

**Feedback from William M. Fraser, former ADB projects officer involved in the SPSPD and HNSDP projects**  
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## Introduction

1. The Social Protection Sector Development Program (SPSPD) and the parallel Health and Nutrition Sector Development Program (HNSDP) were prepared in unusual (perhaps unique) circumstances. It could be assumed that the SPSPD/HNSDP experience might not be directly applicable/comparable to more conventionally prepared and implemented ADB projects but there are still useful lessons to derive that are not captured by the PER. This is partly attributable to a static/conventional approach to post-evaluation. The PER emphasizes the “what” of the SDPs rather than the “why” or “how” and in doing so overlooks some potentially useful lessons for ADB and the Government. The PER addresses many of the central issues and achievements of the SPSPD (and parallel HNSDP) but incomplete ADB records and/or loss of institutional memory result in several errors of fact and limit the rigor of the analysis of the SDP successes (and failures). The potential benefits of the PER process in terms of lessons learned for future project design and implementation and for improved and more responsive internal procedures are not fully realized. This is not intended as a criticism of those involved in PER preparation but points to broader issues of retention and use of operationally relevant information within ADB. Given the unusual circumstances of SDP preparation and implementation, it would be instructive to compare the SPSPD and HNSDP with contemporary ADB SDPs (notably the Community and Local Government Services SDP (CLGSSDP)), and examine timelines before and after approval.

2. Although the PER focuses on the SPSPD, it is virtually impossible to separate the SPSPD and HNSDP when discussing design or implementation issues. PER coverage of the SPSPD health sector component is limited – there is no mention of the health sector in the Executive Summary although there is some discussion of health in the text. This may be an editorial decision since the health components of the SPSPD were discussed more fully in the PER for the HNSDP. However this separation is largely arbitrary given the substantial overlap of SPSPD and HNSDP<sup>1</sup>.

3. It is also difficult to separate the initiatives and activities of the SDPs from those introduced subsequently under the broader social safety net (Jaring Pengaman Sosial or JPS) supported by Government and other donors. Although the SPSPD and HNSDP acted as the catalyst, some activities initiated subsequently by Government under the JPS umbrella may have detracted from overall SDP impacts by causing a loss of focus and diffusing the attention of overburdened Government staff. Throughout SPSPD and HNSDP implementation there was constant tension between the narrow focus on the poor and most vulnerable prescribed by the SDPs and the temptation to stretch coverage to include more beneficiaries as additional resources became available. For example, it was difficult for front-line personnel to deny scholarships to the near-poor (or non-poor) or to provide supplementary feeding to poor children, often within the same family, outside the originally defined age range.

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<sup>1</sup> The SPSPD was approved 9 July 1998. HNSDP Fact-finding took place from 18 November to 4 December 1998 and the HNSDP was approved 25 March 1999, nine months after the SPSPD.

## **SDP Design, Scope and Implementation Arrangements**

4. The PER takes a fairly static view of the SPSDP although circumstances demanded a far more process-oriented approach in design and implementation than was typical of contemporary ADB projects. The SDP designs were less deterministic than conventional projects since they were developed in a rapidly-changing environment of great uncertainty. Concrete data, e.g., on the distribution and severity of crisis-related impacts on the poor, was not readily available; what data existed were often incomplete, unreliable and contradictory. However, delaying introduction of a social safety net until reliable data became available was not an option since delay would exacerbate consequences of the crisis that could be irreversible, e.g., nutritional deficiencies among mothers and infants.

5. The SPSDP was designed with the expectation that many changes in scope or implementation arrangements would be required during implementation as additional resources were mobilized from other agencies, and as better data on the differential impacts of the crisis emerged to improve targeting of resources. The simplified resource allocation and funds flow mechanisms and decentralized management arrangements developed under the SPSDP were designed to be responsive to changing needs and sufficiently flexible to accommodate anticipated changes.

