ADB

Report and Recommendation of the President to the Board of Directors

Project Number: 40003
October 2007

Proposed Program Cluster, Loan, and Technical Assistance Grant
Republic of Indonesia: Poverty Reduction and Millennium Development Goals Acceleration Program

Asian Development Bank

CURRENCY EQUIVALENTS

(as of 31 August 2007)

Currency Unit	–	rupiah (Rp)
Rp1.00	=	$0.0001065190
$1.00	=	Rp9,388

ABBREVIATIONS

ADB	–	Asian Development Bank
ASEAN	–	Association of Southeast Asian Nations
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 operasional sekolah (operational assistance to schools)
BPS	–	Central Board of Statistics
BSNP	–	Board of National Education Standards
CCT	–	conditional cash transfer
CDC	–	communicable disease control
CHC	–	community health center
CRC	–	citizen's report card
DAK	–	Dana Alokasi Khusus (special development fund)
DAU	–	Dana Alokasi Umum (general development fund)
DOTS	–	directly observed treatment—short course
GDP	–	gross domestic product
GER	–	gross enrolment rate
GTZ	–	Deutsche Gesellschaft fur Technishe Zusammenarbeit
HIV/AIDS	–	human immunodeficiency virus/acquired immunodeficiency syndrome
IMF	–	International Monetary Fund
km	–	kilometer
LIBOR	–	London interbank offered rate
MDG	–	Millennium Development Goal
MMR	–	maternal mortality rate
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
MMR	–	maternal mortality ratio
MSS	–	minimum services standard
NER	–	net enrolment rate
NHA	–	national health account
NTT	–	Nusa Tenggara Timur
O&M	–	operation and maintenance

PER	–	public expenditure review
PKH	–	Program Keluarga Harapan
PKPS-BBM	–	fuel subsidy reduction compensation program
PRMAP	–	Poverty Reduction and Millennium Development Goals Acceleration Program
RH	–	reproductive health
RPJM	–	Rencana Pembangunan Jangka Menengah (Medium-Term Development Plan)
PSC	–	Program Steering Committee
SNPK	–	Strategi Nasional Penanggulangan Kemiskinan (National Poverty Reduction Strategy)
SP	–	subprogram
TA	–	technical assistance
TB	–	tuberculosis
UNDP	–	United Nations Development Programme
WHO	–	World Health Organization

NOTES

(i) The fiscal year (FY) of the Government and its agencies ends on 31 December. FY before a calendar year denotes the year in which the fiscal year ends, e.g., FY2007 ends on 31 December 2007.

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

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CONTENTS

LOAN AND PROGRAM SUMMARY

Borrower	Republic of Indonesia
The Proposal	The proposal comprises (i) a program cluster concept for the Poverty Reduction and Millennium Development Goals Acceleration Program (PRMAP) consisting of three subprograms, (ii) a proposed program loan for Subprogram 1 of the PRMAP, and (iii) technical assistance (TA) for Strengthening Social Services Delivery.
Classification	Targeting Classification: Targeted intervention — non-income Millennium Development Goals (MDGs) Sector: Multisector (education; health, nutrition, and social protection; law, economic management, and public policy) Subsectors: Basic education, health programs, economic management Themes: Inclusive social development, governance, gender and development Subthemes: Human development, public governance, gender equity in capabilities
Environment Assessment	Category C
Rationale	Indonesia's progress towards achievement of the MDGs by 2015 is mixed. Significant disparities exist in achievements across regions and income groups. While solid progress is noted in many areas, accelerated improvements are needed to meet the international and national MDG targets. Poverty levels increased in 2006, reversing previous gains, with almost 40 million (17.7%) poor, and 49% of the population living on less than $2 a day. This is far from the MDG target of reducing the proportion of people below the poverty line to 7.6% of the population by 2015. Progress toward some of the health-related targets is particularly off-track. Maternal mortality rates remain stubbornly high, malnutrition and child mortality rates are higher than in many neighboring countries, and about 582,000 new cases of tuberculosis are recorded every year. The infant mortality rate is three times higher for the poorest 20% of the population than for the richest 20%, and about half of the children from the poorest quintile of households do not enroll in junior secondary school. The poor suffer disproportionately from a lack of access to quality education and health services and have lower health and education outcomes. The Government has gradually increased social sector expenditures to meet its ambitious poverty reduction and MDG-related targets. Several critical measures were initiated to expand and reorient public expenditures towards the education and health sectors, improve the efficiency of health services for the poor, and expand access, equity and quality of basic education. A significant portion of the savings generated by removal of the fuel subsidy was utilized to mitigate impacts on the poor through the Fuel Subsidy Reduction Compensation Program (PKPS-BBM) launched in 2005. The PKPS-BBM Program provided unconditional cash transfers to the poor, operational

assistance to schools (BOS), and a basic healthcare and insurance program (ASKESKIN) for the poor and quasi-poor. The Government has also initiated critical policy actions to expand and improve social sector delivery at the decentralized district level.

