities that had been purchased (such as rainwater collection equipment and pumps for wells) were not used because beneficiaries preferred to use the rivers for personal hygiene. It can be assumed that health promotion activities, which were supposed to be conducted by the community health workers, were unable to change the behavior of beneficiaries. MOH noted that ADB procurement regulations were cumbersome and difficult to understand and that more continuous hands-on support for procurement matters and procedures from ADB would have been appreciated.

I. Performance of Consultants, Contractors, and Suppliers

26. The performance of the technical consultant team, the International Science and Technology Institute, Inc. (ISTI), was not fully satisfactory. The team was unable to develop a plan of operations for the central level or operational guidelines for the provincial and district levels. After the midterm review, a technical project director was appointed by MOH to assist the central, provincial, and district levels to prepare operational guidelines. The technical project director strengthened project implementation by improving the quality of services through training health care providers and introducing new nutrition indicators. The recruitment of consultants was carried out in accordance with ADB's *Guidelines on the Use of Consultants*.

27. The performance of contractors and suppliers was satisfactory. Delivery of goods and services was delayed because of a lack of counterpart funds and insufficient experience in evaluating bids and finalizing contracts by the MOH. Vehicles, computers, and medical equipment such as dental units and x-ray machines seen during the Project Completion Review Mission's¹⁹ visit to two provinces²⁰ were of appropriate quality, reflecting the satisfactory performance of contractors. Damage to goods such as computers was attributed to poor packaging and insufficient training on the use of computers by health staff.

¹⁷ For example, speedboats were originally to be procured through international shopping. ADB agreed to local shopping since the speedboats were locally manufactured.

¹⁸ Independent Auditor's Report on the Consolidated Financial Statements for fiscal year March and December 2000.

¹⁹ Project Completion Review Mission, 17-29 April 2005.

²⁰ Bengkulu and Central Kalimantan.

J. Performance of the Borrower and the Executing Agency

28. By most indicators, the performance of MOH before and after the midterm review was partly satisfactory in meeting project objectives. This was largely because of the additional staff and administrative requirements needed to implement the SSN from 1998 to 2001. The implementation of regional autonomy in 2000 has provided opportunity for district governments to formulate their own policies and programs including health and to decide what programs and services will be delivered but the quantity and quality of health services is influenced by local political processes. Health staff suddenly had to take decisions on selecting types of medicines and equipment, which was the responsibility of the central government prior to decentralization. This created challenges for provincial and district level authorities who were overwhelmed with administrative and managerial tasks in addition to the implementation of ADB's safety net programs, the SPSPDP and the HNSDP. Implementing a complex project such as FHN at the district level added to the workload and resulted in a lack of leadership, an inadequately staffed project management office (PMO), and no detailed work or procurement plans. These contributed to significant delays in implementation. Achievement of project objectives was compromised because of the inadequate capacity of NGOs and CBOs; the absence of clear roles, responsibilities, and coordination mechanisms between MOH and BKKBN; and an inadequate BME system.

K. Performance of the Asian Development Bank

29. A total of eight ADB missions (208 person-days) were fielded. This was above the average for a project of this size but still proved to be inadequate given the need to review and adjust project interventions, especially during the Asian financial crisis and the transition towards decentralization. However, ADB staff resource inputs were constrained because of the preparation and implementation of two major program loans, the SPSPDP and the HNSDP, which assisted the Government's SSN (see para. 9). After the midterm review, ADB increased its efforts with MOH and BKKBN to address delays in project implementation. It was responsive to the needs that arose during implementation. Reviews of procurement procedures and contract awards were conducted in a timely manner. However, more assistance, preferably through the Resident Mission, to MOH to help it to comply with ADB procurement regulations, would have strengthened project implementation but the time and staff resources were not available. The midterm review enabled adjustments to be made to project implementation, but these proved to be insufficient. A major change in scope could have redirected activities and amended project target indicators to help the achievement of project objectives. Given the implementation of the major program loans, SPSPDP and the HNSDP, which overlapped partly in terms of health activities and geographic areas with the Project, the limited human resource and technical capacity of MOH and implementing agencies, and decentralization, project implementation should have been suspended or terminated after the midterm review. The performance of ADB is therefore rated partly satisfactory.

III. EVALUATION OF PERFORMANCE

A. Relevance

30. The Project was in line with the Government's health policy objectives and the ADB country strategy. However, strategies and implementation mechanisms were not adequately modified in response to the changing context of the Asian financial crisis and the beginning of decentralization. The midterm review recommended (i) a stronger focus on encouraging families and communities' active involvement in identifying health problems and the underlying causes

of ill-health and (ii) identification of locally acceptable solutions for preventive activities. However the review did not adjust project activities and target indicators enough and did not reinforce the BME system sufficiently.²¹ Further, the midterm review was carried out during the first year of decentralization, which provided an opportunity to involve provincial and district governments in developing policies, strategies, and resource allocation to adjust the implementation of project activities more appropriately based on local needs and capacities. The recommendations of the midterm review were only partly relevant in addressing project objectives. At appraisal, the Project was designed as a central project approach, therefore local governments were not involved in the coordination of project planning, budgeting, and supervision. The Project is assessed as partly relevant.

B. Efficacy in Achievement of Purpose

31. The Project's efficacy at meeting its immediate objectives was limited by the diversion of project activities. It had some success with its first objective to strengthen the quality of health services but was less successful with its more ambitious objective to increase the capacity of families and rural communities to make informed decision about health, nutrition, and family planning. Instead of coordinating and streamlining social mobilization for better health, nutrition, and family planning between provincial health offices, BKKBN, and NGOs, interventions were implemented through vertical health programs, which separately from each other focused on the prevention and eradication of specific communicable diseases. Improvements to the quality of basic health services at provincial and district levels were affected by delays to the training of health providers and the provision of medical equipment, vehicles, and training materials.

