Summary of Terminal Evaluation Findings

1. Outline of the Project		
Country: Republic of Indonesia		**Project Title** : Project for Improvement of District Health Management Capacity in South Sulawesi Province (PRIMA Kesehatan) Phase 2
Issues/Sector: Health		**Cooperation scheme :** Technical Cooperation Project
Division in charge : JICA Indonesia Office		**Total cost: JPY 290 million equivalent**
Period of Cooperation	(R/D): Nov. 2010~ Mar. 2014	**Counterpart Agencies** : South Sulawesi Provincial Government: Regional Development Planning Board (BAPPEDA), Health Office (DINKES), Community Empowerment and Local Governance of Villages and Wards (BPMPDK) District Governments of Barru, Bulukumba and Wajo: Health Office, Community Development and Village and Ward Development (BPMD), Regional Development Planning Board (BAPPEDA), District Financial Management Office (DPKD)
		Supporting Organisations in Japan: N/A

1-1 Background of the Project

In the Republic of Indonesia (hereinafter referred to as Indonesia), while the overall quality of life is showing an improvement, regional gaps in development are widening. Compared to the official poverty rates in Java and Bali (12.5%) and Sumatra (14.4%), those in the Eastern region such as Sulawesi (17.6%), Maluku (20.5%), Nusa Tenggara (24.8%) and Papua (36.1%) are much higher, indicating a need for appropriate development interventions in the Eastern regions, if the regional imbalances are to be corrected.

Decentralisation of the governance system was instituted in 2001 and ever since various powers and functions, including those related to development planning, human and financial resources and health care delivery, have been decentralised to the regional governments. However, due to differences in local capacities and not-so-clear demarcations between the central and regional governments, the decentralisation also has been contributing to the widening regional gaps, causing such problems as delayed disbursement of budget and deterioration in quality of the public services. Establishing effective and efficient local governance systems is still an issue in Indonesia.

Indonesia has in recent years seen great improvement in terms of health but still lagging behind many ASEAN countries. Infant mortality rate in Indonesia was 31 per every 1000 live births (Malaysia: 6, Philippines: 26, Thailand: 13) and maternal mortality rate 420 per 100,000 deliveries (Malaysia: 62, Philippines: 230, Thailand: 110), while access to improved sources of water was 80% (Malaysia: 99%, Philippines 93%, Thailand: 93%).

JICA implemented from Feb. 2007 to Feb. 2010 a Project for Improvement of District Health Management Capacity in South Sulawesi Province (PRIMA Kesehatan) in Barru, Bulukumba and Wajo districts in the South Sulawesi Province and developed and implemented a mechanism in which communities and governments work together to improve community health. This model was proven to be effective in strengthening community health but faced issues of sustainability in terms of finance, policies and regulations. This Phase 2 cooperation of the above-mentioned project aims to overcome those remaining challenges by modifying the model developed during the Phase 1 period so that it fits in the existing system of planning and budgeting and also by integrating into the "Desa dan Kelurahan Siaga Aktif" programme (the national health promotion programme by the Ministry of Health) of the national government.

1-2 Project Overview

This project aims to strengthen sustainability of the mechanism developed under the project in the Phase 1 stage, in which communities and governments work together for primary health care. The mechanism is to be instituted and implemented in the same target districts involved in the Phase 1, namely Barru, Bulukumba and Wajo. The governments of the three districts and the South Sulawesi province as well as all the communities in

the three target districts will receive technical assistance to set up and operate the mechanism ("Prima-K mechanism") so that community-initiated health interventions ("PHCI activities") are planned and implemented as a part of regular development interventions without relying on external resources.

(1) Overall Goal

① Quality of Primary Health Care in the target district is improved
② The mechanism of Primary Health Care in which community and government work together is disseminated.
③ Regional Development Mechanism in which community and government work together is strengthened.