6. It is important to recognize that, as the SPSDP was being designed, no other external assistance to ensure continued functioning of the social sectors had been committed or was anticipated. External assistance from other sources was being proposed primarily as general budget support and aimed at addressing identified deficiencies in the financial sector. The World Bank was developing a Social Safety Net Adjustment Loan (SSNAL) intended to improve functioning of existing safety nets, to improve “problematic, ineffective, delayed or outright corrupt” Government institutions<sup>2</sup>, to protect social expenditures crucial to the poor, and to eliminate ineffective or poorly targeted programs<sup>3</sup>. Shortly before SPSDP approval, the World Bank reallocated substantial anticipated savings within several on-going education sector loans to expand the school block grant and scholarship component developed under the SPSDP. Other external agencies also began to commit assistance to the education sector. Formal changes in scope and implementation arrangements of the SPSDP were processed to accommodate the actions of the World Bank and other aid agencies e.g., provincial coverage of the SPSDP education component had to be adjusted to complement the World Bank resources and to minimize administrative overlaps.

7. However, although the SPSDP catalyzed substantial additional assistance for education, the Government and ADB were unable to mobilize additional assistance to complement the SPSDP health, family planning and nutrition activities. Accordingly, the HNSDP was processed to reinforce and expand coverage of the SPSDP health components. Subsequent reallocation of funds within the SDPs to reflect changed geographical responsibilities for education and expanded ADB responsibility for health, and to respond to evolving needs, further blurred the distinctions between the SPSDP and HNSDP.

8. Although the SPSDP had anticipated, and circumstances demanded, frequent changes in scope or implementation arrangements during implementation, the PER tends to view such

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<sup>2</sup> An internal World Bank report, written in late 1997, had been leaked to the national press in August 1998. The report suggested 20-30 percent of World Bank lending might have been lost to leakage, inefficiency or diversion by government officials and politicians.

<sup>3</sup> Programs protected included scholarships and school programs, sale of rice at subsidized prices, employment creation schemes and imports of inputs for generic medicines.

changes negatively. Since most ADB projects are planned in detail based on data assembled prior to approval, changes in project scope or implementation arrangements tend to be viewed as a reflection of inadequate preparation or oversight. The PER attributes many such changes to delays in implementation of the health sector component. While the health sector component was inherently more complex, and did encounter delays during implementation (see below), the changes in scope primarily reflect rationalization and consolidation of resources to facilitate implementation and disbursement<sup>4</sup>.

9. The PER para 17 notes that changes during implementation (specifically expansion of the scholarship and school grants programs) did not adversely affect other programs or components because there were adequate savings “due to initial overestimation of the allocation for school block grants and delays in procurement of blended infant food”. Savings were largely due to exchange rate changes during implementation rather than errors in initial cost estimates<sup>5</sup>.

10. More significantly, PER para 84 suggests that the “striking difference in the Government’s financial commitment to the education sector and the combined health, nutrition and family planning sector raises questions about the composition of the SPSDP.” This inference appears based on the actual utilization of SPSDP resources and does not consider the parallel funding for health, nutrition and family planning provided through the HNSDP. Availability of the HNSDP with its resources devoted entirely to health, nutrition and family planning, allowed an increase in SPSDP education sector expenditures without compromising SPSDP health objectives. While it could be argued, in aggregate terms, the Government spent less on health, nutrition and family planning than it did on education, this reflects abundant external assistance for education and the dearth of external assistance for health rather than a SPSDP design issue.

11. Para 84 continues: “The health sector suffered from complexity of design, slow implementation preparation, and during implementation a follow-up program became available (i.e., the HNSDP). If so, in hindsight, the wisdom of the SPSDP could well be called into question. Should the SPSDP have continued as a two sector investment, both very complicated, and charted unknown territory at a time of fundamental sociopolitical turmoil and changes? Or should the two sectors have been separated into different loans?” As noted above, when SPSDP was processed there had been no commitment of resources for the social sectors from any external agency (apart from a portion of the promised World Bank SSNAL) and there was no guarantee of any ADB social sector assistance beyond the SPSDP. The SPSDP was designed within available resources to address the most critical social impacts of the crisis. The later availability of additional resources, including the HNSDP, allowed SPSDP-supported programs to expand to cover larger numbers of people at-risk. The PER suggestion that it would have been preferable to focus on either education or health or to process two parallel loans simply does not reflect reality at the time SPSDP was being processed. Even had it been possible from a resource perspective to process parallel interventions, the operational benefits would have been limited. The SPSDP and HNSDP adopted complementary policy frameworks and the same basic implementation structure.

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<sup>4</sup> References to delays in the SPSDP health and family planning and nutrition components in PER paras 19, 20(iii) and 20 (v) should be reconsidered in this context.

