ADB

Program Completion Report

PCR: INO 32516

Health and Nutrition Sector Development Program (Loans 1675-INO and 1676-INO) in Indonesia

June 2005

Asian Development Bank

CURRENCY EQUIVALENTS

Currency Unit – rupiah (Rp)

		At Appraisal	At Program Completion
		26 February 1999	28 July 2004
Rp1.00	=	$.000115	$.000125
$1.00	=	Rp8,700	Rp8,000

ABBREVIATIONS

ADB	–	Asian Development Bank
BAPPEDA II	–	district planning agency
BAPPENAS	–	National Development Planning Agency
BKKBN	–	National Family Planning Coordinating Board
CDC	–	communicable disease control
CIMU	–	central independent monitoring unit
DCC	–	district coordinating committee
EA	–	executing agency
FPFW	–	family planning field worker
HNSDP	–	Health and Nutrition Sector Development Program
ICB	–	international competitive bidding
IEC	–	information, education, and communication
IMR	–	infant mortality rate
MOF	–	Ministry of Finance
MOH	–	Ministry of Health
MOHA	–	Ministry of Home Affairs
MOSA	–	Ministry of Social Affairs
OAGO	–	Auditor General's Office
PCSS	–	Procurement Contract Summary Sheet
PIU	–	project implementation unit
SOE	–	statement of expenditures
SPSDP	–	Social Protection Sector Development Program
TA	–	technical assistance
TB	–	Tuberculosis

NOTES

(i) The fiscal year (FY) of the Government of Indonesia ends on 31 December.

(ii) In this report, "$" refers to US dollars.

CONTENTS

BASIC DATA

A. Loan Identification

1.	Country	Indonesia
2.	Loan Numbers	1675 and 1676
3.	Program Title	Health and Nutrition Sector Development Program
4.	Borrower	Government of Indonesia
5.	Executing Agency	
	Program Loan	Ministry of Finance
	Project Loan	National Development Planning Agency (BAPPENAS)
6.	Amounts of Loans	$100.0 million Program Loan $200.0 million Project Loan
7.	Project Completion Report Number	PCR: INO 897

B. Loan Data

1.	Appraisal	
	– Date Started	2 February 1999
	– Date Completed	19 February 1999
2.	Loan Negotiations	
	– Date Started	22 February 1999
	– Date Completed	23 February 1999
3.	Date of Board Approval	25 March 1999
4.	Date of Loan Agreement	25 March 1999
5.	Date of Loan Effectiveness	
	– In Loan Agreement	25 March 1999
	– Actual	25 March 1999
	– Number of Extensions	0
6.	Closing Date	
	Program Loan	
	– In Loan Agreement	30 September 2000
	– Actual	22 December 2000
	– Number of Extensions	1
	Project Loan	
	– In Loan Agreement	31 December 2001
	– Actual	28 July 2004
	– Number of Extensions	2
7.	Terms of Loan (Program Loan)	
	– Interest Rate	Variable
	– Maturity (number of years)	15 years
	– Grace Period (number of years)	3 years
	Terms of Loan (Project Loan)	
	– Interest Rate	Variable
	– Maturity (number of years)	23 years
	– Grace Period (number of years)	3 years

8. Disbursements

a. Dates

Initial Disbursement	Final Disbursement	Time Interval
14 October 1999	28 July 2004	54 months
Effective Date	**Original Closing Date**	**Time Interval**
25 March 1999	31 December 2001	33 months

b. Amount

Category or Subloan		Original Allocation	Last Revised Allocation	Amount Canceled	Net Amount Available	Amount Disbursed	Undisbursed Balance
A.1	Health Services-Poor Family	38,320,000	26,935,278	(11,384,722)	26,935,278	26,935,278	0
A.2	Safe Motherhood-Poor Family	29,790,000	19,523,407	(10,266,593)	19,523,407	19,523,407	0
B.	Communicable Disease Control	8,040,000	6,014,218	(2,025,782)	6,014,218	6,014,218	0
C.1	Nutrition-Infant Feeding	17,610,000	10,703,031	(6,906,969)	10,703,031	10,703,031	0
C.2	Nutrition-Supplementary Feeding-Children Under 2	34,660,000	29,927,447	(4,732,553)	29,927,447	29,927,447	0
C.3	Nutrition-Supplementary Feeding-Pregnant Women	11,140,000	9,399,805	(1,740,195)	9,399,805	9,399,805	0
C.4	Revitalization of Food and Nutrition Surveillance System	620,000	0	(620,000)	0	0	0
D.	Revitalization of Posyandu	8,940,000	12,287,652	3,347,652	12,287,652	12,287,652	0
E.1	Family Planning	2,590,000	1,596,742	(993,258)	1,596,742	1,596,742	0
E.2	Increasing Use of Long-Term Method	11,250,000	10,287,071	(962,929)	10,287,071	10,287,071	0
E.3	Increasing Access of Services	1,660,000	2,096,002	436,002	2,096,002	2,096,002	0
E.4	Maintaining Quality of Services	4,500,000	1,680,228	(2,819,772)	1,680,228	1,680,228	0
F.	Programs for Street and Neglected Children	18,200,000	9,621,935	(8,578,065)	9,621,935	9,621,935	0
G.	MOH Systems Development	4,500,000	689,429	(3,810,571)	689,429	689,429	0

Category or Subloan	Original Allocation	Last Revised Allocation	Amount Canceled	Net Amount Available	Amount Disbursed	Undisbursed Balance
H. Training and Staff Development	2,000,000	4,242,161	2,242,161	4,242,161	4,242,161	0
I.1. Implementation -Social Awareness, Health Promotion & Health Awareness	3,000,000	790,204	(2,209,796)	790,204	790,204	0
I.2 Implementation -Provincial/ District Monitoring & Supervision	1,510,000	8,451,211	6,941,211	8,451,211	8,451,211	0
I.3 Implementation -Program Management Operation Research and Evaluation	1,670,000	5,968,320	4,298,320	5,968,320	5,968,320	0
Total	**200,000,000**	**160,214,134**	**39,785,859**	**160,214,134**	**160,214,139**	**0**

MOH = Ministry of Health, posyandu = village health post.
Source: Loan Financial Information System and Loan Agreement.

Program Loan Tranche Releases

1st Tranche Release	$50.0 million	25 March 1999
2nd Tranche Release	$50.0 million	22 December 2000

9. Local Costs (Financed)
   – Amount $120.3 million
   – Percent of Local Costs 43.0%
   – Percent of Total Costs 31.8%

C. Program/Project Loan Data

1. Program Cost ($ million)

Cost	Appraisal Estimate	Actual
A. Program Loan		
Foreign Exchange Cost	100.00	100.00
B. Project Loan		
Foreign Exchange Cost	49.38	39.91
Local Currency Cost	150.62	120.31
Total	**300.00**	**260.22**

2. Financing Plan – Project Loan ($ million)

	Appraisal Estimate			Actual		
Cost	**Foreign**	**Local**	**Total**	**Foreign**	**Local**	**Total**
A. Implementation Costs						
Borrower-Financed	77.70	201.35	279.05	59.06	159.48	218.54
ADB-Financed	49.38	150.62	200.00	39.91	120.31	160.22
Total	**127.08**	**351.97**	**479.05**	**98.97**	**279.79**	**378.76**
B. Interest During Construction						
Borrower-Financed[a]	12.62	0.00	12.62	0.00	0.00	0.00
Total	**12.62**	**0.00**	**12.62**	**0.00**	**0.00**	**0.00**

ADB = Asian Development Bank.
[a] ADB's Asian Currency Crisis Support Facility (ACCSF) of the Japan Special Fund provided a grant of $13.13 million for interest payment assistance.

3. Cost Breakdown by Project Component – Project Loan ($ million)

	Appraisal Estimate			Actual		
Component	**Foreign**	**Local**	**Total**	**Foreign**	**Local**	**Total**
Essential Health Services	13.71	54.40	68.11	9.50	36.96	46.46
Communicable Disease Control	1.60	6.44	8.04	1.15	4.86	6.01
Nutrition	18.02	46.01	64.03	10.70	39.33	50.03
Revitalization of Posyandu	1.63	7.31	8.94	2.24	10.05	12.29
Family Planning	11.20	8.80	20.00	9.93	5.74	15.67
Programs for Street Children	0.91	17.29	18.20	0.48	9.14	9.62
MOH Systems Development	0.96	3.54	4.50	0.14	0.55	0.69
Training and Staff Development	0.00-	2.00	2.00	0.00	4.24	4.24
Implementation	1.35	4.83	6.18	5.77	9.44	15.21
Taxes and Duties	—	—	—	—	—	—
Contingencies	—	—	—	—	—	—
Interest During Construction[a]	—	—	—	—	—	—
Total	**49.38**	**150.62**	**200.00**	**39.91**	**120.31**	**160.22**

— Data not available during PCR mission.
MOH = Ministry of Health, posyandu = village health post.
[a] ADB's Asian Currency Crisis Support Facility (ACCSF) of the Japan Special Fund provided a grant of $13.13 million for interest payment assistance.

4. Project/Program Schedule

Item	**Appraisal Estimate**	**Actual**
Date of Contract with Consultants		
Project Strategic Development, international		6 August 1999
Project Policy Analysis, international		6 August 1999
Nutrition Surveillance, Monitoring and Evaluation, local		6 August 1999
Project Implementation Spec., international		6 August 1999
Project Implementation Spec., local		20 September 2000
Policy Analysis and Review, local		5 December 2000
MOH PIU Coordinator		12 December 2000
Training Coordinator, local		5 December 2000
Public Awareness Campaign, local		5 December 2000
Project Management, local		2 January 2001
Public Awareness Campaign Package		24 November 1999
Printing of Implementation Guide and Leaflet		31 January 2000

Item	Appraisal Estimate	Actual
Program Evaluation Advisor, international		20 September 2000
Program Evaluation Grants Manager, local		20 September 2000
Project Management		2 January 2001
Public Awareness Campaign Package		2 January 2001
Clinical Training of Post-Abortion Care		10 January 2002
Operational Research		8 February 2002
Independent Monitoring of Street Children		17 June 2002
Final Project Evaluation of HNSDP		16 July 2003
Dates		
First Procurement		May 2000
Last Procurement		August 2003
Other Milestones		
First Tranche Release	25 March 1999	25 March 1999
Last Tranche Release	March 2000	22 December 2000
First Block Grant Release	—	10 November 1999
Last Block Grant Release	—	1 September 2002

— Data not available.
HNSDP = Health and Nutrition Sector Development Program, MOH = Ministry of Health, PIU = project implementation unit.

5. Project/Program Performance Report Ratings

Implementation Period	Ratings	
	Development Objectives	Implementation Progress
From 31 March 1999 to 31 January 2001	Satisfactory	Satisfactory
From 28 February 2001 to 31 May 2001	Satisfactory	Highly Satisfactory
From 30 June 2001 to 31 December 2003	Satisfactory	Satisfactory

D. Data on Asian Development Bank Missions

Name of Mission	Date	No. of Persons	No. of Person-Days	Specialization of Members
Loan Fact-Finding	9–27 November 1998	7	73	a, c, j, k, n, o, q, r
Loan Appraisal	2–19 February 1999	7	73	a, c, j, k, n, o, q, r
Loan Inception	10–18 May 1999	1	9	a
Loan Review	11–22 October 1999	1	12	a
Loan Review	5–9 June 2000	1	5	a
Loan Review	12–23 February 2001	2	24	d, p, o
Mid-Term Review	11–21 June 2001	2	21	d, o,
Loan Review	16–20 December 2002	2	10	g, o
Special Loan Administration	10–18 November 2003	2	30	b, o
Subtotal During Project Implementation		**25**	**257**	
Project Completion Review[a]	18- 29 April 2005	2	20	

a = Manager, b = Principal Project Specialist/PAU Head, c = Senior Project Implementation Specialist, d = Senior Project Specialist, g = Senior Social Sector Specialist, j = Senior Economist, k = Project Economist, n = Counsel, o = Young Professional, p = Assistant Project Analyst, q = Resident Health Advisor, r = Consultant/Financial Analyst.
[a] The project completion report was prepared by S. Wendt, Social Development Specialist and Mission Leader; M. Pampolina, Assistant Project Analyst; and a Health Specialist Staff Consultant.


INDONESIA
HEALTH AND NUTRITION SECTOR DEVELOPMENT PROGRAM
(as completed)
110°00'E
130°00'E
10°00'N
0°
10°00'S
South China Sea
Celebes Sea
PACIFIC OCEAN
Java Sea
Banda Sea
Arafura Sea
INDIAN OCEAN
Banda Aceh
NANGGROE ACEH DARUSSALAM
Medan
NORTH SUMATRA
Pekanbaru
RIAU
SUMATRA
Padang
WEST SUMATRA
Jambi
JAMBI
BANGKA
BANGKA-BELITUNG
Pangkal Pinang
SOUTH SUMATRA
BENGKULU
Palembang
Bengkulu
BELITUNG
LAMPUNG
Bandar Lampung
JAKARTA
Serang
BANTEN
WEST JAVA
JAVA
CENTRAL JAVA
Semarang
Bandung
Surabaya
Yogyakarta
EAST JAVA
YOGYAKARTA
BALI
Denpasar
LOMBOK
Mataram
SUMBAWA
WEST NUSA TENGGARA
FLORES
EAST NUSA TENGGARA
SUMBA
TIMOR
TIMOR-LESTE
Kupang
BRUNEI DARUSSALAM
MALAYSIA
Pontianak
WEST KALIMANTAN
KALIMANTAN
EAST KALIMANTAN
Samarinda
CENTRAL KALIMANTAN
Palangkaraya
SOUTH KALIMANTAN
Banjarmasin
NORTH SULAWESI
Manado
Gorontalo
GORONTALO
Palu
CENTRAL SULAWESI
WEST SULAWESI
SULAWESI
Mamuju
SOUTH SULAWESI
Kendari
Makassar
SOUTHEAST SULAWESI
Ternate
NORTH MALUKU
HALMAHERA
SERAM
Ambon
MALUKU
Manokwari
WEST IRIAN JAYA
PAPUA
Jayapura
PAPUA NEW GUINEA
Project Area
National Capital
Provincial Capital
Provincial Boundary
International Boundary
Boundaries are not necessarily authoritative.
N
0 200 400 600
Kilometers

05-2174 RM

I. PROGRAM DESCRIPTION

1. In July 1998, the Asian Development Bank (ADB) approved the Health and Nutrition Sector Development Program[1] (HNSDP). It comprised (i) a program loan of $100 million[2] to support reforms to improve basic social services, and structural changes to enhance the HNSDP's efficiency and effectiveness; and (ii) a project loan of $200 million to fund interventions in health, family planning, and nutrition; and to help street children in selected provinces. The Program Framework is attached in Appendix 1.

2. The primary objectives of the HNSDP were to (i) secure access of vulnerable groups to essential health, nutrition, and family planning services; (ii) ensure maintenance of the nutritional status of vulnerable groups; and (iii) reduce the incidence and impacts of communicable diseases associated with poverty and malnutrition. Specifically, the program loan aimed to mitigate the impacts of the 1997 economic crisis by (i) maintaining access of the poor to quality health services; (ii) mobilizing additional resources for health and family planning; (iii) enhancing decentralized management, participation, and transparency; (iv) advancing organizational changes of the Ministry of Health (MOH); and (v) improving the efficiency of health services delivery. The project loan aimed to (i) ensure continued operation of health centers; (ii) improve the nutrition of the poor, especially mothers, infants, and children, through complementary feeding; (iii) strengthen control of communicable diseases associated most with poverty; (iv) promote family planning and reproductive health programs; and (v) assist street children in urban areas. The HNSDP covered health, nutrition, and family planning services for the poorest families in 27 provinces, while the assistance to street children was implemented in 12 cities.[3] Two technical assistance (TAs) grants totaling $3 million were attached to the loans: TA 3175-INO: Monitoring and Evaluating the Health and Nutrition Sector Development Program; and TA 3176-INO: Capacity Building for Decentralized Health Services Management.[4] Separate TA completion reports evaluated the TAs.[5]

II. EVALUATION OF DESIGN AND IMPLEMENTATION

A. Relevance of Design and Formulation

3. The HNSDP was an integral part of a larger assistance program ($2.8 billion) that ADB provided to mitigate the adverse socioeconomic consequences of the Asian financial crisis.[6] The Government faced the prospect of very large numbers of people falling into poverty, which would reverse the human development achievements in the previous 2 decades. The number of poor swelled from 23 million in 1996 to 34.5 million in 1998, and then further to 49.5 million in

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[1] ADB. 1999. *Report and Recommendation of the President to the Board of Directors for Proposed Loans and Technical Assistance Grants to Indonesia for the Health and Nutrition Sector Development Program.* Manila.