(2) Project Purpose

The mechanism of Primary Health Care in which community and government work together is established and operated in the target districts

(3) Outputs

① Capacity of community to conduct community-centred Primary Health Care Improvement (PHCI) activities in line with the local governance system is strengthened
② Capacity of Health Centres and Sub-District Offices to facilitate and support community-centred PHCI activities is strengthened
③ Capacity of District to manage community-centred PHCI activities is strengthened.
④ Capacity of Province to supervise and disseminate community-centred PHCI activities is strengthened

(4) Inputs（as of November 2013）

Japanese side: A total of JPY 290 million equivalent

Project personnel: 6 persons (Long-term: 3, Short-term: 3), for a total of 58.16 man/month
Provision of equipment: IDR 123,440,000
Local operational expenses: IDR 16,255,414,000 （equivalent of JPY 141,861,000）
Trainees received: 53 persons

Indonesian side:

Counterpart personnel: A total of 77 persons
Land, buildings and facilities: Project offices in Makassar, Barru, Bulukumba and Wajo with some office furniture and utilities such as water and electricity
Operational expenses: IDR 361,567,000 (equivalent of JPY 3,155,000) for seminars and workshops, in addition to expenses related to duty travels of related personnel

2. Evaluation Team

Japanese

Leader	Mr. Shinichi Tanaka	Senior Representative, JICA Indonesia Office
Regional Development	Dr. Makoto Inaba	Regional Development Program Manager, JICA
Cooperation Planning 1	Ms. Tomoko Enoki	Project Formulation Advisor, JICA Indonesia Office
Cooperation Planning 2	Ms. Ida Gosal	Program Officer, JICA Indonesia Office
Evaluation Analysis	Ms. Naomi Imani	Consultant, Global Link Management, Inc.

Indonesian

drg. Rarit Gempari, MARS	Head of Division of Community Empowerment and Partnership	Health Promotion Center, Ministry of Health
dr. Marti Rahuyu Diah Kusuma	Staff of Division of Community Empowerment and Participation	Health Promotion Center, Ministry of Health

Drs. A. Irawan Bintang, MT	Head of Division of Organizational and Human Resources Development	BAPPEDA, South Sulawesi Province
M. Ilyas	Acting Section Head of Human Resource Development	BAPPEDA, South Sulawesi Province
dr. H.A. Mappatoba, DTAS, MBA	Head Division of Community Health	Health Office, South Sulawesi Province
Drs. Haryamin, APT, M.Kes	Head Section of Health Promotion and Community Empowerment	Health Office, South Sulawesi Province
Ir. H. Muhammad Kasim Alwi	Head	BPMPDK, South Sulawesi Province
Ir. Musran A. Muchsin, M.Si	Head of Sub-Division of Programme	BPMPDK, South Sulawesi Province

Mission Period	24 Nov. ~ 20 Dec. 2013	Type of Evaluation：Terminal Evaluation

3. Results of the Evaluation

3-1. Project Performance

(1) Project Purpose

The project purpose is considered to be achieved with the current status of the assigned indicators as follows: (i) 97.8% of the communities in the target districts, as against the target of 80%, successfully complete all the activities of the Prima-K mechanism for the 2nd cycle (2012) and that a similar result is expected for the 3rd cycle (2013); and (ii) the "Implementation Guidelines for the Prima-K Mechanism (also known as "Supplement")" developed by the project was officially issued by the District Governments concerned, thus could be considered as one of the official documents that institute the Prima-K mechanism as an official system.

The completion rate above is likely to decline after the project ends, however, as it was achieved with substantial interventions by JICA project staff, who will be withdrawn once the project is over.

(2) Outputs

Output 1: Capacity of community to conduct community-centred Primary Health Care Improvement (PHCI) activities in line with the local governance system is strengthened

Almost all (98.9%) the 367 communities in the target districts are currently implementing PHCI activities financed by the regular budget of the respective communities. In 2012, 97.2% of the planned activities were implemented, indicating that the overwhelming majority of the communities involved in this project are able to accomplish the activities under the Prima-K mechanism with the technical and moral support provided by the project. As to the real capacity of the communities, however, the Terminal Evaluation (TE) found that majority of the communities still require substantial facilitation if they are to continue with the Prima-K mechanism, and in this sense, the capacities of the facilitators from Health Centres (HC) and Sub-district offices (SDO) to provide technical support and monitor developments are extremely important as there will be no more project-employed Field Facilitators (FF) to help them once the project is over.

