ADB

Completion Report

Project Number: 40003-013
Loan Number: 2361
May 2017

Indonesia: Poverty Reduction and Millennium Development Goals Acceleration Program

Asian Development Bank

CURRENCY EQUIVALENTS

Currency Unit – rupiah (Rp)

		At Appraisal (31 August 2007)	At Project Completion (31 December 2008)
Rp1.00	=	$0.0001063830	$0.0000896861
$1.00	=	Rp9,400	Rp11,150

ABBREVIATIONS

ADB	–	Asian Development Bank
ASKESKIN	–	Asuransi Kesehatan untuk Keluarga Miskin (Basic Health Care and Insurance for the Poor Program)
BAPPENAS	–	Badan Perancanaan Pembangunan Nasional (National Development Planning Agency)
BOS	–	bantuan operasional sekolah (operational assistance to schools)
BPS	–	Badan Pusat Statistik (Central Board of Statistics)
BSNP	–	Board of National Education Standards
CDC	–	communicable disease control
DAK	–	Dana Alokasi Khusus (special development fund)
GDP	–	gross domestic product
MDG	–	Millennium Development Goals
MNCH	–	maternal neonatal and child health
MOF	–	Ministry of Finance
MOH	–	Ministry of Health
MOHA	–	Ministry of Home Affairs
MONE	–	Ministry of National Education
MORA	–	Ministry of Religious Affairs
MOWE	–	Ministry of Women's Empowerment
MSS	–	minimum services standard
NHA	–	national health account
PRMAP	–	Poverty Reduction and Millennium Development Goals Acceleration Program
RPJMN	–	Rencana Pembangunan Jangka Menengah Nasional (National Medium-Term Development Plans)
TB	–	tuberculosis

NOTES

(i) The fiscal year (FY) of the Government of Indonesia and its agencies ends on 31 December. FY before a calendar year denotes the year in which the fiscal year ends, e.g., FY2009 ends on 31 December 2009.

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

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BASIC DATA

A. Loan Identification

1.	Country	Indonesia
2.	Loan Number	2361
3.	Program Title	Poverty Reduction and Millennium Development Goals Acceleration Program
4.	Borrower	Government of Indonesia
5.	Executing Agency	National Development Planning Agency (BAPPENAS)
6.	Amount of Loan	$400 million
7.	Program Completion Report Number	1615

B. Loan Data

1.	Appraisal	
	– Date Started	22 August 2006
	– Date Completed	08 September 2006
2.	Loan Negotiations	
	– Date Started	18 September 2007
	– Date Completed	18 September 2007
3.	Date of Board Approval	30 October 2007
4.	Date of Loan Agreement	23 November 2007
5.	Date of Loan Effectiveness	
	– In Loan Agreement	21 February 2009
	– Actual	07 December 2007
	– Number of Extensions	0
6.	Closing Date	
	– In Loan Agreement	31 March 2008
	– Actual	31 March 2008
	– Number of Extensions	0
7.	Terms of Loan	
	– Interest Rate	LIBOR + 0.60%
	– Maturity (number of years)	15 years
	– Grace Period (number of years)	3 years
8.	Terms of Relending (if any)	Not applicable
	– Interest Rate	
	– Maturity (number of years)	
	– Grace Period (number of years)	
	– Second-Step Borrower	

9. Disbursements

a. Dates

Initial Disbursement	Final Disbursement	Time Interval
14 December 2007	14 December 2007	0
Effective Date	**Actual Loan Closing Date**	**Time Interval**
07 December 2007	31 March 2008	3.83 months

b. Amount ($ million)

Tranche No.	Date Disbursed	Amount
Tranche 1	14 December 2007	$400
Total		**$400**

10. Local Costs (Financed)

- Amount ($) — Not applicable
- Percent of Local Costs — Not applicable
- Percent of Total Cost — Not applicable

C. Program Data

1. Program Cost ($ million)

Cost	Appraisal Estimate	Actual
Foreign Exchange Cost	400	400
Total	400	400

2. Financing Plan ($ million)

Cost	Appraisal Estimate	Actual
Implementation Costs		
ADB-Financed – Single Tranche	400	400
Total	400	400

ADB = Asian Development Bank.

3. Cost Breakdown by Program Component ($)

Component	Appraisal Estimate	Actual
Not applicable		

4. Program Schedule

Item	Appraisal Estimate	Actual
Release of Single Tranche	7 December 2007	10 December 2007
Completion of Work	Not applicable	Not applicable
Equipment and Supplies	Not applicable	Not applicable
Dates		
First Procurement	Not applicable	Not applicable
Last Procurement	Not applicable	Not applicable
Completion of Equipment Installation	Not applicable	Not applicable
Start of Operations		
Completion of Tests and Commissioning	Not applicable	Not applicable
Beginning of Start-Up	Not applicable	Not applicable
Other Milestones	Not applicable	Not applicable

5. Program Performance Report Ratings

	Ratings	
Implementation Period	Development Objectives	Implementation Progress
From 31 October 2007 to 31 December 2008	Satisfactory	Satisfactory

D. Data on Asian Development Bank Missions

Name of Mission	Date	No. of Persons	No. of Person-Days	Specialization of Members
No data available				

Note: Identification missions and Fact-finding mission were conducted in 2006. However, no files on missions such as Back-to-office reports were available to project completion report team at the time of the preparation of the PCR.

I. PROGRAM DESCRIPTION

1. The Asian Financial Crisis started on 2 July 1997, when the Government of Thailand, burdened with a huge foreign debt, floated its currency. This led to the collapse of the currency and triggered a widespread contagion throughout other Asian countries, leading to the decline in the values of currencies, assets, and stock markets in the countries in region and beyond. Indonesia was severely affected by this crisis (1997 -1998) and solicited financial assistance from the International Monetary Fund (IMF) in October 1997.[1] The Government of Indonesia made persistent efforts to recover from the financial crisis. The government instituted wide-ranging structural reforms to remove the distortions that made the country vulnerable to the 1997 financial crisis, such as restructuring the financial sector and reforming fuel subsidies. These measures led the country's economy to improve gradually through 1999 and achieve a relatively steady economic growth between 2000 and 2006. Real gross domestic product (GDP) growth rose from the post-crisis level of 0.8% (in 1998) to 2%–3% during 2000–2002, and reached 5.5% in 2006.[2] While the government had largely managed to attain its goal of fiscal prudence, it had not been able to maintain its development expenditures—particularly on education and health—at the scale needed to accelerate economic growth, poverty reduction, and social development at par with its regional neighbors.

2. The government realized that human capital accumulation was essential to sustaining economic and social development and, at the Millennium Summit in 2000, committed to achieving the Millennium Development Goals (MDGs) by 2015. The government reiterated this commitment at the UN General Assembly in September 2005. However, Indonesia's progress towards the MDGs was slow and even reversed direction in 2006. Poverty levels as measured by the national poverty line increased from 16.7% in 2004 to 17.8% in 2006 (almost 40 million poor), reversing the previous decline from 23.4% in 1999.[3] Progress toward some of the health-related targets was particularly off-track. Maternal mortality rates remained stubbornly high, malnutrition and child mortality rates were higher than in many neighboring countries, and approximately 582,000 new cases of tuberculosis were recorded every year. In 2002, about half of the children from the poorest quintile of households did not enroll in junior secondary school (footnote 2).

3. The government gradually increased social sector expenditure and launched several policy reforms and new programs to accelerate the achievement of the MDGs. Due to its ambitious poverty reduction program, and despite the reorientation of fiscal resources towards the social sectors, Indonesia was facing large financing requirements to support its MDG agenda and required flexible financing arrangements to support its social development objectives. Responding to this need, the Poverty Reduction and Millennium Development Goals Acceleration Program Loan (PRMAP) was designed to support the Government of Indonesia in its commitment towards achievement of the MDGs; particularly, those related to poverty reduction (MDG 1), education (MDG 2), gender equality (MDG 3), and health (MDG 4, 5, and 6). PRMAP was prepared as a program loan consisting of three subprograms, with three loan tranches as part of a bigger umbrella program. The first subprogram (SP1) of the program cluster was implemented between April 2005 and March 2007. All reform actions specified in the policy matrix for SP1 were completed by March 2007. PRMAP was approved by the ADB Board in October 2007 (footnote 2) with the first tranche of $400 million released in December 2007. A tranche of $200 million

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[1] Indonesia Investment. 2016. www.indonesia-investments.com

[2] ADB. 2007. *Report and Recommendation of the President to the Board of Directors (RRP): Proposed Program Cluster, Loan, and Technical Assistance Grant to Republic of Indonesia for Poverty Reduction and Millennium Development Goals Acceleration Program.* Manila.

[3] World Bank. World Development Indicators. http://databank.worldbank.org/data/home.aspx (accessed 20 December 2016).

each was envisaged for SP2 and SP3. PRMAP was the largest social loan provided by ADB to any member country at the time. The expected outcome of the program was improved access, equity, and quality of service delivery in education and health.[4]

4. To support the government in achieving the policy actions under SP2, ADB provided associated technical assistance (TA) to key line ministries, including the Ministry of National Education (MONE), the Ministry of Religious Affairs (MORA), and the Ministry of Health (MOH). The TA was approved by the ADB Board in October 2007 and was implemented in close collaboration with the Government of Australia. The estimated total cost of the TA was $2.7 million of which, ADB provided funding for $1.5 million, the Government of Australia contributed $1.0 million, and the Government of Indonesia contributed $200,000. The TA successfully delivered what was originally expected.[5] The government decided to fund the activities to achieve the Poverty Reduction and Millennium Development Goals with their own budget and requested ADB not to proceed with the second subprogram. The cluster loan was closed in March 2008 and ADB did not finance the subsequent subprogram loans.

II. EVALUATION OF DESIGN AND IMPLEMENTATION

A. Relevance of Design and Formulation

5. At appraisal, the policy-based loan was highly consistent with ADB's country strategy. The program was in line with ADB's health and education sector policies, operational plan, and country programming. It was also aligned with the government's National Medium-Term Development Plan (RPJMN), 2005–2009, which sought to raise the levels of sustainable economic growth, create jobs, and accelerate the achievement of the MDGs.[6]

6. ADB has supported its developing member countries in achieving the MDGs since 2002, within the framework laid out in ADB's Enhanced Poverty Reduction Strategy[7] and the Medium-Term Strategy II, 2006–2008.[8] At an operational level, ADB has been committed to assisting its developing member countries to integrate the MDGs into their national poverty reduction strategies and to monitor their progress. In 2004, ADB, United Nations Development Programme, and the United Nations Economic and Social Commission for Asia and the Pacific embarked on a regional partnership to support monitoring of MDG progress, raise awareness, develop capacity, and improve policies and institutions related to the achievement of the MDGs. ADB's country strategy and program[9] (CSP) for Indonesia, 2006–2009 identified MDG acceleration as one of its five strategic areas of engagement.[10] ADB's support to accelerate the MDGs in Indonesia was focused on prioritizing and reorienting public expenditure toward health (including nutrition) and education, and on improving the quality, efficiency, and effectiveness of social service delivery. PRMAP was mentioned in the CSP as a key input in the realization of this strategy.

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[4] Footnote 2. A single design and monitoring framework was prepared for all subprograms. The program took a programmatic approach, with each policy action carried out under SP1 supposed to be fortified by activities listed under SP2 and SP3.

[5] ADB. 2011. *Technical Assistance Completion Report to the Board of Directors (TCR): Strengthening Social Service Delivery for the Poverty Reduction and Millennium Development Goals Acceleration Program (TA 4984-INO)*. Manila.

[6] Government of Indonesia. 2005. *National Medium-Term Development Plan*. Jakarta.

[7] ADB. 2004. *Enhancing the Fight Against Poverty in Asia and the Pacific. The Poverty Reduction Strategy of the Asian Development Bank*. Manila.

[8] ADB. 2006. *Medium-Term Strategy II, 2006-2008.* Manila.

[9] ADB. 2005. *Country Strategy and Program for Indonesia, 2006–2009.* Manila

[10] Footnote 9. The five strategic areas of CSP, 2006–2009 are: (i) improved infrastructure and infrastructure services; (ii) deepened financial sector; (iii) improved decentralization; (iv) accelerated MDG achievement; and (v) strengthened environment and natural resources management.

7. The design was prepared through an MDG-related policy dialogue between ADB, the government, and other relevant development partners that took place since early 2005.[11] As a result of the policy dialogue, the PRMAP was designed as a cluster program consisting of three consecutive subprograms, each supported with a single tranche loan release. Indonesia had a large financing need to support its MDG agenda in 2005–2006 and required urgent budget support to improve progress in achieving the MDGs. ADB decided on a single tranche program as Indonesia required flexible and timely financing arrangement. PRMAP supported the government's efforts as it entered the second generation of fiscal reforms and the reorientation of fiscal resources to accelerate attainment of the MDGs.[12]

8. The national development planning agency, BAPPENAS, was the executing agency, while the line ministries, Ministry of National Education (MONE) and Ministry of Health (MOH) were the implementing agencies. This implementation arrangement was appropriate and overseen by a program steering committee and a technical committee, comprising representatives of BAPPENAS and ministries with responsibilities related to the MDGs.[13] The implementation arrangement at the design stage was sufficient.

9. Policy actions under SP1 were carried out by March 2007, prior to loan approval. Out of 20 policy actions under SP2, 17 were also supported by the TA. The combined design and monitoring framework (DMF) was comprehensive and designed to apply to all three subprograms. Policy outcomes were achievable; but, not all 20 policy actions were relevant to complete the outputs. For example, only sex-disaggregated indicators were used to assess the output gender equity in access to health and education services. The policy actions for education service delivery meeting minimum service standards (MSS) focused on implementing MSS rather than improving the actual service delivery.

10. Some performance indicators were weak. Two out of six outcome indicators were designed without baseline data while a few output indicators were not easy to monitor. The project completion team incorporated additional indicators: (i) Gross secondary enrolment ratio increased, was added as to measure improved access, equity, and quality of service delivery in the education sector. Two new indicators were added to assess outputs of education policy reform: (ii) Junior secondary enrolment rates for the poor increased; and (iii) Corruption Index measuring perceived level of public sector corruption reduced. Two new indicators were added to measure the outputs of health policy reform: (iv) Share of pregnant women receiving prenatal care increased, and (v) Antiretroviral therapy coverage (% of people living with HIV) increased.

11. ADB carried out a risk assessment prior to loan approval, identifying a potentially limited impact on education and health outcomes. Mitigation mechanisms were prepared for all except for one risk factor: a potential lack of clarity of obligations by each level of government involved. No mitigation mechanism was prepared for this risk, as it was anticipated that this risk was

[11] Development partners engaged in the preparation of the project design included the Australian Agency for International Development, the Canadian International Development Agency, the European Commission, Deutsche Gesellschaft fur Technishe Zusammenarbeit, Japan International Cooperation Agency, Kreditanstalt fuer Wiederaufbau (KfW) Bankengruppe Development, Nusa Tenggara Timur, and the United States Agency for International Development.

[12] The government of Indonesia started a comprehensive reform agenda to boost growth over the medium term. Fiscal reforms undertaken prior to appraisal of this loan included the restructuring of the tax agency and the adoption of a key tax reform bill.

[13] Ministry of Finance (MOF), MOH, MONE, MORA, Ministry of Women's Empowerment (MOWE), Ministry of Home Affairs (MOHA), and Central Board of Statistics (BPS).

mitigated by the development of minimum services standards that were supposed to guide all levels of government to work toward quality improvement of service delivery.

B. Program Outputs

12. The PRMAP focused on the three principal policy areas: cross-sector policy reforms, national policy reforms in the education sector, and national policy reforms in the health sector.

1. Cross-sector Policy Reforms

13. Activities in this core policy area supported and intended to enhance strategic government-led reform initiatives that were expected to achieve (i) increased budget allocations for health and education; (ii) improved performance incentives and geographical resource allocations to districts for education and health; (iii) a uniform system for targeting MDG-related health and education services to poor households; (iv) gender equity in access to health and education services; and (v) a planning framework for MDG acceleration.

14. **Increased budget allocations for health and education, focused on MDG-related programs.** Budget allocations of (i) 1.1% of GDP for health in 2012 exactly match the target value of 1.1% (health), and (ii) 3.4% of GDP for education, while not meeting the target of 3.9%, is an increase from 2004.[14] Financial allocations for the operational assistance to schools' program (BOS) and basic health care and insurance for the poor (ASKESKIN) have been increased and sustained. Financial allocations to BOS increased from Rp5.1 trillion in 2005 to Rp10.2 trillion in 2006 and Rp19 trillion in 2009; allocations to ASKESKIN increased from Rp2.3 trillion in 2005 to Rp3.6 trillion in 2006.

15. **Improved performance incentives and geographical resource allocations to districts for education and health**. The objective of this policy action was partly achieved. The government significantly increased the size and scope of its special development fund (DAK), targeting health and education.[15] Still, the fund did not provide operational expenditures for health and education or incentives for the districts to improve their performance in service delivery. The government also established a targeting system to re-direct allocations towards the districts most in need and a monitoring system to track the use of DAK funds at the district level. MONE, MORA, and MOH issued revised annual technical guidelines for the allocation of DAK funding, but the parliamentary review of DAK funds allocation tends to result in a broad distribution of DAK funds to all districts, instead of the poorest districts.

16. **A uniform system for targeting MDG-related health and education services to poor households**. The objective of this policy action was achieved as the target survey-based database was implemented. BAPPENAS, in coordination with the Central Board of Statistics (BPS), MOH, and MONE, prepared guidelines on establishing a survey-based database to identify poor households in 2007. In 2008, BPS implemented the Pendataan Program Perlindungan Sosial (Data Collection for Social Protection Program) 2008 to identify poor households that lack access to key MDG-related health and education services. This survey is used as a tool to improve the targeting and administration of social protection, poverty reduction,

[14] Government education spending as a share of GDP increased to 3.4% in 2012 from 2.7% in 2004, and the health budget as share of GDP increased to 1.1% in 2012 from 0.9% in 2004. World Bank. 2016. World Development Indicator. http://databank.worldbank.org/data/home.aspx (accessed 20 December 2016); Central Board of Statistics (BPS) – Statistics Indonesia. https://www.bps.go.id/ (accessed 20 December 2016).

[15] Footnote 2. Under SP1, the annual DAK financial allocation in the national budget for health and education increased sevenfold between 2004 and 2007.

health support for the poor, and educational scholarship programs. Its usage by MONE, MORA, and MOH in targeting the poor achieved SP3.