<sup>5</sup> PER FN36 correctly notes that “initial cost calculations were based on US dollar unit costs. The sharp depreciation of the rupiah allowed increased coverage of ADB support”. Para 20(i) states that “expansion was made possible due to doubling and even tripling of the exchange rate between the time of budgeting, loan fact-finding and loan approval”. Internal inconsistencies in the PER should be corrected.

## Context – KKN and Decentralization

12. Preparation, processing and initial implementation of the SPSDP occurred during a period of rapid and fundamental political, as well as social, change in Indonesia. The financial crisis began to affect Indonesia in the third quarter of 1997: between August 1997 and early 1998 the value of the rupiah declined by 70 percent. Domestic financial and social instability increased. Riots in Jakarta (14 May 1998) triggered the resignation of President Suharto 21 May 1998<sup>6</sup>. The monetary crisis, *Krismon* (Krisis Moneteris), of August 1997 had become the *Kristal* (Krisis Total).

13. PER para 92 notes “the SPSDP was designed, executed and completed under a still highly centralized regime right before decentralization took effect in January 2001”. This is partly correct. After 30 years of centralized rule, strong pressure was felt by the Habibie administration to give local governments a greater voice. The first Regional Autonomy Law, under which power was devolved primarily to district and municipal governments was adopted in May 1999. A revised law on decentralization was adopted with effect from January 2001. When the SPSDP and HNSDP were designed the Government was highly centralized with a monolithic administrative structure: provincial governors, district heads, municipal mayors, and village heads were all appointed by central government generally from within the military or government bureaucracy. The SPSDP and HNSDP strongly advocated decentralization of basic social services. The most important SPSDP innovations were the delegation of decision-making authority over resources to districts, providing incentive mechanisms (unfortunately not fully utilized) to reward desired behaviors (e.g., for schools and health centers to become more actively engaged in outreach), consolidating budgets at the school and health center level, and decentralizing authority for planning and management as the basis for more efficient management, greater accountability, transparency, and local accountability and improved responsiveness to the needs of the community.

14. The SDPs anticipated (some observers<sup>7</sup> suggest the SDPs may have triggered) broader Government devolution programs but under-estimated the speed of administrative decentralization. The rapid acceleration of decentralization between 1999 and 2001 did adversely affect SDP implementation since, among other things, uncertainty about the division of responsibilities among levels of government delayed planned financial systems development and staff training programs.

15. Corruption within the bureaucracy was endemic. As noted in PER FN30: “At the time of SPSDP implementation, Indonesia was suffering from the crisis and still in its infancy of reforms, fighting what was known as KKN (corruption, collusion and nepotism) toward improved governance. Hence the emphasis was on ensuring funds flows to final beneficiaries, eliminating intermediaries while assuring proper use of funds by block grant recipients. Demands for good governance practices of accountability and transparency were only developed thereafter.” As noted above, the SDPs were designed specifically to encourage greater accountability, transparency, and local responsibility.

16. It is not correct to conclude (PER para 41): “Due to the novelty of numerous initiatives under the SPSDP, no lessons were available from earlier projects on how to manage and administer a program of this size and complexity.” ADB had extensive experience with pre-crisis

<sup>6</sup> SPSDP Fact Finding was completed April-May 1998. Loan negotiations, delayed as a result of the civil unrest, were held in Jakarta 11-12 June 1998. The SPSDP was approved 9 July 1998.

<sup>7</sup> Annette Clear of the University of California at Santa Cruz noted in *Indonesian Decentralization and Civil Society: Opportunity or Obstruction* that “the process of decentralization was sped up to meet the funding cycle of the ADB.

project implementation in Indonesia and the lessons were clear: rapid and effective action critically depended on avoiding and/or bypassing centralized decision-making and established Government budgeting and funds transfer systems. The block grant funding mechanism and the use of non-Government channels (i.e., using post office accounts) increased local management control, greatly accelerated the speed of funds transfer and substantially reduced leakage.