[2] Japan Bank for International Cooperation cofinanced the Program with a loan of ¥35,280,000,000.

[3] Jakarta, Medan, Bandung, Yogyakarta, Surabaya, Semarang, Ujung Pandang, Ambon, Bandar Lampung, Mataram, Pandang, and Palembang.

[4] ADB. 1999a. *Technical Assistance to Indonesia for Monitoring and Evaluating the Health and Nutrition Sector Development Program.* Manila.

———. 1999b. *Technical Assistance to Indonesia for Capacity Building for Decentralized Health Services Management.* Manila.

[5] ADB. 2003a. *Technical Assistance Completion Report for Monitoring and Evaluating the Health and Nutrition Sector Development Program.* Manila.

———. 2003b. *Technical Assistance Completion Report for Capacity Building for Decentralized Health Services Management.* Manila.

[6] ADB provided five support loans and associated TAs. The loans were the (i) Financial Governance Reforms Sector Development Program ($1.5 billion), (ii) Social Protection Sector Development Program ($300 million), (iii) Health and Nutrition Sector Development Program ($300 million), (iv) Power Sector Restructuring Program ($400 million), and (v) Community and Local Government Support Sector Development Program ($320 million).

1999. To support the Government's Social Safety Net programs providing food assistance, health care, scholarships, and employment opportunities, the HNDSP aimed to prevent health conditions of the most vulnerable people from worsening, and to safeguard their access to health services. The project loan focused on maintaining health services in the short term, while the program loan sought to promote policies to address structural weaknesses and deliver health services in a more flexible and responsive manner.

4. The HNSDP design was innovative and geared to meeting the exigencies of the crisis, while introducing new ways of delivering health services. The Program's approach was characterized by six major innovations: (i) the allocation of funds from center to districts was based on a district poverty/nutrition index, rather than on total population; (ii) decision-making was more decentralized than had been attempted before, enhancing transparency and fostering local decision-making and ownership; (iii) a block grant mechanism[7] was adopted to channel funds directly to district health centers to help cover operations costs; (iv) funds were transferred directly to health centers and midwives through local post offices to bypass the usual mechanism through the State Treasury of the Ministry of Finance (MOF); (v) independent monitoring was established to provide continual monitoring of the effectiveness of the HNSDP and accuracy of the funds transfer;[8] and (vi) complaint resolution units were established to solve problems or complaints related to the implementation of the HNSDP.

5. The HNSDP was appropriate and timely in view of the mounting social implications of the crisis. Based on the lessons from the recessions since the oil crisis in the late 1980s, which significantly affected the health and nutrition of the population in general and the poor in particular, maintenance of the recurrent expenditure levels on health services was seen as an urgent need to avoid widespread hardship and an erosion of human capital.

B. Program Outputs

6. The status of policy compliance under the program loan is in Appendix 2. The program loan supported the initiation of nationwide policy reforms to ensure inclusion and equity for the poor in health services. It also enhanced decentralized management to improve the efficiency of health services delivery systems. To ensure access of the poor to health services, MOH implemented a mechanism for allocating funds from the central level to districts based on poverty criteria. The rapid devolution of powers to districts following the passage of the decentralization laws[9] provided impetus for reforms relating to decentralized health management. MOH provided assistance to strengthen local capacity in health service delivery, including planning, management, and institutional development. The policy loan required the Government to maintain the allocation of public resources for basic health services at the FY1997 level. However, this was not achieved fully. The proportion of the central budget allocated to basic health services declined from 3.7% in FY1997 to 3.1% in FY2000, and was 3.2% in FY2003. This decline reflected, in part, the delegation of responsibility for maintaining basic health services to local governments under decentralization legislation enacted in 1999.

7. Prior to Board consideration, 29 policy actions in the Program's policy matrix were completed, fulfilling the conditions for the release of the first tranche at loan effectiveness on 25 March 1999. An additional 36 conditions were fulfilled for the release of the second tranche of

[7] The block grants represented government subsidies targeting the poor, to the level of Rp10,000 per family per year.

[8] TA 3175-INO: Monitoring and Evaluating the Health and Nutrition Sector Development Program provided for independent monitoring and evaluation of the Program. A central independent monitoring unit (CIMU) was established at the national level and independent nongovernment organization-based monitoring networks in the 27 provinces covered by the HNSDP.

[9] The People's Consultative Assembly passed Decentralization Laws 22 and 25 in 1999.

the program loan, which enabled ADB to transfer the second tranche on 22 December 2000. The policies espoused under the HNSDP have continued after program completion. A budget for continuation of the HNSDP was ensured by allocating funds from the reduced subsidies for oil to support health activities targeting the poor. Funds for outreach health services by the village midwives initiated under HNSDP were guaranteed until 2005. The Government has also approved regulations, based on the experiences of HNSDP, describing in detail the criteria and formulas for allocating funds from the central Government to local governments, where poor districts will receive additional central Government budget transfer for health. In terms of strengthening management and responsiveness of the health centers, no specific follow-up activities have been initiated since program completion.

8. Appendix 1 compares the performance of the Program with the Program Framework included in the Report and Recommendation of the President to the Board of Directors.[10] The HNSDP, to a large extent, succeeded in achieving its targeted outputs as 11 million households gained access to primary health services. At appraisal, the Program aimed to provide access to primary health services for 15.3 million[11] households. As a result of the HNSDP, 91.5%[12] of the targeted households were provided with health cards for free primary health services.[13] There were no specific targets set for utilization of health cards during appraisal of HNSDP. However, poor families increased their utilization of health care from less than 10% before the HNSDP to 17–19% in 2001 and to 29.9% in 2003—slightly higher than the average for Indonesia.[14] The relatively low utilization of health care might be due to distance, lack of transportation, communication, education, and community habits.

9. In 2003, 76.8% of the targeted women received antenatal care, while 68.2% received postnatal care. A national survey[15] concluded that the higher attendance rate for antenatal and postnatal care among women health cardholders showed that the HNSDP contributed to equity in access to these facilities. Some 1.6 million high-risk pregnant women received safe motherhood services,[16] compared to an appraisal target of 1.9 million. Birth attendance by health professionals for health cardholders was between 80.1% (West Java) and 99% (Jakarta), compared with the national average of 89.5%.[17] The data provide strong evidence that deliveries were well attended, which might indicate that barriers to access—such as distance or cost—were reduced among health cardholders. The target rate of referral to hospitals for pregnant women with complications or in emergency, birth, or postpartum period was 9.7% (FY2000), 7.9% (FY2002), and 6.7% (FY2003). The actual rate of referral to hospitals among non-cardholders was only 3.2%, which suggests that an increasing number of women benefited under the HNSDP by getting referrals to hospitals.

10. The complementary and supplementary feeding program for children did not reach the target of 100%. In FY2003, 65% of entitled infants 6–12 months old (323,000 children) received supplementary food, and 68% of children 12–23 months old (663,000) received supplementary

[10] ADB. 1999. *Report and Recommendation of the President to the Board of Directors for Proposed Loans and Technical Assistance Grants to Indonesia for the Health and Nutrition Sector Development Program*. Manila.
[11] At the HNSDP appraisal, East Timor was included in the Program.
[12] Appendix 8 indicates the provincial differences regarding access to health cards.
[13] The services provided were basic health services, antenatal, delivery and postnatal care; complementary feeding for infants 6–11 months old and pregnant/postnatal women suffering from chronic energy malnutrition; and supplementary feeding for children 12–59 months old.
[14] ADB. 2003. *Technical Assistance Completion Report for Monitoring and Evaluating the Health and Nutrition Sector Development Program.* Manila.
[15] British Council. 2002. *National Survey Final Report*.
[16] Safe motherhood services included (i) four visits for antenatal care during pregnancy; (ii) birth attendance by the health provider; (iii) three visits to provide postnatal care; and (iv) first line obstetric emergency care and referral to a more appropriate level of health services, if necessary.
[17] British Council. 2002. *Independent Monitoring and Evaluation of the Health and Nutrition Sector Development Program Final Report.*, Jakarta.

food. Coverage decreased as children's ages increased. A national survey found that mothers paid fewer visits to integrated health posts where food was distributed after a child's immunization was completed. The nutritional improvements for mothers at risk were significantly higher than the achievements of the feeding programs for children, although the improvements for mothers did not reach the target of 790,000 pregnant women. In FY2003, 71.9% of mothers with chronic energy deficiency received supplementary food. The revitalization of *posyandus* (monthly outreach activity organized in the community by volunteers with the support of health center staff) was very successful as 94% of the targeted posyandus received a revitalization package.[18] A nutrition surveillance system was revitalized to provide nutrition mapping for all provinces.

11. The communicable disease control (CDC) component provided adequate supplies of vaccines to all community health centers in all provinces. Community health centers had more than 90% of the supplies of all required vaccines. In addition to immunization, the HNSDP covered two communicable disease programs, tuberculosis (TB) and malaria. The Program aimed to reduce TB cases by 70%[19] and cure 80%. Of the identified TB cases, 88.6% of the cases were treated and 34% recovered.[20] Although the program target was not met, the CDC program ensured equal access between poor and non-poor.

12. To strengthen family planning and reproductive health programs, 58 million oral contraceptives, 3.3 million vials of injectable contraceptives, and 187,000 sets of implants were distributed. Savings from lower-than-expected prices on contraceptives allowed the supply of contraceptives to be increased. The procurement of additional contraceptives significantly enhanced the program objective to reach more poor households. The allocation of funds from the Operational Assistance Fund to family planning field workers (FPFW) made it possible to increase the number of FPFWs providing supervision and information, and persuading poor households to visit the family planning service centers more often. The funds also allowed the implementation period to be extended from the originally planned 12 months to cover the entire HNSDP.

13. The original allocation for posyandus revitalization was $8.9 million for 2 years. In the original design of the HNSDP, 65,000 posyandus were to be revitalized. During implementation, however, MOH requested the expansion of the coverage to 120,000 posyandus following the demonstration of impact of the work of the Kadres[21] and the significant support provided by the posyandu. ADB agreed to the expansion. Additional funding of $3.9 million was required for transportation of Kadres, increasing the budget to $21.7 million. These activities were completed within 1 year of implementation.

14. The HNSDP provided funding for 107 open houses in FY2000 and 94 in FY2003. The Program also provided 9,200 scholarships (over 2 years) for primary, junior, and senior secondary education to street children; and 7,500 scholarships for vocational and technical education. More than 6,000 street children received supplementary food.[22] During program appraisal, a specific target was not set for this component.

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[18] The revitalization package consisted of training of Kadres, provision of information, education, and communication (IEC) materials, including growth charts, equipment such as weighing scales, and transportation of Kadres.

[19] As measured by sputum conversion.

[20] Interviews with community health staff confirmed that the main obstacle to improving the recovery rate of TB is a high dropout rate of patients taking medication.

[21] Kadres are volunteers working in posyandus

[22] Evaluation studies suggest that the child absences decreased by 70% and more children enrolled in extracurricular activities, improving their lifestyle and opportunities for income. Summary of the HNSDP, Indonesian Child Welfare Foundation, Department of Social Affairs. 2003. *Independent Monitoring Report, Research and Development Department.* Indonesia.

C. Project Costs

15. At appraisal, the project costs[23] were estimated at $479.05 million equivalent. ADB was to finance $200 million of this amount (42%) through a project loan. The Government was to provide parallel financing[24] of $279.05 million, or 58% of the project costs. The actual project loan costs totaled $378.76 million equivalent, of which the Government contributed $218.54 million (58%) and ADB financed $160.22 million (42%).

16. During implementation, ADB approved the Government's requests to (i) increase the ceiling of the initial deposit in the imprest account from $20 million to $50 million, (ii) reallocate loan proceeds to cover higher expenditures expected in the final year of project implementation after the completion of Loan 1623-INO: Social Protection Sector Development Program (SPSDP), and (iii) reallocate and partially cancel loan proceeds for the remaining activities before final program completion.

D. Disbursements

17. As a contribution to the Government's policy reforms, the program loan provided quick-disbursing assistance in two equal tranches. The first was released at loan effectiveness on 25 March 1999. The second tranche was disbursed 9 months later than envisaged due to delayed compliance with second tranche release conditions.[25] The proceeds of the loan channeled through MOF financed the foreign exchange costs of commodities produced in, and procured from, ADB's member countries. The local currency proceeds of the program loan supported the Government's nationwide policy reforms designed to safeguard access of the poor to basic health services.

18. Almost all project loan funds were channeled through an imprest account ($110 million) at Bank Indonesia and distributed by PT Pos Indonesia, the Indonesian mail service. PT Pos Indonesia distributed funds through its nationwide network of post offices directly to the beneficiaries. Exceptions involved the funds for the procurement of blended food and contraceptives ($22.8 million), which were distributed by direct payment. A small proportion was channeled through the conventional State Treasury system of MOF.[26]

19. To expedite disbursement of the HNSDP loan funds, ADB agreed to provide an initial deposit and replenishment to maintain a balance of $20 million[27] in the imprest account. The $20 million initial deposit was much lower than the $50 million that had been provided for the preceding SPSDP[28], even though the scope and range of activities of the HNSDP was more wide-ranging in comparison to the SPSDP. The Government augmented the small deposit in the MOF imprest account with bridge funds, although this was not included in the Loan Agreement. However, the fund augmentation was only done during the first funding tranche, and was only possible when the Government's financial condition permitted. Therefore, the Government proposed an increase in the initial deposit for imprest account, which ADB approved in March

[23] Cost by project component is in Appendix 3.
[24] Use of parallel financing mechanism rather than the more conventional joint financing of subprojects was justified because it avoided the rigidities and delays inherent in processing and/or amending the Government budget.
[25] The schedule was not kept, largely because of the Government's preoccupation with administrative restructuring, bureaucratic reform, and staff changes introduced following presidential elections in October 1999, and the accelerated implementation of decentralization legislation adopted in mid-1999.
[26] To cover staff training and staff development.
[27] The initial deposit was transferred to the MOF imprest account in two installments. The first $10.0 million on 14 October 1999, and the remaining $10.0 million on 3 November 1999.
[28] This initial deposit was also intended to accommodate disbursements for support activities (i.e., social awareness, a health promotion and health education program, district and provincial monitoring, program management, research, and evaluation).

2001. ADB provided an additional $30 million, increasing the total deposit to $50 million. This amount was sufficient to ensure a much higher rate of disbursement between replenishments.

20. The fund disbursements were delayed mainly due to the small initial deposit ($20 million) and later-than-anticipated submission of the statement of expenditure (SOE) of the actual amount disbursed to the recipients from the local post offices. This delayed the submission of withdrawal applications, slowing the processing of those applications.[29] As a result, the release of funds to health centers and village midwives was delayed. The collection of funds by the numerous recipients involved also was delayed. Poor socialization and unfamiliarity with procedures were the main causes of funds not being withdrawn.

21. The absorption rate for the loan was excellent at more than 99% for each replenishment between January 2000 and March 2002. The fund withdrawal rate was good, consistently exceeding 90% by community health centers and 85% by village midwives. An average of 90% of community health centers and village midwives presented regular expenditure reports supported by receipts, demonstrating appropriate utilization of the funds. Despite the difficulties, the system of transferring funds through the post office[30] proved more efficient than conventional disbursement through the Government's Treasury Office. The service provided by post office staff generally was commendable. The leakage of program funds was very small, and virtually none was attributable to the post office.

