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CHIPPS FINAL EVALUATION

PHASE I: DECENTRALIZATION LESSONS

by

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I, of course, am responsible for all errors and interpretation in this report.

EXECUTIVE SUMMARY

This evaluation of the \$11 million Comprehensive Health Improvement Program -- Province Specific (CHIPPS) focuses on the objective of decentralization. The central issue was to evaluate the impact of the project on the national level (Pusat) of the Ministry of Health (DepKes). What did Pusat learn about decentralization from the experience in the CHIPPS provinces?

Decentralization is analyzed as a power relationship between Pusat and the lower administrative levels (province, kabupaten, kecamatan). This relationship does not necessarily involve different functions but rather involves the following dimensions:

- 1) the establishment of provincial and local (kabupaten) technical capabilities to decide priorities and solve local problems.
- 2) increasing provincial capability to negotiate with Pusat over target-setting, policy, program activities, and evaluation of activities that are funded by Pusat budgets.
- 3) local initiatives persuading Pusat to change its national policies by a) adopting the technical intervention that was developed at the provincial level, and, b) allowing flexibility in implementation at lower administrative levels.
- 4) increasing responsiveness of provincial health officials to the priorities and involvement of kabupaten and lower level health officials.
- 5) increasing capability of health officials at provincial and kabupaten to negotiate with their respective governmental levels for additional funds assigned to health or redistribution of provincial and local health funds.
- 6) both the capabilities and activities at the province level and the decentralization process vis a vis Pusat should be sustainable after the CHIPPS funding stops.

The evaluation found that CHIPPS has achieved significant achievements along all dimensions:

- 1) provincial and kabupaten technical, managerial and planning capacities have been strengthened,
- 2) all three provinces have been able to negotiate with Pusat to change the distribution of Pusat controlled resources to correspond with provincial and local conditions,
- 3) Pusat has adopted both the technical interventions and the local flexibility implied in those interventions in its national policies,
- 4) provincial officials have become somewhat more responsive to kabupaten and lower level priorities and initiatives,
- 5) in selected provinces and kabupatens health officials have been successful in gaining some local government resources for health activities,
- 6) many of the interventions and capabilities as well as the decentralization process are likely to be sustained after the funding stops.

These achievements are important, however, they are qualified successes.

- 1) there are continuing weaknesses in the skills and capacities at the local and provincial level,
- 2) Pusat responsiveness to provincial initiatives is still limited,
- 4) Pusat adoption of CHIPPS initiatives as national policy has often involved modifications that render the programs less effective than the CHIPPS activities,
- 4) provincial level responsiveness to kabupaten participation and priorities is still quite limited.
- 5) the project has engaged some local and provincial government support but many have been unresponsive. Even the supportive governments have not provided major funding to support health efforts,
- 6) sustainability may be fragile for financial reasons and personnel changes.

It is important to note that much more might have been achieved 1) had the project been designed differently, 2) had greater attention to Pusat level been achieved earlier in the project, and 3) had more attention to financial issues (both financing mechanisms and cost analysis) been achieved.

For each of these dimensions the report recommends:

PROVINCIAL AND KABUPATEN CAPABILITIES

- 1) Continuing efforts to upgrade provincial and local skills should focus on a) health system problem solving as well as epidemiological skills, b) strategic level planning, c) management skills.
- 2) A major component of the Final Evaluation should focus on the effectiveness of the training programs that have been implemented by CHIPPS to improve these skill levels. The lessons learned from comparative analysis of these evaluations should be used to design and implement skill upgrading programs in other provinces.

STRENGTHENING PUSAT RESPONSIVENESS TO PROVINCES

- 1) Major efforts should be launched at Pusat, with USAID support, to establish a simplified, high quality health/management information system that will encourage Pusat responsiveness to decentralized units and their priorities.
- 2) CHIPPS initiatives in data systems should be evaluated in detail in a subsequent stage of this Final Evaluation to provide lessons for this broad reform effort.
- 3) Pusat, with USAID support, should begin a process of major restructuring in order to encourage practical integration of separate administrative units so that responsiveness to provincial and local level initiatives can be facilitated.

INCREASING PUSAT INVOLVEMENT AND RESPONSIVENESS

- 1) Future projects designed to encourage decentralization should make every effort to include Pusat in the design and implementation of project activities. Pusat units need a financial stake in order to assure greater responsibility and responsiveness to decentralization initiatives.

- 2) Greater efforts to define policy implications of CHIPPS experiences for Pusat:

---Seminars should be designed to discuss policy and program alternatives of the CHIPPS interventions, rather than simply reporting on CHIPPS projects.

---Pusat Taskforces from various divisions and departments should be formed for policy formulation in central areas of CHIPPS (data management; drug management; Posyandu initiatives like relewans, use of kader, etc.) AID should assist in funding these taskforces.

- 3) Continued coordination with the World Bank sponsored project in East Kalimantan and NTB should be encouraged.

- 4) Organizational structure of CHIPPS and similar projects should encourage the creation of Implementation Taskforces as a forum for integration of implementation of CHIPPS activities among several Pusat implementing units.

INCREASING PROVINCIAL RESPONSIVENESS TO LOWER LEVELS

- 1) Training programs during the rest of the CHIPPS project should be designed to enhance kabupaten level capacities in all, rather than selected, kabupaten.
- 2) CHIPPS should coordinate with the national training program for kabupaten management. If possible CHIPPS trainers should comment on the proposed modules and should be involved in implementing them.

IMPROVING NEGOTIATIONS WITH PROVINCIAL AND LOCAL GOVERNMENTS

- 1) Provincial and local health officials should continue to support integrated activities and to utilize data to encourage government officials to support health initiatives with local funds.
- 2) Efforts to retain fees in the health sector should be supported by Pusat and US/AID. These fees should be controlled by the administrative level at which they are generated in order to strengthen decentralization.

IMPROVING SUSTAINABILITY

- 1) Immediate efforts to provide reports and involve newly appointed officials should be made to assure on-going knowledge and participation in CHIPPS activities before the termination of the project.
- 2) In divisions where only one official is involved with CHIPPS, efforts to involve other officials should be made.
- 3) At the provincial level, attempts should be made to provide a transition period when personnel are transferred so that officials involved in CHIPPS activities can give an orientation to their replacements.

FINANCING ISSUES

- 1) Cost-effectiveness analyses (or simply cost analyses where data on effectiveness is not obtainable) should be implemented -- either as part of the on-going CHIPPS projects or as special component of the final evaluation -- to demonstrate 1) the cost-effectiveness of project interventions, 2) the costs of sustaining current activities, 3) the costs of adopting CHIPPS models on a national scale or in other provinces. Health planning officials from the Planning Bureau and from the relevant Technical Directorates should be involved in this evaluation.
- 2) Future projects which have decentralization and sustainability objectives should involve health economists in early project activities to encourage attention to cost analysis and to establish baseline data.
- 3) Financial evaluation of the CHIPPS project include review of the financing mechanism and consideration of alternatives that might involve greater Pusat participation and modifications of the normal national budgetary system of DepKes. These modifications should increase flexibility of response to provincial initiatives and demonstration of the effectiveness of block grants to provinces.
- 4) Financial evaluation should review the process of AID/National disbursements during CHIPPS and make recommendations regarding the potential for sustaining CHIPPS activities through modest support in future projects.

I. INTRODUCTION: DECENTRALIZATION

This report is the first phase of the final evaluation of the Comprehensive Health Improvement Program -- Province Specific (CHIPPS): an \$11 million loan and grant package signed in 1981 and scheduled to terminate September 1989. The project supported manpower development -- primarily nurses training in the three provinces and physician field training in two provinces (COME) -- and the development of provincial and local capacities for health management, planning and implementation. As the project evolved this later objective came to be interpreted as a means to promote decentralization of the Ministry of Health (DepKes). This phase of the evaluation focuses on the lessons learned at the national level (Pusat) about decentralization.