17. **Gender equity in access to health and education services.** This policy action was achieved since sex-aggregated indicators on health and education were collected for the entire country, surpassing the target value of collection in 30% of districts. Under SP1, BAPPENAS completed an evaluation of the implementation of gender mainstreaming in nine sectors (2006), including health and education.[16] MOH issued a ministerial decree in 2006, outlining steps for better gender mainstreaming within its ministry. MONE issued the National Action Plan with Gender Equality in 2005.[17] MONE, Ministry of Women's Empowerment (MOWE), and MOHA have signed a memorandum of understanding to enhance their efforts to reduce the female illiteracy rate through non-formal education and life skills opportunities. Under SP2, BAPPENAS, with MONE, MORA, MOH, and MOWE proposed a list of key health and education indicators disaggregated by sex. Under SP3, those indicators are reflected in the medium-term development plans of MONE, MORA, and MOH. Indicators on health and education disaggregated by sex available on the BPS website show equal access to health and education in Indonesia. The ratio of girls to boys in primary education has shifted from 96.4 in 2007 to 103.8 in 2011, and the ratio in tertiary education improved from 98.4 in 2007 to 110 in 2011. School completion rates among women have been increasing and primary school completion rates by gender even reversed. In 2007, primary completion rate among male students was 97.5% and among females was 95.8% while in 2013, the male completion rate was 99.0% and the female rate reached 102.2%.[18]

18. **A planning framework for MDG acceleration.** This policy outcome has been achieved at a national level, surpassing the target of the MDGs being included in the development plans of 20 districts, five provinces, and MOH, MONE, and MORA. The MDGs were included as a key element in the RPJMN and the national poverty reduction strategy under SP1. Under SP2, the report *A Roadmap to Accelerate Achievement of the MDGs in Indonesia from 2010–2015* was prepared by BAPPENAS in partnership with ADB and Australian Aid and published in 2010.[19] The government issued guidelines directing local governments to mainstream the MDGs when preparing district medium-term development plans and district poverty reduction strategies. Under SP3, the medium-term development plans of the national government, MONE, MORA, MOH, and MOWE included the MDG targets as key priorities. The Government of Indonesia has also mainstreamed the MDGs in the National Long-Term Development Plan (RPJPN), 2005–2025, RPJMN 2005–2009, RPJMN 2010–2014, and National Annual Development Plans (RKP), as well as documents of the State Budget (APBN).[20]

2. Policy Reforms in the Education Sector for Millennium Development Goals' Acceleration

19. PRMAP was designed to support the government's objective of universal basic education leading to (i) improved access to junior secondary schools in under-served areas, (ii) improved operations and maintenance (O&M) support for smaller and remote schools, (iii) increased

[16] BAPPENAS. 2006. *Evaluation on the Implementation of Gender Mainstreaming in Development Sectors.* Jakarta.
[17] Government of Indonesia, Ministry of National Education. 2005. *National Action Plan: Education for All.* Jakarta.
[18] World Bank. 2016. World Development Indicator. http://databank.worldbank.org/data/reports.aspx?source=education-statistics-~-all-indicators (accessed 26 April 2017)
[19] BAPPENAS. 2010. *A Roadmap to Accelerate Achievement of the MDGs in Indonesia*. Jakarta
[20] BAPPENAS. 2005. *National Long-Term Development Plan (RPJPN), 2005–2025.* Jakarta; BAPPENAS. 2005. *National Medium-Term Development Plan (RPJMN 2005-2009)*. Jakarta; and BAPPENAS. 2010. *National Medium-Term Development Plan (RPJMN 2010-2014)*. Jakarta

affordability of education by poor students and/or households, (iv) enhanced quality and equitable deployment of teachers, (v) education service delivery that meets the MSS, (vi) improved planning and implementation of education services, and (vii) greater transparency of education outcomes to enhance accountability.

20. **Improved access to junior secondary schools in under-served areas.** This policy action has been achieved. To reduce primary school drop-out and increase transition to junior secondary, one-roof schools were designed combining primary and junior secondary levels, thereby reducing travel distance and costs. Between 2005 and 2007, MONE and MORA allocated Rp4.252 billion ($465 million) for the establishment of 2,416 integrated schools and the construction of 1,345 new junior secondary schools and 32,921 new classrooms in existing junior secondary schools. MONE and MORA have further expanded the number of integrated schools by rehabilitating and/or building new schools and classrooms in 70 priority districts. Under SP2, MONE prepared a participatory school mapping in 70 priority districts with low net enrollment rates to better understand and respond to demand-side issues.[21] While data on travel distance to schools is unavailable, gross enrolment in secondary schools increased from 69.7 % in 2008 to 79.2 % in 2010 and 82.5 % in 2015, suggesting improved access to education.

21. **Improved O&M support for smaller and remote schools.** This policy outcome has been achieved. The BOS program was introduced in 2005 and expanded in subsequent years. It provides funds to cover school O&M through block grants to schools based on student head counts. The BOS program needed to be better adapted to small, remote schools and those with many poor students. Under SP2, BAPPENAS, MONE, and MORA conducted a comprehensive review of the allocation, financing, and implementation policies of BOS and revised the operations manual twice. The 2006 revisions improved the focus on poor students and fostered transparency. The 2007 revisions stressed the role of parents and the community in oversight and requirements for record-keeping and documentation.

22. **Increased affordability of education by poor students and/or households.** This policy action has been achieved. In 2006, transition scholarships were introduced to improve net enrolment rates in junior secondary schools and to help poor primary school graduates meet the costs of entering junior secondary school. About 147,000 poor students initially received scholarships in 2006 and the number increased in the following years. In 2008, 623,885 poor students received scholarships from MONE or MORA to attend junior secondary schools. The average allocation for each MONE scholarship recipient was Rp720,000 per student per year, which is in line with the average costs of education as estimated by the National Socio-Economic Survey (Susenas) in 2006. In 2009, the government allocated 0.8% of the national education expenditure to scholarships for the poor.[22] In nominal terms, the allocation of funds for scholarships more than doubled from around Rp700 billion in 2008 to Rp1.6 trillion in 2009.

23. **Enhanced quality and equitable deployment of teachers.** This policy action has been achieved. In 2005, Parliament approved Law 14/2005 on Teachers and Educational Personnel. It reflects improvements in teacher deployment, qualification, competency, and professional

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[21] Ministry of National Education. 2014. *Achievement of the Indonesian Safe School Implementation.* Jakarta. The participatory school mapping was based on a pilot GIS-based school mapping undertaken in six provinces in Java. It was used by MONE and MORA to target individuals and school infrastructure investment in remote and underserved areas. The school mapping was also utilized to identify 75% of schools located in potential disaster risk areas in 2011 as part of the government initiative for school disaster management.

[22] Of this amount, 62% was allocated to regular school students with the remainder allocated to *Madrasah* students. Madrasahs are schools managed by Ministry of Religious Affairs and these provide additional religious subjects in addition to general subjects.

status. The law created a "certification" mechanism to ensure teachers' professional competency level. It was the government's intention that by 2015, Indonesia's school system would only allow certified teachers to teach.[23] With the support of the TA, MONE and MORA have further promoted professional development and developed incentives for the deployment of basic education teachers in underserved areas.[24]

24. **Education service delivery that meets the minimum services standards.** This policy action was achieved. The government has established a National Standards Development Agency, Badan Standar Nasional Pendidikan (BSNP), which develops educational standards. BSNP developed legislation on "Standards on Content" (Regulation No 22/2006), and "Standards on Competence" (Regulation No 22/2006). Through these regulations, BSNP established eight national standards of education and formulated an indicator framework for assessing teacher performance. A set of MSSs has been approved (27 service indicators, of which 14 refer to schools and 13 to the districts).

25. **Improved planning and implementation of education services.** This policy action was achieved. MONE and MORA completed a joint plan for the achievement of 9-year basic education, the Grand Design for Basic Education, 2006–2009,[25] in 2006. MONE, MORA, and BAPPENAS prepared an assessment of the performance of the basic education sector, including its progress towards achieving the MDGs. This assessment was used as an input in the preparation of RPJMN, 2010–2014.[26]

26. **Greater transparency of education outcomes to enhance accountability.** This policy outcome was achieved. In 2009, Bogor Agricultural University, PRMAP-ADB-BAPPENAS conducted a Parent Satisfaction Survey (PSS), which evaluated parents' satisfaction with the access to and the quality of basic education services in Indramayu, West Java.[27]The policy action also aimed to increase the share of women participating in school committees and district education boards. In 2009, the Directorate General for Primary and Secondary Education Management of MONE signed a circular letter requiring that at least 40% of the members of district education boards and school committees be women. Indonesia improved its ranking in the Transparency International Corruption Index, measuring perceived levels of public sector corruption, from 126 in 2008 to 100 in 2010 and 88 in 2015.

3. Policy Reforms in the Health Sector for Millennium Development Goals' Acceleration

27. The PRMAP was intended to support the government's reform agenda, which sought to expand and improve the equity and quality of MDG-related health services for the poor, by improving (i) public financing for MDG-related health programs, (ii) targeting of public health

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[23] World Bank. 2010. *Transforming Indonesia's Teaching Force,* Vol.1 Executive Summary, p. 8. Washington, DC.

[24] ADB, AusAID and BAPPENAS. 2009. *Technical Assistance to Indonesia for Strengthening Social Service Delivery for Poverty Reduction and Millennium Development Goals Acceleration Program* (TA 4984-INO): Final Report. "Based on this Law 14/2005 on Teachers and Education Personnel, MONE and MORA have initiated implementation of programs for professional development and incentives for deployment of formal basic education teachers in underserved areas."

[25] Ministry of National Education. 2006. *Grand Design for Achieving Universal Compulsory 9-Year Basic Education 2006–2009.* Jakarta

[26] Footnote 19. The government approved RPJMN, 2010–2014 with its focus on the provision of good quality basic education services for boys and girls in underserved areas.

[27] Government of Indonesia. BAPPENAS and Bogor Agricultural University. 2009. *Executive Summary: Parent Satisfaction Survey of Basic Education Services Provided by the Decentralized School Systems*. Jakarta. The PSS included parents of students from the government's decentralized basic education system, elementary schools and junior secondary schools grades 6 and 9, principals, and school committee members.

financing for the poor, (iii) effectiveness of maternal neonatal and child health (MNCH) and reproductive health service delivery by influencing provider behavior, (iv) effectiveness of communicable disease control (CDC) through integrated programs, (v) monitoring of MDG-related health performance, and (vi) information with regard to MDG-related health expenditures.

28. **Increase public financing for MDG-related health programs.** This policy action was partially achieved. Between 2005 and 2007, MOH increased its budget allocation for MDG-related health programs by more than 50%. While these increased budget allocations were supposed to be sustained under SP2, fiscal constraints relating to a major increase in the price of petroleum in 2007/2008 did not allow increases similar to those in 2005–2007. Hence, while real budget allocations per capita for MNCH/CDC programs in 2007 increased by 16% compared to 2006, real per capita budget allocation decreased by 19% in 2008. Allocations then increased marginally (by 0.5%) between 2008 and 2009. It was therefore assessed that the program was partially able to meet the targets of yearly budget increase from 2007 to 2011.

29. **Improve targeting of public health financing for the poor.** This policy action was achieved through the introduction of ASKESKIN in 2005 to provide free health services to eligible poor and user-based analyses.[28] Health insurance coverage among the poor largely increased from 21.6% in 2005 to 40.8% in 2011. ASKESKIN seems to have had a positive though small effect on utilization: ASKESKIN coverage increased utilization of public care for the poorest quartile by 0.043–0.05 visits per month.[29] The program also led to a decline in out of pocket[30] and catastrophic payments.[31]

30. **Improve effectiveness of maternal neonatal and child health and reproductive health service delivery by influencing provider behavior**. In May 2006, the government modified recruitment and contracting of temporary doctors and midwives by adding financial incentives to attract them to remote areas. It also introduced incentives to attract health providers to poor and remote areas.[32] Available data for poor/remote areas indicate a steady increase in service coverage, including for women. The data indicates a shift from the use of traditional birth attendants to skilled midwives (140 midwives per 100,000 population exceeded the target value of 30), an increase in antenatal care contacts, and a decrease in the number of malaria cases and incidence of tuberculosis (TB), indicating the positive effects of increased utilization of health service since 2007. Further, absenteeism of health workers was reduced by 40% since 2006.

31. **Improve effectiveness of communicable disease control through integrated programs.** The TB treatment rate at 88% surpassed its target of 85%, but the TB detection rate at 73% remains below its target value of 80%. The goal of reaching 80% of the HIV/AIDS risk population with prevention programs could not be attained, leading to a partial achievement of this policy outcome. Still, among those living with HIV, the share covered by antiretroviral therapy increased from 2% in 2007 to 5% in 2011 and 9% in 2015. The government has developed comprehensive strategies for CDC (especially for HIV/AIDS, malaria, and TB), including an elaboration of the roles and responsibilities of various ministries, and mechanisms for coordination

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[28] ASKESKIN was subsequently renamed Jamkesmas and expanded to also cover the near-poor.

[29] R. Sparrow et al. 2010. Social Health Insurance for the Poor: Targeting and Impact of Indonesia's Askeskin Program. *HEFPA Working Paper 1*. Jakarta: The SMERU Research Institute.

[30] Out of pocket payments for the poorest quintile decreased from 5.17% of non-food expenditures in 2005 to 4.43% in 2006. Without ASKESKIN / Jamkesmas, poorest households would be expected to have the highest out-of-pocket costs as a share of total expenditure. (Sparrow et al. 2010).

[31] The program further lead to a decline in catastrophic payments from 0.58% in 2005 for the poorest quintile to 0.44% in 2006 (Sparrow et al. 2010).

[32] Provider payment mechanisms introduced through ASKESKIN were abolished as a compulsory scheme in 2007.

of efforts across ministries. The National AIDS Commission has finalized the national strategy for HIV/AIDS mitigation for 2008 to 2012. The national strategy has been approved by the MOH (Strategic Plan for HIV/AIDS Mitigation in Indonesia, 2008–2012). MOH has since published the National HIV and AIDS Strategy and Action Plan, 2010–2014 as a continuation and improvement of the previous strategy.[33]

32. **Improve monitoring of Millennium Development Goals-related health performance.** This policy action has been achieved. MOH has prepared a revised list of district MSSs and indicators. The list contains eight types of MSSs with 28 indicators. Key criteria in developing the revised list of indicators included the need to monitor local government progress and performance in achieving the MDGs. Of the 28 indicators, 10 refer directly to MNCH services, while others monitor CDC-related aspects, such as TB detection rates, cases of diarrhea treated, or the number of villages in the district that receive timely disease outbreaks response. This initial list has been revised to include all health-related MDGs in the MSSs and to define the roles and responsibilities of the central and local governments related to the MSSs.[34]

33. **Improve information about Millennium Development Goals-related health expenditure.** This policy outcome has been achieved as targeted since national health accounts (NHA) have been institutionalized and produced twice. A Public Expenditure Review was conducted in 2007 by BAPPENAS and Ministry of Finance (MOF) with the support of the World Bank. The review did not include detailed information on public sector health expenditures by program, as this information was not readily available. This lack of information was addressed under SP2. In 2007, with assistance from the World Health Organization, a new NHA team was set up to revisit the NHAs of 2002–2004 and prepare future NHA. The team produced a full set of NHA estimates for 2002–2004 and for 2005–2009.

C. Program Costs

34. The PRMAP was a single tranche loan of $400 million from ADB's ordinary capital resources. Disbursement of the loan followed the procedures and related requirements for a program loan. ADB also provided a piggy backed technical assistance grant (TA4984-INO) of $1.5 million to assist the implementation of subsequent SP2 of the PRMAP.[35]

D. Disbursements

35. The program loan of $400 million for the SP1 was disbursed in December 2007 in a single tranche upon loan effectiveness to the Borrower in accordance with the provisions of ADB's *Loan Disbursement Handbook* (2015). The loan proceeds were used to finance the full foreign exchange costs (excluding local duties and taxes) of items produced and procured in ADB member countries, excluding the items specified in the list of ineligible items and imports financed by other donors.[36]

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[33] Government of Indonesia, Ministry of Health. 2010. *National HIV and AIDS Strategy and Action Plan, 2010–2014.* Jakarta. The 2010–2014 plan contains a comprehensive set of strategies, prioritized activities and analyses of the costs and available sources of financing for the MOH component of the government's response to the HIV/AIDS epidemic.

[34] Law (UU) No. 23 of 2014 stresses the central government's responsibility for setting standards to be used by local governments (provincial and district/city) in delivering basic health services. The health MSSs regulate the quality of regional planning and budgeting processes, and the implementation techniques and financing mechanisms.

[35] ADB. 2007. *Strengthening Social Service Delivery for the Poverty Reduction and Millennium Development Goals Acceleration Program.* Manila.

[36] No supporting import documentation was required, if the value of Indonesia's total imports minus imports from nonmember countries, ineligible imports, and imports financed under other official development assistance was

E. Program Schedule

36. The period specified for the loan was 7 December 2007 to 31 March 2008, with a single tranche loan of $400 million to be disbursed when the government had met the conditions for loan effectiveness. Disbursement occurred on 10 December 2007 and the loan was closed on 31 March 2008, as planned.

F. Implementation Arrangements

37. A program steering committee and a program technical committee were established to oversee implementation of the program cluster as designed at appraisal stage. The Deputy Minister for Human Resources and Cultural Affairs, BAPPENAS, chaired both committees, which included representatives from all relevant ministries and agencies (MOF, MOH, MONE, MORA, MOWE, MOHA, and BPS) with responsibilities related to the MDGs. BAPPENAS was the executing agency for coordinating the implementation of the PRMAP and established an executive secretariat. MONE and MOH were the implementing agencies and established sectoral technical committees and secretariats for the education and health sectors.

G. Conditions and Covenants

38. All 17 loan covenants were complied with and compliance with these covenants was *satisfactory.* The status of compliance with loan covenants is specified in Appendix 3.

H. Related Technical Assistance

39. ADB implemented piggy backed technical assistance (TA 4984-INO)[37] between January 2008 and January 2010 to assist key line ministries BAPPENAS, MONE, MORA, and MOH in supporting the government to achieve policy actions under SP2. The performance of consultants, contractors, and suppliers financed through the TA is rated *satisfactory*. The consultants worked closely with the executing agency, project implementation units, and ADB and played a key role in ensuring the accomplishment of most of the policy actions, and that all reports were submitted timely. The consultancy outputs were produced efficiently and were highly effective in assisting the government to achieve most of the policy actions (17 out of 20 fully achieved and 3 partially achieved). Based on the outputs produced, the TA was rated successful in the TA completion report (Appendix 6).

I. Consultant Recruitment and Procurement

40. There was no procurement and consultant recruitment under this loan, given that loan proceeds were released on a single tranche. Consultants were hired using QCBS method for capacity building activities under TA 4984-INO, which was associated with the loan (Appendix 6).

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equal to or greater than the amount of the loan disbursed during the given year. The PRMAP provided for retroactive financing for expenditures incurred by the government 180 days prior to loan effectiveness. The government certified its compliance with this formula with its withdrawal request.