22. Disbursements for centralized procurement (blended food, contraceptives, laboratory reagents and consumables, and family planning equipment) were carried out through direct payment procedures. The delay in the procurement of blended food undermined the disbursement for complementary feeding. The first round of international competitive bidding (ICB) for the procurement of blended food for 12 cities was canceled. The procurement of the total requirement of blended food nationwide was later carried out in one round.

E. Program Schedule

23. The HNSDP was approved on 25 March 1999 and declared effective on the same date. The program loan was closed on 22 December 2000 upon the release of the second tranche, 2 months later than the original date of 20 September 2000. The original closing date for the project loan was 31 December 2001, though it did not close until 28 July 2004 following two extensions. The first extension, from 31 December 2001 to 31 December 2002, was to allow proper absorption of the remaining transfers of grant funds and to complete procurement (i.e., blended food, contraceptives, reagents for CDC, computers, and software development). The second extension, from 31 December 2002 to 31 December 2003, allowed the completion of delayed activities during project implementation. A detailed program schedule comparing actual achievements with appraisal targets is in Appendix 4.

F. Implementation Arrangements

24. Leveraging earlier project experience, the HNSDP duplicated the implementation structure of SPSDP, and used existing management and coordination mechanisms. MOF was the Executing Agency (EA). An advisory steering committee chaired by the National Development Planning Agency (BAPPENAS) and comprising senior representatives from MOF, MOH, Ministry of Social Affairs (MOSA), Ministry of Home Affairs (MOHA), and National Family Planning Coordinating Board (BKKBN) provided guidance to the Program. At the working level, a technical committee, made up of directors of the same ministries, supported the

[29] The Executing Agency reported unusually long delays in processing withdrawal applications (6 months) by ADB during the first year of implementation.
[30] Appendix 6 provides an overview of disbursements through the PT Pos Indonesia.

implementation of the Program. The committee provided support on technical matters, and determined the allocation of resources to districts within the project area. A program secretariat was established in BAPPENAS to coordinate all program activities. Funds were budgeted through the development budgets of the major line ministries concerned: MOH for health and nutrition, BKKBN for family planning, and MOSA for street and neglected children.

25. An implementation unit was established in MOH, and coordination committees were established at provincial, district and subdistrict levels, chaired by the District Planning Agency (BAPPEDA II) representing all the line ministries and local governments concerned. The most important of these committees were the district coordinating committees (DCC), because they played a core role in resource allocation and in monitoring the Program.[31] To promote transparency and accountability, the committee invited the participation of nongovernment members and civil society. At the subdistrict level, village health committees were responsible for (i) overseeing the implementation of planned activities, (ii) withdrawing and properly using program funds, (iii) procuring the necessary goods and supplies through direct purchase, and (iv) reporting on the use of funds and activities. Program activities were implemented in close collaboration with the *puskesmas* (district health centers), the chiefs of the villages, the village midwives, and the communities.

26. The SPSDP secretariat within BAPPENAS, headed by a full-time executive secretary and appropriately staffed, served as the secretariat for the steering and technical committees of the HNSDP. During processing of SPSDP, the project secretariat was assigned responsibility for centralized procurement and consultant recruitment. All parties agreed during processing of the HNSDP, and reconfirmed during the HNSDP Inception Mission, that separate project implementation units (PIUs) would be established in MOH and BKKBN. A similar, but smaller, unit was established in MOSA to coordinate street children programs. Since the PIUs assumed responsibility for day-to-day project implementation, the role and responsibilities of the project secretariat were refocused on SPSDP/HNSDP coordination, monitoring, and reporting to avoid duplication or overlap. To ensure a consistent approach, the detailed procedures specified for the SPSDP were applied to the HNSDP.

G. Covenants

27. The status of compliance with the loan covenants is in Appendix 5. In addition to the program-related policy conditions, the Loan Agreement specified several covenants concerned with reporting requirements, implementation arrangements, record keeping, procurement, and monitoring and evaluation. All covenants were complied with, although no specific measures were implemented to provide health and nutrition outreach services to culturally distinct communities within the project areas. Health and nutrition outreach services provided under the HNDSP included support to culturally distinct communities as part of the basic social services provided by health centers.

H. Related Technical Assistance

28. Two TA packages were attached to the Program:[32] TA 3175-INO and TA 3176-INO. TA 3175-INO provided for monitoring and evaluation of the Health and Nutrition Sector Development Program. The TA was designed to monitor independently (i) fund flow of block grants; (ii) delivery of benefits to intended beneficiaries; and (iii) impact of the Program on the

[31] The DCCs allocated resources to the subdistricts based on population and level of poverty.

[32] ADB. 1999a. *Technical Assistance to Indonesia for Monitoring and Evaluating the Health and Nutrition Sector Development Program*. Manila.
———. 1999b. *Technical Assistance to Indonesia for Capacity Building for Decentralized Health Services Management*. Manila.

provision of health, nutrition, and family planning services to the most vulnerable groups. TA 3176-INO supported Government efforts to decentralize management of health services delivery to improve efficiency and quality. The monthly monitoring system maintained a high standard of coverage and data quality, and achieved a rapid turnaround from data collection to distribution of regular reports on analyzed and collated data. TA 3175-INO and TA 3176-INO were rated successful.

I. Consultant Recruitment and Procurement

29. The procurement process and consultant recruitment followed the procedures and regulations stated in the Project Administration Memorandum/ADB,[33] *Procurement Guidelines* of *ADB,* and the Presidential Decree on procurement of goods and services for Government institutions. All procurement stated in the Loan Agreement and the Project Administration Memorandum was identified in the Government investment budget, in the allocation and the annual target.

30. Procurement by MOH of personal computers and peripherals had to be rebidded, resulting in a 1-year delay.[34] The first round of bidding for the ICB procurement of blended food for 12 cities was canceled, and the procurement of the entire requirement of blended food nationwide later was carried out in one round. An investigation by the Auditor General's Office (OAGO)/ADB of possible impropriety in the evaluation of the bids delayed the procurement process by about 15 months.[35] This delay affected the distribution from district warehouses to the posyandus. Therefore, an additional $2,000 was necessary to support the distribution (including renting additional warehouses and transportation) of blended food.

31. Achieving consensus between MOH's procurement team and ADB on procurement guidelines and requirements for goods and services (i.e., consultant services) in the formulation of the Health Management Information System, Health Official Information System, and Health Financial Information System was very time consuming. When consensus was reached, the HNSDP was at the final stage of implementation. MOH requested ADB not to pursue this activity, because the MOH was not interested in a limited study as envisaged in the original terms of reference for this component, and it was not possible to conduct a more comprehensive study within the remaining implementation period of the Project. MOH, therefore, requested ADB to cancel the funds allocated for this activity. ADB endorsed this request.

32. The procurement of contraceptives proceeded as planned. However, all contracts were amended during the procurement process to request an extension of the implementation period. The requirement to use ICB for blended food caused considerable delay. Thus, ADB agreed to the procurement of a smaller order of blended food using local competitive bidding, while the bulk of the order was procured under ICB. Procurement of these items was carried out according to ADB's *Guidelines for Procurement*. Overall, the procurement of the goods was satisfactory.

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[33] A minor recording problem occurred with the consultant's payroll. ADB records showed that BAPPENAS consultants were paid more than the contract price, but an error in the recording process created the appearance of an overpayment. In submitting withdrawal applications, MOF overlooked the Procurement Contract Summary Sheet (PCSS) number. As a result, all payments were recorded under the old PCSS number since each of the consultants was given two PCSS numbers. ADB resolved the problem.

[34] Due to depreciation of the rupiah, the winning bidder requested a renegotiation of the contract to decrease the quantity and increase the unit cost. ADB did not approve this.

[35] The investigation concluded (17 November 2000) that the parties involved in the bidding did not commit any irregularities.

J. Performance of Consultants, Contractors, and Suppliers

33. Generally, all consultants, contractors, and suppliers performed their tasks satisfactorily. However, some consultants did not submit progress reports to ADB and to the secretariat in BAPPENAS in a timely manner. Suppliers requested an extension of delivery of (i) blended food from 180 to 270 working days, (ii) computers and peripherals from 90 to 180 working days, (iii) medicine for CDC from 90 to 150 working days, and (iv) contraceptives from 270 to 390 working days. These extensions did not impair project implementation.

K. Performance of the Borrower and the Executing Agency

34. The success of the Program was, in large part, due to the Government's sustained commitment to providing basic social services to the poor during a national crisis. As the Borrower, MOF maintained budgetary provisions for the social sectors at pre-crisis levels, despite considerable pressure to reduce public expenditures because of declining revenues. This might have been decisive in preventing the collapse of health services. Despite initial reservations, MOF demonstrated considerable flexibility in signing a memorandum of agreement with PT Pos Indonesia. This agreement established a mechanism that allowed funds to bypass MOF's conventional public expenditure system through the State Treasury. In the context of the extraordinary circumstances in which the Program operated, the performance of the Borrower and EA was satisfactory.

L. Performance of the Asian Development Bank

35. During implementation, ADB fielded seven review missions to evaluate the progress of policy reform and project loan implementation. These missions undertook field visits, consulted with beneficiaries, worked with consultants, coordinated with other international development agencies, and discussed policies necessary for the implementation of the second tranche conditions. ADB did not field any review missions in the last year of implementation of the project loan, and MOF expressed concerns that the review missions included few field visits. Aside from these issues, ADB—through its headquarters and resident mission staff—contributed to the successful implementation of the Program. ADB demonstrated a positive approach in working with the Government, particularly in increasing the initial deposit in the imprest account from $20 million to $50 million, which facilitated program implementation. The performance of ADB was satisfactory.

III. EVALUATION OF PERFORMANCE

A. Relevance

36. The design of the HNSDP was highly relevant as a short-term response to the financial crisis as well as to the need for longer-term structural reforms. Even relatively short-term interruptions in the provision of health, nutrition, and family planning services would have had significant economic costs in the longer term. Protecting access to basic services was considered an important investment in the health and future productivity of poor and vulnerable groups. The strategy of the Government, in collaboration with ADB, was to reach the vulnerable groups and maintain the delivery of essential health services to the poor. This strategy involved measures to bypass ordinary bureaucratic systems to ensure direct and expeditious support to health service providers and beneficiaries. Focused and targeted project support, supplemented by a program of systematic policy reforms, was required to maintain access to, and the quality of, health services. Policy reforms in the social sectors had been on the Government's agenda since the mid-1990s, and had been a major topic of discussion between the Government and

external aid agencies before the crisis. After the passage of the decentralization laws, policy reforms provided a basis for the development of decentralized mechanisms for providing social services. The HNSDP helped to prepare the groundwork for decentralized delivery of social services, which is one of the Program's most enduring legacies. The policies espoused under the HNSDP have proved highly relevant. Assessment of policy implementation and continuing action (as laid out in Appendix 2) also suggests that the program was highly relevant. In respect of the project loan, the interventions designed to implement the above policy were well utilized and thus proved their relevance.

B. Efficacy in Achievement of Purpose

37. The program loan was highly successful in mitigating the impact of the crisis on the most vulnerable groups. It anticipated, and significantly contributed to, the fundamental restructuring and reform of the health sector through decentralization, including greater decentralized decision-making and more focus on access to health services for the poor. When formulated, the HNSDP was ahead of its time in pushing for decentralization to increase sustainability and accountability, and to make the management of health services more responsive to local needs by promoting greater decentralized decision-making than had ever been attempted.

38. The project loan largely achieved its targets, helping to (i) secure access of vulnerable groups to essential health, nutrition, and family planning services; (ii) ensure maintenance of the nutritional status of vulnerable groups; and (iii) reduce the incidence and impacts of communicable diseases. Evidence from monitoring[36] and studies by the Central Independent Monitoring Unit (CIMU) and MOH suggests that program resources largely reached the targeted beneficiaries, helped maintain access to effective health services for poor households, and protected populations from a deterioration in their health status. Block grants provided to health centers ensured that the quality of services was maintained. Block grants to village midwives helped maintain their services, and appeared to be an effective incentive for them to increase and improve their outreach services. This extended contact with pregnant women, particularly in remote areas. The HNSDP was also very successful in implementing health and nutrition programs in villages, revitalizing integrated community health posts. Its presence in all Indonesian villages was central to improving immunization rates, increasing monitoring of children, and supplying households with family planning services. By the end of the HNSDP, referrals for complications during pregnancy and childbirth had increased to levels comparable with those of the non-poor.

39. A lack of resources was the major factor limiting access of the poor to health care. As health card ownership reached 91.5% of poor households (as defined by health centers), utilization of health centers by poor families rose from less than 10% before the program to 17–21% (comparable to rates among the general public) by the end of the HNSDP.[37] The infant mortality rate (IMR), which was 46 per 1,000 live births in 1999, declined to 35 per 1,000 live births in 2000 and 33 per 1,000 live births in 2001. In 2002, however, the IMR increased to 43 per 1,000 live births. The decrease from 1999 to 2001 could have been due to the effect of mobilizing midwives, or the increase of mothers seeking professionally trained staff for their deliveries. While the IMR did fluctuate some during the crisis, it did not increase significantly as has been seen in other countries during economic crises.[38] The maternal mortality rate decreased from 49 per 100,000 live births in 1998 to 33 per 100,000 live births in 2002. This suggests that trained midwives have contributed to reducing risks of pregnant mothers.

[36] Summary of the HNSDP, Indonesian Child Welfare Foundation. Department of Social Affairs. 2003. *Independent Monitoring Report, Research and Development Department.*
[37] CIMU Health National Survey and Sentinel Sites Survey.
[38] For example in Brazil the IMR increased by 40% during the 1960 economic crisis.

40. Complementary and supplementary feeding under the Program was less successful. Long delays and irregular arrival of funds led to inconsistent supplies and breaks in the Program. Approximately 65% of entitled children received complementary food. However, the nutritional status improved during the crisis.[39] The evaluation study[40] found that the weight of children receiving supplementary feeding improved 50%. With the provision of contraceptives, the number of injectable users increased among the general population and the poor. In 2000, 33.8% of poor families used injectables, compared with 31.5% of poor families in 1998. The prevalence of contraceptives increased from 50.5% in 1992 to 57% in 2002 and 60.3% in 2003. The HNSDP was highly efficacious in achieving its objectives of maintaining access to health and family planning services for vulnerable groups during the economic crisis.

C. Efficiency in Achievement of Outputs and Purpose

41. The efficiency of the HNSDP depended upon the accuracy of targeting, which was based on the availability of accurate data. District, subdistrict, and village teams identified the target beneficiaries (poor families) using a mix of national and local criteria based on guidelines provided by the HNSDP. In most provinces, village midwives, community health center staff, family planning staff, integrated health post posyandu cadres, and the village head worked together to collect, review, and verify the listing of poor families. The HNSDP guidelines required that the list of target beneficiaries be reviewed every 3 months. However, verification of the listing was difficult due to the isolation of some poor families. Studies[41] have suggested that targeting was not always done consistently, and the HNSDP sometimes covered others than the poor at the village level. However, evaluation studies[42] that reviewed estimates on targeting of program benefits to the poor suggest that the accuracy of targeting in health services ran as high as 91–93%. Poor knowledge and understanding of the HNSDP by the communities at the outset limited the targeting and utilization of health services. However, improvements were shown from late 2000 onward.

42. The efficiency of the HNSDP implementation also was evaluated. The lack of training of staff responsible for implementation, and the assumption that the DCCs would have the capacity to work out the details of implementation by themselves, were overlooked. These shortcomings resulted in the delays in the initial stages of the Program, particularly when funds were received too late to ensure adequate supply for the feeding program. The DCCs were supposed to make regular visits to monitor the use of funds by community health centers and village midwives. Studies indicate, however, that less than half made one monitoring visit per month. Communication from health providers to the DCC was better with more than 80% of community health centers and village midwives sending regular reports.

