

Republic of Indonesia

FY2016 Ex-Post Evaluation of Technical Cooperation Project

“Project for Improvement of District Health Management Capacity in South

Sulawesi Province/Project for Improvement of District Health

Management Capacity in South Sulawesi Province Phase 2”

External Evaluator: Ito Haruo, ICONS Inc.

0. Summary

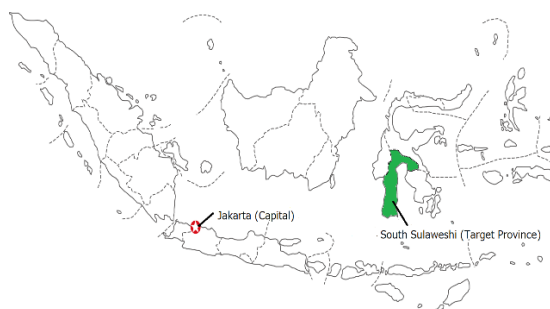
The Project for Improvement of District Health Management Capacity in South Sulawesi Province (hereinafter referred to as “Phase 1”), has developed the PRIMA-K mechanism¹ of Primary Health Care Improvement² (hereinafter referred to as “PHCI activities”) in the target area, South Sulawesi Province (Barru, Wajo, and Bulukumba districts), to improve the health administration services in Indonesia. In addition, the Project for Improvement of District Health Management Capacity in South Sulawesi Province Phase 2 (hereinafter referred to as “Phase 2”) was implemented to integrate the PRIMA-K mechanism developed in Phase 1 into the existing Indonesian local administrative systems (development planning and budget systems) in order to establish a sustainable mechanism. The purpose of Phase 1 and Phase 2 (hereinafter collectively referred to as “the project”) is highly relevant in terms of Indonesian health policy, development needs, and Japan’s “Indonesia Country Assistance Program” for creating a democratic and fair social structure. Moreover, each output contributes to achieving the project purpose, such as the development of the PRIMA-K mechanism (Phase 1) and the establishment of the mechanism (Phase 2). These achievements have also contributed to generating impact effects, such as the improvement of health indicators, the dissemination of the PRIMA-K mechanism in other villages and districts, and the utilization of the PRIMA-K mechanism in other sectors. Therefore, its effectiveness and impact are high. Its efficiency is also seen as high because both the project period and project cost in both phases are within the plan. In terms of sustainability, although there are some problems in the organizational structure of the provincial government, other related organizations have no issues with the implementation system. The sustainability of the project is evaluated as high, comprehensively taking into consideration its policy/institutional, technical, and financial aspects.

¹ PRIMA-K is the name of the project (Project for the Improvement of District Health Management Capacity in South Sulawesi Province (Kesehata refers to health)). The PRIMA-K mechanism seeks to implement voluntary health activities at the village level using the ordinary budget by district governmental organizations, rather than relying on external funds. (See Figure 1, Overview of the PRIMA-K Mechanism). Other terms such as PRIMA-K model, PHCI mechanism, and PHCI model were used, but “the PRIMA-K mechanism” is applied consistently throughout this ex-post evaluation report.

² The PHCI activities (improving health and sanitation environment activities) consist of the cycle of planning, implementation, and evaluation by community members at the village/ward level. These activities are led by the community to build toilets, water purification, sewage treatment facilities, and integrated health posts (Posyandu), which provide maternal and child health, family planning, nutritional development, vaccination, and diarrhea control, and awareness-raising activities on health and sanitation.

In light of the above, this project is evaluated to be highly satisfactory.

1. Project Description



Project Location



Infant medical checkup at an integrated health post in a village established by PHCI activity

1.1 Background

Indonesia has been decentralized since 2001, and as a result of a substantial transfer of authority, personnel, and financial resources for community development from central government to local government, the provision of health services has become the responsibility of local government. However, due to the insufficient capacity of local administrators and unclear role-sharing between central and local governments, delays in budget execution, a declining quality of administrative services, and an increase in regional disparity have been generated. Therefore, the establishment of an effective and efficient local administrative system remained one of the issues.

Regarding the health situation, the major health indices are lower than in neighboring ASEAN countries, as the infant mortality rate in 2008 (per 1,000 live births) was 6 cases in Malaysia, 26 cases in the Philippines, 13 cases in Thailand, and 31 cases in Indonesia. The maternal mortality rate (per 100,000 live births) was 62 in Malaysia, 230 in the Philippines, 110 in Thailand, and 420 in Indonesia. In addition, the improved water source utilization rate remained at 80% in Indonesia versus 99% in Malaysia, 93% in the Philippines, and 93% in Thailand³.

To address this situation, Phase 1 was implemented from February 2007 to February 2010 with the aim of developing the PRIMA-K mechanism that contributes to improving the regional health situation in cooperation between community and government in the Barru, Bulukumba, and Wajo districts in South Sulawesi Province. Although the effectiveness of the mechanism has been confirmed in terms of strengthening regional health, securing the policy and the institutional and financial sustainability of the

³ All sources of health data were quoted from the "State of the World's Children Special Edition 2010" (UNICEF)

mechanism remained an issue. Consequently, Phase 2 was implemented to ensure sustainability by improving the PRIMA-K mechanism built in Phase 1, by integrating this mechanism into Indonesia's local administrative system (plan formulation and budget execution), as well as ensuring consistency with the national program of the Ministry of Health "Desa dan Kelurahan Siaga Aktif"⁴ (hereinafter referred to as "Desa Siaga Aktif").

1.2 Project Outline

Table 1: Project Outline

		Phase 1	Phase 2
Overall Goal		Management capacity of Primary Health care (hereinafter referred to as "PHC") in target districts is improved.	(1) Quality of Primary Health Care in the target districts is improved. (2) The mechanism of Primary Health Care (PRIMA-K mechanism) in which community and government work together is disseminated. (3) The regional development mechanism in which community and government work together is strengthened.
Project Purpose		To develop the community-centered primary health care improvement (PHCI) model (PRIMA-K mechanism) in target districts	The mechanism of Primary Health Care (PRIMA-K mechanism), in which community and government work together, is established in the target districts.
Outputs	Output 1	Community-centered health activities are implemented through the community participation.	The capacity of the community to conduct community-centered PHCI (Primary Health Care Improvement) activities in line with the local governance system is strengthened.
	Output 2	The supports to PHCI Team in sub-district and villages provided by Health Centers (hereinafter referred to as "HCs") are improved.	The capacity of HCs and Sub-district office (hereinafter referred to as "SDO") to facilitate and support technically community-centered PHCI activities is strengthened.
	Output 3	The health management capacity of the target districts is improved to conduct PHCI activities.	The capacity of districts to support systematically community-centered PHCI activities is strengthened.
	Output 4	The capacity of the province government to facilitate introduction and dissemination of the PHCI model is improved.	The capacity of the province government to supervise and disseminate community-centered PHCI activities is strengthened.
Total Cost (Japan side)		387 million yen	290 million yen
Period of Cooperation		February 2007 - February 2010	November 2010-March 2014
Implementing Agency		Ministry of Health (Center of Health Promotion) South Sulawesi Provincial Government (Regional Development Planning Bureau, Health Department) Barru, Bulukumba, Wajo districts (Health Department, Regional Development Planning Bureau)	Ministry of Health (Center of Health Promotion) Ministry of the Interior (Community Village Development General Administration) South Sulawesi Provincial Government (Regional Development Planning Bureau, Health Department, Community Promotion / Village / Ward Administration Bureau) Barru, Bulukumba, Wajo districts (Health Department, Community/Village Promotion Bureau, Regional Development Planning

⁴ This project is consistent with the vision of the national program "Desa dan Kelurahan Siaga Aktif" promoted by the Ministry of Health. In the "Desa dan Kelurahan Siaga Aktif," effective utilization of the human and financial resources that exist in villages is encouraged to promote a healthy lifestyle at the village level. In order to promote community-based health activities, a Health Council (K3) consisting of various stakeholders is established at each district, sub-district, and village level, and K3 is expected to play a role in linking the health administration system with the community.

		Bureau, Financial Management Bureau)
Other Relevant Agencies / Organizations	None	None
Supporting Agency/Organization in Japan	International Development Center of Japan (Project Contract)	None
Related Projects	None	None

Source: Documents provided by the Japan International Cooperation Agency (JICA)

As shown in the counterpart organizations and activities of each phase listed in Table 2, the names of counterpart organizations differ between Phase 1 and Phase 2. Although the names of organizations were changed in Phase 2 to reflect their respective activities, the basic activity contents remain unchanged. The names of counterpart organizations in Phase 2 are applied in this ex-post evaluation.

Table 2: Counterpart Organizations and Activities of Each Phase

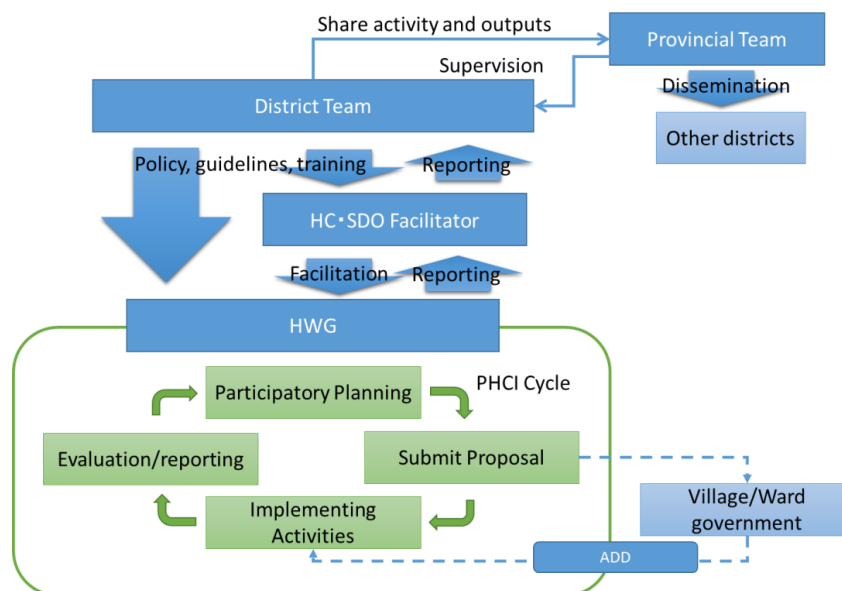
Counterpart Organizations		Activities
Phase 1	Phase 2	
【Village/ward PHCI Team】 ·Community leader ·Religious leader ·HC staff ·Village office staff	【Health Working Group (hereinafter referred to as “HWG”) in Village/Ward】 ·Community leader ·Religious leader ·HC staff ·Village office staff	<ul style="list-style-type: none"> Analyze health-related problems in the community Plan and implement PHCI activities
【Sub-district PHCI Team⁵】 ·SDO staff ·HC staff	【HC/SDO facilitator⁶】 ·SDO staff ·HC staff	<ul style="list-style-type: none"> Analyze regional health-related problems Plan health promotion or preventive activities according to community needs Prepare proposals on activities, prepare reports and implement training on fund management for HWG
【District Implementation Team】 ·Regional Development Planning Board ·District Health Office	【District Team】 ·Regional Development Planning Board ·Financial Management Office ·Community and Village Government Empowerment Board ·District Health Office	<ul style="list-style-type: none"> Manage mechanisms based on the community (systematic support) Plan and implement training program for HC/SDO facilitator and HWG
【Provincial Government】 ·Regional Development Planning Board ·Provincial Health Office	【Provincial Team】 ·Regional Development Planning Board ·Provincial Health Office ·Community Empowerment and Village Governance Board	<ul style="list-style-type: none"> Implement supports to share project information with other districts within the province

Source: Created by the evaluator based on the materials provided by JICA

⁵ During Phase 1, facilitation of PHCI activities was mainly conducted by field facilitators employed by the project. In Phase 2, the field facilitators transferred their experience to HC/SDO facilitators who took part of the role of the PHCI activity facilitation.