[37] ADB. 2007. *Technical Assistance to Indonesia for Strengthening Social Service Delivery for the Poverty Reduction and Millennium Development Goals Acceleration Program*. Manila. The associated TA focused on the implementation of national policy reforms in the health and education sectors, and on improving efficiency of public spending on health and education targeting women and economically disadvantaged population in remote areas. The TCR for TA4984 was circulated on 10 May 2011 (IN.66-11).

J. Performance of the Borrower and the Executing Agency

41. Overall, the performance of the government and its agencies involved in the program is rated *satisfactory*. The government's coordinating committee, chaired by the representative from BAPPENAS, effectively coordinated with ministries and the Australian development partner the monitoring and reporting of the achievements of the policy actions under SP1 before and after loan effectiveness. The performance of the ministries of health and education was also *satisfactory*. BAPPENAS institutional capacity was rather limited initially, but improved through the TA and, subsequently, became sufficient to achieve the goals of the program. The borrower worked hard at meeting the loan effectiveness requirements and all policy actions under SP1 were achieved prior to appraisal. The borrower provided high-level support during the preparation missions and complied with all loan covenants under SP1. The staff of line ministries monitored and communicated the status of achievements to ADB.

K. Performance of the Asian Development Bank

42. ADB's performance in processing and implementing the loan is rated *satisfactory*. ADB fielded five missions during a period of 12 months for the preparation of the program and policy discussions to support the implementation of SP1. The program was delegated to Indonesia Resident Mission in 2009. The project preparatory technical assistance provided for SP2 was appropriate and effective. A small team of ADB staff involving the mission leader and education, health, and gender specialists processed the loan in about 12 months. The education component strongly benefitted from an ADB education specialist based at IRM during program preparation and implementation. ADB processed the loan and disbursed the loan immediately after effectiveness in December 2007. ADB also actively participated in quarterly monitoring meetings with government counterparts and development partners.

III. EVALUATION OF PERFORMANCE

A. Relevance

43. The PRMAP was assessed as *relevant.* The program was relevant with respect to ADB's country strategy for Indonesia, and the government's national development plan to accelerate its MDGs on poverty, education, health, and gender equality. Overall, the design of the PRMAP was relevant in terms of modality, implementation arrangement, and most of the policy actions.

44. The TA provided was *relevant* in supporting the policy actions. All policy actions under SP1 and 17 out of 20 SP2 policy actions were achieved with the support of the TA.

45. ADB and the Government of Australia, who provided an additional grant of $1 million for the TA, continued supporting the policy reforms. The Government of Indonesia maintained a strong commitment to the program and decided to allocate its own budget to its implementation. The government requested ADB not proceed with processing the second SP loan in May 2009. Hence, while the loan supporting SP1 was highly relevant at appraisal, given the achievement of all policy actions under SP1 and most of SP2 actions plus some SP3 actions, proceeding to the subsequent loan to support the second and third subprograms became less relevant as most policy actions were already achieved. Although this change altered the original PRMAP cluster loan, at completion, the program's content remained aligned with the context of the ADB's CSP and the government's national plan.

B. Effectiveness in Achieving Outcome

46. The program is rated *effective*. The PRMAP focused on the three principal policy areas: cross-sector policy reforms, national policy reforms in the education sector, and national policy reforms in the health sector. Policy actions under SP1 directly contributed to achieving most of the intended outcome and output indicators. The program increased the national budget for education to 3.4% of GDP and the national budget for health to 1.1% of GDP in 2012 from a baseline of 2.7% for education and 0.9% for health in 2004. It established a uniform system for targeting the poor that increased their access to health and education. Utilization of public health services by the poor increased by 54%. Net enrolment of the poor in junior secondary education increased by 18% between 2008 and 2010, met its target of 65% in 2011, and showed further improvements in subsequent years. At 91.5%, the share of birth attended by skilled personnel in 2015 surpassed the target value of 85% and is an improvement from the baseline value of 72% in 2005. The female illiteracy rate decreased by 35% compared to a target value of a 30% decrease. Indicators show a large improvement in access to health and education by the poor and women.

47. Output indicators for national policy reforms in the education sector were achieved. Annual surveys on parents' satisfaction with basic education services were conducted from 2009 onwards and circular letter was issued to ensure that school boards consist of at least 40% of women (footnote 26). In primary school, 35% of teachers and a larger share of secondary school teachers have four-year degrees, though the target of an additional 10,000 teachers working in remote areas could only be half achieved. The government reviewed the scholarship program for the poor to improve targeting, leading to 42% of poor eligible students receiving a scholarship in 2009; this improved to 62% in 2014. Output indicators for national policy reforms in the health sector were mostly achieved: absenteeism of health workers decreased and NHAs have been institutionalized and updated at least twice. The program was only partly able to achieve its targets for diseases: the TB detection rate remains below target, but the TB treatment rate surpassed its target. HIV/AIDS prevention programs were not able to reach risk populations sufficiently but managed to reach already affected populations. Having met most of the targets of output and outcome indicators, the program achieved its intended outcome.

48. The PRMAP is unlikely to have an adverse environmental impact. Social criteria were considered explicitly through gender-based indicators. Adverse effects on ethnic groups or material risk seemed unlikely. The increased transparency and accountability of the ASKESKIN program through program reports, a relatively well-managed government budget, and strong commitment of the government to the MDGs mitigated risks identified at appraisal.

C. Efficiency in Achieving Outcome and Outputs

49. The program is rated *efficient* in achieving its objective and scope, as it was efficiently managed by BAPPENAS, other key ministries, and ADB. Executing and implementing agencies ensured the full achievement of all policy actions under SP1 prior to the Board's loan approval. The preparation and implementation of SP1 was cost-effective, done by ADB staff and a few staff consultants. The TA also provided efficient support for SP2. The TA implementation period was extended by 5 months due to the additional support requested by the government. Initially, the program was meant to support 10 policy actions only; with the extension, it supported the accomplishment of all 20 policy actions. This program is a single tranche loan. The fiduciary risk

assessment[38] indicated that sound regulatory framework was in place and that the government continued efforts to improve fiscal transparency and financial management capacity. Furthermore, the government's significant budget allocation for the education and health sectors sustained the overall objectives and targeted outcomes as supported by the PRMPAP program.

D. Preliminary Assessment of Sustainability

50. The sustainability of the PRMAP is rated as *likely sustainable*. The sustainability of the program depends largely on the continued political and financial commitment from all levels of government to poverty alleviation and equal access to education and health services. This commitment is illustrated by continued and extensive reforms in education and health such as the teacher reform which was initiated by the Law 14/2005 on Teachers and Education Personnel and the introduction of a compulsory national health insurance system in 2014 to further improve health care for those too poor to afford private care but not poor enough is to be considered under ASKESKIN. Social sector spending as part of total government expenditure has increased continuously since 2010. Health expenditure as a percentage of government expenditure increased from 4.5% in 2001 to 5.7% in 2014. Education expenditure as a percentage of government spending increased from 11.6% to 17.6% over the same period.

51. The institutionalization of policy actions supported by the program is another key factor that determines sustainability. PRMAP included policy actions that were institutionalized and embedded in education and health. The introduction of a uniform system for identifying and targeting the poor has been used to improve targeting of educational scholarships to the poor. The sustainability of educational outcomes is fostered through targeting remote areas via junior secondary school scholarships for poor students. In 2009, 42% of students from the poorest households received a scholarship increasing to 62% in 2014. The quality of education remains in the spotlight through Law 14/2005 on Teachers and Educational Personnel, introducing a certification mechanism to address teachers' professional competency levels. A 4-year training course for primary school teachers, a requirement for the new certification, is a good first step towards a comprehensive teacher reform to improve the quality of education.[39] The establishment of a BSNP is likely to lead to improved standards of education.

52. Improvements in health are likely to be sustained through the follow-up of the ASKESKIN program targeting primary, secondary, and tertiary care to poor beneficiaries. Since 2014, the Government of Indonesia has integrated ASKESKIN's follow-up program into a new, single-payer, universal health care program,[40] demonstrating the government's long-term vision to provide health care to the poor and near poor. Minimum service standards for basic health services help ensure the provision of quality health care at a national standard.[41] The government has

[38] ADB. 2012. RRP: *Proposed Programmatic Approach, Policy-Based Loan for Subprogram 1, and Technical Assistance Grant, Inclusive Growth through Improved Connectivity Program*. Manila

[39] While the certification program proved to be a good first step in the direction of comprehensive teacher reform, no significant differences could be found between certified and uncertified primary school teachers in terms of student learning outcomes or teacher competences. (Chang et al. 2014).

[40] Changing service provider mechanism from fee-for-service to a single payment scheme improves the efficiency of the health system and the quality of the care, further addressing service providers' incentives focusing more on quality of health care not quantity of service deliveries at hospitals. While the Jamkesmas benefit package is standardized at the national level, districts can set the reimbursement rates for various services based on local conditions. Though the scheme initially utilized a fee-for-service reimbursement mechanism Jamkesmas began transitioning to a Diagnosis Related Group provider payment system in 2009.

[41] M. Roudo and T. Chalil. 2016. Depolarization in Delivering Public Services? Impacts of Minimum Service Standards (MSS) on the Quality of Health Services in Indonesia. Journal of Regional and City Planning. 27 (1). pp. 1–15. Minimum service standards (MSS) are output targets covering a minimum quality of basic public services set by the

developed and produced national accounts annually to ensure solid financial information on health expenditures is available to support a better allocation of resources.

E. Impact

53. The development impacts are rated *satisfactory*. The program is likely to have a positive impact on accelerating progress towards the targets in education and health set out by the MDGs and contributing to poverty reduction and gender equality. Education outcomes improved over the program period from 2007 to 2011. Enrolment in primary education was near universal in 2015 and enrolment in lower secondary education increased significantly from 41.9% in 1992, which is the MDG baseline, to 77.8% in 2015. Still, access to lower secondary education needs continued attention. The program also had a positive impact on improving health outcomes, particularly regarding maternal health; it had less of an impact on communicable diseases.

54. The program was categorized with a gender equity theme. PRMAP achieved its targeted gender equity dimensions targeted: gender mainstreaming was institutionalized in the education and health ministries and gender inequalities in health and education reduced substantially. Female illiteracy reduced by 35% and maternal health improved as indicated by 91.5% of births being attended by skilled health staff compared to the baseline value of 72%. Women perform equally well or better in accessing and completing primary and secondary education and female infants are less likely to suffer from underweight or stunting than male infants.

55. PRMAP also contributed to poverty reduction, with poverty rates decreasing from 17.8% of Indonesians living below the national poverty line in 2006 to 11.0% in 2014. More importantly, the poverty gap between urban and rural areas shrank between 2006 and 2014 (from 8.3% in 2006 to 5.6% in 2014) due to a reduction in rural poverty. As the gender gaps in access to education and health narrowed, and poverty in rural and urban areas decreased, it is possible to conclude that the program had a positive impact on inclusive growth benefitting all individuals, including marginalized populations such as female and people in rural areas.

IV. OVERALL ASSESSMENT AND RECOMMENDATIONS

A. Overall Assessment

56. Overall, the program is rated *successful*. While the program was highly relevant in the design stage and at completion, it is therefore rated as *relevant* overall because of weaknesses in some outcome and output indicators. Modality, implementation arrangement, and policy reform actions were appropriate. The program's design was in line with ADB's health and education sector policies, ADB's operational plan and country planning, and the government's development plan. The loan was *effective* since it achieved its objectives in its three key policy areas. Given the limitations of national gender data, it is noteworthy that the program exceeded the set targets on health and education in addition to addressing gender issues. The program was rated *efficient.* The program preparation, appraisal, negotiation, and disbursement of the first tranche were

national government that should be fulfilled across districts. By setting nationwide standards, MSS make local authorities accountable to local population and government and the national government in delivering services. MSS aim to improve the quality of services delivered through this strong accountability mechanism. Roudo and Chalil (2016) evaluate the introduction of health services MSS in Indonesia on the quality of health service delivery for 54 local governments. The quality of service delivery is estimated through self-reported achievement rates of targets laid out in the MSS. Using a composite index of 14 core indicators laid out in the MSS, the authors show that the quality of health service delivery improved from 2010 to 2013, the period following the introduction of health MSS in 2009.

smooth and timely. All policy actions under SP1 were achieved before the loan became effective and, with the TA support, most SP2 and some SP3 actions, which were originally scheduled to be achieved under subsequent SP loans, were also achieved. The cluster program was well managed by the executing agency, BAPPENAS. The program outcome is *likely* sustainable due to the government's continued strong commitment to the MDGs, which are included in the government's long-term development plans, and due to the program's institutionalization of several policy actions that sustain its progress up until now.

B. Lessons

57. PRMAP's design had the commendable goal to accelerate the achievement of several MDGs. The well-conceived and structured TA associated with the program addressed the obstacles presented by system inefficiencies and limited capacity. A remaining challenge is to establish more effective planning, monitoring and evaluation systems to ensure that policies and programs work effectively at the local/community level. It is crucial to ensure that output and outcome indicators have a well-defined baseline value and that follow-up data collections occur. More in-depth consultations at the sub-national level during the design and preparation stages could have been helpful in designing the most appropriate indicators. The program's success depended largely on accurate implementation, including the collection of appropriate data, adequate human resources, the capacity of local government, defining the appropriate indicators, and setting the right incentives for local authorities to achieve the indicators defined. Further development of all these steps will also support the improved implementation of MSS.

C. Recommendations

1. Program Related

58. While access to health insurance among the poor has increased, a recent study concluded that the program's targeting system was weak.[42] In 2010, only 47.6% of the holders of the health card for the poor were considered poor, hence, more than half of the program participants were non-poor. The targeting system could be strengthened utilizing proxy means testing to reduce exclusion and inclusion errors. Further, achieving the SDGs would require mapping targets against the national medium-term plan and setting up the institutional structures to support implementation, monitoring and reporting. The monitoring mechanism should be institutionalized at the national and provincial levels of government. The government should carry out a budget costing to estimate what resources the line ministries will require to implement SDGs. The result of this analysis should guide the government's decision in aligning medium-term expenditure with the national medium-term development plan (RPJMN) and SDG targets.

2. General

59. The current general format for project and program evaluation and review is not conducive to the proper evaluation of single-tranche macroeconomic policy reform programs. As all program policy conditions were achieved prior to the Board's approval and the reform agenda spanned the medium term, it would have been more appropriate to (i) examine program performance in the context of a multiyear and multi-program review, (ii) review broader program outcomes as affecting changes in socio-economic trends over the medium term, and (iii) develop more systematized donor coordination mechanisms in Indonesia.

[42] Haritmurti et al. (2013). *The Nuts & Bolts of Jamkesmas, Indonesia's Government-Financed Health Coverage Program for the Poor and Near-Poor*. UNICO Studies Series 8. Washington, DC: The World Bank.

UPDATED PROGRAM DESIGN AND MONITORING FRAMEWORK

Design Summary	Performance Targets/Indicators	Achievement	Data Source
Impact To accelerate progress towards achieving the MDGs in education (MDG 2), and health (MDG 4–6) and contribute to poverty reduction (MDG 1), and gender equality (MDG 3)	By 2015, have attained the following progress towards the MDG targets:		
	• Proportion of population below the national poverty line: 7.6%	Headcount at national poverty line was 11.0% in 2014[a]	Central Board of Statistics (BPS) data
	• Net enrolment ratio of 95% in primary education and 80% in junior secondary	Net enrolment in primary in 2015: 96.7%. Net enrolment in junior secondary: 77.8%[b]	Central Board of Statistics (BPS) data
	• Ratio of girls to boys in basic education: 100%	Gender parity index in primary gross enrollment increased from 0.972 in 2000 to 1.038 in 2011[a]	WDI
	• Under-5 mortality rate per 1000 births: 32	Under-5 mortality rate per 1000 births: 27.2 in 2015[a]	WDI
	• Maternal mortality rate per 100,000 live births: 102 (baseline: 313 in 2012 [national estimate])	Maternal mortality rate per 100,000 live births: the modeled estimate for 2015 is 126[a]	WDI
	• Malaria prevalence rate per 100,000 people: less than 1000 (baseline: 1850 in 2010[c])	Notified cases of malaria per 100,000 people: 1850 in 2010[c]	BAPPENAS
	• HIV prevalence among pregnant women: less than 0.04% (baseline: 2.5% in 2011[d])	HIV prevalence among pregnant women:	National Aids Commission
	• Tuberculosis prevalence rate per 100,000 people: less than 200	Tuberculosis prevalence rate per 100,000 people in 2015: 395 (95% UI: 255–564)[e]	WHO
Outcome Improved access, equity, and quality of service delivery in the education and health sectors to accelerate progress toward the MDGs	By 2012: • Proportion of births attended by skilled health personnel increased from 72% to 85%	**Achieved.** 91.51% of birth attended by skilled personnel in 2015.[a]	WDI
	• Difference in per capita expenditure for health and education between the poorest and the richest quintile	No baseline data. Unable to utilize this indicator.	