The proposed PRMAP fits within the context of Indonesia entering into a second generation of fiscal reforms and reorientation of fiscal resources to accelerate attainment of the MDGs and achievement of its poverty reduction and social development goals. The proposed PRMAP has thus been designed to recognize and support government reform efforts to develop and implement MDG-related policy actions, while establishing a flexible policy framework to deepen and expand the reforms in the medium term. The policy dialogue has resulted in the design and development of the PRMAP as a program cluster of three consecutive subprograms, each of them supported with a single tranche loan release.

Impact and Outcome

Impacts and outcome. The PRMAP impacts will be to accelerate progress towards achieving the MDGs ("MDG acceleration") in education (MDG 2), and health (MDGs 4, 5, 6) and contribute to the Government's poverty reduction (MDG 1) and gender equality (MDG 3) agenda. The program's outcome is improved access, equity, and quality of service delivery in the education and health sectors to accelerate progress toward the MDGs. It will be implemented in accordance with national priorities as reflected in the current medium term development plan. The program will assist the Government in the ongoing re-orientation of fiscal expenditures to the social sectors and the reduction of regional disparities. PRMAP will include three main pillars with the following policy outputs:

(i) Cross-sectoral reforms. The PRMAP support will result in: (a) an increased budget allocation for health and education, especially focused on MDG-related programs; (b) improved performance incentives and geographical resource allocation to districts for education and health; (c) a uniform system for targeting the poor to achieve health and education-related MDGs; (d) gender equity in health and education services; and (e) a planning framework for MDG acceleration.

(ii) Policy reforms in the education sector for MDG acceleration. The PRMAP will lead to: (a) improved access to junior secondary schools in under-served areas, (b) improved operations and maintenance (O&M) support for smaller/remote schools, (c) increased affordability of education by poor students/households, (d) enhanced quality and equitable deployment of teachers, (e) education service delivery that meets minimum service standards (MSSs), (f) improved planning and implementation of education services, and (g) greater transparency of education outcomes to enhance accountability.

(iii) Policy reforms in the health sector for MDG acceleration. Program support will result in (a) increased public financing of MDG-related health programs, (b) better targeting of public financing for health services for the poor, (c) improved effectiveness of maternal

neonatal and child health (MNCH) care and reproductive health (RH) service delivery through influencing provider behavior, (d) improved effectiveness of communicable disease control (CDC) through integrated programs, (e) improved performance and monitoring for health-related MDGs, and (f) improved financial information with regard to MDG-related health expenditures.

Cost Estimates and Financing Plan

Indonesia faces large financing requirements to support its ambitious poverty reduction MDG agenda over the medium term. For Subprogram 1 (SP1), the Government has requested that ADB provide a loan of $400 million. For subsequent Subprograms, the Government envisages support from ADB of $200 million each.

Program Loan Amount and Terms

The SP1 loan of $400 million from ADB's ordinary capital resources will have a 15-year term, including a grace period of 3 years; an interest rate determined in accordance with ADB's London interbank offered rate (LIBOR)-based lending facility; a commitment charge of 0.75% per annum; conversion options that may be exercised in accordance with the draft loan agreement, the loan regulations, and ADB's conversion guidelines; and such other terms and conditions set forth in the draft program loan agreement.

Program Period and Tranching

SP1 has been implemented from 1 April 2005 to 31 March 2007. All actions included in the policy matrix under SP1 have been taken during these 2 years. The program period for Subprogram 2 (SP2) is from 1 April 2007 to 31 March 2009 and Subprogram 3 (SP3) will be implemented from 1 April 2009 to 31 March 2011. The loans supporting the subprograms of PRMAP will be disbursed in a single tranche upon declaration of loan effectiveness.