43. Funds flowed directly to the targeted poor households through the services of PT Pos Indonesia. During the first year of implementation, this mechanism was not developed adequately. Midwives and puskemas had to wait for the decree issued by the district and/or mayor to get the funds. In some regions, the issuance of these decrees could take a year, causing program delays. The efficiency of implementation improved, particularly in the second year. In general, independent monitoring helped prevent corruption and maintain a high

[39] As show in Appendix 7, underweight children decreased from 29.8% in 1998 to 24.8% in 2000. The percentage of severely underweight children dropped from 10.7% in 1998 to 7.6% in 2000.
[40] Department of Community Nutrition and Family Resources. *Evaluation Study of the Health and Nutrition Sector Development Program*.
[41] ADB. 2002. *Independent Monitoring and Evaluation Program of the HNSDP*; ADB, British Council. *Social Safety Net: Protecting the Poor from Economic Crises, Lessons Learned from Indonesia 1998-2003*.
[42] British Council. 2002. *Independent Monitoring and Evaluation of the Health and Nutrition Sector Development Program Final Report.* Jakarta.

standard of implementation, which improved efficiency. Overall, the implementation process was less efficient.

D. Preliminary Assessment of Sustainability

44. The policy component of the HNSDP included policy actions aimed at ensuring the sustainability of basic social services to the most vulnerable groups. The commitment to maintain the proportion of Government spending devoted to basic social services was achieved. Since the Program finished, the development budgets for health have been maintained. The Government has redeployed public funds that previously supported fuel subsidies since 2002.[43] In 2005, to ensure the fulfillment of basic health services to the poor, the Government issued a law on *National Social Security System (UU Sistem Jaminan Sosial Nasional).* Under this law, social security programs will be implemented through an insurance scheme, which entitles poor people to free services. Additionally, in 2004, the Government developed a draft policy framework for sustainable protection of the needy and disadvantaged groups to reduce their vulnerability through TA 4124-INO: Sustainable Social Protection.

45. The HNSDP demonstrated that giving health center managers authority over integrated budgets, and flexibility to manage funds in response to local needs, can improve service delivery. Local participation in resource allocation is now a requirement under the decentralized administrative structure. Further, the principle of nongovernment involvement has been given powerful endorsement with, for example, the establishment of district committees with civil society participation. Independent monitoring, another successful innovation introduced by the HNSDP, is a sustainable idea, given that adequate funding is available for this activity. As Indonesia develops more transparent and accountable modes of governance, internal government systems for critical self-scrutiny and impartial oversight by external organizations must be developed. The Government should recognize the value of independent monitoring. The HNSDP interventions are likely to be sustainable.

E. Environmental, Sociocultural, and Other Impacts

46. The HNSDP was avowedly pro-poor. Although aimed primarily at crisis alleviation, rather than poverty reduction, the underlying assumption was that the poor were the hardest hit by the crisis and, therefore, most deserving of support. Despite some problems in identifying target populations and occasional anomalies in the selection of beneficiaries, the HNSDP largely reached those in greatest need.

47. The crisis brought poverty reduction to the center of the policy agenda, and the HNSDP helped to demonstrate that something could be done about it. It helped to establish the principle of positive discrimination in favor of the poor. This principle is now reflected, for instance, in the funding formula for decentralized allocations from the center to the districts. The HNSDP also had an impact on governance. By introducing practical features aimed at enhancing transparency and accountability, the HNSDP was in tune with the public clamor for reform and an end to corruption, collusion, and nepotism. It also was in line with long-term aims of promoting more open, representative, and responsive forms of governance. Innovations associated with the HNSDP included (i) the insistence on nongovernment participation in the coordinating committees, (ii) the attempts to increase public awareness, (iii) the embryonic structures and systems put in place for dealing with complaints, and (iv) the idea of independent monitoring. Not all these innovations were immediately successful. However, the Program did establish a set of expectations regarding transparency and accountability, and this has served as a benchmark for future programs.

[43] This Program ended December 2004.

48. Institutional development and other impacts were significant. The HNSDP promoted innovations such as block grant funding, direct fund flows, decentralized decision-making, and nongovernmental participation. The HNSDP generated greater awareness among communities of the importance of health and family planning services. Through the formation of DCCs and complaint resolution units, participation of the community (as well nongovernment organizations) in the execution of the HNSDP increased.[44] The HNSDP was not envisaged to have, and did not have, any environmental or land acquisition/involuntary resettlement impacts.

IV. OVERALL ASSESSMENT AND RECOMMENDATIONS

A. Overall Assessment

49. The HNSDP helped to mitigate the adverse impact of the economic crisis; and to promote incremental reforms aimed at improving access to basic health services, the quality of those services, and the efficiency of their management. Despite its innovative approaches, the short planning time, and unstable political and economic conditions at the outset, the Program achieved its objectives. The Program adopted a life-cycle approach, which proved to be successful. When food consumption is restricted for some household members, the whole household will be affected. Data indicate that focusing on nutrition interventions for infants, children, and women at risk improved the nutritional and health status of rural and urban communities during the crisis. The issues addressed in the Program policy matrix (see Appendix 2) were, despite the emergency nature of the loan, central to reforms in the health sector. In all of the policy areas, activities have continued, building on the initiatives introduced substantially through the program loan.

50. Much evidence suggests that the policy of free provision of services for those with health cards increased the use of the community health centers and village midwives, especially for safe motherhood services. This outcome of the HNSDP could have significance for the future, as it appears that poor members of communities accounted for the increase in health system utilization rates. The lack of experience and familiarity with implementation procedures by program management accounted for many of the problems in the first year. Additionally, delays in some program activities, socialization campaigns, and distribution of blended food reduced the effectiveness of the HNSDP during the first year of implementation. These problems were rectified, and the outputs of the Program were largely achieved. Overall, the Program was rated successful, at the higher range of this category.

B. Lessons Learned

51. One of the principal lessons from the HNSDP is that ADB and the Government are capable of developing an effective large-scale emergency package in a timely manner. However, strong leadership and support from Government are required. The HNSDP was based on the simple idea of delivering funds directly to targeted groups, but the task of identifying beneficiaries was considerably more difficult than expected. Another lesson is that circumvention of a conventional funds flow mechanism that is slow and subject to leaks is possible, allowing the disbursement of funds directly to beneficiaries and providers of basic social services for vulnerable groups.

[44] However, the Program seemed to have a negative impact in some areas, where it was observed that the spirit of mutual assistance (*gotong royong*) among the community members decreased.

52. The Government made a commitment to a set of policy reforms that were needed in support of decentralized service delivery and which reinforced the project loan interventions and strengthened the impact of the HNSDP. Although introduced as short-term assistance, the reforms in the policy matrix were a necessary part of the package. The program loan supported the initiation of nationwide sustainable policy reforms to ensure the inclusion of and equity access of the poor in key health services, and enhanced decentralized management to improve the efficiency of social services delivery. This has proved relevant after the crisis as well, as the Government faces challenges in maintaining and improving the quality of health and nutrition services under decentralization.

53. From the outset, the HNSDP lacked effective capacity development of staff to undertake their new responsibilities. Under the centralized system, staff were not used to making decisions. The budget for training staff on HNSDP procedures arrived late in some districts, and some community health centers started their activities before receiving any guidelines or training. The impact was significant. The distribution of block grants to health centers was delayed significantly, because managers did not feel comfortable disbursing the funds. Evaluation studies[45] also confirmed that members of village and district committees did not comprehend completely the principals of the HNSDP.

C. Recommendations

1. Program-Related

54. Future programs should ensure, as with HNSDP, the Government's sustained commitment to providing budget for social services to the poor. A post-program budget for continuation of the HNSDP was ensured by allocating funds from the reduced subsidies for oil to support health and education activities. And a new law on National Social Security System, issued in April 2004, includes support to poor people's access to health services. To maintain the commitment from the National Government and local governments, it is necessary to establish incentives for local governments to improve access to health services. The incentives provided by HNSDP were to establish an institutional framework which provided more decision-making power to the districts in terms of provision of health services.

55. It is important to maximize the use of local inputs. In districts in Indonesia where the quantity and variety of food supplies are adequate, locally produced food should be used in supplementary feeding programs. In disaster-stricken areas, where civil unrest and/or natural disasters cause the population to flee or prevent populations from obtaining food, the Government and external aid agencies might consider a rapid intervention with blended food. In order to support policy change, public education and awareness about the need for change should be fostered and efforts should be made to ensure the appropriate timing of an information campaign. Local nongovernment organizations or women's groups, sponsored by district health authorities, could provide the socialization, marketing, and information campaigns.

2. General

56 Targeting of project resources should be emphasized to ensure that all the poorest at the local level receive subsidized services. In many cases, national poverty criteria are not applicable locally, thus local criteria become more important in targeting. Large countries, such as Indonesia, might not need national criteria for poverty. Rather, national guiding principles about how poverty is defined, and how poverty indicators and criteria can be developed locally,

[45] ADB. 2002. *Independent Monitoring and Evaluation Program of the HNSDP*; ADB, British Council. *Social Safety Net: Protecting the Poor from Economic Crises, Lessons Learned from Indonesia 1998–2003*.

might be more effective. If local poverty criteria had been reviewed constantly and indicators of poverty monitored, the HNSDP would have been targeted better.

57. Serious attempts to provide social protection will necessitate a deliberate redistribution in favor of the poor. To improve the basic health status of the population, scarce resources will have to be channeled into areas of greatest need. Programs that attempt to give a little benefit to everyone are not efficient in reducing poverty. The Government should ensure that social protection programs are in place before another crisis occurs. These programs can address the needs of the poor in good economic times, and should be adaptable to combat the effects of a crisis. Reliable and timely information on the poor should be made available, and safety net programs should be evaluated frequently.

58. As suggested in the *Special Evaluation Study on Asian Development Bank's Crisis Management Interventions in Indonesia*[46], ADB should refine the framework for provision of crisis assistance. This framework should be comprehensive and should clearly recognize the special purpose and characteristics of crisis assistance. Further, it should develop procedures and practices at local government level for its processing and implementation, and outline arrangements for internal coordination and functioning of a checks-and-balances system in decision-making.

[46] ADB. 2001. *Special Evaluation Study on the Asian Development Bank Bank's Crisis Management Interventions in Indonesia.* Manila

PROGRAM FRAMEWORK

Design Summary	Performance Indicators/Targets	Monitoring Mechanisms	Outcomes/ Achievements
Goal Mitigate the impact of the financial and economic crisis on the poor			
Purpose 1. Access by vulnerable groups to essential health services maintained for 15.3 million poor households	1.1 Facilitate access to essential health and family planning for the poor	• Block grants to health centers • Public awareness campaigns • Revitalize national nutrition surveillance systems • Establish partnership between public health network and NGOs • Consultant inputs and training for identifying needs of culturally distinct communities	• Some 11 million households gained access to essential primary health care (70% of the coverage target). • Health cards were distributed to 92% of the identified poor households. • Public awareness campaigns were undertaken in 2001. • National nutrition surveillance system was reactivated, including a sentinel surveillance system in vulnerable provinces for food shortages and high prevalence of child malnutrition. • NGOs were involved in the complaints resolution units, and managed and monitored open houses for street and neglected children. • A specific training module was not designed.
	1.2 Develop proactive strategies targeting the poor	• Provision of block grants for intensified outreach activities • Training for midwives in targeted villages • Revitalization of *posyandus* (outreach activities organized in the community by volunteers with the support of health center staff)	• Midwives received block grants. • Midwives trained. • 208 mini-labs provided to midwives. • 94% of the targeted posyandus received revitalization package.[1]
	1.3 Better identify and assist vulnerable groups at risk from malnutrition	• Complementary feeding program for infants 6–11 months old, children 12–59 months old, and women at risk	• 65% of target coverage achieved for infants 6–11; 68% of target coverage achieved for children 12–59 months old; 72% of target

[1] Training of community health volunteers, provision of equipment, and promotional materials.

Design Summary	Performance Indicators/Targets	Monitoring Mechanisms	Outcomes/ Achievements
			coverage achieved for women at risk.
		• Reactivating FNSS	• FNSS revitalized to provide nutrition mapping for all provinces.
	1.4. Strengthen preventive and health promotion activities	• Health and nutrition programs for street and neglected children • Social marketing and health promotion campaigns • Inputs for monitoring, diagnosis, and treatment for communicable diseases	• 6,000 street and neglected children received food supplements. • Socialization and health promotion campaigns conducted in 400 districts. • Laboscopes (medical equipment) delivered to eight provinces.
		• Immunization programs for childhood illnesses • Health education programs in schools	• Adequate supply of vaccines in all provinces. • No activities have been undertaken.
2. Mobilize additional resources of essential health and nutrition services	2.1.Increase the share of government resources allocated to health, family planning, and nutrition 2.2. Maintain priority allocation of public resources to basic health services 2.3. Increase resource allocation to poor communities	Provision of block grants for health centers • Provision of block grants for midwives for outreach services • Develop a formula for allocating resources to districts based on an objective measure of poverty • Develop nutrition surveillance systems for better needs assessment • Training activities for PLKB	• No specific activities undertaken. • Block grants allocated to health centers ($26 million). • Block grants allocated to midwives ($20 million). • Formulas to target poor households have been adopted, based on poverty data from National BKKBN, SUSENAS and adjusted to the local context. • Surveillance system was established at national and district level. • 35,000 PLKB trained.
	2.4. Encourage greater private sector expenditure on health care	• Review of income tax act to provide incentives for greater investment in employee health care	• Review of income tax still ongoing.
3. Maintain quality of essential health services	3.1. Maintain intensity of supervision and monitoring activities for basic health services	• Train health centers to increase responsiveness to community and improve efficiency • Training in oversight and monitoring role of village and district health communities	• Training conducted for health centers on management. No new procedures have been introduced to increase responsiveness to communities and efficiency.
	3.2. Maintain training programs for basic health personnel	• Training in rational use of drugs and standards protocols for diagnosis and treatment	• Training conducted.
		• Training and monitoring	• Training conducted. No effective training evaluation system has been developed.

Design Summary	Performance Indicators/Targets	Monitoring Mechanisms	Outcomes/ Achievements
	3.3. Maintain family planning programs for the poor	• Assistance to develop outsourcing of training	• No outsourcing of training.
		• Provision of contraceptives and materials • Training of counseling and technical skills improvement	• Contraceptives distributed in all provinces. Sufficient supply of contraceptives. • 10,800 PLKB trained in counseling. • Grants to midwives provided incentives for outreach activities.
4. Enhance decentralization, participation, and transparency	4.1 Delegate authority to local levels for planning and resource allocation to improve targeting of resources to the poor, and enable flexible and timely response to emerging health issues 4.2. Develop local management capacity 4.3. Strengthen community oversight of basic health and nutrition services	• Capacity building in planning and management for consolidated budgeting • Evaluation of capacity-building program through TA • Training models developed through TA • NGO participation in beneficiary targeting and monitoring • Review of health system organizations and structure • Capacity building in operational planning and management	• TA 3176 provided essential data on management capacity and performance of health services, which provided inputs to the design of training modules on management capacity and performance of health services. • NGOs participated in monitoring of support to street and neglected children. Some NGOs are preparing a proposal including monitoring of services provided by health centers. • Strategic development adviser employed to support review of health system organizations and structures.
		• Integrated health planning and budgeting for all districts • Capacity building in planning and management for local nutrition surveillance committees	• Training on integrated health planning and budgeting conducted for all districts. All districts have prepared action plans for integrated health planning and budgeting.
		• Training of local committees	• Training module developed by MOH on special budget allocation for health services for the poor.
		• New selection criteria for heads of health centers to increase responsiveness to community	• New selection criteria introduced.
5. Introduce structural changes and development of MOH	5.1. Develop strategic development plan for MOH	• Systems development assistance, training, and capacity building in planning and implementing health	• Health management and financial management systems developed based on basic minimum standards.