Output 2: Capacity of Health Centres and Sub-District Offices to facilitate and support community-centred PHCI activities is strengthened.

The capacities of HCs and SDOs were strengthened through developing a pool of facilitators in every sub-district to assist Health Working Groups (HWGs) by training some of their staff in technical matters related to Prima-K mechanism. The TE found, however, due to an absence of a system to fill gaps created by trained facilitators transferred to other duty stations, the pools of facilitators set up by the project are diminishing to the extent that some of them may not be able to adequately respond to the needs of the communities. In view of the importance of the HC/SDO facilitators in sustaining the Prima-K mechanism, the project may need to officially establish a system, which not only takes care of vacancies created by inevitable staff rotations but also keeps their motivation and technical capacities through official recognition, fair

incentives and appropriate organisation.

Output 3: Capacity of District to manage community-centred PHCI activities is strengthened.

In each of the target districts, a district team was established drawing its members from the four relevant agencies (DINKES, BAPPEDA, BPMD and DPKD), which then together with the JICA project team created a system through which the PHCI activities of the HWGs are financed by the regular budget of the communities. The capacities of the district teams have been strengthened through (i) training on technical issues of the Prima-K Mechanism so that they can function as trainers (of HC/SDO facilitators), and (ii) financial resources provided from the regular budget of the district governments to implement routine activities under the Mechanism. While their technical and financial capacities are considered quite sufficient, there remain some managerial issues including (i) lack of an appropriate monitoring system to see how well and to what extent the Prima-K Mechanism is utilised by the communities and (ii) weak coordination within the district teams, in addition to the need for instituting (iii) a system to ensure availability of HC/SDO facilitators as identified in the previous section. These weaknesses appear to impinge upon implementation of the exit plans established following the recommendation by the Mid-Term Review, of which implementation was found to be somewhat lagging.

Output 4: Capacity of Province to supervise and disseminate community-centred PHCI activities is strengthened.

This output is yet to see substantial development. With regard to the province's supervising PHCI activities in the target districts, most of the activities designed to be implemented by the provincial team were carried out/organised by the JICA team, perhaps as a reflection of the limited function of the provincial government in supervising now autonomous districts.

With the "learning by doing" methodology of capacity building employed by this project, it is rather unrealistic to expect development of capacity in dissemination of the Prima-K Mechanism within the project period, as dissemination could only take place after the effectiveness of the model is reasonably established. The provincial team is planning to assist several districts that expressed interest in adopting the mechanism starting 2014. It is a new initiative for the province and they are not clear about how and to what extent the provincial team, which does not have the first-hand experiences in developing the mechanism (as it was done by the districts), would assist the autonomous districts in implementing their own projects. As the provincial team repeatedly expressed their needs for technical assistance in this matter, these issues must be sorted out to a practicable extent before the project ends.

3-2. Summary of Evaluation Results

(1) Relevance

The project has high relevance in terms of local policies and needs. Health is one of the 11 strategic priorities in Indonesia's medium-term development plan and its priority status is also reflected in similar plans of South Sulawesi province and the three target districts. At the same time, strengthening of local governance continues to be an agenda after more than 10 years of decentralisation, and effective and transparent systems for local governments to efficiently utilise financial resources are very much wanted especially in view of the increasing trend of the amount of the village allocation fund (ADD). Development of the Prima-K Mechanism, which utilises the standardised planning system of Musrenbang, is highly relevant in this context as it contributes both to health and local governance. On the other hand, the project's relevance to the Japanese official development assistance policy to Indonesia has somewhat declined when the policy was modified in 2012 to give more emphasis to economic growth.

(2) Effectiveness

The effectiveness of the project appears to be high in view of the achievement of the project purpose.