17. The PER is critical of achievements under the SPSDP in reducing corruption (Appendix 5, para 31). Although the SPSDP innovations provide effective mechanisms to reduce leakage in funds transfer and to increase transparency, these initiatives must be sustained and strengthened over several years to have a discernable impact on endemic corruption. To expect significant changes within the life of the SDPs is somewhat optimistic but a Governance and Decentralization Survey (2004) by Gajah Mada University supported by the World Bank concluded “large majority of Indonesians see improvements in public health, public education and local administration in the aftermath of decentralization” (65% of respondents cited improvements in public health services, 60% cited improvements in public education). However, the survey also confirmed that corruption and inefficiency continued to impede delivery of quality services: 36% of respondents admitted that they had to pay bribes for public services.

### **Health Sector – The Role of Health Cards and JPKM**

18. The PER para 48 notes that health cards (*kartu sehat*) were “first introduced by the SPSDP and continued through the HNSDP and beyond”.<sup>8</sup> This is not correct. Health cards predated the SPSDP<sup>9</sup>. Health cards were distributed by village heads and were often misused: recipients were frequently village employees or well-connected families, rather than the poor. Initially, only families with valid residence permits were eligible for health cards. Since Government discouraged rural-urban migration, it was sometimes difficult – without payment of facilitating fees – to obtain a residence permit. In addition to the substantial moral hazard associated with the capture and use of the cards by the non-poor, the health cards, as initially implemented by the Ministry of Health (MOH), were linked to specific health centers and might not be accepted by health centers elsewhere, geographically limiting access to health care.

19. The SPSDP and HNSDP focused on improved service delivery, particularly of those services most important to the poor, and required MOH to maintain a package of essential services accessible to all, including basic curative and preventive services such as vaccination, antenatal consultation, and micronutrient supplementation where indicated. The principle adopted for the SPSDP (and HNSDP) was that service should be provided to those identified or recognized as poor by the health service providers regardless of whether they were able to present a health card. During SDP preparation, it was feared that the urban poor, particularly seasonal migrants or those who had recently migrated in search of work, would not have residence permits and hence could not obtain health cards. The SPSDP and HNSDP required Government to review targeting and entitlement mechanisms to ensure that administrative requirements did not act as a barrier to access to basic health services and emphasized measures to ensure access to free health care for the truly needy without health cards.

20. The capture of health cards by the non-poor also creates problems in planning and monitoring utilization of health services: utilization statistics tend to record presentation of the card rather than the true status of the user (i.e., the user of a card is presumed to be poor

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<sup>8</sup> Appendix 5 para 20 also states incorrectly: “The poor families are eligible to receive a health card (*introduced under the SPSDP*) from the health centers and countersigned by the village head...” (emphasis added).

<sup>9</sup> See the HNSDP RRP (para 21 and Appendix 2, para 16).

although fewer than half of card holders would be eligible for free care if criteria were applied strictly).

21. Similarly ADB did not support or endorse general introduction of the Community Health Managed Care program (*Jaringan Pelayanan Kesehatan Masyarakat or JPKM*) through SPSPD or HNSDP. JPKM was based on a 1992 law on managed care and had been tested on a limited scale in the mid-1990s with assistance from the United States Agency for International Development (USAID). Initial trials demonstrated that the JPKM model developed by MOH was unsustainable and administratively complex. ADB recognized that it would be especially difficult to develop community health insurance schemes in communities with reduced income, where scarce household resources would be consumed meeting basic needs. Accordingly, the SDPs focused on health service delivery, rather than health financing deferring more intensive exploration of health financing issues to a later date by those agencies already active in this area, notably the World Bank and USAID.

22. However MOH strongly advocated an immediate national roll-out of JPKM, including establishing administrative offices (and appointing salaried staff) in each of the more than 300 districts and municipalities. In context of the SPSPD it was agreed only to support further testing of JPKM in four districts in Central Java<sup>10</sup>. ADB agreed to the limited pilot test expecting it would demonstrate that the pre-conditions for a successful national JPKM program did not exist. The pilot test was expected to fail and it did.<sup>11</sup> The PER assesses the pilot managed care scheme as ineffective, inefficient and unsustainable – confirming the ADB position during SDP processing. However, the pilot test did succeed (at least temporarily) in avoiding the substantial wastage of resources inherent in the national JPKM plan.

### **Procurement Issues**

23. PER para 16 notes that “procurement of contraceptives using ICB proceeded as planned, in part due to the extensive experience in this area of BKKBN. Lack of MOH experience with ICB processing and/or staff for blended food procurement caused considerable delays”. In fact, delays were encountered for both contraceptives and blended food. The principal cause of delayed procurement was not inexperience but reluctance of the agencies to accept procurement abroad.