CHIPPS was designed to improve problem solving capabilities at provincial levels by providing financial and technical assistance resources in three provinces -- Aceh, West Sumatra, and Nusa Tenggara Timur (NTT). As the project was implemented the objective became more an explicit attempt to promote decentralization. The project was to assist the province, kabupaten and kecamatan levels initiate and implement innovative approaches to local health problems and to demonstrate to Pusat that the provincial and local levels were capable of assuming responsibilities in a decentralized administrative structure.

Prior to CHIPPS a major characteristic of the health system in Indonesia was the centralization of administrative power in the Pusat level of DepKes. Centralization was perceived as having several characteristics that inhibited rational and effective administration of health care. First, decisions made by Pusat often ignored provincial and local differences -- imposing unnecessary uniformity that brought neither equity nor rationality to the distribution of health services. Secondly, because Pusat made most of the decisions about policy, planning, manpower, distribution of supplies provincial capabilities in these areas were not allowed to develop.

It was hoped that a project that developed and demonstrated provincial and local capacities would foster decentralization. The provinces were selected as examples of provinces with different capabilities and characteristics that would be representative of the wide variation among Indonesian provinces -- however, explicitly excluded were the most developed provinces of Java and Bali. West Sumatra was chosen as a province with one of the highest rates of infant mortality in the country but with motivated health officials who needed assistance to realize their own initiatives. Aceh was a closed

province that resisted central efforts and advice. NTT is one of the poorest provinces in Indonesia -- with low levels of human and financial resources.

The project provided loan and grant funds that were funnelled through the national budgetary system to be accessed by the three provinces. The normal budgetary process (DIP) provided loan funds that initially made up \$6 million of the project funding. Grants (initially \$3 million) were exempt from the normal DIP process and could be more flexibly used by the provinces subject to approval by USAID and the Project manager (Pimpro) in the Planning Bureau of the Secretariat of DEPKES. Because of the limitations imposed by the DIP process and the requirement for counterpart funds which were unavailable in the aftermath of the fiscal crisis, in 1986 and 1987 and additional \$2 million in grants were added to the project and \$1.2 million of the loan funds were converted to grant, allowing a more rapid and flexible response to provincial initiatives.

Technical Assistance was provided by three long term consultant positions -- one for each province -- and other long term consultants for all three provinces -- management specialist, Udai Pareek, and Dr. Soebekti -- and a variety of short term consultants -- notably from CDC/Atlanta, YIS, a local consulting firm, Indonesian academic institutions and from Pusat.

The project encouraged the development of a problem-solving approach (called an "epidemiological approach") at the province and local levels. This approach involved the utilization of epidemiological data as a first step to defining health problems. Subsequent steps in the problem-solving approach involved using the data to select, implement, monitor and evaluate specific interventions to solve the identified problems.

The core of this approach was data collection, management and analysis. Health officials, therefore needed to learn 1) the importance of data, 2) the necessary skills for collecting and analyzing data and selecting appropriate interventions to solve problems, 3) the utilization of data for monitoring and evaluating interventions, and 4) the effective presentation of data for persuading others (at the local government levels as well as Pusat) to support selected interventions. To develop this capacity, CHIPPS provided funds for technical assistance, training, surveys, and support for specific interventions.

Pursuing these objectives the project supported a wide variety of discrete activities in each province. There was a general list of major activities that were areas that were to be supported by project funds; however, there was no

predetermined plan that rigidly defined project goals and activities since the objective of the project was to encourage local initiatives. The project tended to begin with a variety of small scale surveys that taught local officials some skills of survey research and the importance of data collection and analysis. Later, as a result of surveys and technical assistance, several major interventions were sponsored by CHIPPS:

- 1) prevalence surveys for communicable diseases, especially neo-natal tetanus and TB;
- 2) health system data collection, management and analysis -- focusing on vital statistics, immunization coverage, disease surveillance, and other health system data (including the recently implemented monitoring and evaluation system - MONEV);
- 3) acceleration of the Posyandu through the use of improved management, supervision techniques and through experimental uses of recent nursing graduates (relewan) and kader;
- 4) drug management systems and standard treatments;
- 5) nutrition interventions.

The project was evaluated in three major periods and several of the specific interventions were evaluated as part of the problem-solving approach. The major evaluations found:

- 1) initial implementation problems due to administrative structures of the project itself and to cumbersome and inflexible national budgetary process (DIP) -- many of these problems were addressed by the time of the mid-term evaluation in 1987;
- 2) failure from the beginning to involve Pusat in ways that would demonstrate the effects, benefits and processes of decentralization;
- 3) lack of attention to cost-effectiveness analysis
- 4) specific problems in implementation of various activities

This report reviews the second issue above: the effectiveness of CHIPPS to sponsor and promote

decentralization. The major focus of this evaluation is to analyze the reaction of Pusat to the decentralization lessons of CHIPPS.

II. CONCEPTUAL AND METHODOLOGICAL ISSUES

A) Governmental Structure

The general government structure is a complex set of vertically organized administrative units which have only relatively recently been established as centralized authority. Indonesia is a highly fragmented and diverse country which only since independence has been successful in establishing a unitary nation-state structure that even today faces centrifugal forces that some fear could lead to fragmentation of the country. One of the more conscious uses of this centralized power has been to attempt to promote greater equality among the provinces through distribution of nationally controlled resources toward the poorer outlying provinces.

The administrative structure and culture in the national government tends to limit initiative at lower levels and concentrate decision-making at the top. However, administrative units are fragmented vertically -- both within and between ministries. DepKes, for instance is made up of five separate Directorates General (Community Medicine, Medical Services, Communicable Disease Control, Food and Drug, and Research and Development), who are loosely coordinated and administered by the Secretary General. The Technical Directorates tend to be relatively autonomous and only coordinate activities with great difficulty.

However, responsibility for health activities at provincial and local levels is shared -- in terms of implementation and funding -- with local governmental units of the Ministry of Internal Affairs (the Governors Office at the Provincial level and the Bupati at the Kabupaten level). These units must also coordinate with the provincial (Bappeda) and local units of the Planning Ministry (Bappenas). These units are also highly centralized by their own ministerial Pusats, however, they have some provincial and local funds (much generated from the fees collected in the health facilities and redistributed by the governments). Funds from the central government and from local sources that are administered by the provincial and local governments are major contributions to the health system.

Viewed from the perspective of DepKes, the separate vertical authority structures of the Ministry of Internal Affairs and Bappenas gives the administrative structure a

strange sense of decentralization since provincial and local health budgets are not fully controlled by DepKes.

CHIPPS attempted to promote decentralization at a time when there was little national level interest in this objective. However, by 1985, in the middle of the CHIPPS project the governmental system came under severe pressures to decentralize. The financial crisis created by the fall in oil prices led to severe austerity program that slashed national budgets and shifted some responsibility for financing government activity to the provinces and local levels. By 1987 Decree Law # 7 formalized the national commitment to shifting authority to lower administrative levels -- making decentralization an explicit national priority. The current development of the Fifth Five Year Plan (Repelita V) stresses the decentralization of administration and the development of lower level capacities to assume greater responsibility and control of funds and implementation.

B) Decentralization

Decentralization is a difficult concept to evaluate. It involves an alteration of existing power relationships between the center of an administrative structure and its periphery. There are no easy measures (indicators) of decentralization because much of the relationship depends on the perception of power relationships by those at the center and at the periphery. Seldom will both center and periphery agree on the character of this power relationship -- the center usually perceiving that it has given up authority faster than the periphery will acknowledge.