Design Summary	Performance Targets/Indicators	Achievement	Data Source
	of districts reduced by 10% • Proportion of funds from education and health programs reaching the poor increased by 20% • Gross secondary enrolment ratio increased. **New Indicator** • Female illiteracy rate reduced by 30% • Utilization of public health services by the poor increased by 30% • Net enrolment ratio of poor in junior secondary increased from 50% to 65%	No baseline data. Unable to utilize this indicator. **Achieved.** Gross secondary enrollment ratio increased from 69.7 in 2008 to 79.2% in 2011. **Achieved.** Female illiteracy decreased by 35% from 2009 to 2015 (9.2% in 2009 to 5.95% in 2015).[b] **Achieved.** ASKESKIN coverage increased utilization of public health service for the poorest quartile from 0.0787 visits per month in 2005 to 0.1217–0.1287 visits per month in 2006, hence an increase of at least 54%.[f] **Achieved.** Net enrolment ratio of poor in junior secondary was 65% in 2012 and 66% in 2013.[g]	World Bank, 2014 (Policy brief 89221)
Outputs **I. Cross-sector policy reforms** 1. Increased budget allocation for health and education, especially focused on MDG-related programs. (MDGs 1-6)	By 2011 • National budget for education is at least 3.9% of GDP and for health 1.1% of GDP. Levels of expenditure per student under BOS and per poor person under ASKESKIN are equal to or greater the level in 2006	**Achieved.** Education budget as a share of GDP in 2013: 3.4% (Not achieved). Health budget as share of GDP in 2012: 1.1% (Achieved)[a] Per student allocations for BOS increased by 57% between 2007 and 2009.[b]	WDI/BPS
2. Improved performance incentives and geographical resource allocation to districts for education and health. (MDGs 1–6)	• At least 20% of DAK[h] funds for education and health are allocated based on performance	Not confirmed by BAPPENAS.	BAPPENAS
3. Uniform system for targeting the poor for achieving the MDGs in health and education established. (MDGs 1–5)	• A uniform database of the poor is established and utilized by MONE, MORA and MOH (at least one program each)	**Achieved.** In 2008 the BPS compiled a national, survey-based database identifying 17,483,989 very poor, poor and near-poor households. The survey, known as the Pendataan Program	BPS

Design Summary	Performance Targets/Indicators	Achievement	Data Source
		Perlindungan Sosialis, is being used as a tool to improve targeting and administration of social protection, poverty reduction, health support for the poor for the poor and educational scholarship programs.[i]	
4. Gender equity in access to health and education services achieved (MDGs 1–6)	• At least four health and education sex-disaggregated indicators collected in 30% of districts	**Achieved.** List of health and education sex-disaggregated indicators collected in all 34 provinces and published on the BPS website: Life expectancy, Population with health complaints (Health); Net enrolment, Educational attainment, Literacy (Education).	BPS
5. Planning framework for MDG acceleration established (MDGs 1–6)	• MDGs included in the medium-term plans of 20 districts and five provinces, and the medium-term plans of MOH, MONE and MORA	**Achieved.** The Government of Indonesia has mainstreamed the MDGs in the National Long-Term Development Plan (RPJPN), 2005–2025), the National Medium-Term Development Plans (RPJMN), 2004–2009 and 2010–2014, and the National Annual Development Plans (RKP) for all districts and provinces, as well as documents of the State Budget (APBN).[i]	BAPPENAS, 2013
II. National policy reform in the education sector 1.Improved access to junior secondary schools in under-served areas (MDGs 1–3)	• Average distance to junior secondary schools reduced in 70 selected districts • Gross enrolment in secondary schools among poor increased. **New Indicator**	This data was not collected. **Achieved.** Gross enrolment in secondary schools increased from 69.7 % in 2008 to 79.2 in 2010 and 82.5 % in 2015**.**	WDI World Bank, 2014 (Policy brief 89221) MONE
2. Improved O&M support for smaller/remote schools (MDGs 2, 3)	• At least 50% of small and remote schools received funds for O&M to comply with MSSs, and poor students attending them do not pay fees	Unable to be confirmed by BAPPENAS/MONE.	
3. Increased affordability of education by poor	• At least 40% of the eligible poor receive scholarships for junior secondary education	**Achieved.** 42% of students from the poorest 25% of the population received a BSM scholarship in 2009 (62% in 2014).[k]	MONE

Design Summary	Performance Targets/Indicators	Achievement	Data Source
students/households (MDGs 1–3)	and 70% of scholarships go to the poor		
4. Enhanced quality and equitable deployment of teachers (MDGs 2, 3)	• At least 30% of teachers are qualified, and about 10,000 additional teachers per year are working in remote areas	**Partially Achieved.** In 2011, 35% of primary school teachers had a four-year degree. The share is much higher among teachers of lower and upper secondary.[1] A program for graduate teachers to work in remote areas was introduced in [insert year]. Currently, about 5,000 teachers are participating in this program. [1]	MONE and MORA data
5. Education service delivery meets MSSs (MDG 2)	• At least 10 districts implement the MSSs established by MONE	Not confirmed by MONE.	
6. Improved planning and implementation of education services (MDGs 2, 3)	• At least 20 of districts prepared joint plans for MONE and MORA schools	**Achieved.** A jointly-planned framework for MDG acceleration has been included in the development plans of 20 districts, five provinces and MOH, MONE, and MORA.	MONE and MORA data
7. Greater transparency of education outcomes to enhance accountability (MDGs 2, 3)	• Annual surveys on parents' satisfaction with basic education services are institutionalized	**Achieved.** Annual surveys on parents' satisfaction with education services were conducted. An example is the Parent Satisfaction Survey conducted in Indramayu, West Java, by the Institute Pertanian Bogor.	Annual surveys on parents' satisfaction
	• Inspector general audit report includes analyzed cases on corruption	Not confirmed by BAPPENAS.	
	• Corruption Index measuring the perceived level of public sector corruption reduced. **New indicator**	**Achieved.** Corruption Index measuring the perceived level of public sector corruption reduced from rank 126 in 2008 to rank 100 in 2010 and rank 88 in 2015.	Transparency International
	• At least 40% of school board members are women in 100 surveyed schools	**Achieved.** MONE issued a circular letter providing a guideline to local district governments requiring that 40% of the members of district education boards and school committees should be women. The letter was signed by the Directorate General for Primary and Secondary Education Management (DGPSEM) of MONE on 2 July 2009.	MONE
III. National policy reform in the health			

Design Summary	Performance Targets/Indicators	Achievement	Data Source
sector			
1. Increased central budget for MDG-related health programs (MDGs 4–6)	• MOH has increased budget allocation for maternal neonatal and child health care and CDC yearly from 2007 to 2011	Not confirmed by BAPPENAS. The new indicator below was created as a proxy for this indicator.	MOH
	• Share of pregnant women receiving prenatal care increased. **New Indicator** (baseline: 93.3% in 2008)	**Achieved.** The share of pregnant women receiving prenatal care increased to 95.4% in 2013.	WDI
2. Improved targeting of public financing for health services for the poor (MDGs 1, 4–6)	• At least 40% of the poor have health cards (baseline: 21.6% in 2005)	**Achieved.** 40.8 % of the poor had health cards in 2011.	Harimurti et al. 2013
	• 60% of benefits from ASKESKIN go to the poor		
3. Improved effectiveness of MNCH and reproductive health service delivery through provider behavior (MDGs 4–6)	• Absenteeism of health personnel from community health centers reduced (baseline: 40% in 2006[m])	**Achieved.** Overall Absenteeism in community health centers is 23.4% in [year]: 26.5% of doctors, 22.8% of midwives and 23.2% of paramedics.	Journal of Public Health, 2015
	• all provinces have at least 30 midwives per 100,000 population	**Achieved**. Midwives per 100,000 population: 140 in 2012.	
4. Improved effectiveness of CDC through integrated programs (MDGs 3–6)	• TB detection rate of 80% and treatment success rate of 85%	**Partially Achieved.** TB detection rate in 2009: 73.1%, TB treatment rate in 2013: 88%.[h]	WHO, 2015 Global TB Report
	• HIV/AIDS: 80% of people most at risk reached by prevention programs	**Not Achieved.** Condom use among young (15–24) unmarried people at last sex (2007): Men: 18.4%; Women: 10.3%. Correct knowledge about HIV/AIDS among young (15–24) unmarried people: Men: 20.3%, Women: 19.8% (2010).[c]	BAPPENAS, 2010
	• Antiretroviral therapy coverage (% of people living with HIV) increased. **New Indicator** (baseline: 2% in 2007)	**Achieved.** The share of people living with HIV and covered by antiretroviral therapy increased to 5% in 2011 and 9% in 2015.	WDI
5. Improved monitoring for MDG-related health performance (MDGs 1, 3–6)	• At least 20% of districts implement the MSS established by MOH	**Achieved.** MSS have been implemented in all districts, and the roles have been defined through TA support.	BAPPENAS, 2010

Design Summary	Performance Targets/Indicators	Achievement	Data Source
6. Improved financial information about MDG-related health expenditures (MDGs 1, 3–6)	• NHAs are institutionalized and have been produced at least twice	**Achieved.** An NHA was produced covering the period 2002–2004. MOH also prepared an NHA for the 2005–2009 period, which was presented in the APNHAN (Asia Pacific National Health Accounts Network) in Seoul, South of Korea.	BAPPENAS, 2010

Activities with Milestones	Inputs
SP1 (by 31 March 2007) • Between 2004 and 2007, the national budget for education increased from 2.8% to 3.9% of GDP, and for health from 0.7% to 1.1% of GDP • BOS increased to Rp10.2 trillion and ASKESKIN increased to Rp3.6 trillion in 2006 • Annual DAK allocation for health and education increased sevenfold from 2004 to 2007, reaching Rp5.3 trillion for education and 3.3 trillion for health • The government issued guidelines on establishing a survey-based database to identify poor households, as part of the PKH, by 2007 • BAPPENAS completed an evaluation of gender mainstreaming implementation in nine sectors, including health and education, by 2006 • MOH issued a ministerial decree outlining steps for better gender mainstreaming within MOH in 2006, and MONE issued the National Action Plan for Gender Equality in 2005 • In 2006, MONE, MOWE and MOH signed an MOU to reduce female illiteracy through non-formal education and life skills opportunities • In 2005, the MDGs were included as a key element in the national RPJM and the national poverty reduction strategy • MONE and MORA adopted a policy to expand “integrated” schools, build new schools and classrooms and allocate Rp4.252 trillion ($465 million) from their budgets • BOS program established in 2005 and expanded in 2006 and 2007 • Transition scholarships to boost junior secondary enrollments for the poor provided to 147,000 students in the 2006 budget • Law 14/2005 on Teachers and Education Personnel approved • National Standards Development Agency established in 2005 and decrees to develop the “Standard on Content” and “Standard on Competence” issued in 2006 • MONE and MORA developed a Grand Design for Nine-Year Basic Education in 2006 • MONE and MORA published National Exam results in 2005 and 2006. • MOH increased budget allocations for MDG-related programs by 50% in real terms between 2005 and 2007 • MOH established the ASKESKIN program in 2005 • In 2006, MOH issued a ministerial decree supporting the contracting of services to physicians and midwives, including incentives to work in remote areas • MOH approved the National Policy and Strategy for Reproductive Health in 2006 • MOH endorsed National Guidelines for Mitigating Tuberculosis in 2006 • In 2007, MOH refined the MSSs • In 2006, BAPPENAS and MOF published the Public Expenditure Review	• ADB program cluster for PRMAP comprising three subprograms, phased at an interval of 24 months between each subprogram • $400 million loan to support SP1 • $200 million loan was initially scheduled to support SP2 and SP3. This was cancelled. • Periodic review of progress under each subprogram • Technical assistance report

Activities with Milestones	Inputs
SP2 (by 31 March 2009) • Financial allocations for BOS (financial allocation per student) and ASKESKIN (financial allocation per poor person) sustained • Analysis of options to revise the technical guidelines for the allocation of the education and health sector DAK completed by MOH, MONE and MORA • Survey-based database identifying poor households for at least 40 selected districts completed by BPS • Sex-disaggregated indicators for the health and education MDGs (at least four indicators) finalized by BAPPENAS, with MONE, MORA, MOH, and MOWE • Comprehensive roadmap for accelerating the attainment of the MDGs prepared by BAPPENAS and Menko Kesra (the Coordinating Ministry of Social Welfare) and approved by the government • Guidelines issued by the government directing local governments to mainstream the MDGs when preparing district medium-term development plans and district poverty reduction strategies • Plan for participatory school mapping by district education offices and school committees in the 70 priority districts completed by MONE • Allocation policy for BOS finalized or other programs for poor and remote districts developed by BAPPENAS, MONE, and MORA • Scholarships included by the government in the proposed 2008 budget (for at least 150,000 students) to increase enrollments and retention of poor students in junior secondary school • Implementation of programs for professional development and incentives for deployment in underserved areas for teachers initiated by MONE and MORA • Eight national standards of education and a plan to monitor adoption of national standards developed by BSNP • Assessment of basic education sector performance, including progress towards the MDGs, completed by MONE, MORA and BAPPENAS • Parents in three districts surveyed on satisfaction with basic education services by BAPPENAS, with findings published through multi-media • Technical guidelines issued by the government requiring at least 40% of members on each district education board and school committee to be women • The allocation of total central budget in real per capita terms for MDG-related programs (MNCH/CDC) increased annually by MOH between 2007 and 2009 • A report on the ASKESKIN program, including (i) types of services utilized; and (ii) profile of program users, disaggregated by sex and province, published annually by MOH • An evaluation of contract provider payment schemes completed by MOH • A strategic plan for HIV/AIDS mitigation in Indonesia, 2008 to 2012, developed and approved by MOH • Revision of a ministerial regulation regarding health-related MSSs finalized by MOH • A plan for an NHAs program developed **SP3 (by 31 March 2011)** • Technical guidelines for the health and education DAK revised • Agreement reached between MONE, MORA and MOH to adopt a uniform system for the targeting of the poor in accessing MDG-related health and	

Activities with Milestones	Inputs
education initiatives • Sex-disaggregated indicators for the health and education MDGs reflected in the medium-term development plans of MONE, MORA and MOH • The medium-term development plans of the government, MONE, MORA, MOH, and MOWE include the MDGs and targets as key priorities • Government fund allocations in the 2010 and 2011 budgets for integrated schools, new schools, new classrooms, and rehabilitation of facilities using the updated school mapping system are equal to or exceed, in real terms, the amount allocated in 2007 • Resources for BOS allocated by the government based on the revised allocation policy and the programs for poor and remote districts • A study to assess the impact of direct financial support to students on enrollment and retention of the poor in junior secondary schools conducted by BAPPENAS • A report demonstrating deployment of teachers to underserved areas published by MONE and MORA • MSSs implemented by the government in at least two categories of national standards in selected geographic areas (in at least 10 districts) • The new medium-term development plan with a focus on provision of good quality basic education services for boys and girls in underserved areas approved by the government • Summary of the MONE and MORA inspectorate general audit reports on major basic education programs such as BOS, posted on the MONE and MORA websites • The allocation of the total central budget in real per capita terms for MDG related programs (MNCH/CDC) between 2009 and 2011 increased by MOH • The design and implementation strategy for the ASKESKIN program revised by MOH to cover a package of integrated health services for the poor, especially MNCH services • Strategies related to contract provider payment schemes (for physicians and midwives) revised and ongoing monitoring and evaluation conducted by MOH • An analysis of the costs and sources of financing for the MOH component of the government's response to the HIV/AIDS epidemic presented to the National AIDS Commission by MOH • NHAs produced for at least one year between 2008 and 2010, and all public, private and donor sources of financing identified by the NHAs program	

ADB = Asian Development Bank, ASKESKIN = Basic Health Care and Insurance for the Poor Program, BAPPENAS = Badan, Perancanaan Pembangunan Nasional (National Development Planning Agency), BOS = Bantuan Operational Subsidi, BSNP = National Education Standards Board, CDC = communicable diseases control, DAK = Dana Alokasi Khusus, GDP = gross domestic product, HIV/AIDS = human immunodeficiency virus/acquired immunodeficiency syndrome, MDG = Millennium Development Goal, MNCH = maternal neonatal and child health care, MOH = Ministry of Health, MOHA = Ministry of Home Affairs, MONE = Ministry of National Education, MORA = Ministry of Religious Affairs, MSS = minimum services standard, NHA = national health account, O&M = operation and maintenance, PKH = Program Keluarga Harapan, PRMAP = Poverty Reduction Millennium Development Goal Acceleration Program, PSC = project steering committee, RPJM = Medium-Term Development Plan, SP1 = subprogram 1, SP2 = subprogram 2, SP3 = subprogram 3.

[a] The World Bank. World Development Indicators. http://databank.worldbank.org/data/reports.aspx?source=millennium-development-goals (accessed 26 April 2017).

[b] BPS – Central Board of Statistics . https://www.bps.go.id/ (26 April 2017).

[c] Republic of Indonesia, Ministry of National Development Planning / National Development Planning Agency (BAPPENAS). 2010. *Report on the Achievement of the Millennium Development Goals Indonesia*. p.11. Jakarta

[d] Indonesia National Aids Commission. 2012. *Country report on the follow-up to the declaration of commitment on HIV/AIDS (UNGASS)*. Jakarta

[e] WHO. 2016. *Global Tuberculosis Report.* Switzerland. p. 26. Estimated epidemiological burden of TB in 2015 for 30 high TB burden countries, WHO regions and globally. Best estimates are followed by the lower and upper bounds of the 95% uncertainty interval. Rates per 100 000 population.

[f] R. Sparrow et al. 2010. Social Health Insurance for the Poor: Targeting and Impact of Indonesia's Askeskin Program. *HEFPA Working Paper 1.* Jakarta: The SMERU Research Institute.

[g] The World Bank. 2015. *Improving Education through the Indonesian School Operational Assistance Program (BOS)*. Policy Brief 96507. Washington DC.

[h] Dana Alokasi Khusus (DAK) funds are specific purpose grants for regional allocations.

[i] Republic of Indonesia, Ministry of National Development Planning / National Development Planning Agency (BAPPENAS). 2007. *Report on the Achievement of the Millennium Development Goals Indonesia.* Jakarta. p.15.

[j] Republic of Indonesia, Ministry of National Development Planning / National Development Planning Agency (BAPPENAS). 2013. *Review of a Decade of Gender Mainstreaming in Education in Indonesia. Summary Report.* Jakarta. p. 2.

[k] International Policy Centre for Inclusive Growth. 2014. Bantuan Siswa Miskin (BSM): Indonesian Cash Transfer Programme for Poor Students. *Research Brief No. 46.* Jakarta.

[l] M. Chang et al 2014. *Teacher Reform in Indonesia: The Role of Politics and Evidence in Policy Making. Directions in Development.* Washington, DC: IBRD/The World Bank.