However, production of the outputs, which are the building blocks for achievement of the project purpose, are curiously less than optimal as observed earlier, indicating some problems in the project implementation. While the modality of capacity building of this project was "learning by doing", the JICA project team carried out some of the tasks to be taken on by the counterparts (CPs). In this way, the project was able to keep up with the schedule but as a consequence some of the capacity building opportunities for CPs were lost. The absence of clear definitions of the capacities to be built at each level in the project design also affected effectiveness of the interventions, as indicated in the oversight on the needs to strengthen management system apparent from the remaining weaknesses of the district and provincial teams identified in the earlier sections.

(3) Efficiency

The project boosts high efficiency in terms of (i) setting up a mechanism through which community-initiated health interventions are financed by the regular budget of the local governments and (ii) getting community-driven health interventions implemented through this mechanism in most of the 367 communities involved in 3 years. Major contributing factors are (i) meticulous project planning process involving district-, provincial- and central-level stakeholders, which resulted in a shared vision on the mechanism to be established as well as in good sense of ownership especially amongst the district-level CPs, (ii) JICA team's taking over some of the tasks designed to be carried out by CPs for the sake of keeping up with the government planning cycle, and (iii) a large number of local project staff deployed, who are in general much more efficient in terms of costs and communication than Japanese experts. Concerning the factors (ii) and (iii), however, there was a trade off between the efficiency and output production as observed in the previous section.

(4) Impact

(a) Prospect of achieving Overall Goals

With regard to the Overall Goal 1, it is rather unlikely that impact of this project is reflected in the macro-level health indicators assigned, as the health interventions undertaken under this project are of small scale and diverse. However, it would be reasonable to expect some positive contributions for community health improvements, as the project has generated communities' interest in health-related issues, reportedly resulting in increased utilisation of health facilities as well as increased participation in community-level activities organised by HCs. With regard to the replication of the Prima-K Mechanism in other districts (Overall Goal 2), it appears quite promising given the current level of interest expressed in adopting the mechanism. Adoption of the mechanism in other sectors (Overall Goal 3) may benefit from more vigorous advocacy and dissemination, as currently the mechanism is not well known outside of the district/provincial teams. Nonetheless, there is an initiative in Barru district in which other sectors are involved in community-level Musrenbang and this may show positive results in line with this Overall Goal 3.

(b) Other positive impact

The project has been reportedly effective in (i) generating communities' awareness and interest in health, in sanitation in particular, which has resulted in substantial increase in voluntary contributions by individuals to the community-initiated health interventions. The project has also been instrumental in availing ADD-like funds to wards and also in demonstrating possibility of utilising ADD for non-construction projects through Musrenbang, to the extent Barru district started a pilot project with 10 villages to use the model involving other sectors.

(c) Negative impact

Some HC facilitators reported increased workload as a negative impact of the project. This was more of a grievance rather than a negative impact, stemming from the current uneven distribution of workload among HC staff and the absence of official recognition and fair incentives/rewards for the extra tasks they shoulder. These issues should be addressed when the districts consider appropriate organisation/ officialise of the HC/SDO facilitators as discussed under the Output 2.

(5) Sustainability

The financial sustainability is very promising. So long as health remains a priority in the development agenda, and so long as political leaders are committed to address priorities identified by their constituents, it is reasonable to assume that both the community-centred PHCI activities and supporting activities by the district governments shall have some funds allocated from their regular budget. The reported plan of the central government to increase the ADD amount also contributes to the Prima-K Mechanism's financial sustainability. The organisational sustainability, on the other hand, is less solid without appropriate management systems to monitor implementation of the Prima-K Mechanism and to coordinate efforts of the involved agencies. Lack of these systems is affecting the implementation of the exit plans established after the Mid-term Review. These issues must be addressed in the currently on-going efforts to design a post-project management system of the Prima-K Mechanism in each target district.

Other issues that may impinge on sustainability include motivation of the HWGs, complexity of the paperwork in the Prima-K Mechanism and the forthcoming election of the village chiefs in 2014. Districts needs to be vigilant to the circumstances and needs of the communities so that appropriate measures are taken in timely manner to mitigate these challenges. JICA could also play a role by fielding monitoring missions from time to time to sustain the motivation of the stakeholders as well as the effects of the project.