Design Summary	Performance Indicators/Targets	Monitoring Mechanisms	Outcomes/ Achievements
		management information system, financial management and monitoring system, and health human resource information and management system	
		• Develop information and reporting systems responsive to data needs at district, province, and central levels to support timely response to emerging health and nutrition concerns	• Districts submitted data to MOH every six months, which are used for planning and monitoring.
		• Streamline data collection and reporting requirements, clarify roles and responsibilities, allocate resources and authority consistent with responsibilities	• Reporting on health data to MOH has been streamlined.
	5.2. Develop information systems	• Develop data analysis capability to support planning and policy formulation • System development assistance, training and capacity building in planning, financial management and monitoring system, and health resources information and management system • More effective control, deployment, and utilization of human resources • Improved performance and efficiency through rationalization and appropriate incentive structure	• Not implemented.
6. Improve efficiency of resource use	6.1. Strengthen responsibility and accountability of local managers 6.2. Strengthen management and responsiveness of health centers	• Clarify responsibilities and develop performance benchmarks • Pilot test utilization of block grant mechanism for flexible personnel management • Targeting based on poverty to improve equity in fund allocation among health centers	• Fund allocation among health centers based on poverty indicators. Block grant funding as introduced by the Project was continued until the end of 2004. New selection procedures of health facility managers adopted.

Design Summary	Performance Indicators/Targets	Monitoring Mechanisms	Outcomes/ Achievements
		• Extend block grant funding mechanism to support health centers directly • Establish of mechanism to improve targeting of Government subsidies • Increase number of facilities with autonomous management and revenue collection responsibilities • Increase accountability of health facility managers • Financial systems development and design of training modules (through TA) • Intensified staff training based on training needs assessment • Ensure effective control/utilization through improved financial management capabilities of staff, comprehensive financial audit systems, and greater community participation	
	6.3. Improve the cost-efficiency of pharmaceutical use	• Streamline essential drugs list • Train health providers in rational use of drugs	• Essential drug lists have been streamlined and training in rational use of drugs has been undertaken.
	6.4. Maintain private sector involvement	• Public/private partnership in monitoring and service delivery	• NGO forum involved in monitoring service delivery

BAPPENAS = National Development Planning Agency; BKKBN = National Family Planning Coordinating Board; FNSS = Food and Nutrition Surveillance System; MOH = Ministry of Health; NGO = nongovernment organization; PLKB = family planning field worker; SUSENAS = National Socioeconomic Survey; TA = technical assistance.

UPDATE ON THE POLICY MATRIX

Policy Priorities	Conditions Fulfilled by Loan Effectiveness 25 March 1999 for First Tranche Release	Conditions Fulfilled by 31 March[1] 2000 for Second and Last Tranche Release	Current Status of Project Completion Review Mission (April 2005)
A. Maintain Access of Vulnerable Groups to Essential Health Services			
1. Facilitate access of the poor to essential health and family planning services	• MOH issued guidelines on 7 October 1998 to implement an objective and transparent system to identify the poor who were eligible for free health services (including family planning). • MOH issued a ministerial decree 18 February 1999 to implement a mechanism to allocate MOH budget to districts based on an objective assessment of the number of the poor in the district.	• MOH issued a ministerial decree defining a package of essential health services (including family planning and nutrition services) that must be universally accessible. • MOH formulated a financing plan for delivery of the essential package of services including collection of user fees of charges linked to the beneficiaries' ability to pay. • MOH issued guidelines, within the framework of regulations on implementation of Law 22/99 and Law 25/99, to district health offices and district health committees, institutionalizing the link between the budget allocated to health centers within the district and the number of poor in the health catchment area.	• In 2002, the Government reduced subsidies for oil. Some of the savings were used to support the safety net program, particularly in health and education. • ADB's new projects (DHS-1), approved in November 2000, and DHS-2, approved in March 2005), support health decentralization and require local governments to prepare local schemes to protect access to health services for the poor. • The Law on National Social Security System issued in April 2004 includes supporting access of poor people to health services.

[1] The schedule was delayed by 9 months (December 2000), largely because of the Government's preoccupation with administrative restructuring, bureaucratic reform, and staff changes following Presidential elections in October 1999, and the accelerated implementation of decentralized legislation adopted in mid-1999.

Policy Priorities	Conditions Fulfilled by Loan Effectiveness 25 March 1999 for First Tranche Release	Conditions Fulfilled by 31 March[1] 2000 for Second and Last Tranche Release	Current Status of Project Completion Review Mission (April 2005)
2. Develop proactive activities targeting the poor	• MOH issued instructions to health centers and village midwives to develop outreach plans for the poor. The plan included (i) the list of poor families in the midwife's area, (ii) the number of pregnant women and young children among these families, (iii) the number of home visits to these families planned for the 3 months of the Program. • Budget allocation to MOH, verified by BAPPENAS 31 March 2000, ensured sufficient budget allocation for village midwives outreach activities for FY2000. • Budget allocation to MOH, verified by BAPPENAS 21 June 1999, ensured sufficient budget allocation for expansion of village midwives' outreach activities for FY2000.	• MOH developed guidelines and introduced procedures to ensure funding for the outreach activities of the village midwives' quarterly activity plans. Implementation of these plans was coordinated and supervised by the health center concerned.	• The program of outreach health services by the village midwives initiated under the HNSDP has proved very successful. Funds were guaranteed until 2005. • With decentralization, local governments will have to take over financing of health, village midwives, and outreach activities. Advocacy campaigns and policy dialogue under ADB's new health sector projects are continuously lobbying local governments to continue outreach programs.
3. Better identify and target vulnerable groups at risk from malnutrition	• MOHA issued instructions requiring the provincial and district committees of the FNSS to submit quarterly reports. Ministerial instruction issued 4 November1998. • The Government issued necessary administrative	• FNSS provided map on malnutrition using geographic information system, and application training completed to district personnel. Quarterly reports are being submitted regularly.	• Village team established to verify and validate data on poor households. • District government issued decree on poverty criteria adjusted to local conditions for better identification of vulnerable and poor households.

Policy Priorities	Conditions Fulfilled by Loan Effectiveness 25 March 1999 for First Tranche Release	Conditions Fulfilled by 31 March[1] 2000 for Second and Last Tranche Release	Current Status of Project Completion Review Mission (April 2005)
	orders (ministerial decree issued by Minister of Food and Horticulture 25 June 1998) to reestablish the intersectoral committee for the FNSS, and appointed the committee members in all provinces and districts.		
4. Strengthen preventive and health promotion programs	• MOH issued an administrative order 18 February 1999 to establish a working group to strengthen health promotion campaigns to address existing health concerns and emerging "lifestyle" issues, specifically including programs to reduce smoking and to promote family life education (especially adolescent reproductive health).	• The Government and MOH earmarked at least 2% of the MOH budget (routine and development) for FY2000, FY2001, and FY2002 for health promotion (before March 2001). Budget allocation, certified by BAPPENAS 31 March 2000 indicated, 2.88% of MOH budget used for health promotion.	• MOH maintained budget allocation for health promotion at least at the same level of 2001.
	• MOH issued an administrative order to establish a working group in cooperation with the Ministries of Education and Culture and Religious Affairs to strengthen health education, including nutrition and reproductive health, in the formal school curriculum.		• The working group is still active. • Health education, including nutrition and reproductive health, has been partly accommodated in school curriculum (competency based curriculum).

Policy Priorities	Conditions Fulfilled by Loan Effectiveness 25 March 1999 for First Tranche Release	Conditions Fulfilled by 31 March[1] 2000 for Second and Last Tranche Release	Current Status of Project Completion Review Mission (April 2005)
B. Mobilize Additional Resources to Support Essential Health and Nutrition Services			
1. Increase the share of Government resources allocated to health, family planning, and nutrition.	• The Government maintained the share of development expenditures allocated to health, family planning, and nutrition in the FY1999 and FY2000 budget at the same level as in FY1997.	• The Government allocated 3.11% of the FY2000 budget (routine and development expenditures) for health, nutrition, and family planning programs (excluding district level allocation). • The Government allocated at least 4% of the FY2001 Budget (routine and development expenditures), and annually thereafter, for health, nutrition, and family planning programs (health sector routine and development expenditures, excluding transfers to provinces and districts). • In the central Government budget allocation for FY2000, the proportion of the budget for health sector declined from 3.70% in FY1997 to 3.11% in FY2000. However, this was offset by provincial and district allocation to basic health services from budget transfers.	• Budget allocated from part of the reduction of oil subsidy being used for ensuring access of poor households to basic health services and nutrition. • The new health sector projects supporting decentralization (funded by ADB, World Bank, and other development partners) give priority to financing primary health care and those services most used by the poor. • Based on the Law on National Social Security System, a new health insurance system managed by PT ASKES was introduced in 2005 with the premium for the poor being paid by the Government. • The proportion of the budget for health, nutrition, and family planning in 2001, 2002, 2003, and 2004 was 2.01%, 2.53%,

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			3.23%, and 3.36%, respectively. (This does not include national budget allocated to districts; starting 2001, when fiscal decentralization was implemented, budgets for social sectors were allocated directly to district governments in form of General Allocation Fund and Special Allocation Fund).
2. Maintain priority allocation of public resources to basic health services		• The Government ensured that the proportion of the Budget (routine and development expenditures, for the health sector, including transfers from the Government to provinces and districts) allocated to basic health services in the FY2000 budget and thereafter was at least the same as in FY1997.	• MOH set national standards and guidelines on nutrition, food, and medicine quality and distribution. MOH uses the standards to monitor the performance of districts and provinces on critical indicators. Districts and provinces will receive block grants from the central Government, and will be responsible for managing their own health planning and budgeting to reflect local needs and priorities and to provide community-oriented health services.
3. Increase resource allocation to poor communities	• The MOH issued an administrative order to develop a funding mechanism to allocate a greater share of public health resources to poor communities based on objective measures of poverty and population.	• The Government issued administrative orders to introduce a resources allocation mechanism, employing objective of poverty and population criteria, to allocate a larger share of Government resources to poorer districts.	• The Government set up regulations describing in detail the criteria and formulas for allocating funds from the central Government to local governments, consistent with Law 25/99. Through the Equalization Fund, poor districts will receive larger budget allocations, in addition to locally

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4. Encourage greater private sector expenditure on health care (prevention and promotion)		• MOF issued an administrative order to establish a working group, with participation from other concerned agencies. The working group was established 17 November 2000. The working group reviewed relevant provisions of the income tax laws and regulations to assess the purposes of calculating income tax liabilities the feasibility of deducting from pre-tax income (i) corporate expenditures on employee health care and qualifying expenditures on health promotion and preventive health care (including health insurance premiums and the investment and recurrent costs for improving occupational health and safety of employees), and (ii) individual expenditures on health insurance premiums. • The Government made sufficient allocation in the FY2000 budget to maintain supervision activities by the health centers (over midwives and subhealth centers) and by district health office over the health centers at least at the same level as in FY1997.	generated revenues. • DHS-2 advocates spending of 5% of the regional annual budget for the health sector by the end of the DHS-2; and will promote an integrated approach to health financing, cross sectoral coordination, public-private partnerships, monitoring of health service performance, and of health status indicators, dissemination of information, and increased transparency and accountability. • The Government issued Law on National Social Security System in April 2004, which encourages greater private sector contribution on health care using health insurance system. • The steering committee convened a national workshop with participation of the private sector, (including employers, insurance providers, and others), professional associations (medical, financial, accounting), and other interested parties, to review and strengthen the recommendations and make specific proposals to MOF for consideration during the next review of the income tax law. The

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			MOF incorporated such recommendations in appropriate administrative orders, ministerial decrees, draft legislation to amend the laws, and regulations on income tax 31 March 2002. • DHS-1 and DHS-2 projects strengthen public-private partnerships in health care delivery and financing.
C. Maintain Quality of Essential Health and Nutrition Services			
1. Maintain supervision and monitoring activities for basic health services	• The Government made sufficient allocation in the FY1999 and FY2000 budget to maintain supervision activities by the health centers (over village midwifes and subhealth centers) and by the district health office over the health centers at least at the same level as in FY1997.	• The Government made sufficient allocation in the FY2000 budget to maintain MOH training activities in the districts and provinces at least at the same level as in FY1997.	• In the context of decentralization, MOH provides assistance to strengthen local capacity in health services delivery, including planning and management; and improve quality, cost efficiency, and sustainability of health and family planning services (implemented in DHS-1 project and continued and extended through DHS-2 project).
2. Maintain training programs for basic health personnel	• The Government made sufficient allocation in the FY1999 and FY2000 budget to maintain MOH training activities in the districts and provinces at least at the same	• MOH submitted to ADB a consolidated training program to strengthen the effective delivery of health services, particularly through enhanced outreach activities and the rational use of drugs, including	• Training program is being implemented and continued.

Policy Priorities	Conditions Fulfilled by Loan Effectiveness 25 March 1999 for First Tranche Release	Conditions Fulfilled by 31 March[1] 2000 for Second and Last Tranche Release	Current Status of Project Completion Review Mission (April 2005)
	level as in FY1997.	appropriate training modules, materials, identification of trainers and schedule for implementation for all districts beginning in FY1999 and FY2000.	
3. Maintain family planning programs for the poor		• Each health center submitted to the district coordinating committee a plan and schedule for delivery of refresher training to all kaders (volunteers working in the *posyandus* (village health post) it supervises using standardized training modules as a condition of replenishing its block grant. • The Government submitted to ADB a medium-term strategy to maintain access to family planning services for the poor, including measures to provide methods of contraception appropriate to the individual needs of the acceptor (cafeteria system) and counseling to acceptors if switching methods becomes necessary due to inadequate suppliers or irregular distribution.	• The mechanisms used under JPS-BK program (SPSDP and HNSDP, and later funded by oil subsidy compensation) has been continued at district level. • BKKBN's 5-year development plan was updated for 1999–2004. • The National Medium-Term Planning has been issued. • Starting on 1 January 2004, BKKBN decentralized its family planning services, and regional governments become responsible for ensuring access to the family planning and reproductive health programs. BKKBN's vision is to help Indonesian families become prosperous, healthy, and independent, with only two children, and to provide access to family planning services for the poor. One policy of BKKBN is to ensure continuous availability of free or subsidized contraceptives for the poor.