24. Extensive discussions were held during SPSPD processing with the World Food Programme (WFP) and UNICEF to coordinate approaches to the production, procurement and distribution of nutritionally adequate complementary food for children between 6 and 12 months of age (i.e., blended food)<sup>12</sup>. These discussions highlighted concerns about the capacity of domestic manufacturers to supply the required quantities of blended food within the timeframe envisaged. ADB therefore insisted on ICB procurement although agreed to domestic procurement to provide urgently needed interim supplies.

25. With respect to contraceptives, ADB’s insistence on ICB procurement was primarily based on cost considerations. Throughout the 1980s and 1990s Government had promoted the

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<sup>10</sup> See the HNSDP RRP (para 24 and Appendix 2, paras 17,18).

<sup>11</sup> Para 20(iv) states (correctly) the JPKM scheme “was strongly supported by MOH but attracted little public support, (and) was judged by the PCR as not particularly successful.” Para 35 adds “The less than satisfactory outcome of the managed health care scheme which the PCR claims had strong MOH support but attracted little public support, should come as no surprise.” Certainly it was not a surprise to ADB.

<sup>12</sup> The selected product met WFP and UNICEF guidelines for infant complementary foods. The food was distributed in distinctive packages, to reduce resale or diversion, adequate for one child for one week.

domestic manufacture of drugs (in reality, manufacture consisted mainly of compounding of imported ingredients and packaging). Domestic value added was small with high import content of most pharmaceuticals (60 – 80 percent). State-owned companies effectively monopolized domestic supply and distribution of drugs: through the 1990s about 80 percent of pharmaceutical needs and all vaccines used in the public health system were sourced from four state-owned enterprises. Limited competition, inefficiency and high mark-ups and profit margins resulted in drug prices that were high by international comparison. To ensure timely and cost-effective procurement, ADB insisted on ICB<sup>13</sup>.

26. Although BKKBN effectively managed the ICB tender process, once it became apparent that two foreign-based suppliers had quoted substantially lower prices for low-dose oral contraceptives, BKKBN resisted the award to the lowest-priced bidder citing the need to conduct full clinical trials (although the domestic product of identical chemical composition had been in use for several years) before the contraceptives could be registered with the MOH. BKKBN argued that the clinical trials would require at least six to nine months and the tender should therefore be awarded to the domestic supplier. ADB did not accept this argument and after some delay BKKBN accepted ADB's position

### **Funds Flow and Disbursement Issues**

27. PER discussion tends to focus on the block grant funding mechanism and the use of non-Government channels (i.e., using post office) to accelerate funds transfer and substantially reduce leakage. While the block grant mechanism was an important innovation, it was part of a larger package of reforms aimed at increasing local management control, responsibility and efficiency of resource use. The most important innovations were the delegation of decision-making authority over SDP resources to districts, consolidating budgets at the school and health center level, and decentralizing authority for planning and management as the basis for more efficient management<sup>14</sup>, greater accountability, transparency, and local accountability and improved responsiveness to the needs of the community. Much more rigorous analysis of the impact of these innovations would appear desirable, perhaps through a separate study.

28. Para 17 of PER Appendix 5 states that Bank Rakyat Indonesia (BRI) "refused to participate in the SPSDP". More accurately, during SPSDP processing it was anticipated that BRI would act as the funds conduit but BRI's refusal to waive or reduce account management fees caused ADB and the Government to use the post office network instead. In retrospect, this was beneficial since the post office had a larger network of offices that were more readily accessible by some beneficiaries and the overall financial cost was much less.

29. The emphasis given to the block funding mechanism also overshadows the importance of parallel (vs joint) financing of activities. The SPSDP and HNSDP employed parallel rather than joint financing with ADB and the Government each financing 100 percent of defined activities. The parallel CLGSSDP employed conventional joint financing of a series of discrete subprojects. Since ADB and Government resources jointly supported each subproject, it was necessary to directly match or link ADB and Government inputs. ADB pre-crisis project experience demonstrated that timely availability of Government resources was often constrained by weaknesses or delays in the domestic budget process. Parallel financing

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<sup>13</sup> In earlier ADB-financed health sector projects, the supply of drugs and pharmaceuticals was financed by the Government since domestic procurement was not acceptable to ADB.