[m] Ramadhan, A.P. and D. Santoso. 2015. Health Workers Absenteeism: Indonesia Urban Public Health Centres. *Journal of Public Health 23(3).*

Source: Asian Development Bank

UPDATED POLICY MATRIX

Outputs	Actions under Subprogram 1 (All actions completed)	Actions under Subprogram 2	Actions under Subprogram 3	Status of Actions at Program Completion
A Cross-sector policy reforms				
1.1 Increased budget allocation for health and education, especially focused on MDG-related programs. [MDGs 1–6]	Real total government budget allocation between 2004 and 2007 increased by: • 65% for the education sector (2.8% to 3.9% of GDP) • 72% for the health sector (0.7% to 1.1% of GDP) In 2006, BOS increased from Rp5.1 trillion in 2005 to Rp10.2 trillion and the ASKESKIN program increased from Rp2.3 trillion in 2005 to Rp3.6 trillion.	Financial allocations for BOS and ASKESKIN (or equivalent program) sustained. **Achieved**	Financial allocations for BOS and ASKESKIN (or equivalent program) sustained. **Achieved**	Education: • Basic education budget as share of GDP: 2.78% in 2004; 2.80% in 2005; and 3.41% in 2006[a] Health: • Total expenditure on health (TEH) increased from Rp28.4 trillion in 2005 to Rp252.4 trillion in 2012; or from Rp357.800 per capita in 2005 to Rp1.055.100 per capita in 2012 • As % of GDP, TEH increased from 2.8% in 2005 to 3.1% in 2012 • General government expenditure on health increased from 28.4% in 2005 to 39.2% in 2012 • As a percentage of TEH, private expenditure experienced fell from 71.6% of TEH in 2005 to 60.8% of TEH in 2012.[b] • As % of GDP, TEH was: 2005: 2.8%; 2006: 2.9%; 2007: 3.1%; 2008: 2.8%; 2009: 2.9%; 2010: 3.0%; 2011: 2.9%; and 2012: 3.1%.[c] As a share of GDP in 2012 • The education budget was 3.4% • The health budget was 1.1%[d] BOS: • "In 2007, the government targeted 41.9 million students through BOS at the primary school level with a budget of Rp11.8 trillion." [e] • "The implementation of school operations assistance grants (BOS) after 2005 coincided with a sudden increase of new hiring by schools. In 2009, the BOS program has been allocated IDR 19 trillion, or 25% of the total central budget for education." [f]

Outputs	Actions under Subprogram 1 (All actions completed)	Actions under Subprogram 2	Actions under Subprogram 3	Status of Actions at Program Completion
1.2 Improved performance incentives and geographical resource allocation to districts for education and health (MDGs 1–6)	Annual DAK financial allocation in the national budget for health and education sectors increased sevenfold from 2004 to 2007	MOH, MONE and MORA, in coordination with BAPPENAS and MOHA, complete an analysis of options to revise the technical guidelines for the allocation of the education and health sector DAK to better address the national priorities of MDG acceleration for education and health. **Achieved**	Technical guidelines for the health and education DAK revised to improve resource allocation to poor districts and MDG-related education and health, and education objectives utilizing recommendations from the analysis completed in 1.2. **Not confirmed**	An analysis of the Special Allocation Funds (DAK) for health and education to better address national priorities of MDG acceleration was completed in 2010 with support of TA 4984-INO.
1.3 A uniform system for targeting the poor to achieve the health and education MDGs is established (MDGs 1–5)	The government issued guidelines on establishing a survey-based database to identify poor households [g] as part of a new poverty reduction program, the Program Keluarga Harapan (PKH), enabling their improved access to MDG-related health and education services.	BPS has completed a survey-based database for selected districts, identifying poor households that lack access to key MDG-related health and education services. **Achieved**	MONE, MORA and MOH have agreed to adopt the improved system for the targeting of the poor in accessing MDG-related health and education initiatives. **Achieved**	"The PKH was started in mid-2007 with a pilot that targeted 500,000 households in seven provinces. In 2008, the program was supposed to expand its coverage to 1.5 million poor households. The PKH is consistent with and supports the MDGs in terms of education, healthcare and gender equality."[h] Several surveys have been conducted in relation to MDG-related health and education services for poor households with the support of TA 4984-INO. In 2008, the Central Board of Statistics (BPS) compiled a national, survey-based database identifying 17,483,989 very poor, poor, and near-poor households. The survey, known as the Pendataan Program Perlindungan Sosial/PPLS 2008 (or the Data Collection for Social Protection Programs, 2008) identified households that lacked access to basic needs and key MDG-related health and education services. This database is used as a tool to improve targeting and administration of social protection, poverty reduction, health support for the poor, rice for the poor, and educational

Outputs	Actions under Subprogram 1 (All actions completed)	Actions under Subprogram 2	Actions under Subprogram 3	Status of Actions at Program Completion
				scholarship programs.
1.4 Gender equity in access to health and education services achieved (MDGs 1–6)	In 2006, BAPPENAS completed an evaluation of gender mainstreaming implementation in nine sectors, including health and education. MOH, MONE, and MORA committed to gender mainstreaming in their respective ministries: • In 2006, MOH issued a new ministerial decree outlining steps for better gender mainstreaming within MOH • In 2005, MONE issued the National Action Plan for Gender Equality. MONE, MOWE, and MOHA have signed an MOU to enhance their efforts in reducing female illiteracy rate through non-formal education and life skills opportunities.	BAPPENAS, with MONE, MORA, MOH, and MOWE, has finalized draft sex-disaggregated indicators for better monitoring of gender equity in the health and education MDGs. **Achieved**	Sex-disaggregated indicators for the health and education MDGs are reflected in the medium-term development plans of MONE, MORA, and MOH. **Achieved**	MOEC regulation 84/2008 provides guidance for institutionalizing and implementing gender mainstreaming in education within MOEC and provincial and district education agencies.[i] "Structures for gender mainstreaming are in place in both MOEC and MORA. The last decade has seen a significant amount of gender equality 'socialization' by MOEC and to some extent MORA. During the course of this review, education officials at all levels were interviewed, and they displayed understanding of and interest in successfully enabling gender equality in education. According to stakeholders consulted for this review, the concept of gender equality was virtually unknown ten years ago, whereas now many more stakeholders have some level of understanding of gender equality." [j] Presidential Regulation 5/2010 on the Mid-Term National Development Plan (RPJMN), 2010–2014 set gender mainstreaming as one of the policy instruments in development policy. [k] RPJMN, 2010–2014 identifies 11 priorities, including education, and three cross-cutting principles as the operational foundations of overall development implementation, namely 1) sustainable development mainstreaming, 2) good governance mainstreaming, and 3) gender mainstreaming. [j] MOF Decree on Guidance for Annual Working Plan and Budget since 2009 – implementation of gender mainstreaming via gender-based budgeting.[k] Monitoring mechanisms of gender equity related to health and education MDGs were developed as part of TA [number]

Outputs	Actions under Subprogram 1 (All actions completed)	Actions under Subprogram 2	Actions under Subprogram 3	Status of Actions at Program Completion
				and sex-aggregated indicators for health and education are published on the BPS website.[l]
1.5 A planning framework for MDG acceleration is established. (MDGs 1–6)	MDGs were included as a key element in the national medium-term development plan (RPJM) and the national poverty reduction strategy.	A comprehensive roadmap for accelerating attainment of the MDGs, prepared by BAPPENAS and Menko Kesra, is approved by the government. The government issues guidelines directing local governments to mainstream the MDGs when preparing district medium-term development plans and district poverty reduction strategies. **Achieved**	The medium-term development plans of the national government, MONE, MORA, MOH, and MOWE include MDGs and targets as key priorities. **Achieved**	"The MDGs serve as an important reference for preparing national development planning documents. The Government of Indonesia has mainstreamed the MDGs in the National Long-Term Development Plan (RPJPN 2005–2025), the National Medium-Term Development Plans (RPJMN 2004–2009 and 2010–2014), the National Annual Development Plans (RKP), as well as documents of the State Budget (APBN)."[i] A Roadmap to Accelerate Achievement of the MDGs in Indonesia from 2010–2015 was prepared by the Minister of National Development Planning / Head of BAPPENAS in partnership with ADB and AUSAID and published in 2010. Law 38/2007 on Division of Functions between national and sub-national governments provides for women empowerment as one of the obligatory functions of sub-national governments. [k] Guidelines directing local governments to mainstream the MDGs in the process of preparing district medium-term development plans and district poverty reduction strategies were prepared and socialized.
B. National policy reform in the education sector				
1. Expand access to basic education, particularly for poor and vulnerable children				
1.1 Improved access to junior secondary schools in under-served areas (MDGs 1–3)	MONE and MORA adopted a policy to expand "integrated" schools to provide primary and junior secondary education within one school location and rehabilitate and/or build new schools and classrooms in 70	MONE has completed a plan for participatory school mapping by district education offices and school committees to enable better targeting and use of investments in school infrastructure	The government has allocated funds in the 2010 and 2011 budgets for integrated schools, new schools, new classrooms, and rehabilitation of facilities using the updated school mapping system	MONE prepared a plan of participatory school mapping for 70 priority districts with low NER. The plan and program were developed using the GIS-based school mapping and monitoring through the integration of Safe Schools data with Education Management Information System (EMIS) during 2010 and 2011. The participatory school mapping has been used by MONE and MORA to enable better targeting and use of investments in school infrastructure in areas with low NER which are often those in remote and underserved areas.

Outputs	Actions under Subprogram 1 (All actions completed)	Actions under Subprogram 2	Actions under Subprogram 3	Status of Actions at Program Completion
	priority districts, and allocated funds in the 2005, 2006, 2007 approved budgets.	in remote and/or underserved areas in the 70 priority districts. **Achieved**	and relevant demographic and education data. New schools were built in those years. **Achieved**	
1.2 Improved O&M support for smaller and/or remote schools (MDGs 2,3)	Funds have been allocated for a school subsidy program—Bantuan Operasional Sekolah (BOS)—for O&M for basic education schools including *Madrasah* (religious schools), eligible *pesantrens* (Islamic boarding schools), and non-Islamic religious schools.	BAPPENAS, MONE, and MORA have finalized an allocation policy for BOS or developed other programs for poor and remote districts. **Achieved**	The government has allocated resources for BOS based on the revised allocation policy and the programs for poor and remote districts. **Achieved**	The first BOS operations manual was issued in June 2005 and was updated in 2006 and 2007, with revised versions issued. The introduction of the BOS in 2005 and its expansion in 2006 and 2007 provided funds to cover school O&M and indirectly eliminate school fees. All public and private schools are eligible for the program. The BOS program provides block grants to schools based on student head counts. MONE reviewed the allocation policy and the financing and implementation of BOS and other O&M support programs. The revisions were based on inputs from district and provincial BOS management teams. The BOS operations manual also reflects lessons learned based on feedback from stakeholders and implementation results as assessed by independent bodies. The 2006 revision of the manual included: (i) a more explicit and consistent statement on the priority of focusing on poor students; (ii) a statement that BOS funding may not be used for activities that are already funded by central or regional government sources, such as salaries for contract teachers and fees for overtime; (iii) provision of forms for financial reporting; and (iv) provision for more transparency through posting BOS allocations on school notice boards." The revision made in the BOS 2007 operational manual included a clear role of parents/community in oversight and requirements for record-keeping and documentation. The 2007 manual explicitly stated that provision of BOS aims to exempt education costs for poor students and to lower education costs for other students so that they shall receive better quality basic education services until they graduate in the frame of fully implementing the 9-years mandatory education policy.

Outputs	Actions under Subprogram 1 (All actions completed)	Actions under Subprogram 2	Actions under Subprogram 3	Status of Actions at Program Completion
1.3 Increased affordability of education by poor students and/or households (MDGs 1–3)	The government has introduced transition scholarships to boost junior secondary enrollments for the poor and provided funds in the 2006 budget.	The government has included scholarships in the proposed 2008 budget to increase enrollments and retention of poor junior secondary students in public and private schools. **Achieved**	BAPPENAS and Balitbang were supposed to conduct a study, including recommendations, to assess the impact of direct financial support to students and/or households on enrollment and retention of the poor in junior secondary schools. **Not confirmed**	In 2009, the government allocated around Rp1.6 trillion ($170 million) of funds for scholarship programs for the poor, which is equal to 1.4% of the central government expenditure on education, or 0.8% of the national education expenditure in 2009. Of this amount, about Rp1.0 trillion (62%) was allocated to regular school students and the remaining Rp619 billion (38%) to *Madrasah* students. In nominal terms, the allocation of funds for scholarship programs more than doubled from around Rp700 billion in 2008 to Rp1.6 trillion in 2009. Overall, the coverage of the scholarship program is estimated to jump from 1.6 million students to 3.7 million students.[m] During 2008, the MONE budget included allocations totaling Rp359,355,600,000 to fund the provision of scholarships to 499,105 poor junior secondary students to attend public junior secondary schools. The average allocation was Rp720,000 per student per year, which was in line with the average costs of education estimated by Susenas in 2006. The 2009 budget included an increased allocation totaling Rp377,040,267,000 to fund 710,057 poor junior secondary students. MORA funding totaling Rp89,841,600,000 for scholarships for 124,780 poor students to attend junior secondary schools during 2008.
2. Improve the quality, efficiency, and effectiveness of basic education service delivery				
2.1 Enhanced quality and equitable deployment of teachers (MDGs 2,3)	Parliament approved Law 14/2005 on Teachers and Education Personnel, which reflects improvements in teacher deployment, qualification, competency, and professional status.	MONE and MORA have initiated implementation of programs for professional development and incentives for deployment of formal basic education teachers in underserved areas. **Achieved**	In 2008, MONE and the World Bank published the report: *Teacher Employment and Deployment in Indonesia*.[n] **Achieved**	The Law 14/2005 on Teachers and Education Personnel was passed in 2005 and intended to address fundamental issues of teacher quality. The law created a certification mechanism to ensure teachers' professional competency level. To be certified, a teacher must have a four-year college or university degree, accumulate sufficient credits from post-graduate teacher professional training, and teach a minimum of 24 hours per week. A certified teacher is then entitled to a professional allowance in an amount equivalent to his or her base salary. It was the government's intention that by 2015, Indonesia's school system would only allow certified teachers to teach.[o]

Outputs	Actions under Subprogram 1 (All actions completed)	Actions under Subprogram 2	Actions under Subprogram 3	Status of Actions at Program Completion
				Professional development and incentives for deployment of basic education teachers in underserved areas were also promoted.
2.2 Education Service Delivery meeting minimum service standards (MSS) (MDG 2)	The government has established a National Standards Development Agency, Badan Standar Nasional Pendidikan (BSNP), which develops educational standards. Decrees have been issued to develop standards on content and competence.	BSNP has developed eight national standards of education and developed a plan to monitor adoption of national standards. **Achieved**	The government has implemented in at least two categories of national standards in selected geographic areas. **Achieved**	The government established eight national standards and is in the process of producing indicator frameworks for assessing teacher performance.[p] In addition, a set of Minimum service standards (MSS) has been approved, which include 27 indicators of services divided into 14 indicators for schools and 13 for the district level.
3. Enhance governance, transparency, and accountability in the delivery of education services				
3.1 Improved planning and implementation of education services (MDGs 2,3)	MONE and MORA developed a Grand Design for 9-Year Basic Education in Indonesia in 2007 to work collaboratively in achieving the national education goals for completion of basic education.	In preparation for the next medium-term development plan, MONE, MORA, and BAPPENAS have completed an assessment of basic education sector performance including progress towards the MDGs, with selected indicators disaggregated by sex. **Achieved**	The government approved the new medium-term development plan with a focus on the provision of good quality basic education services for boys and girls in underserved areas. **Achieved**	In [year]. MONE, MORA, and BAPPENAS prepared an assessment of basic education sector performance, including progress towards the MDGs with selected indicators disaggregated by sex. The assessment was based on studies undertaken by MONE, MORA, and BAPPENAS with support from development partners including the Asian Development Bank (ADB), the World Bank through the Education Sector Assessment, UNESCO, AusAid, and the European Union. These assessments were used as inputs in the preparation of the National Medium-Term Development Plan (RPJMN), 2010–2014 and cover: achievements related to equitable access to basic education, quality of teaching and learning outcomes; governance, accountability and public image; key issues and challenges; and policies and strategies.
3.2 Greater transparency of education outcomes to	MONE and MORA have published national exam results to enable a nationwide	BAPPENAS has contracted an independent agency to survey mothers	Summary of MONE and MORA Inspectorate General Audit	The Parent Satisfaction Survey (PSS) was contracted to the Institute for Research and Community Service at the Institut Pertanian Bogor. The PSS evaluated parent satisfaction relating to access and quality of basic education services in

Outputs	Actions under Subprogram 1 (All actions completed)	Actions under Subprogram 2	Actions under Subprogram 3	Status of Actions at Program Completion
enhance accountability (MDGs 2,3)	comparison of the performance of rural and urban schools.	and fathers (or other guardians) on satisfaction with the basic education services provided by the local school system and published its findings through multimedia. **Achieved** The government has issued technical guidelines explicitly requiring that at least 40% of members on each district education board and school committee be women. **Achieved**	Report on the implementation of major basic education programs such as the BOS posted on MONE and MORA websites. **Achieved**	Indramayu, West Java. The data was used to inform the district of dimensions of basic education service delivery that should be further strengthened, related to achieving MDG targets 2 and 3. The PSS covered parents of students in the government's decentralized basic education system's elementary schools (SDs) and junior secondary schools (SMPs) grades 6 and 9, principals, and school committee members. The results have been placed on the BAPPENAS website. The existing guidelines (Kepmendiknas no. 944 tahun 2002 and Petunjuk Teknis Pemberdayaan Komite Sekolah 2007–2009) do not include the requirement that at least 40% of the members of district education boards and school committees be women. Instead, MONE issued a circular letter to provide a guideline to local district governments on this issue. The circular letter, which was signed by the Directorate General for Primary and Secondary Education Management (DGPSEM) of MONE on 2 July 2009, stated that at least 40% of the members of district education boards and school committees be women. The technical guideline aims to ensure greater transparency of education outcomes to enhance accountability.
C National policy reform in the health sector				
1. Expand access to health services, especially for the poor and women				
1.1 Increased central budget for MDG-related health programs (MDGs 4–6)	MOH increased the central budget allocation for MDG-related programs between 2005 and 2007 by 50%.	MOH has increased the total central budget allocation in real per capita terms for MDG-related programs (MNCH/CDC) annually between 2007 and 2009.	MOH has increased the total central budget allocation in real per capita terms for MDG-related programs (MNCH/CDC) between 2009 and	The government's policy intent has been to increase central budget allocations in real per capita terms for MNCH/CDC-related programs. Real per capita budget allocations for MNCH/CDC programs in 2007 represented a 16% increase compared to 2006. However, real per capita budget allocations for these programs fell by 19% in 2008 due to fiscal constraints resulting from the major increase in the price of petroleum during 2007–2008. Real per capita budget

Outputs	Actions under Subprogram 1 (All actions completed)	Actions under Subprogram 2	Actions under Subprogram 3	Status of Actions at Program Completion
		Partially achieved	2011. **Not confirmed**	allocations for these programs were increased marginally (by 0.5%) in 2009.
1.2 Improved targeting of public financing for health services for the poor (MDGs 1, 4–6)	MOH has established the ASKESKIN program for poor beneficiaries, providing a package of services that includes primary (e.g., obstetric delivery services), secondary, and tertiary care, and allowing the use of government and appointed non-government providers (including midwives, health centers and hospitals).	MOH has published annually a report on the ASKESKIN (or equivalent) program, including analyses of (i) types of services utilized, and (ii) a profile of program users, disaggregated by sex and province. **Achieved**	MOH has revised the design and implementation strategy for the ASKESKIN (or equivalent) program to cover a package of integrated health services for the poor, especially MNCH services (including the provision of prenatal, postnatal, obstetric delivery services and contraceptives). **Not confirmed**	The required report is published annually. It includes an analysis of services utilized, as well as data permitting more extensive analysis of utilization including analysis of the profile of program users by province. It does not analyze program users by sex, but MOH has put in place mechanisms that do allow such analysis drawing on available databases (including in the Askeskin/Jamkesmas system), and pilot analyses have been undertaken.
2. Improve the quality, efficiency, and effectiveness of basic health service delivery				
2.1 Improved effectiveness of MNCH and reproductive health service delivery by influencing provider behavior (MDGs 4–6)	In [year], MOH issued a ministerial decree supporting the contracting-out of services to non-government providers (physicians and midwives), including incentives to work in remote areas.	MOH has completed an evaluation and recommendations regarding contract provider payment schemes, analyzing (i) the impact on the distribution of providers to poor/remote areas and among women; and (ii) utilization of health-related MDG services (MNCH/CDC).	MOH has revised their strategies related to contract provider payment schemes (for physicians and midwives) and is conducting ongoing monitoring and evaluation. **Achieved**	The contract provider payment scheme has gone through several design changes over time. It was abolished as a compulsory scheme in 2007; instead, incentives were introduced to attract health providers to poor and remote areas. Data is insufficient to undertake a thorough analysis of the compulsory schemes; while the current, voluntary scheme has only operated for a short time. Available data for poor/remote areas indicate that there has been a steady increase in service coverage, including for women, who are major beneficiaries of better-staffed health centers and referral services, and of village midwives. While utilization data is hard to come by, available information indicates a shift from the use of traditional birth attendants to skilled midwives, an increase in ante-natal care contacts, and a decrease in the number of malaria cases and incidence of TB, indicating the