Executing Agency

National Development Planning Agency (BAPPENAS)

Procurement

The loan proceeds will be used to finance the full foreign exchange costs (excluding local duties and taxes) of items produced and procured in ADB member countries, excluding ineligible items and imports financed by other bilateral and multilateral sources. In accordance with the provisions of ADB's simplified disbursement procedures for program loans,[1] the loan proceeds will be disbursed to the Borrower. No supporting import documentation will be required if the value of Indonesia's total imports minus imports from nonmember countries, ineligible imports, and imports financed under other official development assistance is equal to or greater than the amount of the loan disbursed during the given year. The Government will certify its compliance with this formula with its withdrawal request. Otherwise, import documentation under existing procedures will be required. ADB reserves the right to audit the use of loan proceeds and verify the accuracy of the Government's certification.

Technical Assistance

The proposed TA supports the strengthening of social service delivery through the implementation of national policy reforms in health and

[1] ADB. 1998. *Simplification of Disbursement Procedures and Related Requirements for Program Loans*. Manila.

education. It will support the Government's efforts to sustain the reforms introduced under SP1 and to refine and achieve the policy reforms under SP2. The TA includes three components: (i) cross-sectoral policy reforms, (ii) reforms in the education sector, and (iii) reforms in the health sector. The total cost of the TA is estimated at $2,700,000, of which $1,500,000 will be provided as a grant from ADB's Technical Assistance Special Fund, $1,000,000 will be cofinanced on a parallel basis by grants from the Australian Agency for International Development, and the rest by the Government.

Program Benefits and Beneficiaries

The key benefits expected from PRMAP are (i) the acceleration of the MDGs and sustained progress in meeting the medium-term poverty reduction and social development objectives, (ii) ongoing re-orientation of public expenditure to the social sectors, (iii) reduction of regional disparities, and (iv) increased access to better quality and more accountable education and health services.

The primary beneficiaries will mainly be the poor and women and children who lack access to quality education and health services. Improved access and equity of social services will contribute to reducing sharp regional and socioeconomic differences; reducing maternal and infant and child mortality rates; and improving control of communicable diseases such as HIV/AIDS, malaria and tuberculosis. Better physical access to schools, the removal of fees, and enhanced quality is likely to result in improved participation and transition rates to junior secondary education.

Accelerating progress towards the achievement of the MDGs will directly benefit women. The policy measures will lead to improvements in (i) girls access to junior secondary education through integrated schools and scholarship schemes, and (ii) women's access to affordable maternal and reproductive health services through increased financing and technical improvements to the ASKESKIN program.

Improved access to basic education will increase productivity and personal income of poor families in the long run. Access to affordable health services and to health insurance will increase productivity and protect the poor from catastrophic health risks, which can plunge them into deeper poverty. The PRMAP will contribute to the development of human resources to better equip the population to take advantage of the opportunities generated by economic growth. It will also have a positive impact on employment by increasing the number of healthcare providers (e.g., midwives) and improving recruitment and deployment of teachers.

Risks and Assumptions

The PRMAP is subject to the following risks:

(i) **Limited impact on education and health outcomes.** Increased central government budget allocations for education and health may encourage local governments to reduce their own allocations. The introduction of performance-based allocation mechanisms and improved systems for monitoring outcomes will mitigate these risks.

(ii) **Corruption and poor governance.** PRMAP may face constraints in the form of weak governance and corruption. However, the Government has considerably strengthened its anti-corruption efforts over recent years.

(iii) **Resistance to the policy reforms by local governments.** Lack of clarity about the reform-related roles and obligations of local government involved in social services delivery, combined with a lack of capacity could pose obstacles for reform implementation. There is also a risk that local governments do not support reforms that increase accountability and impose further monitoring of their policies and actions. Recent steps taken to clarify roles and responsibilities through development of minimum services standards, and current support provided by ADB and other development partners to a number of districts for capacity development, are expected to reduce these risks.

(iv) **External and domestic economic shocks.** Increased oil prices or other adverse regional or domestic events that have a contagion effect could reduce the fiscal space available for reform implementation. To date, Government efforts to balance the budget and improve economic management have reduced this risk.

(v) **Government commitment to the MDGs.** A lack of government commitment could reduce the momentum for policy reforms focused on accelerated achievement of the MDGs. However, Government actions indicate strong commitment to the poverty reduction and MDG acceleration agenda in the medium term.