32. The Project also aimed to set up the village midwife program, which was introduced in 1997. The village midwife can play an essential linking role between communities and health care providers and is critical to effective outreach services. However, too little emphasis was given to reinforcing midwives' roles in supporting community-based health services and health promotion. A 40% reduction in high-risk births and other quantified project objectives can only be considered aspirations, since they do not appear to have been derived from nationally relevant epidemiological, behavioral, or health system analyses of what could be realistically achieved with the project inputs within the given timeframe.

33. Providing seed capital for income generation activities²² became a focus of the Project. At appraisal, it was agreed that the Project would support training activities related to income generation activities but not investment capital or seed funds.²³ The Project spent about \$3.8 million on seed capital, which was largely used to help households to purchase food and for agricultural development activities. It is doubtful that poor families benefited from income generation schemes because they were not eligible for these schemes.

34. The underachievement in project outputs was thus mainly due to (i) external conditions such as the parallel implementation of the SSN and decentralization; (ii) inadequate understanding of the Project's objectives and strategies by the provincial and district project staff and relevant stakeholders during the first 3 years of project implementation; (iii) strategies that were not fully appropriate, especially with regard to improving access to quality health care services for poor communities in remote areas; (iv) substantial delays in the provision of technical and administrative guidelines and training at the provincial and district level;

²¹ As recommended during appraisal, the Project would have required extensive BME to monitor whether activities were appropriately designed and targeted.

²² Rp20,000,000 seed money were allocated for 651 project villages, which were an equivalent of \$1,860,000 based on the exchange rate \$1=Rp 7,000).

²³ MOU of Loan Appraisal Mission of June 1996, p. 5.

(v) inadequate availability and limited capacity building of NGOs; and (vi) the absence of coordination between MOH and BKKBN in training and delivery of family planning services. In addition, the Asian financial crisis of 1998, which severely affected Indonesia, influenced implementation of some activities, such as strengthening community health financing.²⁴ The Project is rated less efficacious in achieving its immediate objectives.

35. Despite the strong focus on developing IEC materials, there was no assessment of the relevance and impact of IEC. Although many printed materials were produced by MOH and BKKBN, leaflets and brochures may not be the best way to communicate health education messages in a culture with strong oral traditions.

36. In terms of direct beneficiaries expected at appraisal, the results did not meet the intended targets with regard to involving poor families in disadvantaged rural areas and front-line service providers in isolated areas. Project activities were not adequately directed at these target groups and not all subdistricts in the target districts were covered.²⁵ The selection criteria of project villages used different categories and classifications.²⁶ Targeting selected villages may help to reduce the poverty of certain groups but is less meaningful for public health interventions.

37. The Project-sponsored fellowship programs benefited a total of 542 government staff. The training contributed to improving the technical capacity of MOH, at central, provincial, and district levels. A full assessment is difficult because MOH was unable to implement an adequate BME system.

C. Efficiency in Achievement of Outputs and Purpose

38. Inadequate project staffing resulted in inefficient project planning and management during the first 3 years and a lack of technical guidance to implement the project activities at the provincial and district levels. The implementing consultant inputs were productive in terms of the number of produced studies. But the output was not adequate because studies did not effectively support project objectives. The Project is rated less efficient in achieving its outputs and purpose.

39. The absence of a project coordinating unit in BKKBN contributed to weak coordination between BKKBN and MOH and therefore inadequate implementation of activities related to reproductive health and family planning.

40. Efficiency of process is also judged by the way in which the Project was implemented by the Government. Project implementation and procurement of goods were delayed by almost 3 years, which limited the potential impact of the Project significantly. Especially procurement of essential equipment to upgrade health facilities started only in the third year of project implementation. The lack of provision for the training of project staff at local government level in a timely manner hampered project implementation and sense of ownership. The efficiency of implementation improved after the midterm review with regard to strengthening the quality of health care services.

²⁴ The Government's SSN Program (JPS-BK) launched in 1998 provided free health care for the poor in all provinces, which resulted in a decline in community health financing schemes.

²⁵ At appraisal, the indicative implementation schedule selected two project villages per district in the first year and 12–15 villages in the second year. The remaining villages were not all targeted during the third year of project implementation.

²⁶ Some target areas were selected based on BKKBN's family welfare classification, others were based on Central Bureau of Statistics (BPS) poverty line.

D. Preliminary Assessment of Sustainability

41. The sustainability of a project depends on sufficient resource mobilization to enable its approaches to be continued. While some project interventions (such as quality assurance and the establishment of community health councils) were adopted as part of national health policy, the limited financial resources of local governments mean they are unable to finance community-based activities or the additional staff recruited under the Project. For the project to be sustainable, the institutional capacities of local governments, CBOs, and NGOs need to be strengthened. There are concerns about the sustainability of the Project. The Project is assessed as less sustainable.

E. Environmental, Sociocultural, and Other Impacts

42. There was no negative environmental impact of the physical infrastructure funded by the Project. Land acquisition was not necessary for the renovation and expansion of health facilities. No environmental impact assessment was carried out. Prior to project preparation, poverty was identified as an underlying cause of the poor health and nutrition status of families. The Project was therefore directed at poor communities at district and subdistrict levels. During appraisal it was agreed that families below the poverty line as defined by the BPS or poor families in the two lowest categories of the BKKBN classification would be the target groups. Income generation was one activity directed at poverty alleviation. The income generated helped to improve household food security especially of poor families during the crisis. However, there were no targeted interventions to address specific health and nutrition needs of vulnerable women, such as those of female-headed households. Behavioral change studies and a survey on violence against women and children in the FHN region were carried out during project implementation and were useful as background information in the sector. Other important achievements were the development of nutrition and family health awareness indicators which were included in the national health policy. Overall, other impacts are assessed as significant.