Previous evaluations appear to have taken quite an extreme view of decentralization, viewing autonomy at the province level as a major goal. Pusat's role in such a scheme would be limited to giving general guidance and supervision and provide a means for coordination among the autonomous provinces (see the Mid-term Evaluation). Such a vision does not have many proponents at the national level in Indonesia and seems to this consultant an inappropriate goal in a system that has so many centrifugal forces and divisions.

Central control will continue to be necessary for more than coordination and guidance purposes. It will be necessary for Pusat to define and implement national priorities that may be at variance with the separate priorities of the provinces and local levels. For instance, although there is significant pressure at provincial levels for the construction of hospitals, it is appropriate national policy for a variety of good reasons, to refuse to approve new hospital construction. Without Pusat control of budget, manpower and regulatory discretion, major inequities, inappropriate health services and

wastage of scarce resources would result. In addition, Pusat is responsible for attempting to redistribute resources and manpower among the provinces -- taking from advantaged provinces and supplying disadvantaged provinces. Although it has not always been particularly effective in pursuing this goal, without Pusat control it is likely that inequalities among provinces would become even greater.

Decentralization is a relationship between Pusat and the lower administrative levels in which both Pusat and the periphery have legitimate concerns over almost all functions. It is therefore necessary to view decentralization not so much as a change in functions between Pusat and the provinces but rather as a shift in power that allows the provinces to negotiate with Pusat from a stronger position.

The scope of work for this evaluation sought the definition and measurement of a "threshold" of administrative capability that would be appropriate for decentralization. Using the definition of decentralization as a power relationship, it is difficult to define a "threshold" since power tends to be difficult to measure and bargaining relationships often change. It would seem unlikely that a strict threshold of capabilities could be established for instance for formal transfer of budgetary control of large blocks of funds to some provinces without severe political resistance in the other provinces as well as Pusat.

Pusat experience in classifying provinces by a variety of indicators (including socio-economic, cultural, and bureaucratic) is not promising. Indeed, the Immunization Department found that the provinces in the lowest category often leapt from lowest to highest immunization coverage in one year.

For the purposes of this evaluation decentralization will be examined along the following dimensions:

- 1) the establishment of provincial and local (kabupaten) technical capabilities to decide priorities and solve local problems.
- 2) increasing provincial capability to negotiate with Pusat over target-setting, policy, program activities, and evaluation of activities that are funded by Pusat budgets.

- 3) local initiatives persuading Pusat to change its national policies by a) adopting the technical intervention that was developed at the provincial level, and, b) allowing flexibility in implementation at lower administrative levels.
- 4) increasing responsiveness of provincial health officials to the priorities and involvement of kabupaten and lower level health officials.
- 5) increasing capability of health officials at provincial and kabupaten to negotiate with their respective governmental levels for additional funds assigned to health or redistribution of provincial and local health funds.
- 6) both the capabilities and activities at the province level and the decentralization process vis a vis Pusat should be sustainable after the CHIPPS funding stops.

A second order of methodological problems in this evaluation comes from the difficulty of determining the role of CHIPPS in achieving decentralization in a system that has other pressures for decentralization. Diffusion of ideas is difficult to track.

There are several incentives for officials not to attribute the source of ideas to CHIPPS. CHIPPS is perceived by officials at all levels as an "alien" project. It is special and funded by a foreign source. Most of the administrative units (especially the Technical Directorates) at Pusat are not directly involved with the project and they jealously guard their own initiatives and administrative "turf". This characteristic leads to a reluctance explicitly to adopt initiatives that have been demonstrated by other "turf" be it Pusat or provinces. Many informants suggested that they introduced ideas that they learned from CHIPPS to their own Directorates but did not attribute the source because of this jealousy.

There also may be a tendency to attribute to CHIPPS ideas and activities that are also supported by other sources. Initiatives for decentralization, as noted above may also come from other provinces -- e.g. mass campaigns for neonatal tetanus were first initiated in NTB with UNICEF support and AID now supports a TT activities as part of the Pusat CDC program.

This evaluation attempted to probe these issues and to track CHIPPS impact on Pusat where it could be documented

explicitly. We attempted to find informants who had knowledge of CHIPPS and could identify it as the source of decentralization. As noted above, many suggested that they introduced ideas from CHIPPS without attribution. We assume also that even if ideas come from other sources, CHIPPS contribution was likely to have reinforced Pusat learning if informants thought there was a direct link.

This evaluation involved a review of key project documents, consultant reports, studies, prior evaluations, other official documents, and a series of interviews at Pusat and in West Sumatra -- a province with many projects viewed by Pusat officials as having been particularly illustrative (see Persons Contacted). Interviews followed the knowledge and experience of the informants rather than a formal questionnaire. Although there was no systematic interview schedule, interviews reviewed the same issues and involved cross checking of information from other informants.

In terms of the usual methodology of evaluation -- one that stresses the reaching of specifically defined objectives (outputs and outcomes) through clearly established activities -- this evaluation has had to depart from the norm. The original project design did not define decentralization. The project was designed as a process (a learning process to develop problem solving capabilities through a variety of activities) and not as a series of specific outputs and outcomes. It depended on the development of local initiatives to define the specific interventions that would form the core activities of the project. The wide variety of activities that were included in the project do not easily lend themselves to a single standard of evaluation -- indeed, it is clear that significant local level learning also came from discrete interventions that failed to achieve their initial objectives.

The methodology of this evaluation, therefore will focus on the five dimensions of decentralization discussed above. It will discuss achievements along each dimension and suggest lessons learned from the level of achievement.

III. STRENGTHS AND WEAKNESSES

CHIPPS was quite effective in achieving some of its objectives in decentralization. As the subsequent sections will demonstrate, this evaluation concludes that:

- 1) technical, managerial and planning capacities in each province and many kabupaten have been strengthened,

- 2) all three provinces have been able to negotiate with Pusat to change the distribution of Pusat controlled resources to correspond with provincial and local conditions,
- 3) Pusat has adopted both the technical interventions and the local flexibility implied in those interventions in its national policies,
- 4) provincial officials have become somewhat more responsive to kabupaten and lower level priorities and initiatives,
- 5) in selected provinces and kabupatens health officials have been successful in gaining some local government resources for health activities,
- 6) many of the interventions and capabilities as well as the decentralization process are likely to be sustained after the funding stops.

These achievements are important, however, they are qualified successes.

- 1) there are continuing weaknesses in the skills and capacities at the local and provincial level,
- 2) Pusat responsiveness to provincial initiatives is still limited,
- 4) Pusat adoption of CHIPPS initiatives as national policy has often involved modifications that render the programs less effective than the CHIPPS activities,
- 4) provincial level responsiveness to kabupaten participation and priorities is still quite limited.
- 5) the project has engaged some local and provincial government support but many have been unresponsive. Even the supportive governments have not provided major funding to support health efforts,
- 6) sustainability may be fragile for financial reasons and personnel changes.

The following section will review these strengths and weaknesses in detail.

It is important to note that much more might have been achieved 1) had the project been designed differently, 2) had

greater attention to Pusat level been achieved earlier in the project, and 3) had more attention to financial issues (both financing mechanisms and cost analysis) been achieved. These weaknesses will also be reviewed in detail.

A. STRENGTHS AND WEAKNESSES

1) PROVINCIAL AND KABUPATEN CAPABILITIES

Viewed from Pusat it is clear that the capabilities of health officials in all three provinces have improved considerably during the period of the CHIPPS project -- although strengths of the different CHIPPS provinces varied. Relative to most other provinces (except perhaps East Java and the Municipality of Jakarta) these provinces are now viewed as special provinces which have better capabilities than other provinces for planning and managing health activities. Part of this respect comes from knowledge that these provinces have additional resources, training and technical assistance. They have been "polished" by AID's support. Prior to AID support none of the provinces was seen as having capabilities to assume responsibilities for planning and managing their own health activities.