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D. Enhancing Decentralization, Participation, and Transparency.			
1. Delegate further authority to local levels for planning and resource allocation in the health sector to improve targeting of resources to the poor, and to enable flexible and timely response to emerging health issues. Develop local management capacity.	• MOH submitted to ADB a plan to extend and accelerate the effective implementation of IHPB for all districts. • The Government issued instructions establishing a legal/administrative framework for the block grant mechanisms as the principal means of financing essential health services at the district level, including health centers and village midwives. • MOF issued an administrative order to adopt specific block grants as the principal mechanism to channel operations and maintenance funds directly to the operational level (e.g., health centers) in all districts. • MOH issued an administrative order delegating responsibility and authority to the district level to identify the poor and vulnerable, allocate resources,	• MOH submitted to ADB proposed revisions to the IHPB system and procedures. • MOH submitted to ADB Decentralized Human Resources Development Plan for staff training to support implementation of the streamlined IHPB system at the district level, and for training of health center staff in integrated budget planning and management, including training needs assessment, training modules and materials, identification of trainers, timetables, and indicative budgets. • MOH submitted to ADB on 17 March 2000 a report on the implementation of the monitoring system to determine whether resources are reaching health centers on a timely basis, and whether these resources are used effectively to enhance quality of services.	• The Government issued necessary instructions and/or regulations to make block grants the principal means of providing central Government funds to the districts. • MOH set national standards and guidelines on nutrition, food, and medicine quality and distribution. MOH uses the standards to monitor the performance of districts and provinces on critical indicators. Districts and provinces will receive block grants from the central Government, and will be responsible for managing their own health planning and budgeting to reflect local needs and priorities, and to provide community-oriented health services. • JPS-BK (SPSDP and HNSDP) developed implementation and utilization of integrated health planning and budgeting (IHPB) in all districts. The IHPB has been implemented. • Because the potential problems of decentralization of health

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	and provide basic health service to manage health services and improve their quality and efficiency.		services are of major concern, all aid agencies involved in the health sector are participating in efforts to strengthen local capacity and assist local governments in identifying needs, developing and implementing appropriate reforms, and making adequate and cost-efficient investments.
2. Strengthen community oversight of basic health and nutrition services	• MOH issued an administrative order establishing a working group to review the role(s) of community organizations involved in health services at the district and subdistrict level and recommendations to strengthen the role of the community in oversight and management, especially financial management, of health sector resources.	• MOH submitted to ADB public awareness training programs for health communities at the district level and their village-level counterparts to clarify functions and responsibilities and to enhance effective community participation in, and transparency of, resource allocation.	• Working group established. Community organization incorporated in MOH monitoring and complaints resolution structures.
E. MOH Organizational Change and Development			
1. Strategic development plan for MOH	• MOH issued an administrative order establishing a high level working group to undertake a comprehensive strategic review of structure and staffing of MOH, including	• MOH submitted a medium-term (5–7 years) strategy for decentralization of human resources management, including an assessment of needed capacity building, systems development, and staff training and redeployment.	• Healthy Indonesia 2010, developed in 1999, describes MOH's vision, strategy, and policy. The vision is to ensure that the Indonesian people live in a healthy environment with healthy living behavior, and

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	redefinition of roles and responsibilities of central, provincial, and district levels to accommodate and support the decentralization process. • MOH issued an administrative order establishing an executive steering committee, with participation of all major MOH operating units and MOH regional units, to coordinate plans, coordinate programs, integrate policy development, and manage the restructuring of MOH.		obtain qualified health services that are effective, efficient, and evenly distributed. MOH developed strategic planning to promote healthy Indonesia based on preventive and promotion approaches. • MOH issued National Health System using the preventive approach of Health Paradigm 2010. • DHS-2 will help strengthen coordination and cooperation among districts and provinces, in particular for epidemiological surveillance and control of communicable diseases, for developing an effective referral system, and for developing capacity in the provincial hospitals to train qualified professionals that will work in the region. Dialogue with regional governments will emphasize the benefits of involving professional associations, local universities, the private sector, and local NGOs in managing local health services. • MOH, together with Parliament, is preparing laws and regulations to ensure people's access to essential health services.

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2. Legislative and regulatory framework	• MOH, in consultation with MOHA and other ministries, identified legislative and regulatory instruments (MOH, MOHA, MOF etc) that require updating or revision to support greater decentralization of health services delivery.	• MOH prepared, in consultation with all ministries concerned, an integrated proposal to update and rationalize the legal and regulatory framework for decentralized health care delivery and management and (i) issued appropriate ministerial instructions (MOH, MOHA, etc.) to address issues within the ministerial competence, and (ii) prepared and submitted draft bills for legislative action.	
3. Information systems development	• MOH issued administrative orders establishing a high-level working group to coordinate preparation and implementation of a program to improve accuracy, reliability, and timeliness of collection, validation, and analysis of data to support operational and strategic decision making.	• MOH submitted to ADB a strategy and timetable (including indicative resources) to develop and implement a single integrated information system to meet health data requirements of all MOH vertical programs and operational units, and to eliminate parallel and redundant data collection and processing systems. • MOH has included accuracy, timeliness, and comprehensiveness of reporting as factors in the performance evaluation for all operational unit managers to ensure continuity, quality, and consistency of routine facility-based reports.	• District health information systems have been developed and pilot tested with ADB and World Bank assistance. • FNSS has been developed at central, provincial, and district levels. It provides map on malnutrition using a geographic information system. Quarterly reports are being submitted regularly. However, the system is not functioning properly in some districts. In addition, the Government issued a decree on the establishment of a Food (and Nutrition) Security Body at central and provincial levels.
4. Improve efficiency of resource use			
a. Strengthen responsibility	• Decree issued by MOHA confirming that unit swadana	• Government devised a policy matrix and guide in reducing subsidies to	

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and accountability of local managers	hospitals (hospitals that have been granted partial financial autonomy with the objective of becoming self-sufficient) are exempted from transferring their revenues to local government, and issue instructions to local governments to permit all district hospitals to retain their revenues and to use such revenues for hospital operational costs.	self-financing swadana hospitals, linking future subsidy to the services provided to the poor. • MOH submitted an evaluation of the feasibility of applying the swadana management concept at the health center level.	• Swadana (self-supporting) management was implemented in provincial and district hospitals. The system was extended to some big primary health centers (puskesmas), particularly in urban (city) areas.
b. Strengthen management and responsiveness of health centers	• MOH and MOHA issued a joint decree providing that the minimum qualification for candidates for the head of a health center will be trained in public health. If the selected candidate does not have prior management experience, appropriate management training will be provided within 6 months of appointment. • MOH will submit to ADB a plan to test and evaluate, on a trial basis, the appointment of trained personnel resident in the community as health center head.	• MOH submitted a proposal to pilot test the provision of block grants to districts and to health centers to cover personnel costs (salaries and allowances) and to permit more flexible staff recruitment, deployment and management, and incentive practices to provide services more efficiently. • MOH established a working group to test and evaluate, on a trial basis, the delegation of authority/flexibility to designated districts to modify staffing patterns of health centers to better meet local requirements, including possible contracting of doctors to provide services to groups of health centers. • The MOH reviewed regulations and procedures on recruitment, assignment, and release of staff;	

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		and, where possible, devised approaches to enable districts to more effectively balance skill requirements and distribution of staff.	
c. Improve the cost-efficiency of pharmaceutical use	• MOH issued an administrative order establishing a working group to review the existing National Drugs List to ensure only those drugs needed for the delivery of essential health services are procured for health centers and district hospitals.	• MOH revised the National Essential Drugs List and ensured the supply of the reduced list of essential pharmaceuticals to all public health facilities. • MOH issued instructions governing the transparent and cost-effective procurement of supplementary drug needs by districts to target local needs effectively.	• Badan Pengawasan Obat dan Makanan (Food and Drugs Control Agency) has been established as a separate institution (previously under MOH). • Proposals have been developed with the Indonesian Medical Association.
	• MOH reviewed adherence of existing guidelines on the rational use of drugs, and devised a training program for all primary health care providers, incorporating a system for monitoring compliance with treatment protocols.	• MOH submitted a plan covering delivery of in-service training on the rational use of drugs to health care providers in all public health facilities (including training needs assessment, proposed training modules and materials, identification of trainers, schedule, and indicative budget).	
	• MOH issued guidelines governing the supplementary purchase of pharmaceuticals by health centers from block grants.	• MOH submitted a proposal on collaboration with professional associations to provide training on the rational use of drugs to private health care providers. • MOH submitted a strategy and program for public information	

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		campaigns targeting users of health centers to provide information on generic drugs and the rational use of drugs.	
d. Maintain private sector involvement	• MOH issued an administrative order establishing a working group to monitor and assess the impact of the crisis on the utilization, performance, and finances of private health providers (including private hospitals and clinics), and to ensure that private sector providers are not discriminated against in implementation of the HNSDP.	• MOH provided a policy statement supporting equitable treatment of private providers in provision of health services to the poor and initiated a study of options to facilitate the involvement of the private sector and private health providers in the implementation of managed health care.	• Measures to ensure equitable treatment of private providers incorporated in MOH Business Plan for a Sustainable Social Safety Net Under Decentralization. Business plan to be finalized within evolving framework of regulations on implementation of Law 22/99 and Law 25/99. • Dialogue with regional governments will emphasize the benefits of involving professional associations, local universities, the private sector, and local NGOs in managing local health services (DHS-2).

ADB = Asian Development Bank; BKKBN = National Family Planning Coordinating Board; DHS-1 = First Decentralized Health Services Project; DHS-2 = Second Decentralized Health Services Project; FNSS = Food and Nutrition Surveillance System; FY = fiscal year; HNSDP = Health and Nutrition Sector Development Program; IHPB = integrated health planning and budgeting; MOF = Ministry of Finance; MOH = Ministry of Health; MOHA = Ministry of Home Affairs; NGO = nongovernment organization; SPSDP = Social Sector Development Program.

PROJECT COST BY COMPONENT
($ million)

Component	Total Project Cost (Appraisal)			Appraisal						Actual						Total Project Cost (Actual)		
				ADB Financing			Government Financing			ADB Financing			Government Financing[a/]					
	Foreign Exchange	Local Cost	Total	Foreign Exchange	Local Cost	Total	Foreign Exchange	Local Cost	Total	Foreign Exchange	Local Cost	Total	Foreign Cost	Local Cost	Total	Foreign Exchange	Local Cost	Total
A. 1. Base Costs																		
Health Services for Poor Families	23.23	59.74	82.97	10.73	27.59	38.32	12.50	32.14	44.64	7.55	19.39	26.94	11.81	25.70	37.51	19.36	45.09	64.45
Safe Motherhood for Poor Families	5.96	53.62	59.58	2.98	26.81	29.79	2.98	26.81	29.79	1.95	17.57	19.52	3.05	23.29	26.34	5.00	40.86	45.86
Subtotal	**29.19**	**113.36**	**142.55**	**13.71**	**54.40**	**68.11**	**15.48**	**58.95**	**74.43**	**9.50**	**36.96**	**46.46**	**14.86**	**48.99**	**63.85**	**24.36**	**85.95**	**110.31**
2. Communicable Disease Control	**3.50**	**14.04**	**17.54**	**1.60**	**6.44**	**8.04**	**1.90**	**7.60**	**9.51**	**1.15**	**4.86**	**6.01**	**1.80**	**6.44**	**8.24**	**2.95**	**11.30**	**14.25**
3. Nutrition																		
Infant Feeding	38.12	0.00	38.12	17.61	0.00	17.61	20.51	0.00	20.51	10.70	0.00	10.70	16.74	0.00	16.74	27.44	0.00	27.44
Supplementary Feeding (Children Under 2)	0.00	75.05	75.05	0.00	34.66	34.66	0.00	40.38	40.38	0.00	29.93	29.93	0.00	39.67	39.67	0.00	69.60	69.60
Supplementary Feeding (Pregnant Women)	0.00	24.12	24.12	0.00	11.14	11.14	0.00	12.98	12.98	0.00	9.40	9.40	0.00	12.46	12.46	0.00	21.86	21.86
Revitalization of Food and Nutrition Surveillance	0.41	0.21	0.62	0.41	0.21	0.62	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Subtotal	**38.53**	**99.38**	**137.91**	**18.02**	**46.01**	**64.03**	**20.51**	**53.36**	**73.87**	**10.70**	**39.33**	**50.03**	**16.74**	**52.14**	**68.87**	**27.44**	**91.47**	**118.90**
4. Revitalization of Posyandu	**6.06**	**27.26**	**33.33**	**1.63**	**7.31**	**8.94**	**4.43**	**19.95**	**24.39**	**2.24**	**10.05**	**12.29**	**3.50**	**13.32**	**16.83**	**5.74**	**23.37**	**29.12**
5. Family Planning																		
Long-Term Method	2.16	3.02	5.18	1.08	1.51	2.59	1.08	1.51	2.59	0.67	0.93	1.60	1.05	1.23	2.28	1.72	2.16	3.88
Supply of Contraceptives	14.41	1.61	16.02	10.13	1.13	11.26	4.28	0.48	4.76	9.26	1.03	10.29	14.48	1.37	15.85	23.74	2.40	26.14
Increasing Access of Services	0.00	1.66	1.66	0.00	1.66	1.66	0.00	0.00	0.00	0.00	2.10	2.10	0.00	2.78	2.78	0.00	4.88	4.88
Maintaining Quality of Services	0.00	4.50	4.50	0.00	4.50	4.50	0.00	0.00	0.00	0.00	1.68	1.68	0.00	2.23	2.23	0.00	3.91	3.91
Subtotal	**16.57**	**10.79**	**27.36**	**11.21**	**8.80**	**20.01**	**5.36**	**1.99**	**7.35**	**9.93**	**5.74**	**15.67**	**15.53**	**7.61**	**23.14**	**25.46**	**13.35**	**38.81**

Component	Total Project Cost (Appraisal)			Appraisal						Actual						Total Project Cost (Actual)		
				ADB Financing			Government Financing			ADB Financing			Government Financing[a/]					
	Foreign Exchange	Local Cost	Total	Foreign Exchange	Local Cost	Total	Foreign Exchange	Local Cost	Total	Foreign Exchange	Local Cost	Total	Foreign Cost	Local Cost	Total	Foreign Exchange	Local Cost	Total
6. Programs for Street Children and Neglected Children	**1.37**	**25.94**	**27.31**	**0.91**	**17.29**	**18.20**	**0.46**	**8.65**	**9.10**	**0.48**	**9.14**	**9.62**	**0.75**	**12.12**	**12.87**	**1.23**	**21.26**	**22.49**
7. Ministry of Health System Development	**2.45**	**9.05**	**11.50**	**0.96**	**3.54**	**4.50**	**1.49**	**5.51**	**7.00**	**0.14**	**0.55**	**0.69**	**0.22**	**0.73**	**0.95**	**0.36**	**1.28**	**1.64**
8. Training and Staff Development	**0.00**	**8.73**	**8.73**	**0.00**	**2.00**	**2.00**	**0.00**	**6.73**	**6.73**	**0.00**	**4.24**	**4.24**	**0.00**	**5.62**	**5.62**	**0.00**	**9.86**	**9.86**
9. Implementation Social Awareness, Health Promotion and Health Education	0.30	3.20	3.50	0.30	2.70	3.00	0.00	0.50	0.50	0.17	0.62	0.79	0.00	0.82	0.82	0.17	1.44	1.61
Provincial/District Monitoring and Supervision	0.15	8.86	9.01	0.15	1.36	1.51	0.00	7.50	7.50	1.98	6.47	8.45	0.00	8.58	8.58	1.98	15.05	17.03
Program Management, Operations Research & Evaluation	1.35	1.15	2.50	0.90	0.76	1.66	0.45	0.38	0.83	3.62	2.35	5.97	5.66	3.12	8.78	9.28	5.47	14.75
Subtotal	**1.80**	**13.21**	**15.01**	**1.35**	**4.82**	**6.17**	**0.45**	**8.38**	**8.83**	**5.77**	**9.44**	**15.21**	**5.66**	**12.51**	**18.18**	**11.43**	**21.95**	**33.39**
10. Taxes and Duties[b]	0.00	3.22	3.22	0.00	0.00	0.00	0.00	3.22	3.22	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Subtotal (A)	**99.47**	**324.98**	**424.46**	**49.39**	**150.61**	**200.00**	**50.08**	**174.34**	**224.43**	**39.91**	**120.31**	**160.22**	**59.06**	**159.48**	**218.54**	**98.97**	**279.79**	**378.76**
B. Contingencies[c]																		
Physical Contingencies	3.69	13.30	16.99	0.00	0.00	0.00	3.69	13.30	16.99	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Price Escalation	11.30	13.70	25.00	0.00	0.00	0.00	11.30	13.70	25.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Subtotal (B)	**14.99**	**27.00**	**41.99**	**0.00**	**0.00**	**0.00**	**14.99**	**27.00**	**41.99**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
C. Interest/Other Charges During Implementatio	**12.62**	**0.00**	**12.62**	**0.00**	**0.00**	**0.00**	**12.62**	**0.00**	**12.62**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
Total Project Cost	**127.08**	**351.98**	**479.07**	**49.39**	**150.61**	**200.00**	**77.69**	**201.34**	**279.04**	**39.91**	**120.31**	**160.22**	**59.06**	**159.48**	**218.54**	**98.97**	**279.79**	**378.76**