⁶ One to three HCs are located in each sub-district and provide health services in both prevention and treatment. The SDO, the branch office of the district government, is the closest administrative body to the community. The project selected several HC and SDO staff as facilitators and trained them in the PRIMA-K mechanism (formulation of plan, proposal and reports, and accounting management) to provide technical assistance to villages/wards for PHCI activities. Facilitators were selected by the HC and SDO and approved by the District Team. Basically, HC facilitators develop and implement the HWG’s activity plan, and the SDO facilitators implement accounting procedure supports and provide training on budget planning and reporting.

Figure 1 is a conceptual diagram of the PRIMA-K mechanism. The HWG formed within the community of each village leads the activities of PRIMA-K. The HWG in the community analyzes and shares local health-related problems and submits a proposal of activities to the participatory planning meeting implemented by the village government (Musrenbang). Once the proposal has been approved, the community conducts activities using the Village Allocation Budget (hereinafter referred to as the “ADD”) according to the guidelines and regulations prepared by the district. As facilitators, HC and SDO staffs monitor and support the technical and administrative procedures of the cycle of HWG activities, such as participatory planning→proposal making→activity implementation→reporting. The district government receives the report from the HC/SDO as needed and improves the budgetary and institutional environment for smooth implementation of the activities. The district government also shares the results of activities with the provincial government and cooperates in giving direction regarding the dissemination of the PRIMA-K mechanism to other areas within the province. The provincial government provides supervision as well as disseminating the mechanism to other districts in the province. This flow from problem analysis to reporting of activities is called a “cycle,” and the cooperation mechanism at each administrative level is regarded as the PRIMA-K mechanism.



Source: Created by the evaluator based on the terminal evaluation report of Phase 2

Figure 1: Conceptual Diagram of the PRIMA-K Mechanism

1.3 Outline of the Terminal Evaluation

1.3.1 Achievement Status of Project Purpose at the Terminal Evaluation (Phase 2)

Considering the achievement of indicators such as the percentage of villages that have completed the PHCI activity cycle and the institutionalization and documentation of the PRIMA-K mechanism, the project purpose of establishing the PRIMA-K mechanism was considered to have been achieved. However, while this achievement was led by training and support in HWG activities by project-hired field facilitators, it was inferred that the possibility of maintaining the level of achievement is low once the project ends.

1.3.2 Achievement Status of Overall Goal at the Terminal Evaluation (Phase 2)

The possibility of achieving the overall goal was evaluated as high, because the health indicators of the overall goal showed improvement trends, and activities directly linked to the improvement of indicators were implemented by the HWG and organized by the project in three target districts. The achievement of the indicator of “dissemination to other areas” was also evaluated as high because other provinces and districts were interested in introducing the PRIMA-K mechanism. Regarding the dissemination of the PRIMA-K mechanism to other than health sectors, although no case of dissemination were confirmed, it was reported that the Community and Village Consultative Board, one of the District Team members, informed village chiefs and village administrative staff about the mechanism through seminars.

1.3.3 Recommendations from the Terminal Evaluation

In order to improve the organizational system necessary to maintain the PRIMA-K mechanism, strengthen democratic and transparent local autonomy by utilizing the Indonesian ADD budget, and empower the community through the implementation of “Desa Siaga Aktif,” the following were recommended to each implementing agency.

Table 3: Recommendations of Terminal Evaluation

Implementing Agency	Recommendations
(1) Project Team	<ul style="list-style-type: none">▪ Provide technical support for the establishment of a management system in each three targeted district to maintain the PRIMA-K mechanism (preparation of public documents such as district governor ordinance)▪ Create “PRIMAK-Kit” (manual, guidelines, and teaching materials)
(2) Target District Teams	<ul style="list-style-type: none">▪ Collaborate across departments and maintain a coordination system▪ Develop a monitoring system▪ Formally appoint HC/SDO facilitators and develop the framework necessary for facilitators to work▪ Reflect on the operating system of the PRIMA-K mechanism

	<p>for official district documents such as the district governor's ordinance and so on</p> <ul style="list-style-type: none"> ▪ Consider the application of the mechanism in non-health sectors
(3) South Sulawesi Province Team	<ul style="list-style-type: none"> ▪ Provide cross-sectional coordination within the province necessary for the application of the PRIMA-K mechanism ▪ Establish a cross-sectional vision for disseminating the mechanism to other districts in the province ▪ Identify the cross-divisional operations necessary for applying the mechanism, and develop implementation, monitoring, and reporting systems ▪ Develop provincial governor ordinances regarding the above-mentioned items
(4) Ministry of Health (Center of Health Promotion)	<ul style="list-style-type: none"> ▪ Examination of organic collaboration between verification of the PRIMA-K mechanism and national policy "Desa Siaga Aktif" ▪ As a result of the verification, disseminate the same mechanism throughout the country when it is deemed effective to do so
(5) Ministry of Home Affairs (Directorate General for Community and Village Empowerment)	<ul style="list-style-type: none"> ▪ Verification of the PRIMA-K mechanism and the integration effect of "Desa Siaga Aktif" with PRIMA-K in three target districts ▪ Promotion and deployment to the whole country as a good example

Source: Terminal evaluation report Phase 2

2. Outline of the Evaluation Study

2.1 External Evaluator

Haruo Ito (ICONS Inc.)

2.2 Duration of Evaluation Study

This ex-post evaluation study was conducted with the following schedule.

Duration of Study: August 2016 - August 2017

Duration of Field Study: November 6 - December 19, 2016, February 26 - March 16, 2017

2.3 Constraints during the Evaluation Study

With regard to the overall goal, one of the aspects of impact of the ex-post evaluation, the indicators of the overall goal are expected to be attained after three to five years of project completion. However, as Phase 2 was completed in March 2014, and the field survey of this ex-post evaluation was in November 2016, it was impossible to obtain data after three years of project completion (in 2017). Some data from 2016 were also not obtained because the data accumulation had been underway. Therefore, the overall goal of Phase 2 was evaluated with the probability of the achievement at the time of the ex-post evaluation.

3. Result of the Evaluation (Overall Rating: A)⁷

3.1 Relevance (Rating: ③)⁸

3.1.1 Consistency with the Development Plan of Indonesia

The purpose of the project at the planning of Phase 1 was consistent with “Reduce disparities in regional development to improve public welfare,” which was prioritized in the “National Mid-Term Development Plan (2005-2009)” and “Promote preventive medical care and health of residents by strengthening the community,” as stated in the “Strategic Plan of the Ministry of Health of Indonesia (2005-2009).” Furthermore, the purpose of the project was supported by the national program “Desa Siaga Aktif,” which has been implemented by the Ministry of Health since 2006 to achieve “social mobilization and community strengthening for a healthy life,” one of the four strategies of the “Strategic Plan of the Ministry of Health.”⁹

These policies were continued in the next five-year plan, the “National Mid-Term Development Plan” (2010-2014) and the “Strategic Plan of the Ministry of Health of Indonesia (2010-2014).” Thus, the relevance to national health policy was confirmed at the time of completion of the project (Phase 1 in 2010, Phase 2 in 2014). It was also confirmed that the project purpose was consistent with the promotion of “Desa Siaga Aktif” in the target province, as stated in the “Health Department Development Plan in South Sulawesi Province (2007-2012) and (2013-2018)” and formulated in accordance with the “Strategic Plan of the Ministry of Health.”

3.1.2 Consistency with the Development Needs of Indonesia

In Indonesia, decentralization has progressed rapidly since 2001, and a substantial transfer of authority, personnel, and financial resources for development, from the central government to local governments, has taken place. However, due to the insufficient capacity of local administrators and unclear role-sharing between central and local governments, delays in budget execution, a declining quality of administrative services, and the expansion of regional disparity were generated. Therefore, the establishment of an effective and efficient local administrative system has remained an issue.

Regarding the maternal and child health indicators at the time of the project planning stage in 2007, shown in Table 4, the infant mortality rate was 35 cases (per 1,000 live births), the under-5 mortality rate was 46 cases (male) and 37 cases (female) (per 1,000 live births), and the maternal mortality rate was 230 cases (per 100,000 live births). Compared with other ASEAN countries, Indonesia’s health indicators remained at a low

⁷ A: Highly satisfactory, B: Satisfactory, C: Partially satisfactory, D: Unsatisfactory

⁸ (3): High, (2): Fair, (1): Low

⁹ The project developed practical guidelines and manuals of K3 concert activities to help implement the “Desa Siaga Aktif” in target districts by utilizing public funds. The project has also defined organizations and roles, and established a human resource development method to continue PHCI activities at each district, sub-district, and village level. Above all, the project contributed greatly to the promotion of the national program.

level. In addition, although the maternal mortality rate at the time of project completion in 2014 fell to 190 cases, it was assumed that the target of 102 cases in Indonesia was unlikely to be attained by 2015.

Table 4: International Comparison of Maternal and Child Health Indicators (2007)

(Unit: Case)

	Indonesia	Thailand	Malaysia	Vietnam	Philippines
Infant Mortality Rate	35	17	9	26	24
Under-5 Mortality Rate (male /female)	46/37	26/16	12/10	36/27	33/22
Maternal Death	230	44	41	130	200

Source: The 2007 State of World Population Report (UNFPA)

Note: Infant mortality, under-5 mortality rate per 1,000 live births, and maternal mortality rate per 100,000 live births

According to the “Strategic Plan of the Ministry of Health in Indonesia (2015-2019),” the degree of health indicators was low, as the proportion of households that meet the standards of “Clean and healthy life behavior” (Perilaku Hidup Bersih dan Sehat¹⁰) (hereinafter referred to as “PHBS”) was 48.7% and “Desa Siaga Aktif” was 67.3% in 2008. Furthermore, as the proportion of households that can access safe water was 60.3% and those with a toilet was 73.2% in 2008, it was evaluated as unlikely that the targets of 85% and 75% respectively would be obtained by 2009. At the time of completion of the project in 2014, the national average of PHBS indicator had increased to 56.6%, but the households had attained the standard of “Desa Siaga Aktif” at 67.1% (2013); therefore, neither of the indicators were attained at the target of 70% in 2014. The lack of health promotion awareness-raising in rural areas and insufficient capacity of communities to implement activities were pointed out as hindering factors in the “Strategic Plan of the Ministry of Health (2015-2019).” It was confirmed that the project aim to improve regional health management capacity¹¹ was consistent with the development needs throughout the project planning to its completion.

¹⁰ This indicator shows that the proportion of households practicing clean and healthy customs according to the following 10 items (1. Assisted delivery by specialized personnel, 2. Exclusive breastfeeding up to 6 months, 3. Checking weight of under-5 children (monthly), 4. Hand-washing ^{before} meals, 5. Using clean water, 6. Using clean toilets, 7. Checking and eliminating the occurrence of bowlers inside and outside the house (weekly), 8. Non-smoking inside house, 9. Daily exercise, 10. Consuming vegetables and fruits daily). The number of households implementing above items divided by the total number of households and calculate the proportion for each community. The indicator is also adopted by the “Strategic Plan of the Ministry of Health in Indonesia.”