The mid-term evaluation also found significant development of province and local capacities. Understanding of the problem solving methods in the "epidemiological" approach (the four stage process -- problem identification, planning interventions, implementation and evaluation) was well established in all provinces by 1987. Understanding of the importance of data and the power of epidemiological information for planning and for persuading other officials in DEPKES and local government officials to understand the local situation was clearly established. Capabilities to collect and manage data were growing, some analytical capacity was developed, and ability to plan interventions was established. There was an effort in all provinces to develop kabupaten and kecamated capacities as well as provincial (kanwil and dinas) capacity.

While almost all activities sponsored by CHIPPS had some element which utilized data in a problem-solving approach, the central activities in this area were: 1) the initial epidemiological training and surveys (TT, TB) that were generated by local initiative strongly influenced by the epidemiological interests and skills of the long term consultants; 2) evaluations of several communicable disease interventions (esp. TT) and field training programs for nurses; 3) vital registration programs; 4) data collection, management, analysis, and evaluation training for kabupaten and puskesmas doctors and staff (e.g. two series of courses in West Sumatra

in 1985 and 1987/8); 5) training in drug management program utilizing two data analysis models -- consumption and epidemiological based estimates; 6) the recently developed monitoring and evaluation system (MONEV) in West Sumatra.

The mid-term evaluation demonstrated that the problem solving approach had been effectively introduced in all three provinces, although the strengths of this approach were mainly in the problem identification area. It does seem to this consultant that viewed from Pusat these skills are much more developed in the CHIPPS provinces than in other provinces. Pusat officials cite the specific interventions that were initiated in TT, TB, drug management and acceleration of Posyandu as examples of activities that were generated by provincial or local initiative -- the results of surveys in some cases (communicable disease priorities) or other sources of problem identification (national targets for Accelerated Posyandu). The interventions chosen to address these problems also came from local and provincial analysis of the situation and innovative ideas about how to modify existing systems to address these problems. For instance, each of the provinces experimented with different variations of mass campaigns and routine programs to address the neo-natal tetanus problem identified by surveys. These experiments were evaluated and results presented to Pusat. They have had an impact on the development of a national TT strategy (see below).

Even efforts that were not successful have been important learning experiences. The various efforts to improve vital statistics in all three provinces have generally met with failure. Nevertheless, some of the processes that were developed contributed to experiments such as the MONEV system which uses registration activities by kader to gather vital statistics on children under 5.

Skills were developed at the provincial level -- in particular the teams that were used for data and drug management training and for survey design and analysis. However, a major effort in the training programs was on the development of these skills at the kabupaten and puskesmas levels. For instance, the 1987/8 West Sumatra training programs in data and drug management involved all the puskesmas doctors and selected members of the puskesmas staff.

While these achievements greatly strengthened the provinces and made them stand out in comparison to non-CHIPPS provinces, there were some limitations identified in the mid-term evaluation. The epidemiological skills of the provincial and local officials needed to be strengthened to produce more accurate data and appropriate analysis. The focus on incidence

of disease as the central indicator of problems, left officials with little understanding of other health system problem indicators. Analytical skills were the weakest link in the problem solving approach. While planning for specific interventions was strong, broader strategic planning was weak. It was also clear that among the provinces West Sumatra had been more successful and NTT less successful in skill development and that within each province some kabupaten and kecamatan were more developed than others.

The early emphasis on epidemiology and the fact that the initial long term consultants were epidemiologists probably contributed to the greater attention given to disease indicators and to problem identification rather than other aspects of the problem solving approach. This emphasis may have been appropriate in the early stages, however, it might have been useful to have had early in-put by other professionals -- health planners, anthropologists, economists -- in the early project activities as well as throughout the rest of the implementation. As we note below, the lack of serious early involvement of health economists and financial analysts has left the project with limited interest and accomplishments in cost-effectiveness analysis. Greater attention to turning problem identification into actual plans for interventions is also weak and might have been strengthened had the long-term consultants focused on developing more analysis and planning skills right from the beginning.

This consultancy could not evaluate the current levels of skills and capabilities in the provinces and local administrative levels, other than to note perceptions of the general trends and comparative development. It will be important for other phases of this final evaluation to assess the levels achieved, compare developments among the three provinces and consider the cost-effectiveness of the approaches used to develop these skills. A special effort should be made to evaluate the effectiveness of the training programs in data and drug management. It would be advisable to design an evaluation component into the plans for upcoming training in the MONEV system so that a baseline can be established for subsequent evaluation.

The important issue for decentralization is that progress has been made in the development of provincial and local level capacities and that this progress has been seen by Pusat as improving the three provinces in relation to most other provinces.

RECOMMENDATIONS:

- 1) Continuing efforts to upgrade provincial and local skills should focus on a) health system problem solving as well as epidemiological skills, b) strategic level planning, c) management skills.
- 2) A major component of the Final Evaluation should focus on the effectiveness of the training programs that have been implemented by CHIPPS to improve these skill levels. The lessons learned from comparative analysis of these evaluations should be used to design and implement skill upgrading programs in other provinces.

2) NEGOTIATION WITH PUSAT

A central element of decentralization is the capacity of lower administrative units to influence decisions and resource (budgetary and manpower) allocation that is controlled by Pusat. Leaving aside, for the moment, the question of whether it is appropriate for Pusat to control policy and resources, it is important that CHIPPS strengthen provincial negotiating power vis a vis Pusat, especially when provincial decisions and priorities are within Pusat policies, programs and priorities.

It should be noted that Pusat learns not only from CHIPPS provinces but also from other provinces and that some level of decentralization has occurred in the more advanced and wealthier provinces -- particularly East Java and the Municipality of Jakarta. East Java, in part because local funding sources often provided funds for health initiatives, was a source of experimentation and new initiatives that were adopted by the Pusat level -- e.g. stratification of health facilities.

As the CHIPPS provinces have improved their capabilities they have been able to strengthen their negotiating capacity vis a vis Pusat -- often altering Pusat decisions over Pusat controlled budgets and policies so as to make them more appropriate to provincial needs. Examples cited by officials at Pusat and in West Sumatra include:

- 1) the modification of targets set by Pusat for such activities as immunization coverage (which affected not only the estimates of vaccine needs for the province but also the standards by which officials are evaluated for personnel decisions -- since reaching targets is an important criteria for advancement).

- 2) the provision of short course TB medicines -- the entire allotment of Pusat national supplies will be given to the West Sumatra program in one kabupaten in part because they were able to demonstrate the high level of TB incidence and the effectiveness of their case finding and case management intervention.
- 3) the drug management system for developing yearly provincial drug procurement proposals were so well accepted by Pusat that the West Sumatra proposal was the only provincial proposal that was left virtually unmodified by Pusat.

At Pusat level, officials often say that they treat the CHIPPS provinces with special attention because they have better information than the national level data. The provinces tend to be able to challenge Pusat established targets (especially for specific diseases), present drug proposals that are not altered by Pusat, and implement changes in national policies that are innovative or more appropriate to provincial or kabupaten needs (such as the TB control program in Pesisir Selatan).

This responsiveness involves persuasion to change national policies for all provinces (to be discussed below), modifications of Pusat decisions for province targets and distribution of Pusat resources (i.e. plans and drugs), as well as exceptions to national policies for province specific problems (e.g. TB control in West Sumatra).