IV. OVERALL ASSESSMENT AND RECOMMENDATIONS

A. Overall Assessment

43. The Project was rated partly successful²⁷. The Project only partly achieved one of its objectives: improving the quality of health services through an increase in the contraceptive prevalence rate²⁸ and an increase in the birth deliveries²⁹ assisted by midwives (which was used as a proxy for utilization of services at health centers). The other objective of increasing the capacity of families to make informed health care decisions was not achieved. The Project was relevant at the time of appraisal but it was not adequately redefined to achieve its development objectives in response to the economic crisis during the Midterm Review Mission. Changes in implementation arrangements due to decentralization did not significantly impact the Project. The other reason for the very limited success of the Project was lack of government leadership. MOH had little commitment to, or ownership of, the Project in the first 3 years of implementation because of inadequate staffing. Visits by the Project Completion Review Mission to the project sites and detailed discussions with the EA suggested that the number of implemented activities

²⁷ This PCR is part of a sample of PCRs independently reviewed by the Operations Evaluation Department. The review has validated the methodology used and the rating given.

²⁸ Based on the Indonesia Demographic and Health Survey 1994 and 2002/2003, the contraceptive prevalence rate increased from 45% in 1994 to 68 % in 2003.

²⁹ All project provinces had rates of attended birth deliveries above 50%, except North Sumatra where the rate was 28.4%.

was limited and that implementation did not meet expectations. Overall, the increased focus on income generation activities did not meet the Project's objectives, but has contributed to enhance household food security of families during the crisis. BKKBN's role and responsibilities were not adequately defined, which resulted in the disintegration of family planning and related IEC activities.

B. Lessons Learned

44. The major lessons learned from the Project were as follows.

- (i) In a changing project context, objectives, basic design, and assurances need to be maintained but activities and indicators should be adjusted to emerging needs to make the Project more relevant, efficient, and effective. This requires systematic and regular assessment and effective response by review missions.
- (ii) Detailed implementation arrangements and coordinating mechanisms of executing and implementing agencies are critical to success and more attention should be paid to them in the project design.
- (iii) Ambitious project targets, especially with regard to behavior change of populations, require EA and IAs to have high levels of technical competence, detailed planning, and continuous monitoring of interventions.
- (iv) Particularly in decentralization, the PMO and project implementation units need to be integrated into an existing unit or department rather than established as stand-alone structures to maximize technical and administrative capacity for project implementation.
- (v) During project appraisal, a set of simple and concise indicators for data collection should be designed and agreed upon to make the BME operational at project inception and review missions should be rigorous in their pursuit of ensuring BME is maintained and updated.
- (vi) Ensuring access to basic health services for the poor means that projects need to identify strategies such as effective outreach programs which address high opportunity costs such as transport costs, time and income lost by attending consultations at health centers, etc. There is work to be done, beyond the interventions included in the Project, in explicitly targeting measures to ensure accessibility to health services.
- (vii) Outsourcing services to NGOs requires commitment at all government levels and thorough assessment of their technical capacity building requirements and accountability mechanisms.
- (viii) Poverty target mechanisms need to be based on clear and consistent indicators, which are accessible and useful for decision-makers.
- (ix) Even in emergency situations, design of projects and programs impacting on the same sector should be coordinated so as to foster synergies and to clearly delineate responsibilities and consistent approaches to sector interventions.

C. Recommendations

1. Project-Related

45. Future projects should provide strong support to project management staff to adjust the project design during implementation if appropriate. There is a need for well trained and highly motivated individuals to staff project management units and to ensure they have clearly defined, well understood, responsibilities to make appropriate managerial decisions.

46. In respect of future health projects, a sound BME system should be established as part of project preparation to enable monitoring of key health indicators and health service utilization in the project areas. Further, communication is key to improve health awareness. More emphasis has to be given not only on the training for behavior change communication but also interpersonal communication and counseling skills of government providers and NGOs.

2. General

47. Based on examples of good practice elsewhere, improvement in health and nutrition status of poor rural communities and the promotion of equal access to quality health service delivery, requires sustainable community-based health care interventions and outreach services.

48. Major problems in the collection, analysis, and reporting of critical health statistics under decentralized systems need to be addressed. Statistics collected from districts and provinces are incomplete. This is reflected in the national statistics, which are undermined by significant under-reporting combined with inaccurate data. There are no incentives or sanctions for hospitals or health centers to report fully or accurately. A comprehensive effort is needed by MOH to simplify current procedures, increase health coverage, and ensure more accurate data. At the district level, an integrated database covering MOH, BKKBN and Ministry of Social Welfare data is needed for meaningful health indicators to be formulated and for performance against these indicators to be measured.

49. An in-depth study of health care financing and health facility utilization should be carried out by ADB. Health funding varies considerably among districts.

50. In a decentralized context, appropriate responses need to be developed to ensure adequate funding is provided on an equitable basis to all health centers. Some health centers receive less funding now than before decentralization. A set of systematic remedial measures is needed to ensure that people receive equal health care opportunities.

PROJECT FRAMEWORK

Design Summary	Project Targets	Project Inputs/Activities	Outcomes/Achievements
Sector goals			
Better health and nutritional status which is maintained through healthy lifestyles and diet.	By the end of the Project, changes in the following health indicators according to base line data (district-specific figures):		
2. Reduced total fertility rate	<ul style="list-style-type: none"> • High-risk births (proxy for MMR) : -40% • IMR : -20% • U5MR : -25% • LBW : -40% • Total PEM : -30% • Iron nutrition anemia <ul style="list-style-type: none"> a) pregnant women : -40% b) U5 : -35% • Total goiter rate : -50% • Total fertility rate : -30% 	Training of providers on anemia, diarrhea, and ARI. No specific interventions to reduce MMR, IMR, and malnutrition in pregnant women and children were carried out by the Project. Community development workers were trained.	BME and HIS were not brought into operation and therefore quantitative data do not exist for the project areas. Based on secondary data from the IDHS, ³⁰ IMR was 46 per 1,000 live births in the period 1998-2002. U5MR was reduced by 37% and LBW by 39% between 1994 and 2003 at the provincial level. Nationally, the total goiter rate increased from 9.8% in 1998 to 11.2% in 2003. The total fertility rate decreased from 2.9 in 1994 to 2.6 in 2003.
Social and economic goals			
3. Increased productivity	<ul style="list-style-type: none"> • Percentage of "poor families" : -20% 		Given the impact of the Asian financial crisis, poverty rates increased about 27% between 1997 and 1998 and declined only slightly from 17% in 1999 to 15% in 2000.
4. Better economic status			
5. Better social organization			