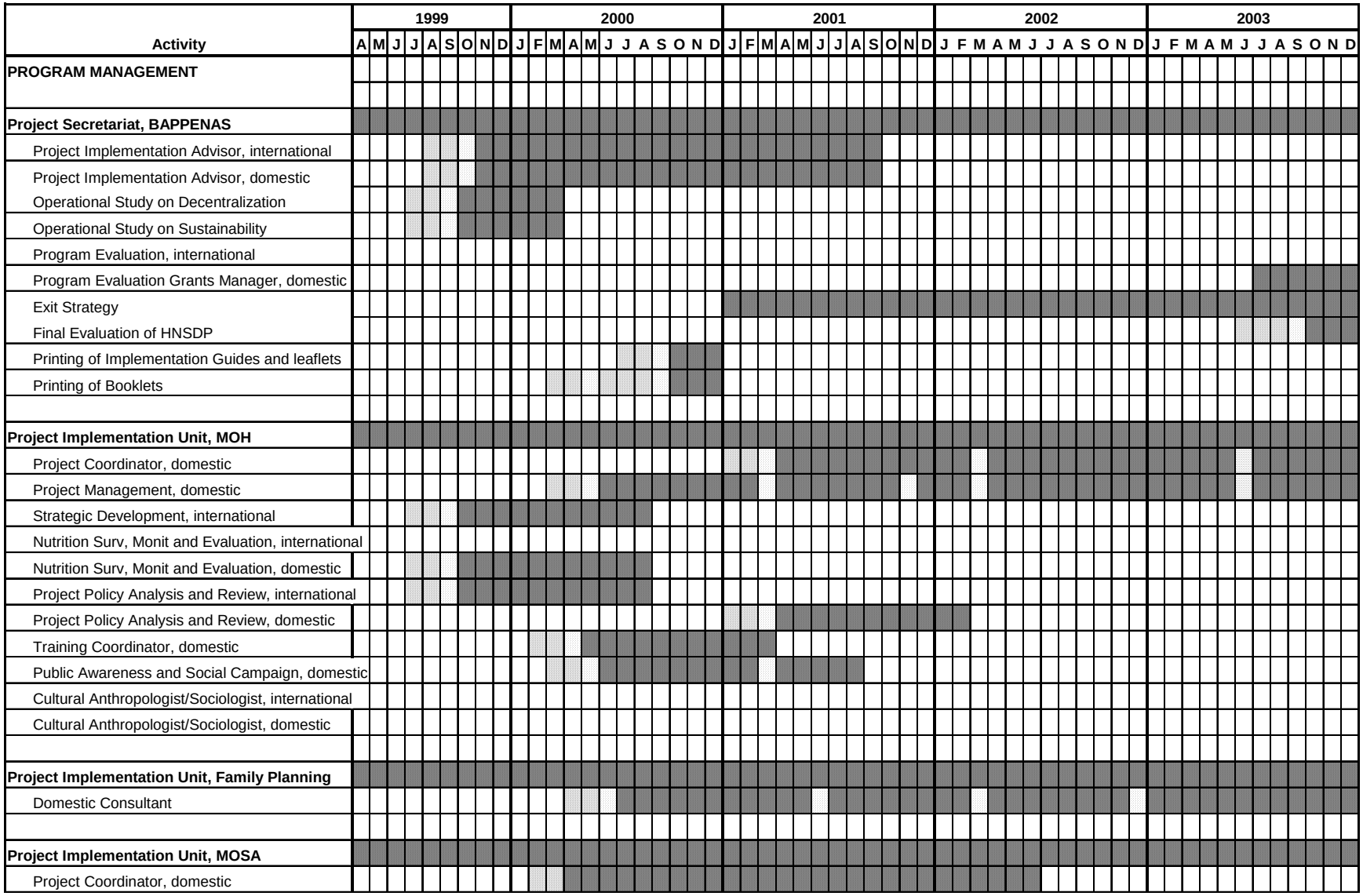
[a] The data is based on the government investment budget provided by the Govenrment of Indonesia. Total project cost representing the Government's total allocation for health/nutrition, including 58% mandatory government investment on a parallel basis, in accordance with the Loan Agreement.

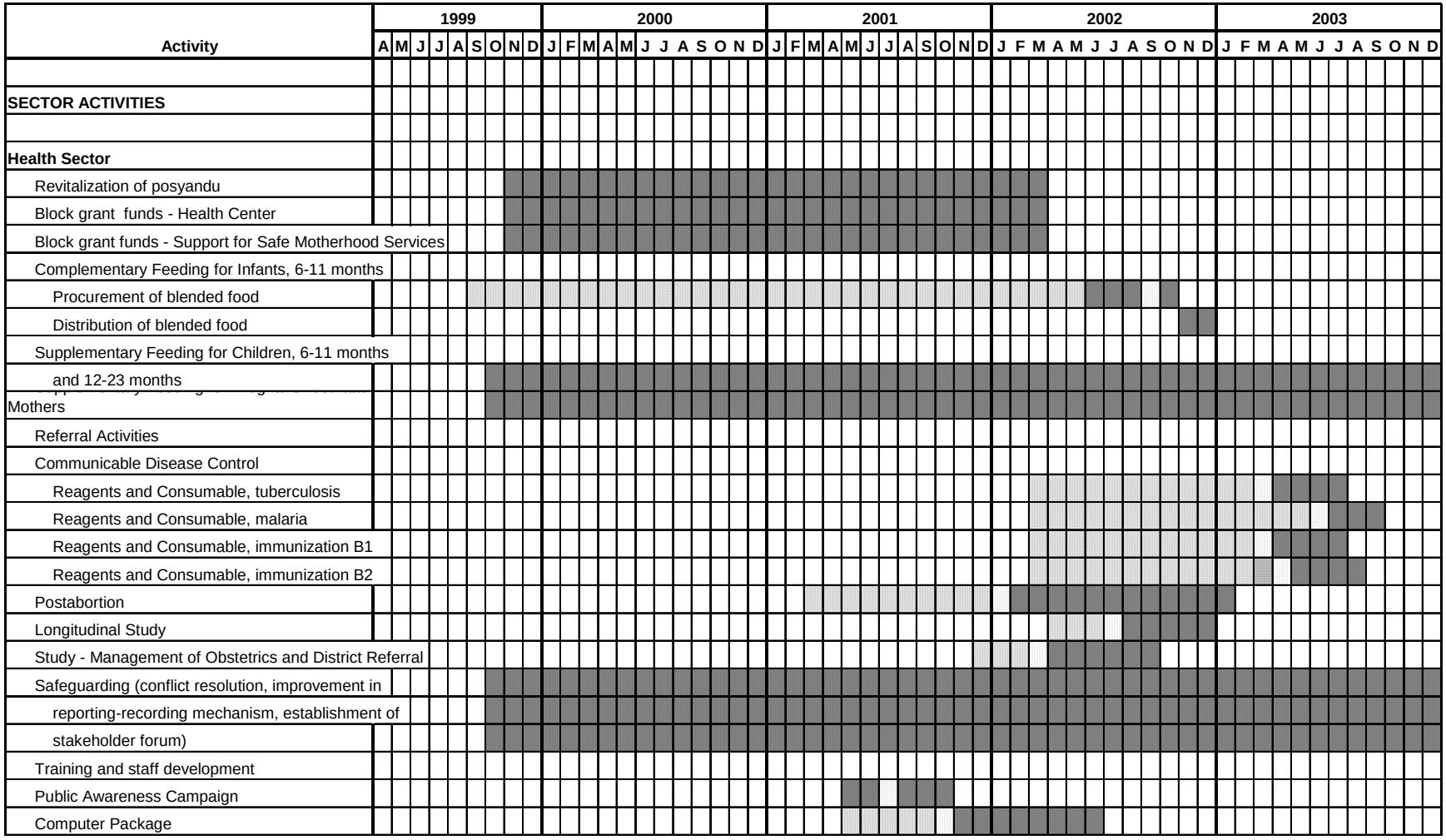
[b] Data not available during PCR Mission.

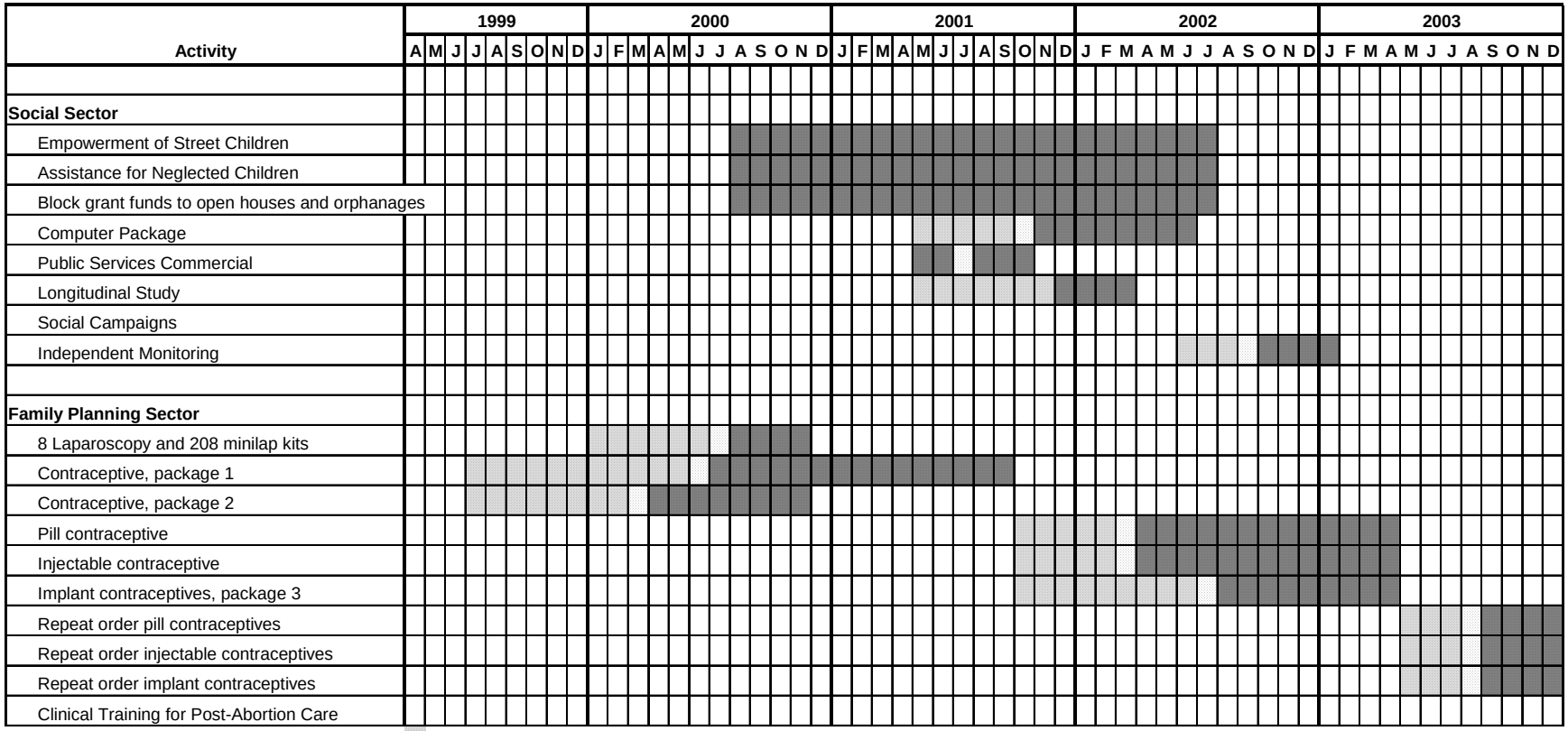
[c] Data not available during PCR Mission.

[d] The interest payment assistance of $13.13 million was provided on a grant basis from ADB's Asian Currency Crisis Support Facility of the Japan Special Fund.

PROGRAM IMPLEMENTATION SCHEDULE




1999
2000
2001
2002
2003
Activity
A M J J A S O N D J F M A M J J A S O N D J F M A M J J A S O N D J F M A M J J A S O N D J F M A M J J A S O N D
SECTOR ACTIVITIES
Health Sector
Revitalization of posyandu
Block grant funds - Health Center
Block grant funds - Support for Safe Motherhood Services
Complementary Feeding for Infants, 6-11 months
Procurement of blended food
Distribution of blended food
Supplementary Feeding for Children, 6-11 months
and 12-23 months
Mothers
Referral Activities
Communicable Disease Control
Reagents and Consumable, tuberculosis
Reagents and Consumable, malaria
Reagents and Consumable, immunization B1
Reagents and Consumable, immunization B2
Postabortion
Longitudinal Study
Study - Management of Obstetrics and District Referral
Safeguarding (conflict resolution, improvement in
reporting-recording mechanism, establishment of
stakeholder forum)
Training and staff development
Public Awareness Campaign
Computer Package



Note:
- Bidding Process
- Month of No Objection Letter
- Implementation

BAPPENAS = National Development Planning Agency; MOH = Ministry of Health; MOSA = Ministry of Social Affairs.

STATUS OF COMPLIANCE WITH LOAN COVENANTS

Covenant	Reference in Loan Agreement	Status of Compliance
1. Except as the Borrower and ADB otherwise agree, all goods and services to be financed out of the proceeds of the loan shall be procured in accordance with the provisions of Schedule 4 and Schedule 5 of the Loan Agreement. ADB may refuse to finance a contract where goods or services have not been procured under procedures substantially in accordance with those agreed between the Borrower and ADB where the terms and conditions of the contract are not satisfactory to ADB.	Article III, Section 3.03	Complied with.
2. The Borrower shall make available, promptly as needed, the funds, facilities, services, land, and other resources that are required, in addition to the proceeds of the loan, for carrying out the Project and for the operation and maintenance of the project facilities.	Article IV, Section 4.02	Complied with.
3. The Borrower shall ensure that the activities of the departments and agencies with respect to carrying out the Project and operation of the project facilities are conducted and coordinated in accordance with sound administrative policies and procedures.	Article IV, Section 4.04	Complied with. The Project Secretariat coordinated the activities of the agencies involved.
4. The Borrower shall make arrangements satisfactory to ADB for insurance of the project facilities to such extent and against such risks and in such amounts as shall be consistent with sound practice.	Article IV, Section 4.05 (a)	Complied with.
5. Without limiting the generality of the foregoing, the Borrower undertakes to insure, or cause to be insured, the goods to be imported for the Project and to be financed out of the proceeds of the loan against hazards incident to the acquisition, transportation, and delivery thereof to the place or installation, and such insurance any indemnity shall be payable in a currency freely usable or repair such goods.	Article IV, Section 4.05 (b)	Complied with.

Covenant	Reference in Loan Agreement	Status of Compliance
6. The Borrower shall maintain, or cause to be maintained, records and accounts adequate to identify the goods and services and other items of expenditure financed out of the proceeds of the loan, to disclose the use thereof in the Project, to record the progress of the Project (including the cost therefore) and to reflect, in accordance with consistently maintained sound accounting principles, the operations and financial condition of the agencies of the Borrower responsible for carrying out the Project.	Article IV, Section 4.06 (a)	Complied with.
7. The Borrower shall (i) maintain, or cause to be maintained, separate accounts for the Project; (ii) have such accounts and related financial statements audited annually, in accordance with appropriate auditing standards consistently applied, by independent auditors whose qualifications, experience and terms of reference are acceptable to ADB; (iii) furnish to ADB, as soon as available, but in any event not later than 9 months after the end of each related fiscal year, certified copies of such audited accounts and financial statements and the report of the auditors relating thereto (including the auditors' opinion on the use of the loan proceeds and compliance with the covenants of the Loan Agreement as well as on the use of the procedures for imprest account/statement of expenditures), all in English language; and (iv) furnish to ADB such other information concerning such accounts and financial statements and the audit thereof as ADB shall from time to time reasonably request.	Article IV, Section 4.06 (b)	Complied with. Auditor's report on audit of financial statements and actions taken by the EA on the recommendations were submitted to ADB.