It is clear that an important element in this strengthened negotiating capacity is the improved data collection, data management and analysis at the provincial and kabupaten levels. Provincial and local health officials are able to use their data extremely effectively to convince Pusat officials that national policies need to be altered to provincial realities. Specific surveys and evaluations, the improved data management systems and the drug management systems have been crucial to empowering provincial officials when they negotiate with Pusat. They have data that Pusat does not have. Their data is recognized by Pusat to be more accurate than the national estimates for the provinces. And Pusat is responsive to provincial arguments based on rational use of data.

It is also clear that Pusat has not been as responsive to provincial bargaining as the provinces would like. Provincial officials can give many examples of failure to convince Pusat of the rationality of their proposals. Many Pusat-established targets are not changed, even if provincial data would support such changes. Drug orders in some cases are altered by Pusat in ways that still remain a mystery to provincial officials.

Participation in national planning process often seems arbitrary to provincial officials. Manpower decisions are also changed by Pusat. Although Pusat officials see the CHIPPS provinces as having strong planning capabilities, these provinces were not particularly favored in the Repelita V planning process, even though this process emphasized decentralization.

It is difficult to evaluate the importance of these complaints. Negotiating with Pusat has to involve compromise and Pusat cannot be expected to respond to all provincial priorities. Indeed, one of the strengths of centralization is that it can impose national objectives on provinces even if provinces resist. Particularly appropriate use of centralization is the imposition of national policies to limit the construction of hospitals and to encourage more equitable distribution of manpower among the provinces. On these issues most health experts will agree that national objectives should be respected and provincial priorities ought to be limited.

Viewed from the perspective of the provinces such limitations may be interpreted as irrational and evidence of a lack of responsiveness by Pusat.

However, it is also clear that some Pusat decisions do not follow a national level set of priorities and objectives. Some decisions are purely arbitrary decisions of Pusat officials who have the power to ignore provincial arguments. Other decisions come from inefficiencies and rigid administrative and regulatory structures at Pusat. For instance, the timing of Pusat drug pricing decisions is out of phase with the time for presenting local level procurement proposals making it difficult to utilize the drug management models efficiently. And the Repelita V process was cut short by a decision made by Bappenas -- leaving little time for provincial input into the crucial program and targeting stage at the end of the process.

Some of the "irrationality" of Pusat response comes simply from lack of sufficient familiarity by many Pusat officials with the strengths of the CHIPPS provinces. This problem will be discussed below in Section B.

The structural constraints are more difficult to address. It is clear that structural reforms at Pusat may be necessary to encourage more rational responsiveness to provincial proposals. The importance of empowering provincial officials with their own data and own analytical capability has been demonstrated. Now it is necessary to assure that Pusat will be rational in its response to provincial data.

Central to the rational use of data at Pusat is the need for Pusat to develop a more integrated, simplified and

responsive health and management information system. Currently there are several competing and onerously burdensome data collection and processing systems. These systems are controlled by different administrative units in different Technical Directorates. They routinely collect data that no one uses and the data is of varying quality. Without a well developed and high quality information system, Pusat officials can often appropriately ignore data because its validity is questionable.

Many of the innovations in data collection and management introduced by CHIPPS and other projects (i.e. the World Bank-supported pilot project of the Pusat Data Center) have been add-on activities that have only supplemented rather than replaced the existing cumbersome information systems. As such they add an additional burden of data collection and analysis to an already overburdened staff. Some studies suggest that considerable staff time is already devoted to supplying routine data that is not utilized (as much as 50% of staff time in some cases).

While, as will be discussed below, some innovations of CHIPPS are being introduced into routine systems, the programs are likely to be more effective and increase efficiency if they can be used to develop a more efficient and simplified information system that would give Pusat data that is necessary for its planning, coordination and logistics purposes while also providing lower administrative levels with data that can be used for their own priority setting, planning, and management purposes -- and, importantly, for negotiating with Pusat.

RECOMMENDATIONS:

- 1) Major efforts should be launched at Pusat, with USAID support, to establish a simplified, high quality health/management information system that will encourage Pusat responsiveness to decentralized units and their priorities.
- 2) CHIPPS initiatives in data systems should be evaluated in detail in a subsequent stage of this Final Evaluation to provide lessons for this broad reform effort.

A second structural constraint on Pusat responsiveness is the lack of integration and knowledge-sharing among separate administrative units of Pusat. At the most general level the vertically organized Directorate Generals, with their built in competition over administrative turf, inhibit coordination and

rational responsiveness to provincial and local initiatives. However, even within single administrative offices, officials responsible for one project often do not share information or coordinate with other officials responsible for other similar projects. This lack of Pusat integration places a major burden on provincial officials who must work through the competing maze at Pusat in order to achieve their objectives.

RECOMMENDATION

Pusat, with USAID support, should begin a process of major restructuring in order to encourage practical integration of separate administrative units so that responsiveness to provincial and local level initiatives can be facilitated.

More modest efforts to encourage greater integration of Pusat activities will be discussed in Section B: Project Design Lessons.

Administrative reforms at Pusat that would give provinces greater control over budgets will be discussed below in Section C on financing.

3) CHANGING NATIONAL STRATEGIES AND PROGRAMS

CHIPPS has had a significant impact on national health strategies and programs. Many of the innovative ideas that have been implemented in CHIPPS provinces have contributed to changes in national policies -- in some cases, CHIPPS provided significant models that have been or are to be adopted by Pusat.

It is important to note that in most cases the models and ideas adopted by Pusat include elements that encourage or recognize the need for province and local level variation and the need to develop provincial and local capabilities. Pusat is not simply using CHIPPS models to impose a new uniform national policy. It is learning from CHIPPS the importance of decentralization in each specific intervention.

Three major examples of this national level adoption of innovations from CHIPPS include:

- 1) nursing field training program,
- 2) drug management program,

3) national TT strategy

In addition, there is considerable interest at Pusat in adopting elements of the recently developed MONEV system.

Perhaps the most important impact on Pusat programs has been in nursing field training. Both national and provincial officials see the CHIPPS experience as crucial to the changes in Pusat strategy in a variety of ways.

The field training component of the CHIPPS program was particularly innovative in that it encouraged greater involvement of the community in the establishment of problems for nursing activities and training. The field experience involved revisions in the nursing curriculum, extension of time for the field experience, and greater involvement of both students and faculty in the communities. These innovations were initiated with varying models in all three provinces and evaluated by the National Education Unit (Pusdinakes). The results of this evaluation have been incorporated into the revised 1988 curriculum. The new curriculum has altered the number of hours for field training, and focused more attention on use of local community for case examples and definition of problems. In addition, funds for the field training are to be covered in the regular DIP allocation.

The national drug control program has also adopted the CHIPPS approach to determining provincial and local procurement proposals. Some training in the methods used by CHIPPS has been sponsored by Pusat. The national strategy is currently being modified by the Health Sector Financing Project and lessons from the CHIPPS model are being applied to the development of this national drug control system.

Also striking is the response of Pusat to the neo-natal tetanus activities of CHIPPS. Although the concern with neo-natal tetanus did not originate with CHIPPS and the mass campaign approach for reaching areas which are difficult to reach in routine system was used in NTB before it was in CHIPPS, the CHIPPS data and programs were strongly influential in the response of Pusat. TT has become one of the major new initiatives of Repelita V in part because of the emphasis on the problem by CHIPPS. Perhaps most important is a newly developed National Strategy for Control of Neo-Natal Tetanus (September 1988). This strategy not only relies heavily on data provided by CHIPPS, but also defines a strategy which includes mass campaigns -- a policy that was reportedly consistently resisted by Pusat until recently.