3-3. Factors promoting better sustainability and impact

(1) Factors related to the project design

In order to find a right way to improve financial sustainability of the model created by the Phase 1, JICA in designing this project had numerous sessions with stakeholders at all levels. This by clarifying the issues and possible solutions enabled the project to start implementation of the activities at once when the project design was finalised. In this way the district-level stakeholders also developed high sense of ownership and good understanding of the mechanism to be developed, which contributed to efficiency as well as high financial sustainability.

While the established mechanism could be used in any sectors, the project managed to win favours of the local governments and politicians by choosing health sector, which enjoys high priority in the official development policies and also often is a public commitment of political leaders at the time of elections.

(2) Factors related to the implementation processes

The multi-agency teams organised, especially those at the district level, were identified by the CPs as one of the major contributing factors, through which issues could be addressed much more efficiently than otherwise. Another contributing factor would be a large number of the experienced local project personnel, without whom the project would not have been able to cover so many communities.

3-4. Factors inhibiting better sustainability and impact

(1) Factors related to the project design

The project by design is ambiguous about the details of the capacity building and no capacity assessment or analysis was undertaken before or during the project period to determine the scope. This resulted in overlooking appropriate management systems as a part of the capacity, compromising the outputs as well as the sustainability of the project.

Another issue was the lack of exit strategies in the project design when such a large number of project staff was involved. Though there was a plan for a gradual reduction of the project personnel, as it was not stipulated in the official reference documents (i.e. Record of Discussion (R/D), Project Design Matrix (PDM) and Plan of Operation), the plan was somehow forgotten and never implemented.

(2) Factors related to the implementation processes

A Japanese project leader was absent for the first three months of the project and also for almost 1 year in the middle of the project. Although the project managed to implement most of the planned activities on the PDM,

other activities such as setting up PDM indicators, following up on the recommendations left by Japanese experts, supervision of the local project personnel and devising/implementing exit strategies did not receive sufficient attention.

The local project staff, or rather mishandling of them, was arguably a major inhibiting factor in terms of the output production. Most of them were well experienced in facilitation but not in capacity building of government institutions. Without appropriate guidance and supervision by a Japanese project leader, they worked in a way to fill the capacity gaps of the CPs rather than building them for the sake of timely implementation of the project.

3-5. Conclusion

Based on the model produced by the previous phase, the project was successful in establishing a mechanism through which community-driven health interventions are financed by local regular resources by utilising the official planning system of Musrenbang. The project purpose was achieved with higher than expected implementation rates of the Prima-K Mechanism, indicating high effectiveness and efficiency of the project. The project, addressing issues related to community health and local governance, is also highly relevant to the local policies and needs.

On the other hand, the capacities of the district and provincial administrations were not fully developed to the level desired. The project needs to do some more work to set up an appropriate administration/management system for the Prima-K Mechanism in each of the district and provincial governments, instituting some kind of monitoring and coordination functions so that the Prima-K Mechanism is systematically managed after the JICA team is withdrawn. The financial sustainability is promising with the increasing trend of ADD, provided the communities and local governments continue to see health as a priority.

The health impact of this project is unlikely to be reflected in the assigned macro indicators but is complementing HCs' interventions in community health improvement. With the interest expressed by some districts in adopting the Prima-K Mechanism and with the provincial team's aspiration to help the process of adoption, there is a good possibility that the mechanism will be replicated in other parts of the province, perhaps also in other sectors than health, in near future.

3-6. Recommendations

(1) To the PRIMA-K Project Team (by 31st March, 2014)

In view of the limited time available, the Team recommends the following two tasks be treated as priorities, to be completed before the end of the project period.