¹¹ This indicator shows whether a community has the intention and ability to overcome their own health problems (1. Establish and actively implement the forum of Desa Siaga Aktif, 2. Assign a full-time volunteer called a “Kader” 3. Secure good access to permanent health facilities, 4. Locate the integrated health posts, and implement health promotion activities, 5. Allocate a village budget for health activity, 6. Community organizations actively participate in various activities, 7. Community sets various provisions to promote Desa Siaga Aktif, and 8. The proportion of households that meets the indicator for clean and healthy life behavior (PHBS indicator)).

3.1.3 Consistency with Japan's ODA Policy

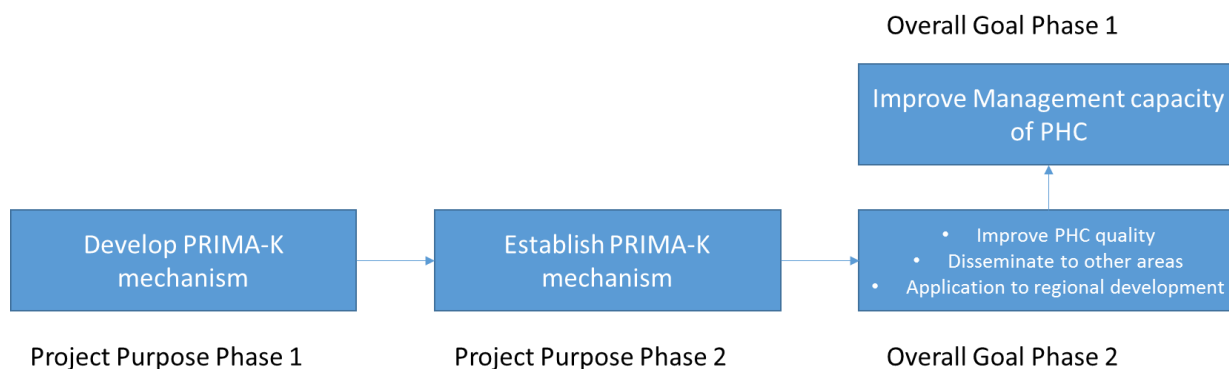
In the "Country Assistance Program for Indonesia" (November 2004), three priority fields (Three pillars) to support "sustainable growth driven by the private sector," "creating a democratic and equitable society," and "peace and stability," and the health sector supported by the project were prioritized in "creating a democratic and equitable society." Promoting a comprehensive approach by utilizing each aid scheme in South Sulawesi Province as a model region (South Sulawesi Province Regional Development Program) was cited in the "Country Assistance Program" for selection and concentration in certain supporting fields and areas. Since the project targeted this area, it was consistent with Japan's policy.

From the above, the implementation of the project is fully consistent with the development policy of the Government of Indonesia, development needs, and Japan's ODA policy, while the project approach has also been appropriate. Therefore, its relevance is high.

3.2 Effectiveness and Impact (Rating: ③)

In this ex-post evaluation, in order to jointly evaluate Phase 1 and Phase 2, the purposes and logic of each project were reorganized as shown in Figure 2 below. The project purpose of Phase 1 was to develop the PRIMA-K mechanism to implement PHCI activities, and this mechanism was established through further strengthening of each administrative level during Phase 2. Based on the project purposes of Phase 1 and Phase 2, the overall goals of Phase 2, such as "improvement of PHC quality," "dissemination to other areas," and "application to regional development" are positioned as further effects. The overall goal of Phase 1 was "Improvement of PHC management ability"; however, since the indicator of the goal was "decrease in the prevalence rate of diarrhea and dengue fever," these indicators are considered to be the final outcomes. In summary, in this ex-post evaluation, the project is regarded as improving ultimately health indicators by enhancing the health environment through developing and establishing the PRIMA-K mechanism for the implementation of PHCI activities.

Therefore, the degree of accomplishment of the project purpose and overall goal indicators of both Phase 1 and Phase 2 were comprehensively confirmed, and reflected to the effectiveness and impact evaluation.



Source: Created by the evaluator based on the materials provided by JICA

Figure 2: Relationship between Project Purpose and Overall Goal for Each Phase

3.2.1 Effectiveness

3.2.1.1 Project Output

With regard to the output indicators, particularly for Phase 2, the number of indicators greatly increased and their contents changed from the time of the preparatory study to the terminal evaluation. However, those changes are seen as appropriate because the overall achievement status of the project activities became measurable concretely due to those changes. In addition, each output indicator was evaluated according to the project design matrix (PDM) used in the terminal evaluation of each phase.

Through the activities of Phase 1, PHCI activities in the community were implemented (output 1), and the PHCI support capacity of the sub-district/village team (output 2), district government (output 3), and provincial government (output 4) were strengthened. As a result, the PRIMA-K mechanism was established (project purpose for Phase 1). For Phase 2, through activities to internalize the PRIMA-K mechanism to the local administrative systems in order to ensure the sustainability of the developed PRIMA-K mechanism, PHCI activities were enhanced based on the local administrative systems (output 1), while the capacity of HCs/SDOs (output 2), district government (output 3), and provincial government (output 4) has been improved. These outputs contributed to establishing the PRIMA-K mechanism (project purpose Phase 2).

Most indicators of outputs have been achieved as shown in Annex 1, and all outputs contributed to the achievement of the project purposes shown below.

3.2.1.2 Achievement of Project Purpose

【Phase 1】

As shown in Table 5, almost all indicators were achieved at the completion of the project Phase 1. Regarding Indicator 1, “the political commitment of the district government,” the District Team planned to disseminate the PRIMA-K mechanism to non-target villages in the district using the district budget. Regarding the budget, PHCI activities

are implemented using allocation from the project (Block Grant¹²), and the Indonesian government did not provide a budget during the project implementation period Phase 1. In Phase 2, PHCI activities using the government budget were realized because the effectiveness of the PHCI activities had been verified in Phase 1. Regarding Indicator 2, “the development of manuals and guidelines for PHCI activities,” these were formulated and the capacity of the community, HCs, and District Team was strengthened through training and practice using these materials. Regarding Indicator 3, “the community initiative to continue PHCI activity and the results of the end-line survey¹³ by Phase 1,” this also showed a strong willingness by the community and HWG members to continue the PHCI activities. The results of the beneficiary survey¹⁴ at the time of the ex-post evaluation also showed that 97% of the HWGs (representative) answered “strongly agree” or “agree” to the statement “HWG members are willing to continue PHCI activities.” Thus, it was confirmed that the initiative of community members has not changed.

Table 5: Achievement of Project Purpose (Phase 1)

Project Purpose	Indicator	Actual	Achievement ¹⁵
Community-oriented health promotion model is developed in the target district	Indicator 1: Political commitment and budget allocation in districts to apply the model	As a political commitment, each District Teams planned to disseminate the PRIMA-K mechanism to non-target villages with the district budget. Measures were discussed to secure the PHCI activity fund (Block Grant) provided by the Japanese side after project completion. Concrete measures such as the utilization of ADD were examined by the district government. In Wajo, a budget for activities of the District Team was allocated from the ordinary budget of the district government during Phase 1.	Mostly achieved
	Indicator 2: Availability of models (development of guidelines, etc.)	Manuals and guidelines were developed to maintain the implementation of the PRIMA-K mechanism, and the capacity of the community. HCs and district government staff were strengthened through training and practice, using those manuals and guidelines.	Achieved
	Indicator 3: Community members are willing to adopt the	According to the following end-line survey, residents and HWG members with experience of PHCI activity showed higher motivation to continue the activity, as compared with those who had not participated in the activities. Based on the results of the	Achieved

¹² The Japanese side provided funds for PHCI activities to the community. In addition to these funds, the community’s own funds (donations, etc.) were also utilized for the activities.

¹³ The end-line survey was conducted in 30 villages of the six districts that have implemented PHCI activities since the beginning of the project in 2007 (Tanete Rilau, Barru, Ujung Loe, Bonto Bahari, Belawa, Tanasitolo). The sample size was as follows: Residents (target: 1,395, non-target: 469), HWG (only target: 145), sub-district health council members (only target: 28), HC staff (target: 63, non-target: 21).

¹⁴ A questionnaire survey was conducted mainly to examine the current situation of the model (PRIMA-K mechanism) developed by the project with 13 HCs/SDOs and 120 HWGs targeted by each of Phase 1 and Phase 2. Regarding the method of beneficiary survey to HWG, questionnaires were distributed and collected from 120 HWGs selected by random sampling from the list of 367 target HWGs. For provincial and district relevant organizations that are not included in the beneficiary survey, the evaluator obtained qualitative data through interviews with representatives of those organizations and used data together with the above quantitative data.

¹⁵ Regarding the level of achievement, the four scales “Achieved,” “Mostly achieved,” “Partially achieved,” and “Not achieved.” were adopted. With a high level of achievement but slightly below the indicator value, “Mostly achieved” was applied; if the indicator value was not attained in some areas or items, “Partially achieved” was applied; and if the indicator value was not attained at all, “Not achieved” was applied.

model and continue health-oriented promotion activities (PHCI)	beneficiary survey in the ex-post evaluation, it was also confirmed that 97% of HWG members were willing to continue the PHCI activities.															
	<p>Table 6: Motivation for PHCI activities¹⁶</p> <table border="1"> <thead> <tr> <th></th> <th>With Experience</th> <th>Without Experience</th> </tr> </thead> <tbody> <tr> <td>Residents</td> <td>3.12</td> <td>1.98</td> </tr> <tr> <td>HWG</td> <td>3.51</td> <td>-</td> </tr> <tr> <td>Sub-district team</td> <td>3.52</td> <td>2.50</td> </tr> <tr> <td>HC staff</td> <td>3.00</td> <td>2.87</td> </tr> </tbody> </table> <p>Source: Document provided by JICA</p>			With Experience	Without Experience	Residents	3.12	1.98	HWG	3.51	-	Sub-district team	3.52	2.50	HC staff	3.00
	With Experience	Without Experience														
Residents	3.12	1.98														
HWG	3.51	-														
Sub-district team	3.52	2.50														
HC staff	3.00	2.87														

Source: Document provided by JICA

【Phase 2】

Table 7 shows the project purpose, the indicators (target values) of Phase 2, and the achievement level of each indicator at the time of the completion. All indicators were achieved.

The proportion of villages that completed PHCI activity exceeded the target value (80%) in each year. In the terminal evaluation report of Phase 2 (2013), however, it was pointed out that the sustainability of phase 2 had some problems because the achievement of these indicators was largely attributed to project-financed field facilitators rather than to their Indonesian counterparts. In order to revalidate this point, the current implementation of PHCI activities was reviewed in the ex-post evaluation. A total of 98% (360/367) of the villages and wards (HWG) had completed the PHCI activity in 2015 without project-financed field facilitators, so it was confirmed that the mechanism for continuous PHCI activities has been established because of the steady implementation of technical transfer to local counterparts (District Team, HC/SDO facilitators). Regarding Indicator 2, “institutionalization of the PRIMA-K mechanism,” the ordinance of the district governor prescribing the integration of the PRIMA-K mechanism and the “Desa Siaga Aktif” for the continuation of PHCI activities was issued in each district by the time of the project completion. The ordinances have remained valid at the time of the ex-post evaluation, and activities have continued based on those ordinances. Furthermore, while the promotion of activities that integrated the PRIMA-K mechanism and the “Desa Siaga Aktif” was clearly stipulated in the “Strategic Plan of the District Health Office” of each district¹⁷, it can be evaluated that the PRIMA-K mechanism in target districts has been institutionalized and established.