Several Pusat officials have expressed interest in the recently developed MONEV system and are looking for means of incorporating some elements of the system into routine

reporting systems and into research projects. It is too early to evaluate this project and its impact on Pusat policy, however, the high level of interest by several officials is encouraging.

Despite these encouraging achievements, the responsiveness of Pusat to CHIPPS innovations continues to be limited. The central element adopted by Pusat tends to the technical innovation (i.e. mass campaigns, curriculum changes, drug estimation models) and not the process of decentralization that is central to these models. For instance, the nursing curriculum has not been altered in a major way to encourage flexibility to respond to local or provincial priorities -- community involvement is to be used as examples rather than a means of altering the number of hours or the types of topics to be treated in the curriculum. The drug management training has been modified so that it can be implemented without additional resources that may have been critical to its success in the CHIPPS provinces (the Health Sector Financing project, however, may in the future make this more effective).

Central to this weakness is the lack of sufficient resources in the project for the development of national level strategy and programs. As will be discussed below, the project initially ignored Pusat and focused its efforts at the province level. Later as major efforts were launched to involve more participation of Pusat, most attention was placed on educating Pusat officials about the activities that were occurring in the project areas -- seminars and site visits presenting descriptions of activities and findings of studies. Seldom was there any effort to develop policy implications for Pusat, or to discuss the modifications that would be appropriate for application of the CHIPPS interventions in provinces that did not have the benefit of additional CHIPPS resources. In a period of national budgetary restrictions, the implications of this approach are that most of the activities may have to be supported by other foreign assistance. CHIPPS might have provided resources at the Pusat level for careful review of the policy implications of the CHIPPS experiences and an analysis of financial implications of national policy changes. These issues and recommendations will be discussed more below in sections B and C.

4) PROVINCIAL RESPONSE TO LOWER ADMINISTRATIVE LEVELS

It was difficult for this consultant to evaluate the details of the province/kabupaten relationship in any systematic way. These comments are based on Pusat interviews

and on interviews and observations in only one province (and only three kabupaten).

CHIPPS began in each province with project activities focused on selected kabupaten. For instance, in West Sumatra two kabupaten (Lima Puluh Kota and Pesisir Selatan) were chosen for the initial epidemiological surveys and interventions and became the central focus for many other activities. The health officials in these kabupaten tended to work collaboratively with the provincial level officials and to gain the confidence of these officials. In addition they also generated their own initiatives -- often with support of their local bupati. Provincial level responsiveness to these kabupaten has been significant as would be expected from the close working relationship that has been established.

More generally, however, even though several programs have been designed to strengthen kabupaten capabilities and to allow kabupaten initiatives and priority setting (i.e. the data and drug management training and MONEV) there seems to be little confidence at provincial level that capabilities at lower levels are strong enough to allow lower-levels to bargain effectively to change their programs. Some leeway apparently is allowed for kabupaten proposals for activities, and some modifications of provincial initiatives appear to have been made based on local level data, most of the activities have been initiated and implemented by provincial officials.

Some of the problem may come from the relatively recent trend to involve all kabupaten in training and interventions. As noted above the initial strategy was to involve only selected kabupaten. It may be that as time goes on the province level officials will become convinced that skills have been sufficiently developed at the kabupaten level. It is clear that, unlike Pusat's relation to the project, the provinces know more about the kabupaten and their activities and could be more involved in local level initiatives.

One of the greatest weaknesses, however, has been the failure to involve the kabupaten levels in the Repelita V planning process. The kabupaten provided data for the situational analysis to the provincial planners, however, they were not involved in the development of the rest of the planning process: the establishment of problem priorities, policy formulation or programming and targeting.

The issue of strengthening the kabupaten level capacities and of decentralizing power to this level have become major priorities of the next five year period. A training module has been developed by Pusat (Planning Bureau, Organizational Bureau and others) with WHO funding to strengthen the kabupaten level in health planning. CHIPPS might try to work with the training

program in each province to support and/or modify the approach to local conditions.

RECOMMENDATIONS:

- 1) Training programs during the rest of the CHIPPS project should be designed to enhance kabupaten level capacities in all, rather than selected, kabupaten.
- 2) CHIPPS should coordinate with the national training program for kabupaten management. If possible CHIPPS trainers should comment on the proposed modules and should be involved in implementing them.

5) NEGOTIATIONS WITH PROVINCIAL AND LOCAL GOVERNMENTS

While it was not possible for this consultant systematically to evaluate the capability of health officials to gain provincial and local government support for health activities, many examples suggest that there is more responsiveness on the part of these governments to initiatives that have received CHIPPS support.

Local governments have provided resources for strengthening or sustaining several CHIPPS activities -- local census, surveys, support for relawan, commitments to fund maintenance of MONEV, etc.

Many of the specific interventions of CHIPPS have been implemented in an integrated way involving local units of other national ministries and local leaders. Particularly important has been the relationships with local PKK (for acceleration of Posyandu and for MONEV), the nursing schools (for field training and relewan). The least effective coordination was with the local census bureau and local government officials for the collection of vital statistics.

Again it is clear that the power that comes from having more accurate data and from using it in effective ways has strengthened the provincial and kabupaten officials vis a vis the local governments. In some cases the effectiveness of this persuasion rests on the willingness or interest of the local and provincial officials. It is also clear that rational decision-making on the basis of data is not always the central means of provincial and kabupaten choice. However, when it is, the information that CHIPPS projects have provided has been useful. In most cases, information is the only tool that health

officials have in their bargaining with local and provincial officials.

Provincial and local officials are often judged by their ability to demonstrate achievement of health objectives. They are impressed by data which shows higher or lower estimates of health indicators than the national level data. This information can often be used to persuade them of the importance of specific interventions to reach targets established in the planning process. In response some officials have provided funds for project activities.

Nevertheless, it is clear that local and provincial responsiveness is limited. Many local and provincial officials are not willing to support additional health efforts and those who are seldom commit significant resources to support CHIPPS initiatives. It appears that the interest and abilities of provincial and local government varies considerably and sometimes depends mainly on the personal relationships between health and other government officials.

A fundamental problem has been the current practice of these governmental levels using the health sector as a revenue producer rather than a sector in need of subsidy. By recent regulation all health units that collect fees should be able to retain at least 25% of those revenues after transferring them to local governmental budgets. Seldom is even this low level of support achieved.

Several national and internationally funded efforts (i.e. World Bank and USAID Health Sector Financing projects) are beginning to address this issue. If provincial and local health officials gain greater access to these funds then they are likely to be able to implement their priorities more effectively. The example of East Java, where greater local and provincial resources are made available to the health sector suggests the importance of this reform.

RECOMMENDATIONS:

- 1) Provincial and local health officials should continue to support integrated activities and to utilize data to encourage government officials to support health initiatives with local funds.
- 2) Efforts to retain fees in the health sector should be supported by Pusat and USAID. These fees should be controlled by the administrative level at which they are generated in order to strengthen decentralization.

6) SUSTAINABILITY

In some respects, CHIPPS is not sustainable and has been criticized for its lavish funding that cannot be continued. Some of the criticism is well taken. The provision of material incentives in some of the projects is generally not sustainable and may undermine routine programs. Until recently little attention was given to considerations of where funding could be found to continue some of the activities that CHIPPS sponsored.

However, CHIPPS was designed to demonstrate what could be done if additional resources were made available at the province level. Some of the costs and some of the incentives may have been necessary in order to initiate new projects which can demonstrate their effectiveness.

Effectiveness has been shown to be a key element in sustainability (see CDIE studies on sustainability). Also important has been the involvement of local officials in the design and implementation of the project as well as the integration of activities into on-going normal administrative processes.