<sup>14</sup> The SDPs also promoted introduction of incentive mechanisms to reward desired behaviors (e.g., for schools and health centers to become more actively engaged in outreach). Unfortunately, these mechanisms were not fully developed or extensively utilized.

avoided many the rigidities and delays inherent in processing and/or amending the Government budget.<sup>15</sup> A comparison of disbursement performance of the SPSDP, HNSDP and CLGSSDP might be instructive and encourage broader application of parallel financing approaches.

30. PER para 58 notes “A major problem in project implementation was delays in replenishing the imprest account”. PER para 88 adds “The beneficiaries of the supplementary feeding program suffered from discontinuation and/or interruptions in their program arising from delays in procurement which in turn was caused by delays in replenishment of the imprest account”. SPSDP design anticipated delays in liquidating and replenishing the imprest/special account since the process required the consolidation of expenditure statements from more than 300 districts, many of which were remote and/or had limited financial reporting capacity. During processing of the SPSDP, the initial deposit for the special account was set at \$50.0 million specifically to accommodate delays in replenishment. However, during processing of the HNSDP, the initial deposit for the special account was arbitrarily reduced to \$20.0 million.<sup>16</sup> The smaller special account was exhausted before the district expenditure statements could be collected and consolidated. Increasing the HNSDP special account from \$20.0 million to \$50.0 million as proposed during processing required approximately six months of staff effort post-approval.

31. Delayed release of the second tranches of the HNSDP (and SPSDP) policy loans is a separate issue. Although not mentioned in the SPSDP PER, the earlier Special Evaluation Study of Crisis Management Interventions (August 2001) concluded that “implementation of policy reforms under HNSDP (was) slower than envisaged. As a result the release of the second tranche was delayed by nine months.” A close examination of the policy matrix would show timely implementation of all policy reforms within the purview of MOH; the delay in the release of the second tranche was attributable solely to delayed action by the Ministry of Finance (MOF) on the one condition for which it was responsible (which required, simply, that MOF establish a working group). The release of the second tranche of the SPSDP policy loan was also delayed approximately 7 months, although most of this delay was attributable to the tardy finalization of a revised letter of intent with the IMF. SPSDP policy conditions were fulfilled by November 1999 but the IMF letter was not signed until January 2000 permitting the tranche to be released in February 2000.

## **Gender Bias**

32. The PER includes several references to perceived gender bias in SPSDP design that are, unfortunately, based on errors of fact or interpretation. PER para 47 is incorrect on many levels and should probably be deleted in its entirety, as should paras 91 and 95 that are based on the same misreading of facts or misunderstanding of loan covenants.

33. The PER sees the SPSDP education component as overly biased in favor of girls, in part because ADB was unaware that more girls than boys were enrolled in junior and senior secondary education (the opposite of most developing countries). PER para 47 says “For ADB, there is a need to avoid stereotypical policies adopted in response to worldwide gender-based calls for action, as spelled out in the Millenium Development Goals (MDGs).” In addition to being anachronistic (the MDGs were not adopted until September 2000, 2 years after the SPSDP was processed), a cursory review of contemporary ADB Indonesia education sector projects will

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<sup>15</sup> The Government budget was formally amended three times in 1998, contributing in each case to substantial delay and confusion in the implementation of many externally-funded projects.

<sup>16</sup> “Normal ADB practice” limited the size of a special account to 10% of the total loan amount.

demonstrate that ADB was fully aware of gender disparities in junior and senior secondary education. The SPSDP tried to ensure all junior secondary students then enrolled continued in school<sup>17</sup>. Given that more girls than boys were enrolled in junior and senior secondary education, especially in madrasahs (religious schools under the Ministry of Religious Affairs), the SPSDP objective was to ensure that the allocation of scholarships did not discriminate *against* girls; it did not call for girls to be given proportionately more scholarships than then-current enrollments justified. The SPSDP required only that girls receive at least half of the scholarships.