¹⁶ The number is the average of five scales (0: I don't want to participate in PHCI activities continuously – 4: I want to participate in PHCI activities continuously).

¹⁷ Promotion of the “Desa Siaga Aktif” is specified in the “District Health Development Strategy Plan in Bulukumba 2016-2021,” “District Health Development Strategy Plan in Wajo 2014-2019,” and “District Health Development Strategy Plan in Barru 2014-2019.”

Table 7: Achievement of Project Purpose (Phase 2)

Project Purpose	Indicator	Actual	Achievement
The mechanism of Primary Health Care in which community and government work together is established in the target districts.	Indicator 1: Percentage of villages completing community-centered PHCI activity cycle (at least 80% in the target districts) ¹⁸	The percentages of villages/wards that completed the PHCI activity cycle were as follows: First cycle (2011): 88% (260/294) Second cycle (2012): 98% (359/366) Third cycle (2013): 95% (347/367)	Achieved
	Indicator 2: The mechanism of Primary Health Care in which community and government work together is institutionalized and stipulated in the official district documents (such as; District Long-term Development Plan, District Mid-term Development Plan, District Annual Working Plan, Strategic Plan of related District Government Institutions (SKPD), and other laws and regulations). ¹⁹	By the time of project completion (2014), the following ordinances of the district governor that indicated the integration of the PRIMA-K mechanism and “Desa Siaga Aktif” for continuation of PHCI activities had been issued in each district. These are still valid at the time of ex-post evaluation, and activity has continued according to the governor’s ordinance. Barru: “Desa/Kelurahan Siaga Active” Bulukumba: “Desa/Kelurahan Siaga Panrita Active” Wajo: “Desa/Kelurahan PRIMA Siaga Active”	Achieved

Source: Document provided by JICA

From the above, the project purposes of both Phase 1 and Phase 2 were achieved.

Regarding the status of outputs from the time of project completion to the time of the ex-post evaluation, with regard to output 1, all 358 HWGs established by the project completion and have continued PHCI activities at an equivalent level during the project period. Regarding strengthening the supporting capacity of the HC/SDO facilitators (output 2), HC/SDO facilitators have been continuing their activities, although some problems have been observed in the frequency of monitoring and the accounting report vilification by SDOs; thus, the function can be judged to have been maintained. Regarding output 3, “strengthening the capacity of the District Team,” the activity continuity of the District Team was institutionalized by district governor ordinances, and their function continues in each target district. Although output 4, “activities relating to the strengthening of Provincial Team capacity,” are still being implemented, the Provincial Health Office (DINKES) pointed out that the involvement of the Provincial Team, especially the Regional Development Planning Board (BAPPEDA) and the Community Empowerment Village/Ward Governance Board (BPMPDK) has been diluted. Moreover some other activities were also stagnating, such as summarizing the results of the practice in the province and cooperating with central government to promote nationwide dissemination

¹⁸ Revised from “Number of villages that have been continuously implementing the cycle of primary health care improvement activities with the support of the government” (in July 2012).

¹⁹ Revised from “The mechanism of Primary Health Care in which community and government work together is institutionalized (stipulated in official district documents such as: District Long-term Development Plan, District Mid-term Development Plan, District Annual Working Plan, Strategic Plan of related District Government Institutions (SKPD), and other laws and regulations)” (in July 2012).

based on the results.

Based on the above, although there are some issues at the output level, major achievements have been confirmed even at the time of the ex-post evaluation. The PRIMA-K mechanism established in Phase 1 and Phase 2 has continued even at the time of the ex-post evaluation and has contributed to generating the following impacts.

3.2.2 Impact

3.2.2.1 Achievement of overall goal

【Phase 1】

The achievement level of the overall goal (Phase 1) is shown in Table 8.

Table 8: Achievement of Overall Goal

Overall Goal	Indicator	Actual	Achievement																																
Management capacity of primary health care in the health sector of target districts is improved ²⁰	Indicator 1: Incidence rates of diarrhea and dengue fever are decreased ²¹	<p>As shown in Table 9, a decrease in diarrhea cases in the target districts was confirmed. On the other hand, the number of dengue fever cases (see Table 10) has increased in the Barru and Wajo districts from the previous year.</p> <p>Table 9: Rate of Diarrhea Cases in Target Districts (Unit: Per 1,000 persons)</p> <table border="1"> <thead> <tr> <th></th> <th>2013</th> <th>2014</th> <th>2015</th> </tr> </thead> <tbody> <tr> <td>Barru</td> <td>42.2</td> <td>39.8</td> <td>21.4</td> </tr> <tr> <td>Bulukumba</td> <td>32.7</td> <td>30.9</td> <td>21.4</td> </tr> <tr> <td>Wajo</td> <td>31.8</td> <td>30.9</td> <td>24.6</td> </tr> </tbody> </table> <p>Source: Questionnaire to district health offices in ex-post evaluation</p> <p>Table 10: Number of Dengue Fever Cases in Target Districts (Unit: Cases)</p> <table border="1"> <thead> <tr> <th></th> <th>2013</th> <th>2014</th> <th>2015</th> </tr> </thead> <tbody> <tr> <td>Barru</td> <td>87</td> <td>64</td> <td>72</td> </tr> <tr> <td>Bulukumba</td> <td>613</td> <td>537</td> <td>252</td> </tr> <tr> <td>Wajo</td> <td>113</td> <td>51</td> <td>199</td> </tr> </tbody> </table> <p>Source: Questionnaire to district health offices in ex-post evaluation</p>		2013	2014	2015	Barru	42.2	39.8	21.4	Bulukumba	32.7	30.9	21.4	Wajo	31.8	30.9	24.6		2013	2014	2015	Barru	87	64	72	Bulukumba	613	537	252	Wajo	113	51	199	Partially achieved
		2013	2014	2015																															
Barru	42.2	39.8	21.4																																
Bulukumba	32.7	30.9	21.4																																
Wajo	31.8	30.9	24.6																																
	2013	2014	2015																																
Barru	87	64	72																																
Bulukumba	613	537	252																																
Wajo	113	51	199																																
	Indicator 2: The number of villages implementing the community-oriented health promotion model has increased	The PRIMA-K mechanism was disseminated from 24 villages (population 320,776 persons ²²) in three target districts of Phase 1 to 358 villages/wards (population 970,071 persons ²³) in Phase 2 through the initiative of target district members.	Achieved																																

Source: Document provided by JICA

In Phase 1, the HWG implemented PHCI activities, comprising the installation of toilets, sewage treatment facilities, wells, and water tanks, to improve infrastructure, and

²⁰ Revised form “Management capacity and service delivery in the health sector of target districts is improved” (in July 2012).

²¹ Revised from “Rates of major infectious diseases (e.g., diarrhea, Acute Respiratory Infection (ARI), Malaria, Tuberculosis (TB), etc.) (in July 2012).

²² Population in 2007.

²³ Population in 2014.

those activities contributed to the improvement of the sanitary environment and hygienic water access²⁴. In addition, it was confirmed that due to awareness-raising activities in health and hygiene (for example, guidance of the use of toilets and hand-washing by HC staff in installed integrated health posts), the number of diarrhea cases, i.e., indicator 1, was significantly decreased, as shown in Table 9.

At the same time, HC staff declared that these activities also contributed to the reduction of dengue cases by eliminating mosquito larvae and raising community awareness. However, the number of dengue fever cases has increased in some districts. The district health office explained that this is because the dengue fever epidemic usually occurs on a three to four-year cycle, regardless of whether or not preventive measures are taken. As a result of the questionnaire to each health office in the target districts, all answered “Yes”²⁵ in response to the question “Do PHCI activities contribute to decreasing dengue fever and diarrhea in your district?” In the results of the beneficiary survey, 96% of HWGs (village chiefs) also answered “Strongly agree” or “Agree” to the statement “PHCI activities have improved the local health situation by the project.” It seems that the implementation of the project has contributed to the improvement of a certain degree the health indicators in the target districts.

Regarding Indicator 2, “the number of villages practicing the PRIMA-K mechanism,” the PRIMA-K mechanism that was developed during Phase 1 was implemented in villages/wards using the district budget during Phase 2. The provision of a highly versatile mechanism in Phase 1 contributed to realizing the implementation of activities using the district budget.

【Phase 2】

The achievement level of the overall goal for Phase 2 is shown in Table 11 below.

Table 11: Overall Goal Achievement

Overall Goal	Indicator	Actual	Achievement																												
1. Quality of Primary Health Care in the target districts is improved	1-1: Health Behavior (PHBS) Indicator is improved from 27.50% (2011) to 59% (2017) in Barru, from 48.7% (2011) to 80% (2017) in Bulukumba, from 18.25% (2011) to 65% (2017) in Wajo	As shown in Table 12, although the PHBS indicator has consistently improved from 2011 (base line), it is unlikely to achieve the target for 2017.	Not achieved (Prediction) (Contributions to improving some indicators were confirmed)																												
		Table 12: Percentage of Households Meeting the PHBS Indicator in the Target Districts (Unit: %)																													
		<table border="1"> <thead> <tr> <th></th> <th>2011 (Base line)</th> <th>2012</th> <th>2013</th> <th>2014</th> <th>2015</th> <th>2017 (Target)</th> </tr> </thead> <tbody> <tr> <td>Barru</td> <td>27.5</td> <td>46.0</td> <td>45.6</td> <td>47.6</td> <td>47.4</td> <td>59.0</td> </tr> <tr> <td>Bulukumba</td> <td>48.7</td> <td>53.3</td> <td>56.8</td> <td>57.7</td> <td>52.6</td> <td>80.0</td> </tr> <tr> <td>Wajo</td> <td>18.3</td> <td>24.5</td> <td>29.4</td> <td>34.7</td> <td>36.4</td> <td>65.0</td> </tr> </tbody> </table>			2011 (Base line)	2012	2013	2014	2015	2017 (Target)	Barru	27.5	46.0	45.6	47.6	47.4	59.0	Bulukumba	48.7	53.3	56.8	57.7	52.6	80.0	Wajo	18.3	24.5	29.4	34.7	36.4	65.0
				2011 (Base line)	2012	2013	2014	2015	2017 (Target)																						
Barru	27.5	46.0	45.6	47.6	47.4	59.0																									
Bulukumba	48.7	53.3	56.8	57.7	52.6	80.0																									
Wajo	18.3	24.5	29.4	34.7	36.4	65.0																									
Source: Questionnaire to district health offices in ex-post evaluation																															

²⁴ As for the PHCI activities conducted by HWGs, 290 activities were implemented for building infrastructure in 2013, of which 66% comprised the building of toilets, 11.7% were integrated health posts, 8.6% were sewage treatment facilities, and 3.8% were wells and water tanks.

²⁵ Three selections, “Yes,” “No,” and “Do not know,” were applied in this question.