Outputs	Actions under Subprogram 1 (All actions completed)	Actions under Subprogram 2	Actions under Subprogram 3	Status of Actions at Program Completion
		Achieved		positive effects of the increased utilization of health services since 2007.
2.2 Improved effectiveness of communicable disease control through integrated programs (MDGs 3–6)	MOH has developed and approved the National Policy and Strategy for Reproductive Health (2006), which specifies multisector approaches for reproductive health, including prevention and treatment of sexually transmitted infections and HIV/AIDS. MOH has endorsed national guidelines for mitigating tuberculosis that specify the MOH plan and strategy for TB control for the period 2006 to 2010, including guidelines for development of public-private partnerships in TB case detection and treatment	MOH has developed and approved an interdepartmental strategy for expanded efforts for HIV/AIDS control (the Strategic Plan for HIV/AIDS Mitigation in Indonesia, 2008–2012). **Achieved**	MOH has published the National HIV and AIDS Strategy and Action Plan, 2010–2014 as a continuation and improvement of the previous National Strategy and Action Plan. This document contains a comprehensive set of strategies and prioritized activities and is in line with Indonesia's Mid-Term National Development Plan, 2010–2014. It includes an analysis of the costs and available sources of financing for the MOH component of the government's response to HIV/AIDS epidemic presented to the National AIDS Commission. **Achieved**	The National HIV and AIDS Action Plan, 2007–2010, and more recently the National AIDS Strategy and Action Plan for 2010–2014 have been launched. [q]
2.3 Improved performance and	MOH has refined the minimum service	MOH has finalized the revision of a		The development of minimum service standards (MSSs) is included in the Law (UU) No. 23 of 2014, which related to the

Outputs	Actions under Subprogram 1 (All actions completed)	Actions under Subprogram 2	Actions under Subprogram 3	Status of Actions at Program Completion
monitoring of health-related MDGs (MDGs 1, 3–6)	standards (MSSs) to emphasize more effectively health-related MDGs (i.e., MNCH/CDC).	ministerial regulation regarding health-related MSSs that (i) includes all health-related MDGs in the MSSs, (ii) includes intermediate indicators that are harmonized to the extent possible with the UN's indicators for health-related MDGs, and (iii) defines the roles and responsibilities of the central and local governments related to the MSSs. **Achieved**		distribution of governance and authority between the central and regional governments (province and district/city), which are regulated based on the criteria of externality, accountability, and efficiency. It states that the central government is responsible for setting the standards to be used by local governments (provincial and district/city) as a reference in the implementation of basic health services. In the regional planning and budgeting processes for the health sector, the type, quality, implementation techniques, and financing mechanisms are regulated in detail in the health MSS. In the implementation of MSSs, the provincial governments have the capacity to represent the central government to assist districts and cities in implementing budgets and overseeing the implementation of basic services. This includes determining the number and qualifications of public service personnel in primary health care.
3. Enhance governance, transparency, and accountability in the delivery of health services				
3.1 Improved financial information about MDG-related health expenditures (MDGs 1, 3–6)	BAPPENAS and MOF have endorsed and published the Public Expenditure Review (2007), including an analysis of government spending for the health sector.	A plan for a national health accounts (NHAs) program has been developed. **Achieved**	The program has produced national health accounts (NHAs) for at least one year between 2008 and 2010 based on the plan developed and has identified all public, private and donor sources of financing. **Achieved**	In 2007, the World Bank published the Public Expenditure Review, which was endorsed by the BAPPENAS and the MOF. It contains a chapter on health, which analyzes how resources are allocated and how effectively they are used in the health sector: "Although expenditures on health have increased substantially since 2000, aggregate spending is still below 1% of GDP. Despite the low aggregate spending on health, Indonesia can still achieve major improvements within the current spending envelope if resources are distributed more evenly across income groups and districts. Government policies in the sector have not been properly reflected in the budgetary allocation, with more resources going to services predominantly used by richer income quintiles (secondary care). Therefore, it is important to better allocate the existing resources before substantially increasing health spending. For instance, all subsidies to secondary care facilities should

Outputs	Actions under Subprogram 1 (All actions completed)	Actions under Subprogram 2	Actions under Subprogram 3	Status of Actions at Program Completion
				be channeled into primary care. There may also be particular merit in subsidizing ambulatory care, especially in remote regions. The current Fuel Subsidy Reduction Compensation Fund (PKPS-BBM) program shows promise in improving the poor's access to primary and secondary inpatient care. There are significant regional discrepancies in per capita public health spending, translating into inequalities in service provision across districts. Public health spending at the district level (combining sub-national, central government deconcentrated allocations) tends to benefit richer districts. This inequality is predominantly driven by the regressive impact of deconcentrated spending." [r] The MOH did a systematic data collection on health expenditures from 1984–1995. This was discontinued during 1995–2000. The implementation of decentralization in 2001 made it difficult to collect data as financial authority was delegated to local governments to allocate public funds to various sectors, including health. In 2007, a new NHA team was set up to revisit the NHAs of 2002–2004. The recommendations resulting from this assessment include: • MOH needs to pay more attention to the development of the NHA methodology, the provision of accurate data, as well as improving the skills of human resources for NHA development; • NHAs need to be reported routinely to update information about health financing in Indonesia at national and international level. Therefore, the development of a national information system on health spending / budget realization based on an NHA standard is needed. It also has to be compatible with the government's financial reporting system.[s] The first NHA team was established in 2007 and was assisted by the WHO. The project was aimed at providing evidence-based data on health expenditure in Indonesia from 2002–2004. The full set of Indonesian NHA estimates for the period of 2002–2004 was published by the MOH in early 2009.

Outputs	Actions under Subprogram 1 (All actions completed)	Actions under Subprogram 2	Actions under Subprogram 3	Status of Actions at Program Completion
				With funding assistance from AusAID, the NHA team is continuing its previous work of collecting, analyzing, and producing health expenditure statistics. The complete set of NHA tables for the period 2005–2009 has been compiled using SHA 1.0 Guidelines to ensure the methodology is consistent with OECD practices.[t]

ADB = Asian Development Bank, ASKESKIN = Basic Health Care and Insurance for the Poor Program, AusAID = Australian Agency for International Development; BAPPENAS = Badan Perancanaan Pembangunan Nasional (National Development Planning Agency), BOS = Bantuan Operational Subsidi, CDC = communicable diseases control, DAK = Dana Alokasi Khusus, GDP = gross domestic product, HIV/AIDS = human immunodeficiency virus/acquired immunodeficiency syndrome, MENKO KESRA = Coordinating Ministry of Social Welfare, MDG = Millennium Development Goal, MNCH = maternal neonatal and child health care, MOEC = Ministry of Education & Culture, MOF = Ministry of Finance, MOH = Ministry of Health, MOHA = Ministry of Home Affairs, MONE = Ministry of National Education, MORA = Ministry of Religious Affairs; MOWE = Ministry of Women's Empowerment, MSS = minimum services standard, MTDP = medium-term development plan, NHA = national health account, O&M = operation and maintenance, PKH = Program Keluarga Harapan, TB = tuberculosis.

[a] BAPPENAS. 2016. Department of Finance, National Education Department, and the Department of Religious Affairs (2004–2006), cited in Report on the Achievement of Millennium Development Goals Indonesia 2007. *MDG Report 2007*. Jakarta. p. 32.

[b] Facts of Indonesia Health Care Financing, at http://www.searo.who.int/indonesia/topics/hs-uhc-hcf/en/ (accessed 4 May 2016).

[c] Universitas Indonesia, Australian DFAT, and Department of Health. Indonesia National Health Accounts 2012. PowerPoint presentation. April 8, 2015.

[d] World Bank. World Development Indicators. http://databank.worldbank.org/data/home.aspx (accessed 20 December 2016).

[e] United Nations. 2007. *The Millennium Development Goals Report*. New York. P. 30.

[f] World Bank. 2010. *Transforming Indonesia's Teaching Force, Volume 1: Executive Summary*. Jakarta p. 16.

[g] Poor households with children under-5 years of age, children on school age (basic education), and pregnant women.

[h] United Nations. 2007. *The Millennium Development Goals Report*. New York. p.15.

[i] Government of Indonesia. National Development Planning Agency (BAPPENAS). 2013. *A Review of a Decade of Gender Mainstreaming in Education in Indonesia, Summary Report*. Jakarta. p.2.

[k] Erny Murniasih, DG Fiscal Balance, Ministry of Finance, Indonesia, *Budgeting for Gender Equality: Experience in Indonesia*. PowerPoint presentation dated 13 June 2012. https://wpqr4.adb.org/lotusquickr/cop-mfdr/PageLibrary482571AE005630C2.nsf/0/0A673D0C26A4CF9148257A360023D7C2/$file/4c2%20Erny%20Murniasih_Budgeting%20for%20gender%20equality_Indonesian%20Experience.pptx

[l] BPS–Statistics Indonesia. https://www.bps.go.id/ (accessed 20 December 2016).

[m] World Bank. 2009. *Scholarships Program in Indonesia: Past, Present, and Future*. Jakarta

[n] World Bank. 2008. *Teacher Employment and Deployment in Indonesia*. Jakarta

[o] World Bank. 2010. *Transforming Indonesia's Teaching Force, Volume 1: Executive Summary*. Jakarta. p. 8.

[p] Evans et al. 2009. *Teacher Education and Development in Indonesia: A Gap Analysis*. Jakarta: USAID. p. 53.

[q] Aids Data Hub. 2011. *Indonesia Country Review.* http://aidsdatahub.org/sites/default/files/country_review/Indonesia_Country_Review_2011._HIV_and_AIDS_Data_Hub_for_Asia-Pacificl(2011)_0.pdf

[r] World Bank. 2007. *Spending for Development: Making the Most of Indonesia's New Opportunities: Indonesia Public Expenditure Review 2007*. Jakarta, p. 25

[s] Indonesia NHA 2002–2004, by the Faculty of Public Health, University of Indonesia; Ministry of Health, Government of Indonesia; and WHO (2009).

[t] P. Soewondo et al. 2011. SHA-Based Health Accounts in the Asia-Pacific Region: Indonesia 2005–2009. *OECD SHA Technical Paper (2011) 3*. p. 4.

Note: Subprogram 1: 1 Apr 2005–31 Mar 2007, Subprogram 2: 1 Apr 2007–31 Mar 2009, and Subprogram 3: 1 Apr 2009–31 Mar 2011.

STATUS OF COMPLIANCE WITH LOAN COVENANTS

Covenant	Reference in Loan Agreement	Status of Compliance
1. BAPPENAS shall be Program Executing Agency and shall be responsible for the coordination of overall implementation of the Program Cluster and reporting to ADB. The Ministry of Finance shall be responsible for the administration and disbursement of the Loan proceeds, and the maintenance of accounts. A Program Steering Committee and a program technical committee shall oversee Program Cluster implementation, shall be chaired by a representative from BAPPENAS and shall include representatives from, at least, the Ministry of Finance, MOH, MONE, MORA, Ministry of Women's Empowerment, the Ministry of Home Affairs and Central Board of Statistics. MOH, MONE and MORA shall be implementing agencies responsible for implementing actions within their respective area of responsibilities, and shall establish sectoral technical committees and secretariats for the education and health sectors.	Schedule 5, para1	**Complied with.**
2. The Borrower shall ensure that the policies adopted and actions taken as described in the Policy Letter, including the Policy Matrix, prior to the date of this Loan Agreement continue in effect for the duration of the Program Cluster Period and subsequently.	Schedule 5, para 2	**Complied with.** All policies adopted and actions taken as described in the Policy Matrix, prior to the date of the Loan Agreement, and continued in effect for the duration of the program and TA.
3. The Borrower shall keep ADB informed of, and the Borrower and ADB shall from time to time exchange views on, sector issues, policy reforms and additional reforms during the Program Cluster Period that may be considered necessary or desirable, including the progress made in carrying out policies and actions set out in the Policy Letter and the Policy Matrix.	Schedule 5, para 3	**Complied with.** BAPPENAS, MONE, and MOH invited ADB to join the regular coordination meetings organized every other month.
4. The Borrower shall engage in policy dialogue with ADB, in a timely manner, on problems and constraints encountered during the implementation of the Program Cluster and on desirable changes to overcome or mitigate such problems and constraints.	Schedule 5, para 4	**Complied with.** BAPPENAS actively engaged in at least five policy dialogues with ADB.
5. The Borrower shall keep ADB informed of policy discussions with other multilateral or bilateral agencies that have implications for implementation of the Program Cluster, and shall provide ADB with an opportunity to comment on any resulting policy proposals. The Borrower shall take ADB's views into consideration before finalizing and implementing any such proposals.	Schedule 5, para 5	**Complied with.** The Borrower kept ADB informed of policy discussions with other donors including the Government of Australia for the additional grant. They also provided ADB

Covenant	Reference in Loan Agreement	Status of Compliance
		with opportunities to comment.
6. The Borrower shall ensure that the Counterpart Funds are used to finance the local currency costs relating to the implementation of Subprogram I and other activities consistent with the objectives of Subprogram I and shall provide the necessary budget appropriations to finance the structural adjustment costs relating to the implementation of reforms under Subprogram I.	Schedule 5, para 6	**Complied with.**
7. The Borrower shall cause BAPPENAS and its Ministry of Finance, MOH, MONE, MORA, Ministry of Women's Empowerment, and Ministry of Home Affairs as well as Central Board of Statistics to monitor the implementation of the Program Cluster and its impacts, and BAPPENAS shall submit to ADB semiannual reports on the implementation of the Program Cluster, including accomplishment of the measures and refinements thereto, set forth in the Policy Letter and the Policy Matrix.	Schedule 5, para 7	**Complied with.** 1st, 2nd and 3rd reports were submitted on time. The final report was submitted in December 2009.
8. The Borrower shall ensure that BAPPENAS conducts, jointly with ADB, a Subprogram I performance completion review at the end of the Subprogram I Period to evaluate the progress of the reform measures and their impact on the Borrower's achievement of the selected MDGs. The Borrower and ADB shall use the findings of such assessment and evaluation to refine the Program Cluster. The Borrower shall actively assist and support ongoing Program Cluster monitoring and evaluation including facilitating consultations with central and provincial agencies, civil society, and other key stakeholders as appropriate and shall ensure that these reports are used at the completion of the Program Cluster to produce a comprehensive report on the overall outcome of the policy reforms described in the Policy Letter and Policy Matrix within 12 months of the end of the Program Cluster Period. To facilitate such reviews, the Borrower shall assist ADB by providing relevant data and information in such detail as ADB may reasonably request.	Schedule 5, para 8	**Complied with.** TA supported the SP1 performance completion review in 2009, and a comprehensive report on overall outcomes was produced in 2010.
9. The Borrower shall, where necessary, cause the entities covered under Subprogram I to comply with all applicable environmental laws, regulations and standards of the Borrower and ADB's *Environment Policy* (2002).	Schedule 5, para 9	**Complied with.** There was no issue with complying with applicable environmental laws and regulations as well as standards of the government and ADB's

Covenant	Reference in Loan Agreement	Status of Compliance
		Environment Policy (2002).
10. The Borrower shall cause Subprogram I to be carried out with due diligence and efficiency and in conformity with sound administrative, financial, educational, health and governance practices.	Section 4.01 (a)	**Complied with.**
11. In the carrying out of Subprogram I, the Borrower shall perform, or cause to be performed, all obligations set forth in Schedule 5 to this Loan Agreement.	Section 4.01 (b)	**Complied with.**
12. The Borrower shall make available, promptly as needed, the funds, facilities, services, and other resources, which are required, in addition to the proceeds of the Loan, for the carrying out of Subprogram I.	Section 4.02	**Complied with.**
13. The Borrower shall ensure that the activities of its departments and agencies with respect to the carrying out of Subprogram I are conducted and coordinated in accordance with sound administrative policies and procedures.	Section 4.03	**Complied with.** SPI conducted and coordinated all its activities in accordance with sound administrative policies and procedures.
14. The Borrower shall maintain, or cause to be maintained, records and documents adequate to identify the Eligible Items financed out of the proceeds of the Loan and to indicate the progress of Subprogram I.	Section 4.04 (a)	**Complied with.**
15.The Borrower shall enable ADB's representatives to inspect any relevant records and documents referred to in LA Section 4.04 (a).	Section 4.04 (b)	**Complied with.**
16. As part of the reports and information referred to in Section 7.04 of the Loan Regulations, the Borrower shall furnish, or cause to be furnished, to ADB all such reports and information as ADB shall reasonably request concerning the implementation of the Program Cluster, including the accomplishment of the targets and carrying out of the actions set out in the Policy Letter.	Section 4.05 (a)	**Complied with.**
17. Without limiting the generality of the foregoing or Section 7.04 of the Loan Regulations, the Borrower shall furnish, or cause to be furnished, to ADB semiannual reports on the carrying out of the Program Cluster and on the accomplishment of the targets and carrying out of the actions set out in the Policy Letter.	Section 4.05 (b)	**Complied with.**

RESULT OF OVERALL ASSESSMENT

Criterion	Weight (%)	Assessment	Rating	Rating Value
1. Relevance	25	The program is rated *relevant* because the program outcome was fully aligned with the government's strategic policies for achieving the millennium development goals, especially in poverty reduction, health, education, and gender equality. The program outcome was fully aligned with ADB's Enhanced Poverty Reduction Strategy and ADB's Medium-Term Strategy II for 2006–2008, which provided the framework for ADB's engagement and support to MDG acceleration and attainment in the region. ADB's country strategy and program (CSP) for Indonesia, 2006–2009 further identified MDG acceleration as one of its five strategic areas of engagement. The loan modality: a single tranche policy loan was appropriate, and implementation arrangement was sufficient. However, some indicators were weak.	Relevant	2
2. Effectiveness	25	The program was able to provide all the planned inputs and achieve the planned outputs. Outcome indicators were achieved and output indicators for all three principal policy areas were mostly achieved.	Effective	2
3. Efficiency	25	The program was efficiently managed by the executing agency, other key ministries, and ADB. Executing and implementing agencies were able to ensure the full achievement of all policy actions under SP1 prior to the Board's approval. The loan was processed and made available to the government relatively quickly as planned. As PRMAP is a single tranche loan, no additional fiduciary arrangements: financial management, procurement and disbursement were in place. However, the fiduciary risk assessment indicated that sound regulatory framework was in place and that the government continues to improve fiscal transparency and financial management capacity. It was assessed that there was no issue with the efficient utilization of overall resources through public financial management in Indonesia.	Efficient	2
4 Sustainability	25	Sustainability of the program is rated likely because (i) the government remains politically and financially committed to poverty alleviation and equal access to education and health services, and (ii) the program included several policy actions that were institutionalized and will help sustain its progress. Main program outcomes and outputs continue to improve. Areas that would need continued attention include poverty alleviation and further investment in the health sector, in particular, TB and HIV/AIDS disease control.	Likely	2

Weighted average: 2.0
Overall Rating: Successful
Note: The overall assessment was conducted based on the methodology presented in ADB's Guidelines for the Evaluation of Public Sector Operations. (ADB. 2016. Guidelines for the Evaluation of Public Sector Operations. Manila.)