34. PER para 91 claims “the project applied a stereotypical gender requirement, ensuring equal distribution between boys and girls on the assumption that without such affirmative action in favor of girls they will be prevented from attending school.” Although there was little reliable data on differential enrollment or drop out rates at the time of SPSDP processing, a contemporary World Bank study<sup>18</sup> on the impact of the crisis on basic education found that overall enrollments at the primary and junior secondary levels had fallen most sharply in urban areas, most notably in Jakarta, and most starkly for females at the junior secondary level<sup>19</sup>. The World Bank study, in isolation, would have justified a stronger bias in favor of girls than adopted by the SPSDP.

35. The issue of perceived gender bias is also raised with reference to street children activities<sup>20</sup>. The Executive Summary of the SPSDP PER notes the HNSDP PER apparently assessed the street children component “as less effective because of the rising numbers seeking the benefits and gender bias in program design, which was not assessed by this evaluation.” SPSDP PER para 74 states “the TA also provided a comprehensive approach involving the community, taking into account the special needs of girl street children”. Para 76 comments that the TA “was highly effective in reaching its objectives” and notes the TA completion report rated the TA as highly successful but “the HNSDP PPER rated this component as less effective”. If there is such sharp disagreement on the effectiveness of a shared component in the two PERs, further examination appears warranted to resolve the contradiction.

36. SPSDP PER para 31, discussing the (many positive) achievements of the street children component, appears to conclude that the number of street children increased during the crisis (as was expected during SPSDP processing). However, the paragraph continues “The OEM believes that even if the number of street children in fact increased, that phenomenon cannot be attributed to the component, which was of rather modest size.” This appears to suggest that the

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<sup>17</sup> The SPSDP focused on junior secondary schools and students since it was judged they would be most vulnerable and at greatest risk of dropping-out. JPS coverage was extended to cover senior secondary students and schools as resources became available from World Bank and other sources.

<sup>18</sup> *The Impact of Indonesia's Economic Crisis on Basic Education: Findings from a Survey of Schools*; World Bank and Ministry of Education and Culture, Indonesia, 25 November 1998. This study was referenced in the HNSDP RRP (Appendix 8, para 4).

<sup>19</sup> PER para 29 and FN29 include gratuitous comments on the expected severity of crisis impacts on education noting that the Scholarships and Grants Program “exceeded expectations, especially in light of a fear instilled by mostly exaggerated estimates prepared at the time”. FN29 lists several World Bank studies and statements that anticipated sharp declines in school enrollments. In the absence of better data these “doomsday predictions” were based on actual experience in Indonesia during the oil shocks of 1986/1987 (when enrollments did drop sharply and did not fully recover for several years).

<sup>20</sup> More than 80 percent of the almost 40,000 street children identified through a 1999 social mapping exercise were boys. The street children programs were intended to be gender-neutral but it was recognized greater attention was needed to the particular problems of girl street children, especially their greater vulnerability to sexual exploitation. The special needs of girl street children were followed-up through a grant from the Japan Fund for Poverty Reduction when those resources became available.

SPSDP capacity building TA was in some way responsible for the increase in the number of street children during the crisis. This requires clarification.

### **Social Development Impact**

37. The PER assessment of the Social Development Impact (PER Appendix 5) is generally sound although discussion, e.g., of health service utilization rates by the poor is confounded by data collection and analysis problems. As noted above, data capture at the health center is normally based on presentation of the health card: those who present a health card are presumed, for record purposes, to be poor. However, since a large proportion of the health cards that have been issued are held by the non-poor (perhaps more than half, depending upon the survey cited), tracking utilization of the health cards may not provide a clear picture of the health seeking behavior of the poor. Without thoroughly 'cleaning' and validating the basic data, it is difficult to draw firm conclusions. However, on a macro level, the outcomes appear positive (e.g., the significant rise in utilization of prenatal services and birth attendance by trained personnel).<sup>21</sup>

38. Para 31 raises a very important point. Although the mechanisms adopted for SPSPD and HNSDP did reduce corruption, long term improvements are possible only when findings of improper or illegal behavior are acted upon. The lack of effective sanctions has undoubtedly encouraged the re-emergence of KKN. One lesson to be drawn is that fundamental changes in bureaucratic culture or behavior will require sustained attention and follow-up over several years, rather than the brief period of the SDPs. A second lesson may be that focused and sustained public information campaigns are crucial elements in introducing and promoting public participation and greater transparency.