It seems clear that CHIPPS has demonstrated its effectiveness in several key areas -- as noted above the national adoption of some of the program assures some level of sustainability -- and local and provincial support is likely for some sustaining activities in each province. Both national and provincial officials seem convinced that some of the projects have been effective enough to be sustained.

CHIPPS is also designed to be responsive to local initiatives in design and implementation (although there is some feeling that early activities responded more to the expertise of long term consultants than to local priorities) and all activities are well integrated into the normal administrative structures.

It is funding issues that are the most problematic in CHIPPS. There was really little effort to design the project so as to gain national funding to replace AID funding at the end of the project. Most successfully sustained projects require a gradual absorption of project costs by the national budgets. While some costs will be absorbed by local funds, and others by other foreign assistance, there appears little of the CHIPPS activities will be maintained with additional national resources. This issue will be discussed below in Section C.

There is also evidence that sustainability may be threatened by personnel changes. It is not clear that a sufficient number of officials -- especially at Pusat -- have been involved in CHIPPS in order to assure sustainability. For

example, the two officials in the Department of Nutrition who were actively involved in CHIPPS are currently receiving overseas training. They have left no institutional memory of CHIPPS in the Nutrition Directorate. Even in departments, such as Immunization, where officials have not changed, the knowledge and interest of single officials is a fragile platform of support. Without wider involvement, such personnel changes can jeopardize achievements. It is possible that changes at province and kabupaten level could also have an effect on the sustainability of CHIPPS achievements.

RECOMMENDATIONS:

- 1) Immediate efforts to provide reports and involve newly appointed officials should be made to assure on-going knowledge and participation in CHIPPS activities before the termination of the project.
- 2) In divisions where only one official is involved with CHIPPS, efforts to involve other officials should be made.
- 3) At the provincial level, attempts should be made to provide a transition period when personnel are transferred so that officials involved in CHIPPS activities can give an orientation to their replacements.

B. PROJECT DESIGN LESSONS

A central weakness of the project design was that it reached out to the provinces in a way that by-passed Pusat. This design avoided having to contend with Pusat obstacles to province development, but it also gave Pusat little stake in the project. For the last two years the project has had to make catch up efforts to make up for this lack of initial involvement.

This lack of Pusat involvement led to a series of obstacles that had to be overcome through a variety of special efforts. The project was viewed as part of the Bureau of Planning and therefore not the responsibility of the other Technical Directorates. It was seen as an "alien" project imposed by AID. Until a Pusat level facilitator was established in 1986 there was no major effort to disseminate the results of CHIPPS activities among the different divisions at Pusat.

In response to the crescendo of recommendations in each succeeding project evaluation, CHIPPS implemented several important activities that appear to have been crucial to the

effectiveness of CHIPPS at Pusat. The Pusat facilitator was able to disseminate reports and coordinate technical seminars and annual presentations at the national level. High government officials as well as program implementors were exposed to CHIPPS experience. In addition, officials from Pusat and other provinces were invited to CHIPPS provinces to observe the activities and some projects (i.e. TB control) have supported technical assistance from Pusat divisions.

It is a testament to the power of well presented data, to the interest of a few key officials at Pusat, and the significant efforts taken in since 1986 to disseminate CHIPPS results and involve Pusat in technical assistance that CHIPPS was able to achieve as much as it did. However, the tasks might have been easier and more accomplished had the Pusat divisions been directly involved through out the project.

While the approaches taken over the last two years have increased the exposure of CHIPPS and have involved greater participation of Pusat in CHIPPS activities, the approaches have been limited by a failure to present the CHIPPS experience in terms that address Pusat level concerns and a tendency to involve only a small number of interested Pusat officials. The seminars that present CHIPPS innovations (annual seminars and special technical seminars) as most seminars in DepKes, tend to be presentations of data and descriptions of activities and are not designed to address policy choices at Pusat level. Although there now is a PIL for Pusat activities, it does not seem to provide resources for the development of Pusat policy analysis of provincial activities. The result is that Pusat officials and officials from other provinces tend to think of CHIPPS experiences as too costly to be applied in other provinces or on a national scale. They have benefitted from the special CHIPPS funding and therefore it is difficult for officials to think about how the innovations could be applied utilizing national resources in a time of declining national budgets. It is noteworthy that the provincial officials who may have learned the most from visiting and observing CHIPPS activities are from the two provinces that are about to receive a major World Bank project that is also designed for decentralization purposes.

Two initiatives might now be taken to attempt to strengthen the development of the policy implications of CHIPPS: 1) policy seminars and 2) policy taskforces.

CHIPPS might sponsor special policy seminars on key issues of CHIPPS interventions -- Acceleration of Posyandu, nurses training, data and drug management, epidemiological training, etc. These seminars should be designed to address policy issues rather than to present findings of CHIPPS activities. They should be focused on designing policy alternatives for

decision makers. Cost analyses should be presented in these seminars. It would be useful for these seminars to focus on broad policy issues and not just CHIPPS. The seminars might evaluate CHIPPS activities along with other experiences relevant to the policy issue being evaluated. These seminars might be funded through PIL 137 and remaining HTRD or PD&S funding.

Policy Taskforces for developing the policy alternatives for the seminars might be established both to structure the seminars and to follow up on their results. Involvement of relevant units of DepKes and other ministries and private sector should be assured. These Taskforces should be modeled on the intersectoral working groups that developed policy analysis for Repelita V.

In conclusion, since the key to decentralization is Pusat's reaction to province capabilities, it is crucial to involve Pusat in the entire process. It appears important that different Pusat divisions have a responsibility and financial stake in project activities in order to recognize the importance of decentralization. As will be discussed below, financial issues may be particularly important to maintaining responsibility and sustainability of project activities.

RECOMMENDATIONS:

- 1) Future projects designed to encourage decentralization should make every effort to include Pusat in the design and implementation of project activities. Pusat units need a financial stake in order to assure greater responsibility and responsiveness to decentralization initiatives.
- 2) Greater efforts to define policy implications of CHIPPS experiences for Pusat:
 - Seminars should be designed to discuss policy and program alternatives of the CHIPPS interventions, rather than simply reporting on CHIPPS projects.
 - Pusat Taskforces from various divisions and departments should be formed for policy formulation in central areas of CHIPPS (data management; drug management; Posyandu initiatives like relewans, use of kader, etc.) AID should assist in funding these taskforces.
- 3) Continued coordination with the World Bank sponsored project in East Kalimantan and NTB should be encouraged.

A second set of design issues relates to organizational issues of the project itself. Several different schemes for organization and reorganization of the CHIPPS project both at the national and at province levels have been recommended by prior evaluations. These include suggestions for greater involvement of different administrative units at all levels, either as advisory teams or as implementors.

Advisory teams alone are not likely to be a very effective mechanisms for increasing coordination and responsibility at Pusat or even at provincial levels. Advisory boards seldom provide opportunities for broad based coordination of activities in several administrative units. They tend to focus on developing broad guidelines for project activities and on formal approval of proposals submitted for project activities. As such they often provide a forum for obstruction rather than coordination. Members of advisory boards seldom share their information widely in the administrative units that they represent.

In contrast, organizational structures that are oriented toward specific implementation, at least at lower administrative levels, appear to have been quite effective in implementing much of the project activities. It is likely that organizational structures (Implementation Taskforces) established with specific responsibility to implement components of the project would be more effective than a broad overall advisory board.

While this consultant is strongly convinced that integration of administrative units is necessary, it should be organizationally designed to focus on specific implementation activities that have objectives established by clear consensus among the implementing units. Otherwise potential for obstruction and inactivity is great.

RECOMMENDATION:

Organizational structure of CHIPPS and similar projects should encourage the creation of Implementation Taskforces as a forum for integration of implementation of CHIPPS activities among several Pusat implementing units.