		<p>Project activities greatly contributed to indicators, particularly “improvements in sanitation status by building toilets and wells,” securing safe water as shown in Tables 13 and 14.</p> <p>Table 13: Percentage of Households with Toilets in Target Districts (Unit: %)</p> <table border="1"> <thead> <tr> <th></th> <th>2012</th> <th>2013</th> <th>2014</th> <th>2015</th> </tr> </thead> <tbody> <tr> <td>Barru</td> <td>77.2</td> <td>79.0</td> <td>83.0</td> <td>87.3</td> </tr> <tr> <td>Bulukumba</td> <td>-</td> <td>84.0</td> <td>84.5</td> <td>85.5</td> </tr> <tr> <td>Wajo</td> <td>80.0</td> <td>83.6</td> <td>84.6</td> <td>91.4</td> </tr> </tbody> </table> <p>Source: Questionnaire to district health offices in ex-post evaluation</p> <p>Table 14: Percentage of Households with Safe Water in Target Districts (Unit: %)</p> <table border="1"> <thead> <tr> <th></th> <th>2012</th> <th>2013</th> <th>2014</th> <th>2015</th> </tr> </thead> <tbody> <tr> <td>Barru</td> <td>83.4</td> <td>85.4</td> <td>88.3</td> <td>89.2</td> </tr> <tr> <td>Bulukumba</td> <td>-</td> <td>83.3</td> <td>84.0</td> <td>84.9</td> </tr> <tr> <td>Wajo</td> <td>81.4</td> <td>85.3</td> <td>85.8</td> <td>87.4</td> </tr> </tbody> </table> <p>Source: Questionnaire to district health offices in ex-post evaluation</p>		2012	2013	2014	2015	Barru	77.2	79.0	83.0	87.3	Bulukumba	-	84.0	84.5	85.5	Wajo	80.0	83.6	84.6	91.4		2012	2013	2014	2015	Barru	83.4	85.4	88.3	89.2	Bulukumba	-	83.3	84.0	84.9	Wajo	81.4	85.3	85.8	87.4	
	2012	2013	2014	2015																																							
Barru	77.2	79.0	83.0	87.3																																							
Bulukumba	-	84.0	84.5	85.5																																							
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	2012	2013	2014	2015																																							
Barru	83.4	85.4	88.3	89.2																																							
Bulukumba	-	83.3	84.0	84.9																																							
Wajo	81.4	85.3	85.8	87.4																																							
	<p>1-2: Number of “Desa Siaga Aktif” increased in target districts: from 56% (2011) to 100% (2017) in Barru, from 100% (2011) to 100% (2017) in Bulukumba, from 69.87% (2011) to 90% (2017) in Wajo²⁶</p>	<p>With respect to the percentage of communities that attained the standard of “Desa Siaga Aktif,” as all districts had attained the target in 2015, the indicator is expected to be achieved in 2017.</p> <p>Table 15: Percentage of Communities that Attained the Standard of “Desa Siaga Aktif” in the Target Districts (Unit: %)</p> <table border="1"> <thead> <tr> <th></th> <th>2011 (Base line)</th> <th>2012</th> <th>2013</th> <th>2014</th> <th>2015</th> <th>2017 (Target)</th> </tr> </thead> <tbody> <tr> <td>Barru</td> <td>56.0</td> <td>57.4</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> </tr> <tr> <td>Bulukumba</td> <td>100</td> <td>75.7</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> </tr> <tr> <td>Wajo</td> <td>69.9</td> <td>87.5</td> <td>94.3</td> <td>95.5</td> <td>96.0</td> <td>90</td> </tr> </tbody> </table> <p>Source: Questionnaire to district health offices in ex-post evaluation</p>		2011 (Base line)	2012	2013	2014	2015	2017 (Target)	Barru	56.0	57.4	100	100	100	100	Bulukumba	100	75.7	100	100	100	100	Wajo	69.9	87.5	94.3	95.5	96.0	90	<p>Achieved (Prediction)</p>												
	2011 (Base line)	2012	2013	2014	2015	2017 (Target)																																					
Barru	56.0	57.4	100	100	100	100																																					
Bulukumba	100	75.7	100	100	100	100																																					
Wajo	69.9	87.5	94.3	95.5	96.0	90																																					
<p>2. The mechanism of Primary Health Care in which community and government work together is disseminated</p>	<p>2-1: The mechanism of Primary Health Care in which community and government work together is implemented in other districts/provinces.²⁷</p>	<ul style="list-style-type: none"> ● For the dissemination to other districts, activities were disseminated to outside of the target districts, Bone and Sidenreng Rappang, and PHCI activities were conducted in 38 villages in Bone (2015) and 106 villages in Sidenreng Rappang (2016). ● In 2016, the provincial government provided training in two cities and one district, Jeneponto, Parepare, and North Luwu. Efforts for dissemination are still continuing. ● Regarding the dissemination to other provinces, it was intended to be integrated into the national program “Desa Siaga Aktif” by the Ministry of Health, but there was no case in which the PRIMA-K mechanism was adopted, and disseminated to other provinces. 	<p>Mostly achieved (Prediction)</p>																																								
<p>3. Regional Development Mechanism, in which community and</p>	<p>3-1: The mechanism in which community and government work together is strengthened to</p>	<ul style="list-style-type: none"> ● Members of the HWG confirmed that PRIMA-K’s approach was used for planning and budget execution in other sectors, but this remains at the individual HWG; it has not been institutionalized in district policies and regulations. 	<p>Mostly achieved (Prediction)</p>																																								

²⁶ Revised from “Increase in Desa Siaga Aktif (villages certified as having an intention and ability to overcome own health problems according to the standard of the Ministry of Health)” (July 2012).

²⁷ Revised from “the mechanism of Primary Health Care in which community and government work together is operated in other districts/provinces in South Sulawesi Province” (July 2012).

government work together, is strengthened	other sectors in the target districts. ²⁸	<ul style="list-style-type: none"> ● To promote the village fund, DANA DESA (hereinafter referred to as “DD”²⁹) was started from 2015. BPMPD introduced the PRIMA-K mechanism as bottom-up planning to promote health activities using DD in training for 500 facilitators adopted by the provincial government. 	
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Source: Document provided by JICA

Although the percentage of households that attained the PHBS indicator (Indicator 1-1 in the overall goal), which shows the quality of PHC, has improved, the target is unlikely to be achieved as of 2017. As a factor of this, the PHBS indicator is composed of various related indicators of the daily health environment, such as the cessation of indoor smoking, daily exercise, and vegetable and fruit intake, which were not fully contributed by the PHCI activities of the project. Furthermore, the target of the PHBS indicator was set based on the “Provincial Health Development Plan.” The 2015 target of the PHBS indicator in South Sulawesi Province was 80% on average, but its target level was considerably high, as, in fact, none of the 24 districts in the province were able to attain the target in this year (The provincial average was 54.6% in 2015)³⁰. Meanwhile, as shown in Tables 13 and 14 in Table 11, the percentage of households that can access toilets and safe water among the PHBS indicators that are highly relevant to the project has improved consistently over the years through such PHCI activities as building toilets, sewage treatment facilities, wells, and water tanks.

Indicator 1-2, the percentage of communities that attained the standard of “Desa Siaga Aktif,” has already achieved the target level in each target district as of 2013. For Indicator 2-1, “dissemination to other districts,” PHCI activities were disseminated to outside of the target districts, the Sidenreng Rappang and Bone districts. On the other hand, regarding the dissemination to other provinces, at the outset, the project intended to integrate its activity into the national program of the Ministry of Health “Desa Siaga Aktif.” However, the PRIMA-K mechanism has not been integrated into the national program. Since the target areas were limited to only three districts in one province in Indonesia, which has a burst territory with varied geographical and cultural backgrounds, the Ministry of Health pointed out that nationwide dissemination could be difficult through generalization of the project mechanism to the target districts.

For Indicator 3-1, “strengthening the regional development mechanism,” the BPMPD, which was one of the counterpart organizations of the project, introduced the PRIMA-K mechanism as a bottom-up planning mechanism in other sectors during the

²⁸ Revised from “the mechanism in which community and government work together is applied to other sectors in the target districts” (July 2012).

²⁹ DD stipulates that 70% is used for poverty reduction, health and education, and infrastructure and agricultural programs, while 30% is used as village office management, salaries, subsidies/incentives to village/community organizations. While ADD is allocated through the local government budget, DD is allocated directly by the Ministry of Finance to the village administrative body via the local government.

³⁰ “The Provincial Health Development Plan in South Sulawesi” (2013-2018).

training of facilitators³¹ in charge of the promotion of DD that began in 2015.

Above all, the targets of some overall goal indicators are too high; therefore, the probability of achievement seems low. However, health environment indicators related to the project activities have been consistently improved; thus, the overall goal by 2017, that “Quality of Primary Health Care in the target districts is improved,” is expected at the time of the ex-post evaluation to be mostly achieved.

The project aims, the development of the PRIMA-K mechanism in Phase 1 and the establishment of its mechanism in Phase 2, were achieved, and the effects of these project purposes have been constantly generated, even at the time of the ex-post evaluation. As a result, the overall goals of both phases with regard to the health and sanitation environment and health indicators have been greatly improved. Furthermore, with respect to the indicator “dissemination of the PRIMA-K mechanism,” the project has disseminated this mechanism to other villages (Phase 1, overall goal), districts, and sectors (Phase 2, overall goal). However, the dissemination of the mechanism to other provinces has not been confirmed. In sum, it is evaluated that the overall project goals have largely been achieved, except for some indicators.

3.2.2.2 Other Positive and Negative Impacts

Effective utilization of DD by activating Musrenbang

The project has organized HWG in communities and has promoted the effective use of DD, starting in 2015, with the functionalization of the bottom-up planning method “Musrenbang.” DD tends to be used for large-scale infrastructure projects, for example, the construction of large-scale roads and facilities, due to the high budget allocation to the community. However, the District Team confirmed that communities with functioning Musrenbang tend to allocate the budget to social development projects, including in the health sector, according to the needs of residents. As the community budget has increased rapidly with DD allocation, activating “Musrenbang” can have an important impact in terms of the effective use of the budget according to community needs.

Raising the awareness of community mutual cooperation

As for other impacts, interviews with community members in this ex-post evaluation revealed that access rates to HCs and other community-level health facilities have been increased through the promotion of awareness-raising by PHCI activities, and “mutual assistance” has also been promoted; for example, residents voluntarily provided

³¹ The village fund facilitators are assigned to the Community and Village Government Empowerment Board of each district to facilitate all development sectors including the health in villages for the promotion of DD implementation. Meanwhile, HC/SDO facilitators of the project assigned in the three target districts provide support for PHCI activities, so there is no duplication in the activities of both facilitators.

materials (cement, wood, etc.) and their workforce to build toilets in the community.

The development of the community-oriented health promotion model in the target districts (Phase 1) and the establishment of the PHC mechanism in which community and government work together (Phase 2), which were the stated as project purpose, were achieved. Regarding the overall goals, the majority of indicators relating to health and sanitation environments and health indicators have also improved, and impacts such as dissemination to other districts and the use of the PRIMA-K mechanism by other sectors were confirmed. Therefore, the effectiveness and impact of the project are high.

Box: Statistical Analysis of the Impact of PHCI Activities on Health Indicators

In this ex-post evaluation, the relationship between the degree of PHCI activities (explanatory variable) and the PHBS indicator (dependent variable), one of the health indicators, was studied by statistical analysis (Regression Analysis) using the results of the beneficiary survey. As a result, a significantly positive relation was confirmed between the number of planned PHCI activities (average: 3.6 activities, standard deviation: 3.8) and actualized activities in 2014 (average: 2.9 activities, standard deviation: 2.7) and the PHBS indicator in 2015 (average: 43.1%, standard deviation: 15.5) in each community in the three target districts.