Overall Assessment Methodology

Criterion	Weight (%)	Assessment	Rating Description	Rating Value
1. Relevance	25	The consistency of the project impact and outcome with country and sector priorities and ADB's strategic objectives, as well as the adequacy of its design in addressing identified development constraints.	Highly relevant Relevant Less than relevant Irrelevant	3 2 1 0
2. Effectiveness	25	The extent to which the project outcome as specified in the DMF (either as agreed at approval or as subsequently modified) was achieved.	Highly effective Effective Less than effective Ineffective	3 2 1 0
3. Efficiency	25	How resources were converted to results, using cost–benefit analysis based on a calculation of the EIRR for investment projects, if feasible, as well as cost-effectiveness analysis. Other indicators, such as a comparison between forecast unit costs (in the RRP) and actual unit costs, and process efficiency should be considered when reliable EIRR or cost-effectiveness analyses cannot be conducted or do not cover the whole project.	Highly efficient Efficient Less than efficient Inefficient	3 2 1 0
4 Sustainability	25	The likelihood that institutional, financial, and other resources are sufficient to sustain the project's outcome over its economic life in an environmentally and socially sustainable way.	Most likely sustainable Likely sustainable Less than likely sustainable Unlikely sustainable	3 2 1 0
Overall Assessment (weighted average of above criteria)	**Highly successful:** Overall weighted average is greater than or equal to 2.50. **Successful**: Overall weighted average is greater than or equal to 1.75 and less than 2.50. **Less than successful**: Overall weighted average is greater than or equal to 0.75 and less than 1.75. **Unsuccessful**: Overall weighted average is less than 0.75. Note: The overall rating becomes automatically less than successful if one or more of the four sub-ratings' value is 0.			

DMF = design and monitoring framework, EIRR = economic internal rate of return, RRP = report and recommendation of the President.
Source: ADB. 2016. *Guidelines for the Evaluation of Public Sector Operations.* Manila.

SUMMARY OF GENDER EQUALITY RESULTS AND ACHIEVEMENTS

1. The Poverty Reduction and Millennium Development Goals Acceleration Program (PRMAP) included reducing gender inequalities in its design. All three principal policy areas—cross-sectoral reforms, reforms in the education sector and reforms in the health sector—included policy actions related to gender equality. Under cross-sectoral reforms, the goal was to improve gender equity in access to quality health care and education. Gender mainstreaming was institutionalized in the concerned ministries and agencies. Reforms in the education sector included improving transparency to better monitor educational outcomes, including those of girls, and an increase in the share of women on school boards. Reforms in the health sector included the improvement of reproductive health service delivery. Further, the program institutionalized the production of sex-disaggregated indicators in education and health to monitor the reduction in gender inequalities.

2. Gender inequalities in Indonesia have fallen in recent years. Table A5.1 depicts sex-disaggregated indicators for education, labor market outcomes, health, and governance. With regards to educational outcomes, women in Indonesia currently surpass men at all levels: women have higher primary, secondary, and tertiary enrollment rates and are more likely to complete primary and secondary education. Nevertheless, the stark improvement in educational outcomes for women does not go hand in hand with better labor market prospects. Female labor force participation only increased marginally from 52.8% in 2007 to 53.5% in 2015. However, those who do participate in the labor market face lower unemployment rates (female unemployment dropped from 10.8% in 2007 to 6.4% in 2013) and tend to be employed in non-agricultural sectors. Some health indicators show improvement, such as 83% of births are attended by skilled health personnel[43]. However, Indonesia is off –track in achieving MDG 2015 target with MMR at 190 deaths per 100,000 live births.[44] When it comes to governance, the share of female members of parliament increased from 12.5% in 1990 to 15% in 2015.

3. The program achieved most DMF impact and outcome gender-specific targets, namely: (i) gender parity index in primary gross enrollment increased from 0.972 in 2000 to 1.038 in 2011, (ii) maternal mortality rate decreased from 313 per 100,000 live births in 2012 to 126 in 2015, (iii) the proportion of births attended by skilled health personnel increased from 72% in [year] to 91.51% in 2015, and (d) female illiteracy rate was reduced by 35% from 2009 to 2015 (9.2% in 2009 to 5.95% in 2015).

4. A more detailed account of achievements in gender equality is provided in Table A5.2. Note that while many DMF targets and policy actions are relevant to gender equality and women's empowerment, Table A5.2 only include those DMF output indicators/targets, and those policy actions that are gender specific. For a more comprehensive overview of the achievements that are relevant to gender, please refer to Appendix 1 and 2 of this report.

Table A5.1: Targeted and achieved reduction in gender inequalities

Gender disaggregated indicators	Baseline (2007)	Target (2015)	Actual achievement (2015 or latest)	Source
Ratio of girls to boys: primary education, 7–12 years (%)	96.4 (2007)	100	103.8 (2011)	WDI

[43] *The Global Gender Gap Report 2014.*
[44] Footnote 43.

Ratio of girls to boys: secondary education, 13–18 years (%)	100.6 (2007)		100	100 (2013)		WDI
Ratio of girls to boys: tertiary education (%)	98.4 (2007)		100	110 (2013)		WDI
Ratio of literate females to males, 15–24 years (%)	99.2 (2008)		100	100 (2011)		WDI
Primary completion rate (% of relevant age group)	Male 97.2 (2007)	Female 95.8 (2007)	100	Male 99.0 (2013)	Female 102.2 (2013)	WDI
Lower secondary completion rate (% of relevant age group)	Male 76.8 (2007)	Female 79.7 (2007)		Male 79 (2013)	Female 83.3 (2013)	WDI
Survival rate to the last grade of primary education (%)	Male 85.7 (2002)	Female 87.1 (2002)	100	Male 77.4 (2007)	Female 82.8 (2007)	WDI
Labor force participation rate (15–64 years old)	Male 86.8 (2007)	Female 52.8 (2007)		Male 86.1 (2014)	Female 53.5 (2014)	WDI
Employment to population ratio	Male 78 (2007)	Female 45.3 (2007)		Male 79.4 (2014)	Female 47.7 (2014)	WDI
Unemployment (% of labor force)	Male 8.1 (2007)	Female 10.8 (2007)		Male 6 (2013)	Female 6.4 (2013)	WDI
Share of female employment in the non-agricultural sectors	58.6 (2007)			66.6 (2013)		WDI
Prevalence of underweight, weight for age (% of children under 5)	Male 20.7 (2007)	Female 18.6 (2007)	MDG target: 15.5	Male 20.5 (2013)	Female 19.4 (2013)	WDI
Prevalence of stunting, height for age (% of children under 5)	Male 41.3 (2007)	Female 38.8 (2007)		Male 37.2 (2013)	Female 35.5 (2013)	WDI
Percentage of population having health complaints	Male 69.3 (2009	Female 67.5 (2009)		Male 62.3 (2014)	Female 59.9 (2014)	BPS
Maternal mortality ratio (modeled estimate, per 100,000 live births)	190 (2007)			126 (2015)		The Global Gender Gap Report 2016 – World Economic Forum
Percent of births attended by skilled health personnel	73 (2007)			83.1 (2012)		WDI
Pregnant women receiving prenatal care (%)	93.3 (2007)			95.7 (2012)		WDI
Proportion of contraceptive users (married women ages 15–49 years) reporting condom use (%)	0.4 (2002)			1.3 (2010)		A roadmap to accelerate achievement of the MDGs

				in Indonesia, p.130
HIV prevalence among pregnant women 15–24 years old (%)	0.07 (2002)			WDI
Notifications of new and relapse TB cases (Male/Female ratio)			1.4 (2014)	TB report p. 43
Proportion of seats held by women in national parliament	12.5 (1990)	Increase by 33%	17 (2015)	WDI

WDI = World Development Indicator
Sources: BPS – Statistics Indonesia. Available at https://www.bps.go.id/ ; World Bank. World Development Indicators. http://databank.worldbank.org/data/home.aspx; WHO. 2015. *Global Tuberculosis Report.* 20th Edition. France

Table A5.2: Gender-specific indicators/targets and policy actions

A. GENDER-SPECIFIC INDICATORS IN THE DESIGN AND MONITORING FRAMEWORK	
Gender-Specific Indicators/Targets	**Achievements** (Data provided in this column are taken from the same sources as indicated in Appendix 1, Updated Design and Monitoring Framework)
Outputs	
I. Cross-Sectoral Policy Reforms: Gender equity in access to health and education services achieved (MDGs 1–6)	
• By 2011: At least four health and education sex-disaggregated indicators collected in 30% of districts. **Achieved**	• List of health and education sex-disaggregated indicators collected in all 34 provinces and published on the BPS website: life expectancy and population with health complaints (health); net enrollment, educational attainment, and literacy (education)
II. National Policy Reforms in the Education Sector: Greater transparency of education outcomes to enhance accountability (MDGs 2,3)	
• At least 40% of school board members are women in 100 surveyed schools. **Achieved**	• MONE issued a circular letter that stated that at least 40% of the members of district education boards and school committees should be women. The letter was signed by the Directorate General for Primary and Secondary Education Management (DGPSEM) of MONE on 2 July 2009.
III. National Policy Reforms in the Health Sector: Increased central budget for MDG-related health programs (MDGs 4–6)	
• MOH has increased the budget allocation for maternal neonatal and child health care and CDC yearly from 2007 to 2011. **Achieved**	MOH increased the total central budget allocation in real per capita terms for MDG-related programs (MNCH/CDC) annually between 2007 and 2009. New indicator used as a proxy for the first indicator: Increase in share of pregnant women receiving prenatal care: increased from 93.3% in 2008 to 95.4% in 2013.
B. **GENDER-SPECIFIC ACTIONS IN THE POLICY MATRIX**	

Policy Actions	Achievements (Data provided in this column are taken from the same sources as indicated in Appendix 2, Updated Policy Matrix)
I. CROSS-SECTORAL POLICY REFORMS: **1.4 Gender equity in access to health and education services achieved (MDGs 1–6)**	
• BAPPENAS completed an evaluation of gender mainstreaming implementation in nine sectors (2006), including health and education. **Achieved**	MOEC regulation 84/2008 provides guidance for institutionalizing and implementing gender mainstreaming in education within MOEC and provincial and district education agencies. "Structures for gender mainstreaming are in place in both MOEC and MORA. The last decade has seen a significant amount of gender equality 'socialisation' by MOEC and to some extent MORA. During the course of this review, education officials at all levels were interviewed, and they displayed an understanding of and interest in successfully enabling gender equality in education. According to stakeholders consulted for this review, the concept of gender equality was virtually unknown ten years ago, whereas now many more stakeholders have some level of understanding of gender equality." Presidential Regulation 5/2010 on the Mid-Term National Development Plan (RPJMN), 2010–2014 sets gender mainstreaming as one of the policy instruments in development policy. RPJMN, 2010–2014 identifies 11 priorities including education and three cross-cutting principles, 1) sustainable development mainstreaming; 2) good governance mainstreaming; and 3) gender mainstreaming, as the operational foundations of overall development implementation. MOF Decree on Guidance for Annual Working Plan and Budget since 2009 – implementation of gender mainstreaming via gender-based budgeting. Monitoring mechanisms of gender equity related to health and education MDGs were developed as part of TA and sex-aggregated indicators for health and education are published on the BPS website.
• MOH, MONE, and MORA have committed to gender mainstreaming in their respective ministries: ○ MOH issued a new ministerial decree (2006) outlining steps for better gender mainstreaming within MOH. ○ MONE issued the National Action Plan for Gender Equality (2005). This was part of the requirements for disbursement of the first tranche. **Achieved**	
• MONE, MOWE, and MOHA have signed an MOU to enhance their efforts in reducing female illiteracy rate through non-formal education and life skills opportunities. **Achieved**	
• BAPPENAS, with MONE, MORA, MOH, and MOWE, have finalized draft sex-disaggregated indicators for better monitoring of gender equity in the health and education MDGs. **Achieved**	
• Sex-disaggregated indicators for the health and education MDGs are reflected in the medium-term development plans of MONE, MORA, and MOH. **Achieved**	
II. NATIONAL POLICY REFORMS IN THE EDUCATION SECTOR: ***3. Enhance governance, transparency, and accountability in the delivery of education services***	
3.1 Improved planning and implementation of education services (MDGs 2,3)	
• MONE, MORA, and BAPPENAS have completed an assessment of basic education sector performance, including progress towards the MDGs, with selected indicators disaggregated by sex, in preparation for the next medium-term development plan.	An assessment of basic education sector performance, including progress towards the MDGs with selected indicators disaggregated by sex, was prepared by MONE, MORA, and BAPPENAS. The assessment was based on studies undertaken by MONE, MORA, and

Achieved • The government approved the new medium-term development plan with a focus on the provision of good quality basic education services for boys and girls in underserved areas. **Achieved**	BAPPENAS with support from development partners including the Asian Development Bank (ADB), the World Bank through the Education Sector Assessment, UNESCO, AusAid, and the European Union. These assessments have been used as inputs in the preparation of the next National Medium-Term Development Plan (RPJMN), 2010–2014 and cover: achievements related to equitable access to basic education, quality of teaching and learning outcomes; governance, accountability, and public image; key issues and challenges; and policies and strategies. All education indicators show an improvement of access to education for women. The ratio of girls to boys in primary education improved from 96.4% in 2007 to 103.8% in 2011. The primary completion rate for girls improved from 95.8% in 2007 to 102.2% in 2013 (it changed from 97.2% in 2007 to 99.0% in 2013 for men). Similarly, the lower secondary completion rate improved from 79.7% for girls in 2007 to 83.3% in 2013 and for boys from 76.8% to 79%. The ratio of literate females to males improved from 99.2% in 2008 to 100% in 2011. All this shows vast improvements for women's education.
3.2 Greater transparency of education outcomes to enhance accountability (MDGs 2,3)	
BAPPENAS contracted an independent agency to survey mothers and fathers (or other guardians) on satisfaction with the basic education services provided by the local school system and published its findings through multimedia. **Achieved**	Pertanian Bogor. The PSS evaluated parent satisfaction relating to access to and quality of basic education services in Indramayu, West Java. The data was used to inform the district of dimensions of basic education service delivery that should be further strengthened, related to achieving MDG Targets 2 and 3. The scope of the PSS covered parents of students in the government's decentralized basic education system, elementary schools (SDs), and junior secondary schools (SMPs) grades 6 and 9, principals, and school committee members. The results were published on the BAPPENAS website.
The government issued technical guidelines for the district education boards and school committees requiring that at least 40% of members on each district education board and school committee be women. **Achieved**	The existing guidelines (Kepmendiknas no. 944 tahun 2002 and Petunjuk Teknis Pemberdayaan Komite Sekolah 2007–2009) do not include the requirement that at least 40% of the members of district education boards and school committees be women. Instead, MONE issued a circular letter signed by the Directorate General for Primary and Secondary Education Management (DGPSEM) of MONE on 2 July 2009, which requires that at least 40% of the members of district education boards and school committees be women. The technical guideline aims to ensure greater transparency of education outcomes to enhance accountability.