I. THE PROPOSAL

1. I submit for your approval the following report and recommendation on a proposed program cluster for the Poverty Reduction and Millennium Development Goals Acceleration Program (PRMAP) to the Government of Indonesia, comprising (i) a first subprogram and a proposed two subsequent subprograms, (ii) a proposed loan for subprogram 1 of the PRMAP,[1] and (iii) proposed technical assistance (TA) for Strengthening Social Services Delivery.

II. THE PROGRAM AND MACROECONOMIC CONTEXT

2. Over the past 2 years, the Government of Indonesia (the Government) has made impressive progress in macroeconomic management, and succeeded in returning the economy to an economic growth path. During this period the Government consolidated gains made over the past few years and instituted wide-ranging structural reforms in various sectors to remove distortions that led to the 1997 financial crisis. 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. Fiscal consolidation has been the central feature of the Government's macroeconomic management. Since the Asian financial crisis of 1997, the Government's principal focus has been on recouping the massive cost of financial sector restructuring, estimated at upwards of $75 billion, or over a third of Indonesia's annual GDP.

3. Economic vulnerability to external shocks has been decreasing due to sound debt management. The central government budget deficit has been reduced from 2.8% to 0.9% of GDP over the 2000–2006 period, while the government debt-to-GDP ratio decreased from 90% to 39.6% over the same period, heading towards the target of 30% by 2010. In 2006, Indonesia prepaid $7.6 billion owed to the International Monetary Fund (IMF). Foreign exchange reserves, supported by returning capital inflows, rose sharply in 2006, from $24.7 billion to $42.6 billion. The ratio of total external debt to GDP fell from 46.7% in 2005 to 34.0% in 2006. However, there are still some debt concerns, due to the fact that around 20% of all tax revenue is needed to pay public debt services. Increased public spending will lead to a rise in the budget deficit from the initial estimate of 0.9% to 1.6% of GDP for 2007. The Jakarta floods in 2007, mudflows in East Java, earthquake damage in East Sumatra and rice purchases for buffer stocks to stabilize prices will contribute to this increase.

4. In 2005, the Government addressed one of the most critical distortions by increasing domestic fuel-oil prices by 29% in March and subsequently by 126% in October. This move saved about $5 billion in 2005 and $10 billion in 2006 that would otherwise have been spent on unproductive fuel subsidies, which were largely regressive and benefited mainly the middle classes. Due to fuel price increases, inflation accelerated to over 18% in October 2005. The central bank raised interest rates from 8% to 9.75% between October 2005 to December 2006 to counter the upward pressure on prices. High interest rates and inflation have had negative consequences on the poor and near-poor. In September 2006, the Central Board of Statistics (BPS) reported an increase from 16.0% to 17.7% in the poverty head count index between February 2005 and March 2006.

5. While the Government has largely managed to attain its goal of fiscal prudence, in the past it has 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 in parity with its regional neighbors. From 1985 to 2001, health sector funding averaged less than 3% of total public expenditure and about 0.5% of GDP, which is much lower

[1] The design and monitoring framework is in Appendix 1.

than the average for ASEAN countries of 2.5% of GDP. In 2001, public expenditure on education was only 2.4% of GDP, one of the lowest rates among similar countries in the region. The past low level of financing has constrained delivery of the quality basic social services required to meet the economy's human capital development needs.

6. Mindful of the need to transform economic growth into sustainable broad-based development, the Government has been gradually increasing public expenditures for the social sectors and providing additional funds to local governments for health and education. The Government has acknowledged that increases in overall social sector expenditures are required if its ambitious targets relating to poverty reduction and accelerated achievement of the Millennium Development Goals (MDGs) ("MDG acceleration") are to be achieved. The 2007 Indonesia Public Expenditure Review (PER)[2] showed that total public education and health expenditures increased significantly from 2001 to 2006. During this period, education expenditures increased from 11.4% to 17.2% of overall national expenditure, while health expenditures rose from 2.6% to 4.5%; measured as a share of GDP, education expenditures rose from 2.4% to 3.6%, and health expenditures from 0.55% to 0.95%. Despite significant increases, Indonesia still spends significantly less than its neighbors on education and health. Annual expenditures on the order of 4% of GDP in both the health and education sectors are required to achieve basic improvements in human development and achievement of the MDGs.