- To provide technical support to the district teams in developing an appropriate management system for the operation of Prima-K Mechanism in each district, which should be included in appropriate authoritative documents such as Bupati's (Governor's) regulation and decree.
- To compile the tools developed during the project period into a "Prima-K Tool Package" to serve as a guiding reference for possible replications by interested parties. The production of this package be ideally completed by the planned national seminar before the conclusion of the project so that it could be widely disseminated.

(2) To the District Teams of Barru, Bulkumba and Wajo

As a matter of priority, an appropriate management system for operation of the Prima-K Mechanism be designed and instituted. The system should include, among others,

- process and procedures for inter-agency collaboration and coordination;
- monitoring system with clear indicators (data/information to be periodically collected), sources of the information, responsible parties and frequency of data collection, compilation and analysis, as well as flow of the information for appropriate and timely decision makings; and
- a system to retain a pool of trained facilitators at every HC and SDO and to ensure supportive environment for them to function effectively and efficiently with good motivation in each sub-district. This may include (a) official appointment of facilitators at HCs and SDOs through decrees (SK), (b) organising them into sub-district teams with appointed team leaders or coordinators and (c) ensuring

supportive supervision provided by appropriate individuals/parties.

- Have the devised management mechanism officially gazetted through appropriate authoritative documents such as Bupati's (Governor's) regulations and decrees.

- Consider possible application of the mechanism in other sectors than health.

(3) To the Provincial Team

- Play facilitative roles for other districts in the province to adopt the Prima-K Mechanism as a team as already started and also as individual agencies in line with the official mandate.

- As it is a new and challenging task for the provincial government to orchestrate inter-sectoral efforts in facilitating autonomous districts in implementation of a programme without provision of funds, the team may like to:

  i. consider drawing up an united vision on the goals and modalities of this initiative of dissemination for the sake of effective inter-agency collaboration; and

  ii. set up an effective mechanism of inter-agency collaboration/coordination for the purpose mentioned above. This may include (a) identifying and assigning certain tasks to appropriate entities/individuals and (b) setting up a monitoring and reporting system; and

  iii. document the above in appropriate media such as a Governor's regulation/decree, which would also legitimise actions/interventions for specific districts. .

(4) To the Central Government

a) Center for Health Promotion, Ministry of Health

- For the sake of synergising the effects of this project with the Desa dan Kelurahan Siaga Aktif programme, the Promkes is encouraged to:

- Examine the Prima-K Mechanism and the initiatives happening in the 3 districts to synergise the effects of the Prima-K and Desa dan Kelurahan Siaga Aktif, and analyse the points which strengthen Desa dan Kelurahan Siaga Aktif;

- Disseminate the good practices in this project nationwide and encourage their replications as appropriate.

b) Ministry of Home Affairs

In view of the accomplishment of this project in terms of (i) strengthening local governance including democratic and transparent utilisation of ADD, and also for the sake of (ii) the community empowerment in Desa dan Kelurahan Siaga Aktif, MoHA is invited to:

- Examine the Prima-K Mechanism and the initiatives happening in the 3 districts to synergise the effects of the Prima-K and Desa dan Kelurahan Siaga aktif, and analyse points which strengthen Desa dan Kelurahan Siaga aktif;

- Disseminate the good practices in this project nationwide and encourage their replications as appropriate.

(5) JICA

JICA is to consider:

- instituting occasional monitoring visits to the three districts as well as to the province, to provide moral support even after the project is concluded;

- possible future technical assistance utilising the benefit and lessons learnt from this project

3-7. Lessons leant

- A project could enjoy a smooth start of implementation when CP agencies were well involved in designing of the project, with good sense of ownership and a shared vision on the project purposes.

- A project should have a solid exit strategy built into its design from the beginning, especially when a large number of project staff is involved. Such strategy must be clearly spelt out in an official documents that serve as the guiding documents for project implementation, namely R/D and PDM.

- In order for a capacity building project to be effective, capacities to be strengthened should be clearly defined in relation to the tasks to be carried out. If such details are not clear from the R/D and/or PDM, stakeholders should organise a session to clarify them at the beginning of the project to analyse, identify and agree on the scope and methodologies of capacity building. A capacity assessment should also be considered in this process.