C. FINANCING ISSUES

It is perhaps in financing that CHIPPS has been the least effective in achieving its goals of decentralization and sustainability. This section will review two central financial issues:

- the financial analysis of CHIPPS project activities
 - in particular the cost-effectiveness analysis.
- the financing mechanisms of the project itself

1) COST EFFECTIVENESS ANALYSIS

One of the central objectives and activities discussed in the Project Paper was the importance of demonstrating the cost-effectiveness of CHIPPS interventions to decision makers at all levels. Nevertheless, CHIPPS activities have generally failed to provide this crucial tool for evaluation of interventions and for persuading officials of DEPKES, BAPPENAS, and other financial institutions of the feasibility of extending to other provinces or nationally interventions that have been supported by CHIPPS extraordinary funding.

Pusat officials, perhaps rightly, often dismiss CHIPPS activities as too expensive for national programs since they enjoy the benefits of grant funding from AID.

Only two cost-effectiveness analyses have been done which focus on the project interventions -- for TT and TB -- and one is planned for the malaria intervention in NTT. Other cost studies have addressed broad -- issues of the costs of general national programs -- such as Rosyandu -- and not on specific project activities.

It is crucial to both the design and sustainability of current project activity and to the objective of disseminating the activities to other provinces that the costs involved in initiating and in maintaining the interventions be evaluated.

Project activities should be evaluated to determine just how costly they have been and how they might be modified so as to be financed from alternative national sources for broader application nationally and for continuing current project activities in each province.

Costs of training, management, surveys, software and hardware, and technical assistance should be analyzed for the data management and drug management activities, and the MONEV

system. Alternative estimates for less ambitious programs should be made.

Estimates of costs of TT, TB, nutrition, and other interventions should be made in order to demonstrate how resources might be better utilized to reach the goals of these projects.

Project costs that are inherent to the development of new activities -- such as LTC, and capital inputs -- should be discounted for the purposes of this analysis. And given the lack of baseline data for project "effects" in many of the interventions may make it impossible to use traditional cost-effectiveness analysis, however estimates of project costs may still be useful if project benefits are deemed important enough to sustain and/or replicate. While analyzing only costs makes it impossible to compare the costs of the project to alternatives which might produce the same or enhanced benefits, it does provide a means of understanding the financial implications of project activities that are perceived to provide important benefits. A central issue of the analysis should be "How much would it cost to implement a similar or modified program elsewhere, on a national scale, or simply to continue the current activity."

It would be useful to involve international and local consultants and officials from the Planning Bureau and from the planning units of each of the relevant Technical Directorates in this evaluation. The greater involvement of different officials from Pusat would give wider recognition of CHIPPS activities and might assure greater sustainability and replicability of CHIPPS initiatives.

RECOMMENDATIONS:

- 1) Cost-effectiveness analyses (or simply cost analyses where data on effectiveness is not obtainable) should be implemented -- either as part of the ongoing CHIPPS projects or as special component of the final evaluation -- to demonstrate 1) the cost-effectiveness of project interventions, 2) the costs of sustaining current activities, 3) the costs of adopting CHIPPS models on a national scale or in other provinces. Health planning officials from the Planning Bureau and from the relevant Technical Directorates should be involved in this evaluation.

- 2) Future projects which have decentralization and sustainability objectives should involve health economists in early project activities to encourage attention to cost analysis and to establish base-line data.

2) FINANCING MECHANISMS OF THE PROJECT

The financing of CHIPPS evolved through the project period in ways that facilitated the disbursement of funds but may not have provided mechanisms for replication or sustainability of project activities. The bulk of the original project was a loan that was to be administered through the normal DIP budgetary procedures of DepKes. This procedure tended to be extremely rigid and made rapid and flexible disbursement of funds to the provincial level difficult. In 1986 and 1987, a significant increase in grant funding and the conversion of a portion of the loan facilitated the process of approval of provincial proposals and providing a mechanism for avoiding the rigid DIP process. Approval at Pusat was limited to the Health Planning Bureau and USAID procedures.

This mechanism facilitated the implementation of the project but did not provide a means for Pusat to learn the advantages of financial mechanisms that grant flexibility to respond to provincial initiatives. The CHIPPS financial mechanism was feasible only because it was a foreign funded grant. It was "alien" to the normal national budgetary process.

While it might have continued to limit the implication of the project, it might have been more appropriate in the long run to have developed a more "national" solution to project funding that would have institutionalized the process of either 1) introducing greater flexibility in the definitions and categories in the DIP process, and/or 2) providing limited "block grants" for research and development at the provincial level.

To some extent it has been reported that there has been some increase in DIP flexibility, however, that process should have been more directly addressed in CHIPPS.

It might have been possible to funnel funds of the project through the Research and Development budgets in different Technical Directorates. These funds might have been identified by project agreement to be assigned as block grants to provinces for local initiatives. A simplified review process (similar to the current Health Bureau/USAID process) might have been institutionalized within the government normal budgetary

processes. An advantage of this option would have been greater involvement of more Pusat officials in the CHIPPS projects.

The central issue is the need to demonstrate to Pusat the effectiveness of having block-grant to province for broadly defined purposes with short term review process. It would be useful to examine the review mechanism of Planning Bureau and AID to suggest model for national R&D budget to be available at province level. Other models for flexible funding at provincial levels might be provided by other AID projects.

RECOMMENDATION:

Financial evaluation of the CHIPPS project include review of the financing mechanism and consideration of alternatives that might involve greater Pusat participation and modifications of the normal national budgetary system of DepKes. These modifications should increase flexibility of response to provincial initiatives and demonstration of the effectiveness of block grants to provinces.

Also important is the issue of the project disbursement trends in relation to national government expenditures. The trends, in part because of the unanticipated reduction in national development budgets following the 1985 austerity program, were a rapid increase in CHIPPS contribution relative to the national development contribution to provincial activities. One estimate suggests that by 1987 CHIPPS was providing 37% of all development funds in West Sumatra.

This trend is dangerous in terms of the sustainability of project activities. Studies have shown that project sustainability is enhanced if national sources of funding increasingly absorb project funding over the life of the project. This process demonstrates greater government commitment and puts financial resources for the activities in clearly defined sections of the national budgets. When the project terminates, the government is then not faced with the difficult task of rapidly transferring major amounts of funding to replace the AID funds. It will have done so in incremental steps over the life of the project.

Since this process was in fact reversed over the life of the CHIPPS project, it is too late to change the budgetary commitments of this project. However, the financial evaluation should review mechanisms that might ease the transition to

national funding after the project terminates. It might consider including in a future project a small amount of provincial block grants to be provided to the CHIPPS provinces for continuation of CHIPPS activities. These block grants might be designed to be funnelled through the R&D mechanisms described above, and the project agreement might require the establishment of a progressive absorption of project costs by national sources as the AID support for block grants are phased out.

RECOMMENDATION:

Financial evaluation should review the process of AID/National disbursements during CHIPPS and make recommendations regarding the potential for sustaining CHIPPS activities through modest support in future projects.

PERSONS CONTACTED

DEPKES - PUSAT - JAKARTA

- Dr. Leimena -- Director General, Community Medicine
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Dr. Linda -- Planning Section

Dr. Henry -- Planning Section

Dr. Hawari -- Planning Section

Dr. Rinal -- Planning Section

Dr. Idrian -- Planning Section

Dr. Saif -- Planning Section

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Staff of Puskesmas Mungo
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Dr. Zulu -- Puskesmas Salido

DOCUMENTS

BASIC PROJECT DOCUMENTS

CHIPPS Project Paper

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Project Process Evaluations: May 1984 and June 1985

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