³⁰ Indonesian Demographic and Health Survey

Design Summary	Project Targets	Project Inputs/Activities	Outcomes/Achievements
			South Kalimantan and South Sulawesi were severely hit by a drought in 1997.
<p>Objectives</p> <p>1. To increase capacity of the families to make informed decisions, and act to improve health</p> <p>2. To improve the quality of the health services, with support of the local authorities</p>	<ul style="list-style-type: none"> • 20% annual increase of families aware of health and nutrition issues and actively participating in community-based activities • Families' cost-sharing in health and FP services: 70% of families participate in health insurance schemes • 30% increase in health services utilization (health centers) 	<p>Training of community development workers and family health agents; IEC activities</p> <p>Income generation schemes to support financing of community health financing schemes</p> <p>Community mobilization for informed health care decision making; training on case management for health providers and nurses</p>	<p>No quantitative assessment on family health awareness was carried out</p> <p>No health insurance scheme was established. The SSN program introduced a health card for the poor, which provided free health care. 90% of poor families owned a health card</p> <p>There was a drop in utilization of health centers by children from birth to 5 years of age by 11% between 1997 and 2000 nationwide³¹ because of the crisis. Based on data from a national survey³² in 2001, 27% of the poor and 70% of the nonpoor used community health centers in the project area</p>

³¹ Indonesian Living Standard Survey. RAND 2004.

³² National Survey for Loans 1675/76-INO: Health and Nutrition Sector Development Program 2003.

Design Summary	Project Targets	Project Inputs/Activities	Outcomes/Achievements
	<ul style="list-style-type: none"> • CPR increase 20% • Prevalence and incidence of project priority diseases (specific targets for each disease, per district) 	<p>Social marketing for contraceptives and social mobilization for family planning</p> <p>Workshops were conducted on safe water and sanitation for communities. Case management training on the control of diarrhea, ARI, and MCH for health providers was carried out</p>	<p>Contraceptive prevalence rate increased from 45% in 1994 to 68% in 2003³³</p> <p>Reduction of childhood diseases was substantial with the exception of diarrhoeal diseases, which declined from 12.9% in 1994 to 8.2% in 2003. The prevalence of ARI decreased from 9.12% in 1994 to 7.7% in 2003. The overall nutritional status based on weight for age for children under the age of 5 years stagnated in the same period.</p>
<p>Outputs</p> <p>A. Family Partnership for Health, Nutrition, and Family Planning</p> <ul style="list-style-type: none"> • Assist families to identify their needs 	<ul style="list-style-type: none"> • 20% annual increase in families able to identify their priorities using FHC 	<p>Field testing of FHC. Selection of family member as family health agent who assisted the work of community development workers in focus groups discussions on identifying priority health problems</p>	<p>Overall Project covered 135,888 families in 654 villages. FHC initially contained too many health issues to be addressed. The information on the FHC collected was more useful for the provider than for the family to enable it to take health care decisions. Only two villages in each project</p>

³³ Indonesia Demographic and Health Survey 2002/2003.

Design Summary	Project Targets	Project Inputs/Activities	Outcomes/Achievements
<ul style="list-style-type: none"> • Inform and educate on health, nutrition, and FP to help them adopt healthy behaviors and lifestyles • Assist in family and community resources mobilization and management • Strengthen local NGOs 	<ul style="list-style-type: none"> • 20% annual increase in number of families reached by IEC in the project area • 50% of “unhealthy” behaviors identified at the beginning have changed • New FP users: + 20% • <i>Dana Sehat</i> (community health financing scheme) promotion • At least one active NGO per district 	<p>Production of TV and radio spots, and print material</p> <p>Health education on personal hygiene promotion and prevention of unhealthy behaviors such as smoking</p> <p>BKKBN conducted training of field workers as part of routine program</p> <p>Income generation aimed to support funding of <i>dana sehat</i> but was used to buy food</p> <p>Capacity building of national, provincial, and district NGOs</p>	<p>district were targeted</p> <p>No reported visits and supervision of families and communities to assess whether IEC has reached the target beneficiaries.</p> <p>While awareness for healthy behavior has been created in areas where community development workers were active, there is no data available, which could reflect how many households have benefited</p> <p>Family planning service availability had declined because of the crisis. Utilization of oral contraceptives declined from 76% in 1997 to 52% in 2000.</p> <p>The <i>dana sehat</i> system has not worked well since the introduction of the SSN health card</p> <p>Only 20% of NGOs performed well at the district level</p>