### **SDP Timelines**

39. An examination of the timelines of the SPSPD and HNSDP should permit a reasonable assessment of the pace of implementation and relative achievements. A clear pattern would emerge of rapid and significant achievements during processing and early implementation, followed by gradual slowing and eventual erosion of early gains. In this the SDPs may not differ greatly from conventional projects, but useful conclusions of general application could perhaps be drawn.

40. At the outset a strong sense of urgency and commitment of both ADB and Government personnel and agencies contributed to major policy break-throughs and significant achievements. Many early advances involved changes in traditional bureaucratic behaviors in both ADB and Government. However, as the sense of urgency declined, the reluctance of both bureaucracies to adapt also declined, causing a slowing and partial reversal of early gains. The PER could have commented more usefully that the breadth of the combined education and health programs placed extreme demands on limited numbers of ADB staff. The high levels of staff involvement during early stages of SDP implementation – critically important in an environment of rapid and far-reaching changes – could not be sustained indefinitely. The inevitable reduction of staff time inputs due to resource constraints, and loss of individual commitment due to staff changes, arguably weakened ADB oversight and contributions after the first 18 months of implementation (when increased attention to consolidating early

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<sup>21</sup> Para 12 notes that while the number of births attended by medical personnel has grown rapidly, "on the other hand" the number of births attended by traditional birth attendants has declined. This decline is the logical consequence of substitution of trained medical personnel for (largely untrained) traditional birth attendants as promoted by the SPSPD and other safe motherhood initiatives.

achievements and concretizing procedures and staff training would have been most appropriate). Loss of detailed project knowledge and ownership through reorganization, rotation of staff between ADB headquarters and the Indonesia Resident Mission, and reassignment of staff between and within divisions contributed to drift and compromise during later stages of SDP implementation. Achievements were not adequately followed up or reinforced and resource allocations were reduced (e.g., Government requests to analyze and document SDP achievements were not supported due to “resource constraints”).

41. The PER omits any reference to the administrative burden that frequent adjustments in scope or implementation arrangements imposed upon ADB staff and the consequent delays in formal confirmation of agreed actions. Although the SPSDP (and HNSDP) was designed to be flexible in implementation, allowing rapid adjustment to meet changing circumstances, all proposed changes were subject to standard internal ADB review and approval procedures. A cursory review of SDP files would provide an indication of staff time, volume of paper and – most importantly – time delays required to effect these changes (e.g., it required ten weeks to reallocate funds from contingency to augment the street children component, and more than six months to reallocate funds for expanded nutrition coverage of young children).

42. Similar effects were evident within Government. SDP achievements on procurement, funds flow and disbursement, as well as sector policy initiatives were arrested and, in some cases, reversed. The loss of the crisis-induced ‘sense of urgency’ contributed to rapid reversion to pre-crisis norms of behavior (e.g., rent-seeking, KKN). For example, PER para 80 comments: “While the extension of block grants was a successful innovation, insufficient directives were available for the use of these funds and hence they lack transparency and accountability.” While the block grants and other SDP-supported changes were arguably improvements over the pre-existing budgetary and funds flow procedures, lack of sustained follow up and reinforcement did limit achievements.

## **Conclusion**

43. SPSDP demonstrates the best and the worst of ADB. SPSDP was processed quickly in response to the perceived urgency. Because of the urgency many internal constraints and or delays were side-stepped/short-circuited. Many established procedures had been introduced ostensibly to improve project quality but in fact prolonged the review and approval process without achieving significant quality gains. Despite (more likely because of) short-circuiting traditional quality control measures, the SPSDP design proved to be robust and effective and arguably introduced the most fundamental changes in the social sectors (indeed in intergovernmental fiscal relations generally) in Indonesia in many years. Unfortunately following approval, the SPSDP and HNSDP had to cope with the full weight of ADB bureaucracy that made even the smallest changes or adjustments agonizingly time consuming and staff resource intensive. In parallel, inertia and resistance to change within the Government bureaucracy slowed implementation. As a result, many of the substantial early achievements of the SDPs were permitted to erode through lack of sustained follow-up.

44. The PER might have drawn many potentially useful lessons from more intensive analysis of the SDPs. Unfortunately, it is apparent from the above-mentioned errors of fact and interpretation that ADB records and/or staff memories do not provide a clear or comprehensive picture of SDP objectives, constraints or accomplishments.

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