Covenant	Reference in Loan Agreement	Status of Compliance
8. The Borrower shall enable ADB, upon ADB's request, to discuss the Borrower's financial statements for the Project and its financial affairs related to the Project from time to time with the Borrower's auditors, and shall authorize and require any representative of such auditors to participate in any such discussions requested by ADB provided that any such discussions shall be conducted only in the presence of an authorized officer of the Borrower unless the Borrower shall otherwise agree.	Article IV, Section 4.06 (c)	Complied with.
9. The Borrower shall furnish, or cause to be furnished, to ADB all such reports and information as ADB shall reasonably request concerning (i) the loan, and the expenditure of the proceeds and maintenance of the services therefore, (ii) the goods and services and other items of expenditure financed out of the proceeds of the loan; (iii) the Project; (iv) the administration, operations, and financial condition of the agencies of the Borrower responsible for carrying out the Project and operation of the project facilities, or any part thereof; (v) the financial and economic conditions in the territory the Borrower and the international balance-of-payments position of the Borrower; and (vi) any other matters relating to the purpose of the loan.	Article IV, Section 4.07 (a)	Complied with.
10. The Borrower shall furnish, or cause to be furnished, to ADB quarterly reports on carrying out the Project and on the operation and management of the project facilities. Such reports shall be submitted in such form and in such details and within such a period as ADB shall reasonably request, and shall indicate, among other things, progress made and problems encountered during the quarter under review, steps taken or proposed to be taken to remedy these problems, and proposed program of activities and expected progress during the following quarter.	Article IV, Section 4.07 (b)	Complied with. Fifteen quarterly reports were submitted to ADB. However, submission of some quarterly reports was delayed.

Covenant	Reference in Loan Agreement	Status of Compliance
11. Promptly after physical completion of the Project, and not later than 6 months thereafter or such later date as may be agreed for this purpose between the Borrower and ADB, the Borrower shall prepare and furnish to ADB a report, in such form and in such detail as ADB shall reasonably request, on the execution and initial operation of the Project, including its cost, the performance by the Borrower of its obligations under the Loan Agreement, and the accomplishment of the purpose of the loan.	Article IV, Section 4.07 (c)	Complied with. Project Completion Report by the Government was submitted to ADB. However, it did not provide details of the Borrower's actual financing of the project cost.
12. Except as ADB may otherwise agree, the Borrower shall establish, immediately after the Effective Date, an imprest fund account (the Special Account) at the Bank Indonesia or a designated state-owned commercial bank to expedite disbursements of the loan proceeds. The imprest account shall be established, managed, replenished, and liquidated in accordance with ADB's *Loan Disbursement Handbook* dated June 1996, as amended from time to time, and detailed arrangements agreed upon between the Borrower and ADB. The initial amount to be deposited into the imprest account shall not exceed the equivalent of $20.0 million.	Schedule 3, para. 7 (a)	Complied with. In March 2001, ADB approved Government request to increase the ceiling of initial deposit from $20.0 million to $50.0 million following initial difficulties in the funds flow caused by large volume of fund transfers that depleted the imprest account, and the slow process of replenishment.
13. Each supply contract for equipment or materials (including contraceptives and complementary feeding packages for infants) estimated to cost the equivalent of $500,000 or more shall be awarded on the basis of international competitive bidding (ICB) as described in Chapter II of *The Guidelines for Procurement*.	Schedule 4, para. 4 (a)	Complied with. Procurement of blended food and contraceptives was done through ICB.
14. Except as provided in this Schedule, each supply contract for equipment or materials estimated to cost less than the equivalent of $500,000 (other than minor items) shall be awarded on the basis of international shopping as described in Chapter II of *The Guidelines for Procurement*.	Schedule 4, para. 5 (a)	Complied with. Procurement of computers and peripherals, consumables for communicable disease control, laparoscope, and minilab kits equipment was through international shopping.

Covenant	Reference in Loan Agreement	Status of Compliance
15. Each supply contract for equipment or materials estimated to cost less than the equivalent of $50,000 may be awarded directly to qualified local contractors or suppliers in accordance with the Borrower's standard procedures satisfactory to ADB.	Schedule 4, para. 5 (c)	Complied with.
16. The Borrower shall ensure that: (i) all goods and services procured (including, without limitation, all computer hardware, software and systems, whether separately or procured or incorporated within other goods and services procured) are designed to be used prior to, during, and after the calendar year 2000 AD (Year 2000), (ii) neither the performance or functionality of such goods and services shall be affected by dates prior to, during, and after the Year 2000; and (iii) such goods and services, and the logic including therein, will operate during each such time period without error relating to date data, specifically including any error relating to, or the production of, date data, which represents or references different centuries or more than one century and the corrected treatment of the Year 2000 as a leap year.	Schedule 4, para. 7 (b)	Complied with.
17. The services of consultants shall be utilized in carrying out the Project, particularly with regard to: (i) strategic planning and development; (ii) surveillance, monitoring, and evaluation; (iii) health and nutrition policy analysis and review; (iv) public awareness and social marketing; (v) training coordination and evaluation; (vi) sociocultural barriers to effective health service delivery; and (vii) project management and implementation.	Schedule 5, para. 1	Complied with. Three international consultants and 12 domestic consultants were engaged.
18. As the Project Executing Agency, BAPPENAS shall be responsible for coordinating the overall implementation of the Project, in cooperation with MOF, MOH, MOHA, MOSA and BKKBN, and other concerned agencies of the Borrower involved in project implementation. BAPPENAS shall coordinate the Project through the deputy chairperson for human resources development.	Schedule 6, para. 1	Complied with.

Covenant	Reference in Loan Agreement	Status of Compliance
19. BAPPENAS shall establish a steering committee composed of echelon 1 representatives (director general or equivalent) from MOF, MOH, MOHA, MOSA, and other agencies concerned and BKKBN, which shall oversee all project activities. The vice chairperson of BAPPENAS shall serve as chairperson of the committee and the deputy chairperson for human resource development shall serve as deputy chairperson of the committee.	Schedule 6, para. 2	Complied with.
20. BAPPENAS shall establish a technical committee composed of echelon II officers from MOF, MOH, MOHA, MOSA, and other ministries concerned and BKKBN which shall provide support on, inter alia, technical matters and shall determine the allocation of resources to districts within the project area most adversely impacted by the Borrower's economic crisis based on population and poverty levels within the districts concerned. The deputy chairperson for human resource development shall serve as chairperson of the committee.	Schedule 6, para. 3	Complied with. In the beginning of project implementation, obtaining and disseminating the decree on funds allocation encountered administrative delays.
21. (a) The Borrower shall establish a project secretariat within BAPPENAS, which, in close collaboration with MOF, MOH, MOHA, MOSA, and other ministries concerned and BKKBN, shall, inter alia: (i) serve as the secretariat for the steering committee and the technical committee; (ii) authorize disbursements of loan proceeds and transfers of counterpart funds, through PT Pos offices concerned, to relevant district and subdistrict accounts; (iii) coordinate the maintenance of project accounts and arrange, as necessary, audit and other reports; and (iv) submit quarterly reports on project implementation to the steering committee and to ADB using a pre-agreed reporting/systematic monitoring format. (b) The project secretariat shall be headed by a full-time executive secretary with qualification and experience acceptable to ADB. (c) The executive secretary shall be assisted by an adequate number of full-time staff responsible for supervision and monitoring and budgeting and financial	Schedule 6, para. 4 (a)	Complied with. The Inception Mission in May 1999 confirmed that separate project implementation units will be established for MOH, BKKBN, and MOSA, with respective project coordinators and appropriate staff.

Covenant	Reference in Loan Agreement	Status of Compliance
management. The Borrower shall ensure that the project secretariat is suitably equipped and adequately staffed. (d) The executive secretary shall consolidate progress reports, monitor project activities, and carry out periodic reviews of the progress of project implementation.		
22. Each DCC established by the Borrower in each district participating in the Project shall be responsible for (i) project coordination, supervision, and monitoring at the district level; and (ii) determining the resources to be allocated to each subdistrict based on population and level of poverty. Each DCC shall (i) be headed by the chairperson of BAPPEDA II, and its members shall include the district heads of concerned agencies involved in project implementation; (ii) meet as often as required, but at least once every 3 months; and (iii) provide quarterly reports to the project secretariat in a prescribed format acceptable to ADB.	Schedule 6, para. 6	Complied with.
23. The steering committee shall determine the aggregate amount of health and nutrition sector grants to be allocated to each district within the project area, and each DCC shall allocate specific grants to the health centers and village midwives within its jurisdiction, according to criteria and procedures agreed with ADB. Upon the request of the executive secretary, after due authorization from the steering committee, MOF shall authorize Bank Indonesia to transfer to the Central PT Pos Office the aggregate amount of health and nutrition sector grants payable to the relevant health centers and the villages midwives in each district within the project area for distribution to the designated accounts established at the PT Pos offices concerned within the project area. Each DCC shall calculate the amount that each health center and each village midwife within its jurisdiction is entitled to, and authorize the relevant district or subdistrict PT Pos office, as applicable, to transfer such designated amount to the account concerned of the relevant health center and village midwife each quarter.	Schedule 6, para. 7	Complied with. In the beginning of project implementation, obtaining and disseminating the decree on funds allocation encountered administrative delays. The identification of the beneficiaries/recipients of block grants through the post office mechanism also was delayed initially.

Covenant	Reference in Loan Agreement	Status of Compliance
24. The Borrower shall establish a PPMS to provide accurate and systematic information and feedback on the quantitative and qualitative aspects of the Project. The PPMS shall collect and compile project monitoring data according to agreed upon indicators and targets. A detailed monitoring and evaluation plan shall be prepared. The collected data shall serve as the basis for assessing the progress of the Project on a quarterly basis. The PPMS shall endeavor to include as many inputs as possible from, and participation by, beneficiary communities and individuals. In addition to the PPMS, the Borrower shall obtain systematic qualitative information related to the impact of the Project on representative communities and individuals.	Schedule 6, para. 8	Complied with. However, regional reporting was not adequate due to a shortage of human resources, knowledge, and awareness about the Program.
25. The Borrower and ADB shall jointly undertake regular reviews of the Project to assess progress, identify any constraints, and agree on strategies for resolving constraints. In addition, the Borrower and ADB shall undertake an MTR of the Project at the end of the first year of implementation. The MTR shall (i) review the scope, design, and implementation arrangements of the Project; (ii) identify changes needed since project appraisal; (iii) assess implementation performance against project performance indicators; and (iv) identify problems and constraints; and, if necessary, recommend changes in the design or implementation arrangements.	Schedule 6, para. 9	Complied with. MTR mission was undertaken during 11–20 June 2001. Project review missions were also undertaken.
26. During project implementation, the Borrower shall cause MOH to develop and implement cooperative arrangements with established NGOs (including domestic and international NGOs, private voluntary organizations, community-based organizations, private sector groups and professional associations) to provide improved public health care service coverage of densely populated urban slum locations within the project area. Within 6 months of the Effective Date, the Borrower shall establish a working group in such connection to identify and design a transparent funds flow mechanism and related operational procedures. NGOs and other organizations and associations will function, in	Schedule 6, para. 10	Complied with.

Covenant	Reference in Loan Agreement	Status of Compliance
collaboration with health centers and other agencies concerned, in targeting and monitoring project beneficiaries and in providing effective service delivery in the relevant locations. Such time-bound action plan will, inter alia, establish target dates for (i) development of appropriate bidding procedures and selection criteria; and (ii) design and operate an appropriate funds flow mechanism.		
27. The Borrower shall encourage the adoption of effective measures to provide outreach health and nutrition services to culturally distinct communities within the project area, including developing and implementing partnerships between government health service providers and NGOs and established social and religious groups for such purpose.	Schedule 6, para. 11	Not complied with. Outreach health and nutrition services have been integrated as part of the regular basic social services by health centers.
28. The Borrower shall ensure that documentary evidence, satisfactory to ADB, shall be submitted to ADB in a timely manner at the start of each year of project implementation, which evidences that adequate budgetary allocations have been made by the Borrower for expenditure on project activities that the Borrower is financing in parallel with ADB.	Schedule 6, para. 12	Complied with.

ADB = Asian Development Bank; BAPPENAS = National Development Planning Agency; BKKBN = National Family Planning Board; ICB = international competitive bidding; IS = international shopping; MOF = Ministry of Finance; MOH = Ministry of Health; MOHA = Ministry of Home Affairs; MOSA = Ministry of Social Affairs; MTR = midterm review; PPMS = project performance monitoring system.

POVERTY, HEALTH, AND NUTRITION INDICATORS, 1995–2002

	Indicator	1995	1996	1997	1998	1999	2000	2001	2002
1	Poverty (%) [a]		17.7		23.5	18.2	19.1	18.4	18.2
	a. Urban		13.6		21.9	19.5	14.6	9.8	14.5
	b. Rural		19.9		25.7	26.1	22.4	24.8	21.1
2	Life Expectancy (year) [b]		64.4			66.2			66.2
3	Under 5 Mortality Rate (per 1,000 live biths) [b]			71		60		45	43
4	Infant Mortality Rate (per 1,000 live births) [b, d]		49	52	49	46	35	33	44
5	a. Underweight Children Under 5 Years of Age (%)[c]	31.7			29.8	26.4	24.8	26.3	27.6
	b. Severely Underweight Children Under 5 Years of Age (%)[c]	12.0			10.7	8.4	7.6	6.6	8.2
6	Maternal Mortality Rate (per 100.000 live births)[d]	390			330			230	230
7	Birth Delivery Assisted by Health Personel (%)				68.0			68.0	64.0
8	Total Fertility Rate (%)				2.7	2.6	2.6	2.4	2.4
9	Coverage of Antenatal Care (%) [c]						93.0	93.0	86.0
10	Coverage of Postnatal Care (%) [c]						77.8	77.4	70.0
11	Percentage Independent Posyandu [c]						14.0	16.0	21.0
12	Chronic Energy Defficiency pregnant [c]						20.1	20.1	17.6
13	Tuberculosis prevalence rate per 100.000 population (WHO) [b]						742	697	609
14	Tuberculosis death rate per 100.000 population (WHO) [b]						67	64	59
15	Tuberculosis; DOTS detection rate; % (WHO) [b]		5.0	8.0	13.0	19.0	20.0	21.0	30.0
16	Tuberculosis; DOTS treatment success; % (WHO) [b]		81.0	55.0	58.0	50.0	87.0	86.0	

a BPS, SUSENAS

b UNDP (2004), Indonesia Human Development Report 2004

c BPS, SUSENAS 1995-2002

d Ministry of Health, Health Profiles

WHO = World Health Organization.

HEALTH CARD OWNERSHIP AND UTILIZATION ACROSS PROVINCES IN INDONESIA

Province	Health Card Ownership		Health Service Utilization
	Coverage of Poor Families (%)	Coverage of Population (%)	Patients = Poor (%)
All provinces	**91.5**	**29.1**	**29.9**
Aceh	89.1	30.2	45.1
North Sumatra	94.0	26.1	27.7
West Sumatra	90.1	17.8	22.4
Riau	89.2	18.7	27.3
Jambi	91.0	24.1	18.8
South Sumatra	81.9	19.7	20.0
Bengkulu	92.8	31.8	35.6
Lampung	96.7	42.4	32.8
DKI Jakarta	79.9	14.5	18.7
West Java	93.9	23.5	17.6
Central Java	96.8	38.5	25.7
Yogjakarta	90.8	27.8	19.4
East Java	98.3	30.2	20.4
Bali	91.5	11.2	8.4
NTB	94.2	34.0	37.6
NTT	97.0	64.7	63.6
West Kalimantan	96.4	26.4	32.5
Central Kalimantan	88.2	24.0	28.6
South Kalimantan	93.3	23.6	27.4
East Kalimantan	93.9	22.7	17.1
North Sulawesi	92.3	33.0	30.1
Central Sulawesi	91.1	30.8	30.1
South Sulawesi	91.7	27.6	28.7
South East Sulawesi	87.4	37.6	49.8
Maluku	81.1	36.7	56.2
Papua	85.0	37.0	60.1

DKI = Daerah Khusus Ibukota; NTB = Nusa Tenggara Barat; NTT = Nusa Tenggara Timur.

Source: British Council. 2002. *Independent Monitoring and Evaluation of the Health and Nutrition Sector Development Programme Final Report*. Jakarta.