Design Summary	Project Targets	Project Inputs/Activities	Outcomes/Achievements
<p>B. Quality of Health and FP Services</p> <ul style="list-style-type: none"> • Reorient service providers to the family partnership approach • Develop an integrated delivery system • Strengthen selected health programs by improving equipment and facilities, and technical skills of the providers • Modify and deliver effective IEC materials • Develop managerial skills at all administrative levels 	<ul style="list-style-type: none"> • Front line workers (health center and village level) understand FHN • Health center management (financial, personnel, time) take into account FHN • Outreach teams exist and function • Area-specific IEC materials available • IEC material is appreciated by users (professionals and beneficiaries) • Increased capacity to manage projects at provincial, district, and health center levels 	<p>Training of providers and village health councils</p> <p>Training of health center staff on project management</p> <p>Training of midwives and community development workers</p> <p>Preparation of local radio spots and print materials for professionals and target groups</p> <p>Training and fellowships for project staff on project management</p>	<p>Staff training in some provinces was delayed for 2 years. There was little continuity in project implementation because of high staff turnover in project teams and limited staff availability due to implementation of SSN</p> <p>Frequent staff turnover and overall delayed training activities (after the midterm review)</p> <p>Midwives worked largely at health facility level due to limited mobility.</p> <p>Quarterly project newsletter and a project website had been developed</p> <p>Management of staff training at local level was delayed. In addition, frequent staff turnover due to human resource requirements to implement SSN</p>
<p>C. Monitoring, Evaluation, and Research</p> <ul style="list-style-type: none"> • Project monitoring/and evaluation 	<ul style="list-style-type: none"> • Functioning BME system 	<p>Studies on family health attitudes</p>	<p>BME system was not operationalized largely</p>

Design Summary	Project Targets	Project Inputs/Activities	Outcomes/Achievements
<ul style="list-style-type: none"> • Operational and behavioral research • Prevention of iron deficiency anemia by targeting adolescent girls <p>D. Project Implementation Support</p> <ul style="list-style-type: none"> • Personnel • Consulting Services • Equipment, supplies, travels 	<ul style="list-style-type: none"> • Understanding of the factors influencing health, nutrition, and FP behavior • Assess cost-effectiveness of FHN approach and evaluate conditions for replication • Develop operational strategy to reduce iron deficiency anemia • Timely and appropriate implementation of the Project (human resources, equipment, civil works, financial resources) 	<p>Sentinel surveillance of 10 villages per district to undertake an analysis of behavior change</p> <p>Studies carried out to develop healthy family index and nutrition awareness</p> <p>No cost-effectiveness analysis of interventions was undertaken</p> <p>No inputs</p> <p>Establishment of central, provincial, and district project secretariats. Recruitment of staff. Consultancies for developing plan of operations, research activities, training programs for NGOs, and</p>	<p>because of inadequate technical aspects at the local level and introduction of SSN. BME did not include project impact indicators with the exception of family health behavior. Data was not utilized for decision-making.</p> <p>Concepts and indicators were developed to reflect families' health and nutrition attitudes. There has been no operational research to analyze underlying factors for health behavior and change</p> <p>Study was carried out on health centers activities in FHN and non-FHN areas</p> <p>No strategy</p> <p>In the absence of a project coordinator who was appointed 3 years after project commencement, detailed plans of operations were nonexistent and provinces and districts had little technical guidance on</p>

LIST OF CIVIL WORKS COMPLETED BY PROVINCE

Province	Provincial capital District	Number of Health Facilities ^a Renovated			
		Village Health Facilities	Training and Development Buildings	Media Production Centers	Family Planning Field Worker Supervisors Rooms
North Sumatra	Medan		1	3	
	North Tapanuli	114			5
	South Tapanuli	107			5
	Nias	70			5
Jambi	Jambi		1	3	
	Bungo Tebo	51			5
	Batang Hari	38			5
	Merangin/Sarko	16			5
Bengkulu	Bengkulu		1	3	
	South Bengkulu	54			5
	North Bengkulu	45			5
	Rejang Lebong	61			5
South Kalimantan	Banjarmasin		1	3	
	Tanah Laut	58			5
	Hulu Sungai Utara	53			5
	Tabalong	65			5
Central Kalimantan	Palangkaraya		1	3	
	Kapuas West	39			5
	Kotawaringin	30			5
	North Barito	28			5
Total		829	5	15	75

^a Includes district health offices, health centers and subcenters, village maternity homes, and integrated health service posts.

SUMMARY OF PROJECT COMMODITIES

Project Commodity	Total Quantity
Equipment	
Implant removal kits	750 kits
Laparoscope	1 piece
Mini laparoscope sets	15 sets
IEC equipment	140 units
IEC training models	6 units
IUD kits	70 kits
Ob-gyne beds	70 pieces
MPC package for BKKBN Headquarters	1 package
MPC for districts	32 packages
MPC for subdistricts	163 packages
Mini MPC	1 set
MPC replacement	6 sets
Desktop video equipment	1 piece
Megaphones as village IEC Kit	651 pieces
Computers for HIS	269 sets
Computers for Dana Sehat	34 sets
Teaching ZOE model	30 units
Typewriters for FPFWs	105 units
Furniture for BKKBN district offices	15 units
Furniture for project secretariat	21 packages
Equipment for village health facilities	846 packages
Molds for water supply and sanitation	100 packages
FHN kits to make blended food	68 packages
Weighing scales for adults	750 units
Dacin weighing scales for under-fives	1302 units
Weighing scales for infants	750 units
X-ray machines	10 units
Home economics sets	2100 sets
Dental sets	74 sets
LAN computers	21 units
Laser printers	21 units
LCD equipment	1 piece
Vehicles	
IEC mobile units	22 units
Motorcycles for FPFWs	652 units
Motorcycles for front-line workers	821 units
Motorcycles for CDWs	501 units
Speedboats and canoes	15 units
Automotives	16 units
Mobile health centers	58 Units