III. NATIONAL POLICY REFORMS IN THE HEALTH SECTOR:	
1. Expand access to health services, especially for the poor and women	
1.1 Improved targeting of public financing for health services for the poor (MDGs 1, 4–6)	
• MOH has established the ASKESKIN program for poor beneficiaries, providing a package of services that includes primary (e.g., obstetric delivery services), secondary, and tertiary care, and allowing the use of government and appointed non-government providers (including midwives, health centers and hospitals). **Achieved**	The ASKESKIN program is a mandatory public health insurance scheme, funded by the central government from general tax revenue and targeted towards the poor. Its benefit package includes inpatient and outpatient care, as well as maternal and preventive care, such as obstetric services, immunizations, and contraceptive treatments. The program also included mobile health services and special services for remote areas.
• MOH has published an annual report on the ASKESKIN (or equivalent) program, including analysis of (i) types of services utilized, and (ii) a profile of program users, disaggregated by sex and province. **Achieved**	The program report is published annually. It includes an analysis of services utilized as well as data permitting more extensive analysis of utilization. It allows analysis of the profile of program users by province (including in the Askeskin/Jamkesmas system), and pilot analyses have already been undertaken.
2. Improve the quality, efficiency, and effectiveness of basic health service delivery	
2.1 Improved effectiveness of MNCH and reproductive health service delivery by influencing provider behavior (MDGs 4–6)	
• MOH has issued a ministerial decree supporting the contracting-out of services to non-government providers (physicians and midwives), including [supporting or providing?] incentives to work in remote areas. **Achieved**	The contract provider payment scheme has gone through several design changes over time. It was abolished as a compulsory scheme in 2007; instead, incentives were introduced to attract health providers to poor and remote areas. Data is insufficient to undertake a thorough analysis of the compulsory schemes. Available data for poor/remote areas indicate that there has been a steady increase in service coverage, including for women, who are major beneficiaries of better-staffed health centers and referral services, and of village midwives. While utilization data is hard to come by, available information indicates a shift from the use of traditional birth attendants to skilled midwives, an increase in ante-natal care contacts, and a decrease in the number of malaria cases and TB, indicating the positive effects of increased utilization of health services since 2007 (World Bank, World Development Indicators).
• MOH has completed an evaluation and recommendations regarding contract provider payment schemes, analyzing (i) the impact on the distribution of providers to poor/remote areas and among women; and (ii) utilization of health-related MDG services (MNCH/CDC). **Achieved**	
• MOH has revised their strategies related to contract provider payment schemes for physicians and midwives and is conducting ongoing monitoring and evaluation. **Achieved**	
2.2 Improved effectiveness of communicable disease control through integrated programs (MDGs 3–6)	
MOH has developed and approved the National Policy and Strategy for Reproductive Health (2006) that specifies multisector approaches for reproductive health, including prevention and treatment of sexually transmitted infections and HIV/AIDS. **Achieved**	The National HIV and AIDS Action Plan, 2007–2010 and, more recently, the National AIDS Strategy and Action Plan for 2010–2014 have been launched. The National Policy and Strategy for Reproductive Health elaborates on the efforts of relevant ministries to improve reproductive health access and outcomes. This policy integrates various

	elements of reproductive health under one coordinating strategy, including maternal health, child health, family planning, and prevention and treatment of sexually-transmitted infections and HIV/AIDS. The maternal mortality rate decreased from 190 per 100,000 live births in 2007 to 148 in 2012. The percentage of births attended by skilled health care personnel improved from 73 % in 2007 to 83% in 2012 and the share of pregnant women receiving prenatal care improved from 93.3% in 2007 to 95.7% in 2012. The share of married women reporting condom use increased from 0.4% in 2002 to 1.3% in 2010.
2.3 Improved performance and monitoring for health-related MDGs (MDGs 1, 3–6)	
• MOH has refined the minimum service standards (MSSs) to more effectively emphasize health-related MDGs (i.e., MNCH/CDC). **Achieved**	The development of minimum service standards (MSS) is included in the Law (UU) No. 23 of 2014 related to the distribution of governance and authority between the central and regional governments (province and district/city), which are regulated based on the criteria of externality, accountability, and efficiency. The law underlines that the central government is responsible for setting the standards to be used by local governments (provincial and district/city) as a reference in the implementation of basic health services. In the regional planning and budgeting processes for health sector, the quality, implementation techniques, and financing mechanisms are regulated in detail in the health MSS. In the implementation of MSS, the provincial governments have the capacity to represent the central government to assist districts and cities in implementing budgets and overseeing the implementation of basic services. This includes determining the number and qualifications of public service personnel in primary health care.
• MOH has finalized the revision of a ministerial regulation regarding health-related MSSs that (i) includes all health-related MDGs in the MSSs, (ii) includes intermediate indicators that are harmonized to the extent possible with the UN's indicators for the health-related MDGs, and (iii) defines the roles and responsibilities of the central and local governments related to the MSSs. **Achieved**	

ASKESKIN = Basic Health Care and Insurance for the Poor Program, BAPPENAS = Badan Perancanaan Pembangunan Nasional (National Development Planning Agency), HIV/AIDS = human immunodeficiency virus/acquired immunodeficiency syndrome, MDG = Millennium Development Goal, MNCH = maternal neonatal and child health care, MOEC = Ministry of Education & Culture, MOF = Ministry of Finance, MOH = Ministry of Health, MOHA = Ministry of Home Affairs, MONE = Ministry of National Education, MORA = Ministry of Religious Affairs; MOWE = Ministry of Women's Empowerment, MSS = minimum services standard, MTDP = medium-term development plan, TB = tuberculosis.

TECHNICAL ASSISTANCE COMPLETION REPORT

Division : Indonesia Resident Mission (IRM)

<table>
<tr><td colspan="3">TA No : 4984-INO: Strengthening Social Service Delivery for the Poverty Reduction and Millennium Development Goals Acceleration Program (PRMAP)</td><td colspan="2">Amount Approved: $1.5 million
Revised Amount: : N/A</td></tr>
<tr><td colspan="2">Executing Agency:
National Development Planning Agency (BAPPENAS)</td><td>Source of Funding:
ADB TA funding program</td><td>Amount Undisbursed:
$78,057.78</td><td>Amount Utilized:
$1,421,942.22</td></tr>
<tr><td>TA Approval Date:
30 – 10 - 07</td><td>TA Signing Date:
15 - 01- 08</td><td>Fielding of First Consultants:
April 2008</td><td colspan="2">TA Completion Date
Original: 31-08-09 Actual: 31-01-10
Account Closing Date
Original:30-11-09 Actual: 17-12-10</td></tr>
</table>

Description. The technical assistance (TA) complemented the second sub-program (SP) of the Poverty Reduction and Millennium Development Goals Acceleration Program Loan (PRMAP), which was designed to support the Government of Indonesia in its commitment towards achievement of the Millennium Development Goals (MDG); particullraly related to education (MDG 2), health (MDG 4,5,6), poverty reduction (MDG 1) and gender equality (MDG 3). Originally, PRMAP was designed as a program cluster consisting of three program loans, with specific policy actions defined for each sub-program. The 1st SP was approved in October 2007 with the first tranche of $400 million released in December 2007. Tranches of $200 million were envisaged for SP2 and SP3. 20 policy actions were specified under SP2 to be achieved by March 2009. The TA provided assistance to key ministries including BAPPENAS (the exceuting agency of the TA), Ministry of Education (MONE), Ministry of Religious Affairs (MORA), Ministry of Health (MOH) to support the Government in achieving the set policy actions.

The TA was implemented in close collaboration with the Government of Australia. The estimated total cost of the TA was $ 2.7 million. ADB provided funding for $1.5 million, the Government contributed $200,000, and the Australian Government contributed $1.0 million. ADB engaged a team of experts to provide technical support to assist the Government in accomplishing the policy actions as specified under the PRMAP program loan. AusAID deployed a consultant team, who provided complementary support particularly focused on advancing health sector reforms.

Expected Impact, Outcome and Outputs of the TA. The expected impact of the TA was to strengthen social service delivery within a framework for accelerated achievement of the MDGs particularly through the implementation of national policy reforms in health and education and improving efficiency of public spending in health and education.
The outcome was to sustain reforms introduced under SP1 and refine and assist the Government to achieve the national policy reforms included under SP2. However, although the PRMAP program loan comprised 20 policy actions under SP2, originally the TA only included 10 outputs grouped under the following three components:
Component 1 provided support to cross-sector policy reforms by assisting BAPPENAS to (i) develop recommendations for strengthening the special development fund (DAK) technical guidelines for the education and health sectors, (ii) finalize a list of selected sex-disaggregated MDG health and education indicators, and (iii) develop a national MDG roadmap, and prepare guidelines on mainstreaming MDGs into district medium-term development plans and poverty reduction strategies.
Component 2 supported reforms in the education sector by (i) assessing the effectiveness of different strategies and programs in meeting the basic education objectives of the Grand Design for Basic Education and assisting these ministries in the development of policy proposals, (ii) demonstrating the use of the "Citizens Report Card" for education, used for surveying parents on their satisfaction with service delivery to improve accountability and education quality.
Component 3 supported reforms in the health sector by (i) reviewing and improving the criteria used for centrally provided budget allocations for MNCH and CDC activities, (ii) supporting analysis and development of recommendations for the revision of the ASKESKIN program design and implementation modalities, (iii) preparing an evaluation of (a) contract provider payment-schemes, and(b) utilization on MNCH and CDC services, particularly women; (iv) assisting in the revision of a ministerial regulation regarding health-related MSSs; and (v) contributing to developing a National Health Account program.

Delivery of Inputs and Conduct of Activities. Originally, the implementation period of the TA was defined as an 20-month period, from January 2008 to August 2009. It was anticipated that only 10 of the 20 policy actions would require technical assistance. However, during TA implementation, the Government requested the TA consultant team to broaden their scope of assistance in order to support the accomplishment of all 20 policy actions. The consultant team responded timely and resourcefully to Government's request to enlarge their assistance. Overall, the consultancy was considered both economic and effective, and delivered high quality of outputs to the satisfaction of the clients.
The given implementation period of 20 months proved to be too short to accomplish all activities required under the policy actions, thus the Government requested for an extention to ensure that the TA-team could continue supporting government agencies involved until works under all 20 policy actions had been completed. ADB supported the request and extended the TA until 31 January 2010. In April 2009, the administration of the TA was delegated from ADB HQ, SESS, to Indonesia Resident Mission (IRM), which improved the communication among goverment agencies, consultants and ADB. The delegation was appreciated by the Government. IRM provided ongoing guidance and support to consultants and the EA and implementing agencies.

Evaluation of Outputs and Achievement of Outcome. The consultancy outputs are considered to have been efficient and effective in assisting the Government to achieve the SP2 policy actions as stipulated in the PRMAP program loan. Out of 20 policy actions, the Government considered 17 policy actions to be fully achieved; while three policy actions are regarded as partially achieved. A summary of the final status of completion of the SP 2 Policy Actions is attached in Annex 1. By achieving most of the policy actions, the TA also contributed to the expected impact to strengthen social service delivery within the MDG framework, with a particular focus on education and health. Overall, Indonesia has generally made good progress towards accelerating achievement of the MDGs. The Government recently announced that the number of population below poverty line in Indonesia declined by 1.51 million, from 32.53 million in March 2009 to 31.02 million in March 2010. The overall progress to reach targets under MDG1 to eradicate extreme poverty and hunger is on track. Education related targets (MDG 2) to achieve universal primary education have been almost achieved; gender equality in all types and levels of education have been nearly achieved (MDG 3). However, the health related MDG targets need special attention. Regional disparities remain as constraints to achieve health targets, reflecting the discrepancy in accessing health services, particularly in underserved and remote areas. The future priorities are to strengthen health systems, improve access to and quality of maternal health, and improve family planning services and provision of information, education and communication messages to communities. Beyond that, communicable disease control efforts must involve all stakeholders and strengthen health promotion activities to increase public awareness. By assisting MOH in preparing a series of comprehensive health budget studies, developing a plan for a national health accounts program, and preparing strategies for HIV/AIDS control and accelerating achievement of health MDG, the TA provided useful inputs to develop strategies aimed at increasing efficiency in the sector, strengthening financing and improving the quality of health care. Due to the limited duration of the TA period and limited resources, it was not feasible to comprehensively address issues related to the overall health system and press forward an all-inclusive reform agenda.

Overall Assessment and Rating. On the basis of outputs produced the TA is rated successful. The TA supported the Government in fully achieving 17 out of 20 policy actions; while three policy actions are regarded as partially achieved. In particular, the TA provided valuable assistance in (i) preparing a MDG roadmap, which was presented at the general annual UN Assembly Meeting, and will be used as a reference for all stakeholders to speed up achievement of the MDGs, (ii) conducting a comprehensive assessments of the health budget, the Basic Health Care and Insurance Program for the Poor (ASKESKIN) and the Operational Assistance Program for Schools (BOS), (iii) completing an analysis of the Special Allocation Funds (DAK) for health and education to better address national priorities of MDG acceleration, (iv) conducting several surveys in relation to MDG related health and education services for poor households, (v) improving monitoring mechanisms of gender equity related to health and education MDGs, (vi) preparing and socializing guidelines directing local governments to mainstream the MDGs in the process of preparing district medium-term development plans and district poverty reduction strategies, (vii) evaluating health contract provider schemes, (viii) developing strategies to strengthen HIV/AIDS control, (ix) revising ministerial regulations related to health MSS and MDGs, (x) developing a plan for a national health accounts, (xi) complete an assessment of basic education sector performance, (xii) developing education standards, (xiii) promoting professional development and incentives for deployment of basic education teachers in underserved areas, (xiv) conducting a survey to assess parent satisfaction with basic education services, and (xv) completing a plan for participatory school mapping. The TA consultants' advice during the implementation phase was highly valuable, ensuring full accomplishment of most policy actions.

Major Lessons. One of the positive lessons from preparing and implementing the policy reforms supported by the TA is that the concerned central government agencies are strongly committed to working to achieve the MDGs. The MDGs have been successfully mainstreamed in broad national strategies and policies and a comprehensive array of programs to reduce poverty and empower the poor are being implemented. Staff of key departments are well informed on the status of achievement of the MDGs. The continuing challenge is to esstablish more effective planning, monitoring and evaluations systems to ensure that policies and programs effectively work at the local/community level.

One of the risks noted in the RRP for PRMAP was that lack of clarity about the obligations of each level of government in the delivery of social services could pose obstacles for the implementation of the reforms at the local level. The experience of implementing the TA has underlined the severity of this risk as contributions from the respective line ministries varied during the implementaton period, which put a heavy responsibility and workload on the EA to carried out tasks required to fullfill the policy actions. Greater attention should have been given to clarifying the roles and responsibilities of the national, provincial and district levels of government in working to accelerate achievement of the MDGs in general and contributing to the 20 policy actions in particular. Some key stakeholders felt that they had not been adequately involved in formulating the list of SP2 policy actions, thus ownership of some policy reforms was sometimes less than anticipated. The lesson learned is that key stakeholders should be closely involved in the project preparation to insure their ownership of the process and commitment to achieve success. Building ownership for the policy reforms is a key determinant for success.

Recommendations and Follow-Up Actions. No follow up action is proposed. Although the TA has delivered the expected outputs and most of the policy actions have been achieved, the Government requested during the Country Programming Mission in May 2009 that ADB should not proceed with processing the second tranche of PRMAP.

Prepared by: Wolfgang Kubitzki Designation: Senior Social Sector Economist

ACHIEVEMENTS OF MILLENNIUM DEVELOPMENT GOALS INDICATORS

Target	Goal	Indicators	Earliest Value (1990–1994)	(2002–2006)	(2008–2010)	Target in 2015	Achievement in 2015 (or latest year)	Source
	Goal 1: Eradicate Extreme Poverty and Hunger							
1	Halve, between 1990 and 2015, the proportion of people whose income is less than $1.25 a day.	Proportion of population below the national poverty line (%)	15.1 (1990)	17.8 (2006)	13.3 (2010)	7.6	11.0 Not achieved in 2014	BPS
		Proportion of population living below $1.25 per day (%)	20.6 (1990)	7.2 (2002)		10.3	16.2 On track in 2014	Human Development Report 2015
2	Halve, between 1990 and 2015, the proportion of people who suffer from hunger.	Prevalence of underweight children (% of children under 5 years old who are underweight)	36.6 (1990)	28.2 (2003)	18.6 (2010)	18.3	19.9 On track in 2013	WDI
	Goal 2: Achieve Universal Primary Education							
3	Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling.	Net primary enrolment ratio (% of children aged 7–12 years enrolled)	88.7 (1992)	94.8 (2006)	94.8 (2010)	98	96.7 Almost achieved in 2015	BPS
		Proportion of grade 1 cohort reaching grade 5 (%)	75.6 (1990)	82.2 (2002)		98	89 On track in 2014	Human Development Report 2015
		Net enrolment ratio in junior secondary education (% of children aged 13–15 years enrolled)	41.9 (1992)	63.7 (2005)	67.7 (2010)	98	77.8 Not achieved in 2015	BPS
		Literacy rate, 15–24 years old (%)	96.6 (1992)	98.7 (2002)	99.5 (2009)	**?**	98.8 (2011)	WDI
	Goal 3: Promote Gender Equality and Empower Women							
4	Eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of	Ratio of girls to boys in primary education, 7–12 years (%)	100.6 (1992)	100.1 (2002)	100 (2010)	100	103.8 Achieved in 2011	WDI
		Ratio of girls to boys	101.3	102.6	100	100	100	WDI

Target	Goal	Indicators	Earliest Value (1990–1994)	(2002–2006)	(2008–2010)	Target in 2015	Achievement in 2015 (or latest year)	Source
	education no later than 2015.	in junior secondary education, 13–15 years (%)	(1992)	(2002)	(2010)		Achieved in 2013	
		Ratio of literate females to males, 15–24 years (%)	97.9 (1992)	99.8 (2002)	100 (2009)	100	100 Achieved in 2011	WDI
	Goal 4: Reduce Child Mortality							
5	Reduce by two-thirds, between 1990 and 2015, the under-5 mortality rate.	Under-5 mortality rate (deaths per 1,000)	97.0 (1990)	38.0 (2004)	33.1 (2010)	32	27.2 Achieved in 2015	WDI
		Infant mortality rate (deaths per 1,000 live births)	57.0 (1994)	35.0 (2002)	27.4 (2010)	19	22.8 Almost achieved in 2015	WDI
	Goal 5: Improve Maternal Health							
6	Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio.	Maternal mortality ratio (per 100,000 births)	390 (1994)	307.0 (2002)	165 (2010)	102	126 Not achieved	WDI
		Proportion of births attended by skilled health personnel (%)	40.7 (1992)	72.0 (2005)	?	90	91.51 Achieved in 2015	BPS
	Goal 6: Combat HIV/AIDS, Malaria, and Other Diseases							
7	Have halted by 2015, and begun to reverse, the spread of HIV/AIDS.	HIV prevalence among pregnant women 15–24 years old (%)		0.07 (2002)	**?**	**?**	**?**	WDI
		Proportion of contraceptive users (married women ages 15–49 years) reporting condom use (%)	1.3 (1992)	0.4 (2002)	1.3 (2010)	0.7	1.3 Off track in 2010	A roadmap to accelerate achievement of the MDGs in Indonesia, p.130
		Number of children orphaned by HIV/AIDS	**?**	18,000 (2002)	**?**	**?**	110,000	UNAIDS webpage
8	Have halted by 2015, and begun to reverse, the	Rate of malaria prevalence per	468 (1990)	1,000 (2001)	**?**	**?**	185 On track in	Report on the

Target	Goal	Indicators	Earliest Value (1990–1994)	(2002–2006)	(2008–2010)	Target in 2015	Achievement in 2015 (or latest year)	Source
	incidence of malaria and other major diseases.	100,000 people					2009	achievement of the MDGs, p.11
		Rate of tuberculosis prevalence per 100,000 people	440 (1990)	125 (2005)	244 (2009)	220	244 On track in 2009	WHO global tuberculosis report 2015, p.15/ Report on the achievement of the MDGs, p.11
Goal 7: Ensure Environmental Sustainability								
9	Integrate the principles of sustainable development into country policies and programs and reverse the loss of environmental resources.	Carbon dioxide emissions (kg per capita)	2.5 (1990)	2.3 (2000)	1.8 (2008)	**?**	2.3 (2011)	WDI
10	Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation.	% of population with sustainable access to an improved water source	38.2 (1994)	50.0 (2002)	84.5 (2010)	69.1	87.4 Achieved in 2015	WDI
		% of population with sustainable access to basic sanitation	30.9 (1992)	63.5 (2002)	57 (2010)	65.4	60.8 Almost achieved in 2015	WDI
11	By 2020, to have achieved a significant improvement in the lives of at least 100 million slum dwellers.	Proportion of households who own or rent their homes	87.7 (1992)	83.5 (2001)	88.3 (2010)	**?**	90.7 Achieved in 2015	BPS

BPS = Central Board of Statistics, MDG = Millennium Development Goals, WDI = World Development Indicators.