The results of the regression analysis using the dummy variable to control the fixed effect of each district identified the positive relation whereby if a community increased one planned activity, the percentage of households that fulfilled the PHBS indicator (households practicing a clean and healthy lifestyle) increased by 1.17% (significant at the 0.1% level), and if a community increased one actualized activity, the percentage of households that fulfilled the PHBS indicator increased by 1.60% (significant at the 0.5% level). This shows the possibility that PHCI activities promote clean and healthy lifestyles in the community and contribute to increasing the number of households that fulfill the PHBS indicator. Furthermore, increasing the number of activities (types of activity) means that the community tries to incorporate a comprehensive approach such as awareness-raising for health promotion, in addition to building infrastructure such as toilets and drinking water facilities. The results, that the increase in the number of activities can be attributed to an increasing percentage of households that have attained the PHBS indicator, suggest that the comprehensive approach may promote a clean and healthy lifestyle in the community.

On the other hand, no positive relationship was confirmed between the PHBS indicator and other explanatory variables, such as the amount of the activity budget, the number of meetings in the community, and training participants. In addition, no statistically significant relationship was confirmed between the PHBS indicator and the number of planned and actualized PHCI activities in 2015. This means that PHCI activities will take some time to increase the PHBS indicator, or that while project activities had already been implemented in 2014, only a few additional effects were generated by activities in 2015.

3.3 Efficiency (Rating: ③)

3.3.1 Inputs

Table 16: Project Inputs

Inputs	Phase 1		Phase 2	
	Plan	Actual	Plan	Actual
(1) Experts	7 persons	Short-term 10 persons (72 MM)	5 persons	Long-term 3 persons Short-term 3 persons (58 MM)
(2) Trainees received	Approximately 4 persons/year (2 years)	12 persons	Not listed	53 persons
(3) Equipment	Equipment necessary for the project office	Computer, printer, copy machine, etc.	Equipment necessary for the project office	Computer, printer, copy machine, etc.
(4) Local expenses	Not listed	Total 105.01 million yen (Of which, Block Grant = 65.94 million yen)	Not listed	Total 141.86 million yen
(5) Field facilitator	Not listed	13 persons (371MM)	Not listed	59 persons (1,566MM)
Japanese side Total project cost	Total 39 million yen	Total 387 million yen	Total 290 million yen	Total 290 million yen
Indonesian Side Total Project Cost	Training and monitoring expenses, action plan, project cost (to be gradually increased)	Total 781 million rupiah (Approx. 6.82 million yen) ³² (Monitoring, partial burden of training expenses)	·Monitoring of counterparts, training/seminars, expenses for meeting attendance ·PHCI activity expenses implemented by the community ·PHCI activity support expenses by HC ·Part of expenses related to training, workshops, seminars	Total 362 million rupiah (Approx. 3.16 million yen) (Central, Provincial, District staffs' business trip expenses, meeting fees, and part of the project activity expenditure by the District government)

* MM stands for man month.

Source: Documents provided by JICA

3.3.1.1 Elements of Input

The input elements of the project are as shown in Table 16. The Block Grant (65.94 million yen) was allocated to each sub-district team and HWG by local expenses in Phase 1 as the input of the Japanese side. The necessity of allocating Block Grants was confirmed by the interview with the Provincial Team as a “priming” before realizing the implementation of PHCI activities using the local budget by enhancing the capacity of the HWG and visualizing the effectiveness of PHCI activities (i.e., the PRIMA-K mechanism was developed in a short time using the Block Grant from the Japanese side, which enabled the effectiveness in improving the health environment to be demonstrated). As a result, the Indonesian government acknowledged the effectiveness of the PRIMA-K mechanism, and

³² To convert foreign currency into yen, the JICA control rate (1.00 rupiah = 0.008727 yen) at the time of the ex-post evaluation was applied (February 2017).

the government budget was allocated from Phase 2. On the other hand, many field facilitators (59 persons) were employed by local expenses from the Japanese side to expand the target into all three villages/wards in three districts and to strengthen the HWG's capacity to apply the local budget. The validity of using field facilitators was confirmed as greatly contributing to the promotion and sustainability of PHCI activities in villages and wards.

The input of the project was evaluated as appropriate, because in the ex-post evaluation, provincial and district team members responded that the inputs of the Japanese side, for example, experts, equipment, local expenses, and training in Japan, were adequate in terms of both timing and quantity.

3.3.1.2 Project Cost

Regarding the project cost, Phase 1 fell within the plan at 96%, while Phase 2 was 100% as planned.

3.3.1.3 Project Period

Between Phase 1 and Phase 2, the implementation period was as planned (100%).

Based on the above, both the project cost and project period fell within the plan. Therefore, the efficiency of the project is high.

3.4 Sustainability (Rating: ③)

3.4.1 Related Policy and Institutional Aspects for the Sustainability of Project Effects

Health Policy

At the central level, the “Strategic Plan for Indonesia of the Ministry of Health (2015-2019)” was formulated based on the “National Medium-Term Development Plan (RPJMN)” (2015-2019) and set the following goals: i. Improvement of maternal and child health and nutrition, ii. Improvement of disease control, iii. Improvement of access to and quality of primary and referral medical facilities in remote/undeveloped/border areas, iv. Improvement of universal health coverage (UHC), v. Provision of sufficient health human resources, medicines, and vaccines, vi. Improvement of the health care system. In order to achieve these goals, the “Indonesia Sehat Program,” the strategy of which is “Residents are actively involved in the prevention and promotion of health to strengthen the community,” was formulated. Thus, the project contributed to promoting this program. In South Sulawesi Province, the target province of the project, the promotion of “Desa Siaga Aktif” to improve community health services by strengthening community capacity was prioritized in the “Provincial Health Department Development Plan in South Sulawesi” (2013-2018). In addition, the “Strategic Plan of South Sulawesi Provincial Health Office” has been

developed in each targeted district based on the abovementioned “Strategic Plan of the District Health Office,” and the promotion of “Desa Siaga Aktif” was integrated with the PRIMA-K mechanism. Furthermore, the improvement of health indicators such as the “PHBS and “Desa Siaga Aktif” indicators, which are also indicators of the project, were applied as overall goals of their plans.³³

Others, Policy of Village Development on Decentralization

Under the former Yudhoyono administration, “Village Law” has been enforced since 2014, and related systems and regulations were developed to provide DD from 2015. The average amount of DD reached one billion rupiah (approx. 85 million yen) in 2015 for each of 77,548 villages nationwide, and is used for infrastructure improvement in relation to community development, including the health sector. Under “Village Law,” strengthening “Musrenbang,” a mechanism for participatory planning by residents, is required for the appropriate planning, implementation, and provision of an accounting report for DD projects. Strengthening the “Musrenbang” function through the PHCI activities of the project promotes the above goal under “Village Law”; therefore, the purpose of the project was highly consistent with “Village Law.” The sustainability of the project effects is also expected because the DD allocated to each community under “Village Law” is utilized for PHCI activities in the target province.

Above all, the project is highly consistent with Indonesian health and village development policies, and thus there is no problem observed in the policy aspect of sustainability.

3.4.2 Organizational Aspects for the Sustainability of Project Effects

Regarding the organizational aspect, the implementing agencies are functioning without any problems, except for a low degree of participation of Regional Development Planning Board and Community Empowerment and Village Governance Board who are part of the Provincial Team. The team is responsible for disseminating the PRIMA-K mechanism to other districts and for sharing with central government. This will be described later. In particular, the number of members of the District Team and the HC/SDO facilitators were increased in the Bulukumba and Wajo districts, while the HC/SDO facilitators trained by the District Team have taken over the roles of field facilitators in the project. In each targeted districts, the reason for this successful succession was that the facilitation work for HWG was able to be incorporated to the routine work of HC/SDO staff through integrating the PRIMA-K mechanism of the project into the Indonesian national program (Desa Siaga Aktif). In addition, the HWG has continued to function in all villages/wards. On this basis,

³³ “The Strategic Plan of Bulukumba District Health Office” (2016-2021), “the Strategic Plan of Wajo District Health Office” (2014-2019), and “the Strategic Plan of Barru District Health Office” (2014-2019).

the organizational aspect for sustainability is evaluated as high, except for some issues in relation to the Provincial Team.

Provincial Team

Twelve out of 13 Provincial Team members still belong to the same departments of the counterpart organizations from the time of the project implementation to the ex-post evaluation (only one member of the Provincial Health Office has transferred). The activities of the Provincial Team are to monitor the disseminated project effects of the target districts and other districts, and to hold seminars to share their experience. The activities of the Provincial Team have continued, even at the time of the ex-post evaluation. On the other hand, the involvement of Regional Development Planning Board and Community Empowerment and Village Governance Board, members of the Provincial Team, was limited at the time of the ex-post evaluation. However, the involvement of those organizations was low and no negative effects on activities were identified, even at the time of the ex-post evaluation.

For the dissemination of project effects to other districts, which is another role of the Provincial Team, the Regional Health Office periodically conducts awareness workshops with other districts. Although some districts show interest in the application of the PRIMA-K mechanism through these workshops, training HC/SDO facilitators to support PHCI activities in the community is required for the actual dissemination. However, the main functions of the provincial government are the coordination of the relevant organizations and they do not have sufficient personnel to implement training for other districts. As a result, only two districts have applied the PRIMA-K mechanism. The Provincial Team stated that support from their development partners is necessary for dissemination to other districts. No issues in sustaining the effectiveness of the project were identified in the organizational aspect of the Provincial Team, such as monitoring of the target, and dissemination and holding experience-sharing seminars. However, organizational improvement is considered necessary for the dissemination of the mechanism to further districts.

District Team

The results of the interview and questionnaire with District Team members, such as District Development Planning Board, Financial Management Office, Community and Village Government Empowerment Board, and District Health Office, show that they have been working closely to conduct periodic meetings and provide training for HWGs. As shown in Table 17, all members of District Teams had received training on PHCI activities at the time of the ex-post evaluation, and the teams have functioned appropriately, mainly comprising members trained in the project. The implementation system was strengthened

in Wajo as the numbers of District Team members and HC/SDO facilitators increased after the project completion. In addition, Wajo and Bulukumba have issued district governor ordinances every year on the establishment of a secretariat for PHCI activities, and provided an allowance to the District Team according to that ordinance. On the other hand, in Barru, as is their policy, PHCI activities have been incorporated into their ordinary work, and no allowance has been paid to the District Team.

Table 17: Number of District Teams, Trainees, and Attendance Rate

(Unit: Persons)

	Project Implementation Period		Time of Ex-post Evaluation	
	No. of Members	No. of Attendance (Attendance Rate)	No. of Members	No. of Attendance (Attendance Rate)
Barru	12	7 (58%) ³⁴	8	8 (100%)
Bulukumba	23	18 (87%)	22	22 (100%)
Wajo	25	24 (92%)	27	27 (100%)

Source: Terminal evaluation report Phase 2, and interview with the District Team in the ex-post evaluation

HC/SDO facilitator

The total number of HC/SDO facilitators has not been compiled. However, the result of the beneficiary survey of HC/SDO shows that the average number of HC facilitators is 6.5 persons per HC (85 persons per 13 HC), and the number of SDO facilitators is 2.4 persons per SDO (29 persons per 12 SDO). The average number is slightly lower than the average in the project terminal evaluation of 6.9 persons per HC (360 persons per 52 HCs), 2.8 persons per SDO (87 persons per 31 SDOs), but the same level of numbers of facilitators has been secured. It was confirmed through interviews with HCs that the number of facilitators is sufficient to support the HWG's PHCI activities after completion of the project because capacity development for the HWG was implemented intensively during the project. Therefore, the current number of persons is evaluated as sufficient to continue the project activities. Moreover, although the transfer of HC/SDO facilitators is not frequent, on-the-job training by other facilitators and the District Team has been provided to newly-appointed HC/SDO facilitators.