Project Commodity	Total Quantity	
IEC Materials		
Growth monitoring cards for under-fives and cards for mother and child health	1,177,450	sheets
Growth charts	210,000	sheets
Manuals, books	9,500	pcs
Microtoise	13,500	pcs
MAC tape	34,000	pcs
FHN cards	230,000	sheets
FHN calendars	3,100	sheets
FHN educational books & media	64,122	manuals
TV serial	16	episodes
Video instructional manuals	123	packs
JPKM books	62,500	pieces
JPKM IEC materials	2,500	packs
Comic Book "Clean Behavior, Healthy Family"	36,500	pieces
Water Supply and Sanitation Participatory Kit	1,200	packs
FHN Bulletin "Warta Berseri"		
- 1 st -7th edition	10,000	pieces
- 8 th -10 th edition	17,000	pieces
- 11 th -14 th edition	10,000	pieces
Takesra and Kukesra books	57,000	pieces
Socio-drama shows	52	episodes
"Program and Audience Analysis"	5	packages
"Formulation of IEC Design"	5	packages
"Media development"	5	packages
"Long distance education"	5	packages
Radio and TV spot packages	7,500	programs
Booklet Development		
- Protocol books	100	pieces
- Flipcharts	1,953	pieces
- Posters	6,510	pieces

BKKBN = National Family Planning, Coordinating Board; CDW = community development worker; FHN = family health and nutrition; FPFW = family planning field worker; HIS = health information system; IEC = information, education, and communication; IUD = intra-uterine device; JPKM = Community Health Maintenance Assurance; MPC = Media Production Center; ob-gyne = obstetrical-gynecological.

REVISIONS IN LOAN ALLOCATIONS

1. The amount of the Asian Development Bank (ADB) loan was reduced twice, by a total of \$7.9 million. From the original \$45.0 million, the final amount became \$37.1 million. The loan amount was progressively reduced because of the devaluation of the Indonesian rupiah during the Asian financial crisis, which resulted in loan savings. The loan amount was first reduced in June 2000 by \$5.4 million because of foreign exchange fluctuations. It was reduced again by \$2.5 million following the pre-country programming review mission in December 2003.

Table A4.1: Loan Allocation
(\$'000)

No.	Category Item	Original Loan Amount	First Change	Second Change	Total Change	Final Loan Amount
1	Civil Works	1,568.0	681.0	681.0	(887.0)	681.0
	MOH	1,169.0	582.0	582.0	(587.0)	582.0
	BKKBN	399.0	99.0	99.0	(300.0)	99.0
2	Equipment and Vehicles	10,765.0	7,349.0	7,349.0	(3,416.0)	7,349.0
	MOH	9,139.0	5,798.0	5,798.0	(3,341.0)	5,798.0
	BKKBN	1,626.0	1,551.0	1,551.0	(75.0)	1,551.0
3	IEC and Materials	5,463.0	5,097.0	5,097.0	(366.0)	5,097.0
	MOH	2,360.0	3,271.0	3,271.0	911.0	3,271.0
	BKKBN	3,103.0	1,826.0	1,826.0	(1,277.0)	1,826.0
4	Consulting Services	4,360.0	2,502.0	2,502.0	(1,858.0)	2,502.0
	MOH	4,323.0	2,487.0	2,487.0	(1,836.0)	2,487.0
	BKKBN	37.0	15.0	15.0	(22.0)	15.0
5	Research Studies (MOH)	583.0	333.0	333.0	(250.0)	333.0
6	Training and Fellowships	5,316.0	7,395.0	7,395.0	2,079.0	7,395.0
	MOH	1,979.0	2,377.0	2,377.0	398.0	2,377.0
	BKKBN	943.0	1,200.0	1,200.0	257.0	1,200.0
	Village Mobilization	2,394.0	3,818.0	3,818.0	1,424.0	3,818.0
7	Workshops and Seminars	2,037.0	4,322.0	4,322.0	2,285.0	4,322.0
	MOH	1,483.0	4,305.0	4,305.0	2,822.0	4,305.0
	BKKBN	554.0	17.0	17.0	(537.0)	17.0
8	Project Implementation Support	2,938.0	2,906.0	2,906.0	(32.0)	2,906.0
9	Interest and Commitment Charges	8,980.0	8,980.0	6,480.0	(2,500.0)	6,480.0
	Unallocated	2,990.0	0.0	0.0	(2,990.0)	0.0
	Total	45,000.0	39,565.0	37,065.0	(7,935.0)	37,065.0

BKKBN = National Family Planning Coordinating Board; IEC = information, education, and communication;
MOH = Ministry of Health.

Source: Asian Development Bank back-to-office reports.

Table A4.2: Dates of Reduction in Loan Amount

Date of Loan Reduction	Amount of Reduction	New Loan Amount
26 June 2000 ^a	\$5.4 million	\$39.6 million
12 December 2003	\$2.5 million	\$37.1million

^a Approved on 11 September 2000 but made retroactively effective to the date shown.

Source: Asian Development Bank.

PROJECT COST BY COMPONENT
(\$'000)

Component	At Appraisal			At Completion		
	Foreign	Local	Total	Foreign	Local	Total
A. Family Partnership for Health						
1. Assist Families to Identify their Needs	0.1	3.8	4.0	0.6	6.7	7.3
2. IEC Dissemination	1.6	3.7	5.3	0.1	3.3	3.4
3. Family and Community Resource Mobilization	2.0	5.4	7.4	0.3	6.4	6.8
Subtotal	3.7	12.9	16.6	1.1	16.4	17.5
B. Improving the Quality of Health Services						
1. Reorient Service Providers	1.5	7.6	9.1	1.7	4.5	6.2
2. Develop Integrated Delivery System	3.9	3.6	7.4	0.3	6.0	6.3
3. Improve Technical Skills of Service Providers	4.1	2.9	7.0	2.0	3.7	5.6
4. Equipment and Drugs	2.1	6.4	8.5	0.8	5.9	6.7
Subtotal	11.5	20.5	32.0	4.8	20.0	24.8
C. Project Monitoring, Evaluation, and Research	0.3	1.8	2.1	0.2	0.6	0.8
D. Project Implementation Support	0.3	3.3	3.5	3.1	0.4	3.5
Total Base Cost	15.8	38.5	54.2	9.2	37.4	46.6
Taxes and Duties	0.0	2.7	2.7	0.0	1.6	1.6
Contingencies	1.5	7.7	9.2	0.0	0.0	0.0
Interest During Construction	8.8	0.0	8.9	5.4	0.0	5.4
Total Project Cost	26.0	48.9	75.0	14.6	39.0	53.6

BPKP = Badan Pengawas Keuangan dan Pembangunan (state auditors); IEC = information, education, and communication. Notes: (i) Totals may not add due to rounding; (ii) Local costs include local government contribution of costs ineligible for loan funding under the Loan Agreement No. 1471-INO. The Government's counterpart funding was taken from annual local budget allocations. Based on BPKP audit reports, withdrawal applications denominated in Indonesian rupiah were submitted using the US Dollar exchange rate of Bank of Indonesia at the time of payment. For withdrawal applications in US dollars, the median exchange rate of Bank of Indonesia at the time of payment was used.

Sources: Basic Data and BPKP audit report on the Family Health and Nutrition Project, 29 September 2004.

SOURCES OF FUNDS FOR PROJECT COSTS
(\$'000)

Source	At Appraisal				At Completion			
	Foreign	Local	Total	%	Foreign	Local	Total	%
External Source								
ADB	26.3	18.8	45.0	60	14.5	17.2	31.7	59
Internal Source								
Government	0.0	30.0	30.0	40	0.0	21.9	21.9	41
Total	26.3	48.8	75.0	100	14.5	39.0	53.5	100

ADB = Asian Development Bank.

Note: The Government's counterpart funding was taken from annual local budget allocations.

PROJECT IMPLEMENTATION SCHEDULE

Activities	1997				1998				1999				2000				2001				2002				2003			
	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
Structure in Place	█																											
First national workshop		█																										
Training/IEC needs identification			█																									
Design/Production of training packages			█																									
Plan of operations ^a			█																									
Engagement of CD consultants			█																									
Preparation HIS (needs, prototype) ^b			█																									
Selection research teams/study design			█																									
Training of province trainers			█																									
CD experts on location				█																								
Training 1st group field teams (72 villages)				█																								
CD experts train field workers and NGOs				█																								
Continuous guidance for FHN field teams				█																								
Self-survey				█																								
Benchmark survey				█																								
CD team starts community building				█																								
Train 2nd group field teams (240 villages)					█																							
Train 3rd group field teams (720 villages)						█																						
Train 4th group field teams (480 villages)							█																					
Midterm evaluation																												
Second national workshop																												
Expansion/consolidation																												
BME activities ^c																												
Operational/behavioral researches																												
National seminars																												
Final evaluation																												
Final national workshop																												

IEC = Information, Education and Communication, CD = Community Development, HIS = Health Information System, NGO = Non-Government Organization, FHN = Family Health and Nutrition, BME = Benefit Monitoring and Evaluation, EA = Executing Agency, BKKBN = National Family Planning Coordinating Board, PCR = Project Completion Report.

^a This was never implemented.

^b HIS was never operationalized.

^c The BME system did not include project key indicators.

Notes: BKKBN implementation was only up to year 2001. The Loan was extended by 15 months, from its original loan closing date of September 2003 to December 2004. Government PCR produced in March 2004. ADB PCR in June 2005.

STATUS OF COMPLIANCE WITH LOAN COVENANTS

Covenant	Reference in Loan Agreement	Status of Compliance
Particular Covenants		
1. The Borrower shall make available promptly as needed the funds, facilities, services, land, and other resources which are required in addition to the proceeds of the loan, for carrying out of the Project and for the operation and maintenance of the project facilities.	Section 4.02	Partly complied with. Delay in the receipt of local budget allocations resulted in delayed project implementation.
2. Submission of annual Audit reports.	Section 4.06 (b)	Complied with.
3. Quarterly Progress Report	Section 4.07 (b)	Partly complied with. Progress reports do not include BKKBN activities.
4. After physical completion of the Project, but not later than three months thereafter, the Borrower shall prepare and furnish to the Bank a report on the execution and initial operation of the Project, including its cost, the performance of the Borrower and accomplishment of the purposes of the Loan.	Section 4.07 (c)	Complied with. Project completion report received on 31 March 2004. Data submitted were incomplete. Government assessment is not in line with ADB's findings during PCR mission.
5. The Borrower shall make arrangements satisfactory to the Bank for insurance of Project facilities to such extent and against such risks and in such amounts as shall be consistent with sound practice.	Section 4.09	Not complied with. There is no insurance for such facilities in Indonesia.
Sector Covenants		
6. The intersectoral Project Coordination Committee (PCC) established under Loan No. 926-INO shall continue to provide operational policy guidance and facilitate interagency coordination. The project director will serve as chairman and the Deputy Project Director shall be the vice chairman for meetings of the PCC. PCC shall meet at least twice a year to discuss the Project.	Schedule 6, para. 5	Partly complied with. A new PCC was established by the Minister of Health on 26 November 1996 for the FHN Project. PCC changed frequently.
7. Within one month after the effective date the Borrower shall establish a Central Project Steering Committee (CPSC), which shall be responsible for advising the Central Project Manager on technical and administrative issues for facilitating Project coordination.	Schedule 6, para. 6	Complied with.