HWG

HWG has continued its function at all 367 villages and wards in the target districts at the time of ex-post evaluation. Many members remain, mainly villagers, and it has been confirmed that many members that were trained in the project are continuing their activities. In Barru, an allowance for HWG members (health volunteers) is paid as an incentive for continuing activities. In total, 98% of HWGs were in operation in 2015, and only a few

³⁴ The percentage is low because the Barru District Team includes governors and director-level officials who are not supposed to be trainers. In order to secure the number of trainers, staff other than District Team members are also trained in Barru.

HWGs have difficulties with their activities. However, disregard for the health sector by village chiefs, weak leadership and motivation of HWGs, and a lack of confidence between chiefs and governments of villages were pointed out in interviews with the District Health Office.

3.4.3 Technical Aspects for the Sustainability of Project Effects

Regarding the skills of implementing agency, it can be judged that the capacity of Provincial and District Teams, HC/SDO facilitators, and members of HWG are sufficient for continuing activities. Furthermore, guidelines have been formulated that combine the PRIMA-K mechanism and “Desa Siaga Aktif” in each district.

Provincial Team

For coordination skills to introduce the PRIMA-K mechanism to other regions in the province, the Provincial Team has held workshops independently, even at the time of the ex-post evaluation, thus confirming whether problems exist.

District Team

As shown in Table 18, the District Teams in the target districts independently implement monitoring of PHCI activities, coordination and explanatory meetings with HC/SDO facilitators, and training for HWG even after the project completion. In the beneficiary survey to the HC/SDO facilitators, 77% of HCs responded “Strongly agree” or “Agree” to the statement “Supports by the District Team are effective for promoting PHCI activities.” Thus, it can be evaluated that the training capacity of the District Team, which has a responsibility to provide training to HC/SDO facilitators and HWG members, has reached a certain level.

Table 18: District Team Activity Record (2015)

(Unit: Times)

	Monitoring	Coordinating Meeting	Explanatory Meeting	Training
Barru	4	4	2	2
Bulukumba	3	5	-	1
Wajo	4	4	1	3

Source: Questionnaire to District Health Office in ex-post evaluation

After the completion of the project, each district independently integrated the PRIMA-K mechanism into the “Desa Siaga Aktif” and developed the technical guidelines shown in Table 19 by referring to the PRIMA-K guidelines. In addition, the PRIMAK-Kit (manual, guidelines, teaching materials), formulated by the project, has been utilized in the training of the District Team and HC/SDO facilitators.

Table 19: Guidelines Integrated with “Desa Siaga Aktif” in each District

Target District	Guidelines	Year of Issue
Barru	Desa / Kelurahan Siaga Panrita Active Implemented Technical Guidelines (No. 26)	2015
Bulukumba	Desa / Kelurahan PRIMA Siaga Active Implementation Ordinance, Guidelines (No. 20)	2015
Wajo	Desa / Kelurahan Siaga Active Implementation Laws, Guidelines (No. 13)	2014

Source: Questionnaire to the District Team in the ex-post evaluation survey

HC/SDO facilitator

It was confirmed through interviews with the HWG that HC/SDO facilitators, mainly HC staff, trained by the project have continuously practiced the project activities and have certain skills in monitoring, providing support, and training HWG members. According to the results of the beneficiary survey, 92% of HC/SDO facilitators responded “Strongly agree” or “Agree” to the statement “HC/SDO facilitators have sufficient ability to support PHCI activities.” The results of interview with HC staff also suggest that the capacity of HC/SDO facilitators is sufficient, although they are not able to provide detailed support as field facilitators employed by the project. Nevertheless, it was confirmed that they continue to conduct PHCI activities to the best of their ability, concurrent with their ordinary tasks.

HWG

Most existing HWG members have taken training courses during the project and confirmed that they have sufficient abilities for planning, preparing proposals, and reporting. According to the results of the beneficiary survey, 89% of HWG members responded “Strongly agree” or “Agree” to the statement “Members of the HWG have sufficient abilities to implement PHCI activities.” In response to the statement “Members of the HWG are willing to continue the activities of the PHCI,” 97% responded “Strongly agree” or “Agree.”

3.4.4 Financial Aspects for the Sustainability of Project Effects

As the financial situation of the implementing organizations, as shown below, the counterpart organizations at each level secure the necessary budget to continue the PHCI activities. Therefore, there is no problem observed in the financial aspects of the sustainability.

Budget of Provincial Team (Provincial level)

In the Provincial Team, the District Health Office has allocated a budget for experience-sharing seminars and workshops and monitoring. As shown in Table 20, the Provincial Team budget was maintained at a certain level both throughout the project period

and after the project completion. Although the number of districts subject to awareness-raising activities varies and the budget varies accordingly, provinces have a sufficient budget to continue their current activities.

Table 20: Trends in Provincial Budget to Support PHCI Activities

(Unit: Rupiah)

Project Implementation Period			After Completion of the Project		
2011	2012	2013	2014	2015	2016
80,058,000	93,136,334	220,325,000	136,310,000	244,580,000	113,000,000

Source: Terminal evaluation report Phase 2, questionnaire to Provincial Team in ex-post evaluation

District Team/PHCI Activity Budget (District level)

ADD concerning PHCI activity support (explanatory meeting, various training, monitoring, PHCI activities of HWG) in each target district has been secured every year since the project completion, as shown in the table below. In addition, DD has been newly allocated since 2015, and has increased rapidly since the full-scale application of DD to PHCI activities³⁵ in 2016. Therefore, it can be said that a sufficient budget has been secured.

Table 21: Trends in District Budget Related to PHCI Activities

(Unit: Rupiah)

	Project Implementation Period			After Completion of the Project		
	2011	2012	2013	2014	2015	2016
Barru	9,513,430,500	8,498,444,500	11,115,510,500	11,091,950,000	12,386,690,000	54,096,576,900
Bulukumba	7,950,287,846	11,264,536,034	17,022,814,874	17,978,127,523	15,566,191,271	37,833,951,120
Wajo	12,510,870,916	12,885,170,916	18,445,989,500	18,073,789,500	18,182,983,772	37,366,377,642

Source: Terminal evaluation report Phase 2, questionnaire to District Health Office in Ex-Post Evaluation

HC/SDO Facilitator Budget (Sub-district Level)

The cost of implementation of the PHCI supports and monitoring by the HC/SDO facilitators in each institution has been allocated from the ordinary budget of the local district. In addition, the Health Activity Support Budget (BOK) from the Ministry of Health is used by HCs for HWG monitoring. According to the results of the beneficiary survey, 13 HCs subject to survey had an average of 219,376,464 rupiah (Approx. 1.86 million yen) in 2016 as a budget for PHCI support and monitoring, while the budget for PHCI support and monitoring by HCs has increased in accordance with the increase in HWG community activities.

³⁵ DD is not allocated to wards; however, project activities continue using subsidies allocated to each ward from the budget of sub-district governments.

Table 22: Budget for PHCI Support and Monitoring by HCs (Average)

(Unit: Rupiah)

2014	2015	2016
61,428,148	81,532,212	219,376,464

Source: Questionnaire to HCs in ex-post evaluation beneficiary survey

Donations from Residents

The donations from residents (Swadaya) for PHCI activities have decreased due to the increase in ADD and DD. Based on the results of the beneficiary survey, HWGs in only 6/120 villages have recorded donations in their accounting reports. The average amount of HWG is 25.86 million rupiah (approx. 220,000 yen). However, as mentioned above, with the increase in ADD and DD, no issue has been raised because the budget allocated for implementation of PHCI activities in the community is sufficient.

Above all, although some issues have been identified in relation to the organizational aspect concerning the involvement of some counterparts in the Provincial Team, no major problems have been observed in the institutional, technical, financial aspects and current status of the operation and maintenance system. Therefore sustainability of the project effects is high.

4. Conclusion, Lessons Learned, and Recommendations

4.1 Conclusion

The Project for Improvement of District Health Management Capacity in South Sulawesi Province (hereinafter referred to as “Phase 1”), has developed the PRIMA-K mechanism of PHCI activities in the target area, South Sulawesi Province (Barru, Wajo, and Bulukumba districts), to improve the health administration services in Indonesia. In addition, Phase 2 was implemented to integrate the PRIMA-K mechanism developed in Phase 1 into the existing Indonesian local administrative systems (development planning and budget systems) in order to establish a sustainable mechanism. The purpose of the project is highly relevant in terms of Indonesian health policy, development needs, and Japan’s “Indonesia Country Assistance Program” for creating a democratic and fair social structure. Moreover, each output contributes to achieving the project purpose, such as the development of the PRIMA-K mechanism (Phase 1) and the establishment of the mechanism (Phase 2). These achievements are also contributed to generating impact effects, such as the improvement of health indicators, the dissemination of the PRIMA-K mechanism in other villages and districts, and the utilization of the PRIMA-K mechanism in other sectors. Therefore, its effectiveness and impact are high. Its efficiency is also seen as high because both the project period and project cost in both phases are within the plan. In terms of sustainability, although there are some problems in the organizational structure of the provincial government, other related organizations have no issues with the implementation system.

The sustainability of the project is evaluated as high, comprehensively taking into consideration its policy/institutional, technical, and financial aspects.

In light of the above, this project is evaluated to be highly satisfactory.

4.2 Recommendations

4.2.1 Recommendations to the Implementing Agency

Recommendations to the Ministry of Health

During the project implementation period, the project shared the results of the project with the Ministry of Health, but after the project completion, due to the personnel change in the Ministry of Health and the declining initiative of the Provincial Team, the results have not been shared by the provincial team. It is recommended, therefore, that the Ministry of Health should compile the results of the PRIMA-K mechanism, which is being continuously implemented by integration with the national program “Desa Siaga Aktif” in the targeted districts. Afterwards, the Ministry of Health should also integrate the above results into the “Desa Siaga Aktif guidelines” to promote dissemination to other provinces.

Recommendations to the Provincial Team

It is recommended that the Provincial Team promote the integration of the PRIMA-K mechanism into the national health program “Desa Siaga Aktif” in other districts in South Sulawesi, by introducing the achievements of the target districts and Bone and Sidenreng Rappang, where the PRIMA-K mechanism has already been disseminated.

Community Empowerment and Village Governance Board is also recommended to promote the use of DD for facilitating PHCI activities within the province by reflecting the project experiences to the Ministry of Village’s training program for DD facilitators (P3MD)³⁶ aimed at the promotion of building infrastructure and rural development projects in the community “facilitator training program” in the national program of. Furthermore, collaboration between DD facilitators and the HWG and utilization of the knowledge of the PRIMA-K mechanism to plan DD projects should be encouraged so that the effective use of DD is promoted, reflecting the needs of residents.