Covenant	Reference in Loan Agreement	Status of Compliance
8. Within one month after effective date, Borrower shall designate in each Project province the chief of MOH Provincial office (Kepala Kanwil Kesehatan) as Provincial Project Manager and the chairman of Provincial BKKBN office as the Deputy Provincial Project Manager.	Schedule 6, para. 7	Complied with.
9. Within one month after effective date, Borrower shall establish in each Province a Provincial Project Steering Committee (PPSC). The chairman of Provincial Planning Agency (BAPPEDA I) shall serve as chairman, and the chief of Provincial Health Services (Kepala Dinas Kesehatan) shall be deputy chairman. The PPSC shall meet at least once every three months.	Schedule 6, para. 9	Partly complied with. Local government is not sufficiently involved in project implementation.
10. Within one month after effective date, the Borrower shall designate in each district participating in the Project the Head of the District Health Services (Dokabu) as the district Project Manager and the head of the district office of BKKBN as the deputy district Project Manager.	Schedule 6, para. 10	Partly complied with. BKKBN had no deputy district project manager.
11. Within one month after effective date, the Borrower shall appoint in each district participating in the Project a District Administrative Officer to supervise day-to-day Project activities in the district supported by a number of qualified staff.	Schedule 6, para. 11	Complied with.
12. Within one month after effective date, the Borrower shall establish in each participating district in the Project a District Family Health and Nutrition Committee (DFHNC) which shall meet once every three months.	Schedule 6, para. 12	Complied with. The name of the committee was the Community Health Council.
13. The Borrower shall ensure that the Village Head (Kepala Desa) of each village participating in the Project establishes a Village Health Committee.	Schedule 6, para. 13	Complied with.
14. The village health committee will identify community health projects to be financed under the Project, submit the proposals to DFHNC, and follow up implementation.	Schedule 6, para. 14	Complied with.

Covenant	Reference in Loan Agreement	Status of Compliance
<p>15. The Borrower shall ensure that in each village participating in the Project that there is at least one properly trained village midwife, nurse, or other appropriately trained front line worker per 100 project beneficiary families at all times during the Project implementation period. The Borrower shall also ensure that the health centers for the project villages are given priority in the appointment of district doctors.</p> <p>16. The Borrower shall ensure that the recipient of the overseas fellowships and local training under the Project, upon completion of the training, remain employed in the related positions for the period stipulated by the Borrower's standard regulations.</p> <p>17. Within three months after effective date, the Project Director shall submit to the Bank for approval (i) proposed program for operational research under the Project, with prioritized areas of study and a detailed plan of action; and (ii) proposed program of research on family health and nutrition issues to be supported under the project.</p>	<p>Schedule 6, para. 15</p> <p>Schedule 6, para. 18</p> <p>Schedule 6, para. 19</p>	<p>Partly complied with. Contracts for village midwives were limited to 3 years and extensions were not always given.</p> <p>Partly complied with. Although all local training was completed during the Project period, overseas fellowships were not completed because PhD students were identified in the last year of project implementation, leaving not enough time for them to complete their studies by the end of the Project in 2003. Most diploma and master studies were completed.</p> <p>Not complied with. There was no detailed plan of action for research and studies because of a lack of coordination among the various implementing units in MOH.</p>
<p>18. During project implementation, the Borrower shall carry out BME activities on a continuing basis. Within six months after loan effectivity, MOH shall provide to the Bank for its approval a program for BME. Such program shall cover at least 10 Project villages in each Project district as well as 10 non-Project villages in each Project district with similar socio-economic conditions as controls.</p> <p>Benefit Monitoring and evaluation program to be established, with comparison between villages in the Project area and outside the Project area.</p>	<p>Schedule 6, para. 21</p>	<p>Partly complied with. Consultants arrived 24 months after loan effectivity. BME activities began, and in the first year, six villages were covered. By November 2001, BME activities covered 12 districts in 4 provinces (excluding South Kalimantan). At Project completion, BME activities covered all districts in the five Project provinces. The BME system did not include Project key indicators.</p>

Covenant	Reference in Loan Agreement	Status of Compliance
Social Covenants		
19. The Borrower shall consult with the Bank on the recommendations which will be made under the Bank-financed TA for Resource Mobilization and Budgeting for Decentralized Services and shall take all necessary steps to implement the agreed-upon recommendations.	Schedule 6, para. 24	Complied with. No integrated budgets since decentralization.
Financial Covenants		
20. The Borrower shall ensure that the project funds are disbursed through the Integrated Health Planning and Budgeting procedure (DIP).	Schedule 6, para. 23	Complied with. Before decentralization, all foreign disbursements went through the national budget (Anggaran Pembayaan Belangiya Negara – APBN). With decentralization, there was no integrated budget.
Others		
21. Established, Staffed, and Operating PMU/PIU. Within one month of loan effectiveness, the Government shall designate the following: a. Director General of Community Health of MOH as Project Director and Deputy for Planning and Program Analysis of BKKBN as Deputy Project Director. b. Director of Family Health of MOH as the Central Project Manager and Chief of Bureau of Planning of BKKBN as Deputy Central Project Manager. c. Borrower shall establish a Project Secretariat which will assist the Central Project Manager with overall planning, budgeting, coordination, and execution of the Project.	Schedule 6, paras. 2 , 3, and 4	Complied with. There was no Project Secretariat for BKKBN.
22. Fielding of Consultants	Schedule 5	Complied with. Recruitment of consultants was delayed for 13 months.
23. Within six months of Loan effectiveness, the executive secretariat shall submit to ADB a program for overseas training and study tours.	Schedule 6, para. 16	Not complied with. Late submission of proposed candidates for overseas training by provinces.

Covenant	Reference in Loan Agreement	Status of Compliance
24. Within six months after effective date, the Borrower shall prepare program for local training and study tours for project staff.	Schedule 6, para. 17	Not complied with. Late submission of local training requirements by the provinces.
25. Mid-term review will be carried out in the third year of Project implementation to assess the Project's progress and achievements against its objectives as well as to identify any problems encountered and to recommend remedial measures if required.	Schedule 6, para. 22	Complied with. Proposed activities did not fully meet Project objectives. Target indicators were not adjusted.

ADB = Asian Development Bank; BAPPEDA 1 = Provincial Planning Agency; BKKBN = National Development Planning Agency; BME = benefit monitoring and evaluation; CPCSC = Central Project Steering Committee; DFHNC = District Family Health and Nutrition Committee; MOH = Ministry of Health; PCC = Project Coordination Committee; PPSC = Provincial Project Steering Committee; TA = technical assistance.