Recommendation to the District Team

³⁶ Program Pembangunan dan Pemberdayaan Masyarakat Desa (Program for Village Development and Community Empowerment. The purpose of the program is to train facilitators who are hired by the Community Empowerment and Village Governance Board and assigned to Community and Village Government Empowerment Board to promote the implementation of DD, which has been allocated to communities nationwide since 2015. The roles of the DD facilitators are the same as HC/SDO facilitators, support for participatory planning, implementation, and monitoring, but they cover all village development fields including health. In addition, although the HC/SDO facilitators cover the HWG activities financed by the ADD, DD facilitators may support DD activities in the community. In addition, although the HC/SDO facilitators of the project are allocated in just three districts, the DD facilitators are allocated in all districts throughout the country. For this reason, no duplication has been observed in both activities.

Capacity development of HC/SDO facilitators and HWG members should be continued to sustain the project activities. At the same time,

The District Team should grasp appropriately the actual activities of HWG by obtaining necessary data on the PHCI implementation status in each community through continuing the monitoring and reflect the factors inhibiting the activities to the training contents, and intensively provide effective supports by following-up on low performance HWGs.

4.2.2 Recommendations to JICA

It is recommended that JICA support the Ministry of Health and South Sulawesi provincial government to compile the achievements of the PRIMA-K mechanism in order to integrate it into the “Desa Siaga Aktif guidelines” of the Ministry of Health for dissemination to other provinces. Regarding dissemination to other districts, JICA should consider the technical support required to set up HWG and provide training to HC/SDO facilitators who support PHCI activities, using the existing resources of the Provincial and District Health Office in the target districts.

4.3 Lessons Learned

Establishment of the Community Activity Model in a Short Term by Financial Assistance Using a Block Grant

In Phase 1, the project improved the capacity of the HWG and stakeholders through implementation of the PHCI activity cycle by allocating a Block Grant to each HWG. Through the PHCI activities, the community realized the effectiveness of improving the health environment, such as building toilets and securing access to sanitary drinking water. Consequently, the shift to local government-based activities using ADD in Phase 2 was realized in a short time. In order to establish the community activity model in such a short term with a view to future implementation by the recipient government, not relying solely on their budget from the beginning, but providing the necessary funds such as a Block Grant from the Japanese side, can be effective in showing the effectiveness of project activities at an early stage.³⁷

³⁷ For Block Grant allocation, the technical cooperation project in the education field in Indonesia, “Local Educational Administration Improvement Program” (2004 - 2008) also allocated a Block Grant. However, it was pointed out in the ex-post evaluation report that the problem had arisen in terms of the sustainability of activities after the project completion. In this education project, a community participatory school improvement activity was implemented by setting up a new county education development committee and allocating a Block Grant to county education development committees and schools. However, school improvement activities have a lower degree of closeness to people’s lives compared to the health sector, and it might be difficult for residents to maintain their motivation except for parents who have pupils in the school. Due to the nature of the activities, it was also difficult to improve education indicators (test score, enrollment rate, dropout rate, etc.), as compared to the ability of the project to visualize the improvement in the health situation, which enabled it to secure the government budget.

Ensuring Sustainability through Integration of Project Activities into National Plan/Program with Developing Practical Guidelines/Manuals and Visualizing Effectiveness of Activities

The project has contributed to the implementation of the national program “Desa Siaga Aktif.” By developing practical guidelines/manual at regional level based on the national program, and maintaining consistency of the indicators between the national program and the project, such as PHBS indicators and Desa Siaga Aktif standards, the project contributions to the achievements of the national program were visualized (for example, improved access of households to clean water in the community). This is a factor that the PRIMA-K mechanism has integrated into the national program “Desa Siaga Aktif” in target districts, and activities of the project (facilitation for HWG etc.) are continuously carried out using the government budget as routine work of the counterparts. In the planning stage of the project, it is crucial to focus on the national plans/programs implemented by the target areas, and to try to develop guidelines/manuals and maintain consistency with the project indicators. In the implementation stage, it is also important for securing the sustainability of the project to integrate project activities into national plans and programs by visualizing the degree of achievement of effect indicators and sharing the effectiveness with the concerned parties through monitoring and seminars.

Setting Appropriate Target Areas for Dissemination to Other Provinces

The dissemination strategy, namely developing a model in three target districts and disseminating the model to other districts in the target province and other provinces, has not fully functioned. Particularly, since the target areas were limited to only three districts in one province in Indonesia, which has a burst territory and various geographical and cultural backgrounds, the Ministry of Health has pointed out that dissemination to other areas, provinces in particular, might difficult by just generalizing the project mechanism applied in the only three target districts. Regarding model projects that aim to disseminate the model to other areas, the characteristic of target areas and project scale necessary for generalizing the model should be scrutinized during the planning stage in detail in response to the scale of dissemination areas and their diversities with the central governments that will play the main role in future dissemination.

Annex 1

Achievement of output indicators (achievement at that time of the completion of the project and ex-post evaluation)

The achievement of output indicators which are the same in contents between Phase 1 and Phase 2 are evaluated jointly. The indicators moved are listed in parentheses.

Example (move from indicator 1-1)

Summary of Indicators	Phase 1 (February 2007 - February 2010)	Phase 2 (November 2010 - March 2014)	Achievement	
			Completion (Phase 2)	Ex-post Evaluation
Output 1	Output 1: Community oriented health activities are conducted with community participation	Output 1: Capacity of community to conduct community centered PHCI (Primary Health Care Improvement) activities in line with the local governance system is strengthened		
1-1		Indicator 1-1: Number of HGW at village/ward level established for PHCI activities : at least 85 % from all villages/wards	Achieved	Continued
1-2		Indicator 1-2: Number of Village Team members trained as implementer of PHCI activity cycle: at least 6 members/Village Team	Achieved	Continued
1-3	(Moved from indicator 1-1): Number of proposals formulated through the participatory process by community	Indicator 1-3: Number of Village team that develop and submit PHCI action plan to village government: at least 90% from all Village Teams	Achieved	Continued
1-4	(Moved from indicator 1-3): Amount of self-fund (SWADAYA) spent for the project is increased	Indicators 1-4: Number of village that allocated budget for community centered PHCI activities: stipulated in Village Annual Budget Plan : at least 75% of villages in target districts)	Achieved	Continued
1-5	(Move from indicator 1-2): Number of proposed activities implemented	Indicator 1-5: Number of activities in action plan that is implemented by using village or district government fund: at least 95% of plan	Achieved	Continued
1-6		Indicator 1-6: Number of Village Team that submitted activity and financial report to the Village Government: at least 95% of village teams	Achieved	Continued
Output 2	Output 2: Support of Health Center towards sub-district/village PHCI Team is improved	Output 2: Capacity of Health Center and Sub-District Office to support technically community centered PHCI activities is strengthened		
2-1		Indicator 2-1: Number of trained facilitators from Health Center and Sub-District Office who provide training for village: at least 60%	Achieved	Continued
2-2		Indicator 2-2: Number of trained HC staff or SDO staff who actually provide training for villagers (target: at least 60%)	Achieved	Continued
2-3	(Moved from indicator 2-1): Number of PHCI Team which includes HC staff	Indicator 2-3: Number of training workshops conducted by Health Centers and Sub-District Office for community people (3 workshops/year)	Achieved	Continued
2-4		Indicator 2-4: Frequency of visiting community by facilitators from Health Center to support and monitor PHCI	Mostly achieved	Mostly continued

		activity by village people: at least 12 times/Health Center/year		
2-5		Indicator 2-5: Number of Health Center which allocate budget for monitoring and providing technical support for community centered PHCI activities: at least 80%	Achieved	Continued
2-6		Indicator 2-6: Number of Activity and Financial Report of Village Team that is consulted and verified by Sub-district Office: at least 80 %	Mostly achieved	Mostly continued
2-7		Indicator 2-7: Number of Health Center that conduct Mini-Workshop involving HWG: 60%	Achieved	Continued
Output 3	Output 3: Capacity to conduct PHCI activities of the target districts is improved.	Output 3: Capacity of District to manage community centered PHCI activities is strengthened		
3-1		Indicator 3-1: One District Team is established in each district (members: Health Office, Community and Village Empowerment Board, Regional Development Planning Board and Financial Management Office)	Achieved	Continued
3-2	(Moved from indicator 3-3): Number of district health officials who receive certificate to be facilitators for PHCI activities	Indicator 3-2: Number of District Team members trained (to train on "mechanism" including financial aspect) :70%	Achieved	Continued
3-3		Indicator 3-3: Allocation of district budget stipulated in District Annual Budget Plan to support community centered PHCI activities (socialization, training, monitoring and village activity implementation)	Achieved	Continued
3-4	(Move from indicator 3-4): Number of monitoring and evaluation for PHCI activity (Move from indicator 3-2): Number of socialization held at the district level	Indicator 3-4: Constant support by District Government staff for community centered PHCI activities: Frequency of monitoring (12 times/year), coordination meeting (4 times/year), Number of socialization and training conducted by District Government (1 time/year)	Mostly achieved	Mostly continued
3-5	(Move from indicator 3-1): Guidelines and the training manuals are available (Move from indicator 2 in Project Purpose): Availability of model (development of guidelines)	Indicator 3-5: Guideline and Manuals for PHCI activities are developed by District team	Achieved	Continued
3-6		Indicator 3-6: Percentage of budget actualization which is planned for community centered PHCI activity from district budget (ADD, ADK, operational budget of district): at least 70%	Achieved	Continued
3-7		Indicator 3-7: Official documents issued by District Government that support internalization of PHCI Mechanism such as recommendation, Head of District Decree, District Ordinance, and District Circular Letter	Achieved	Continued
3-8		Indicator 3-8: End-line data is prepared and analyzed by District Team at the end of Project	Mostly achieved	Mostly continued

Output 4	Output 4: Capacity of the province government to facilitate introduction and dissemination of the PHCI model is improved.	Output 4:Capacity of Province government to supervise and disseminate community centered PHCI activities is strengthened		
4-1		Indicator 4-1:One Provincial Team is established in South Sulawesi Province	Achieved	Mostly continued
4-2		Indicator 4-2:Number of Provincial Government staff trained: at least 6 persons trained	Achieved	Continued
4-3		Indicator 4-3:Frequency of coordination meeting among Provincial Government staff: at least 2 times/year	Achieved	Not continued
4-4		Indicator 4-4:Availability of provincial plan and strategy for dissemination of the PHC mechanism	Mostly achieved	Mostly continued
4-5	(Moved from indicator 4-1): Number of and/or frequency of monitoring and evaluation by provincial health office for the project activities	Indicator 4-5:Frequency of monitoring by Provincial Government staff (on community centered PHCI activity): at least 2 times/year	Mostly achieved	Mostly continued
4-6	(Moved from indicator 4-2): Number of workshops for experience sharing and disseminating project activities	Indicator 4-6:Number of socialization/dissemination workshop/seminar conducted (on progress of community centered PHCI activity): at least 5 times/year	Achieved	Mostly continued
4-7		Indicator 4-7: Allocation of provincial budget stipulated in Provincial Annual Budget Plan to support community centered PHCI activities (through socialization,) site visits, dissemination activities etc.) (Unit: Rupiah)	Achieved	Continued
4-8	(Move from indicator 4-3): Mobilization of provincial health office both provincial and national governments to promote activities	Indicator 4-8:Frequency of consultancy to Central Government (on progress of community centered PHCI activity): at least 2 times/year	Mostly achieved	Not continued
4-9		Indicators: 4-9:Training Module and Guideline for PHCI activities are developed by Provincial Team: 1 (one) Guideline book and 1 (one) training module	Mostly achieved	Mostly continued