7. Debt management and steady economic growth combined with the creation of additional fiscal space has provided the confidence to increase public expenditures for tackling poverty reduction and investing in health and education. A significant portion of the savings generated by removal of the fuel subsidy was utilized to mitigate the impacts of the fuel price increases on the poor. In 2005, the Government launched a Fuel Subsidy Reduction Compensation Program (PKPS-BBM) focused on the poor. This released funds for pro-poor social expenditures. The PKPS-BBM included four different sub-programs: (i) unconditional cash transfers to the poor, (ii) operational assistance to schools (*bantuan operational sekolah,* [BOS]), (iii) basic health care and health insurance (ASKESKIN program) for the poor and quasi-poor, and (iv) a rural infrastructure program.

8. While increased investments in the social sectors are critical, the Government has been acutely aware of other constraints that impede efficient public expenditure management, including (i) limited capacity at the district level to design and deliver education and health expenditure programs, resulting from the rapid pace at which decentralization reforms were introduced; and (ii) political and regional autonomy considerations, which had to be balanced with the devolution of resources and responsibilities for education and health service delivery to the districts to ensure that national policy objectives, such as the attainment of the MDGs, are achieved. Fundamental challenges have emerged in relation to the lack of clarity on functional assignments, financial management, accountability, and monitoring and evaluation of the efficiency of public social expenditure programs. In light of these constraints, the Government, with the support of ADB and other development partners, has adopted comprehensive reforms to strengthen the overall policy, legal and regulatory framework relating to local government finance.

9. In 2005, the Government requested that ADB provide a program loan to support its poverty reduction and social development objectives over the medium term. The program would be designed to support the education and health reform agenda and improve the effectiveness of public expenditure programs targeted at accelerating achievement of the health- and education-related MDGs. Since early 2005, ADB has been engaged in an MDG-related policy

[2] World Bank, BAPPENAS, and MOF. 2007. *Indonesia Spending for Development: Public Expenditure Review.* Washington, DC.

dialogue with the Government and other relevant development partners. ADB has prepared assessments of the education and health sectors, identified constraints, and discussed key sector issues and related medium-term reforms for the attainment of the MDGs with relevant ministries. Policy dialogue was conducted through several consultations; pre-fact-finding, fact-finding, and appraisal missions; and ongoing policy dialogue by Indonesia Resident Mission and ADB teams working on health and education projects. During this period, the Government has taken initial critical steps and instituted a range of policy actions to set the pace for reforms aimed at accelerating achievement of the MDGs. The Government requested that ADB work towards a medium-term commitment of resources to support the MDG acceleration program, with particular attention to the health and education sectors.

10. Indonesia is entering into a second generation of fiscal reforms and reorientation of fiscal resources, aimed at achievement of the MDGs within a stable macroeconomic framework, and the proposed PRMAP fits within this context, which is characterized by the Government's objectives of: (i) enhancing the quantity and quality of social public expenditures; (ii) improving local government accountability without stifling basic regional autonomy principles; and (iii) adopting sound and sustainable resource allocation mechanisms to target poverty reduction and MDG acceleration, especially in lagging areas. Viewed within the above macroeconomic context, Indonesia is emerging as a middle-income country that seeks flexible financing arrangements to support its development objectives. As a result, the proposed PRMAP has been designed to recognize and support Government reform efforts to develop and implement policy actions leading to MDG acceleration, while establishing a flexible policy framework to deepen and expand the reforms in the medium term. The policy dialogue has resulted in the design and development of the PRMAP as a program cluster of three consecutive subprograms (SP), each supported with a single tranche loan release. Subject to satisfactory progress, the three subprograms will be phased at intervals of about 2 years.

III. THE SECTORS

A. Sector Description and Performance

11. At the Millennium Summit in September 2000, the Government committed to meeting the MDGs by 2015, and the Government reiterated this commitment and presented the country's 2005 MDG progress report[3] at the UN General Assembly in September 2005. The President of Indonesia renewed and reinforced Indonesia's commitment to the MDGs during the state address for the presentation of the 2007 budget. Special attention was given to issues of poverty, education and health. The Government's Medium Term Development Plan for 2005–2009 (RPJM) and its National Poverty Reduction Strategy (SNPK), are characterized by a strong focus on policies and programs for social justice, equity and quality of basic social services, especially health and education.

12. The RPJM, which presents the Government medium-term vision, lays out an ambitious poverty reduction and social development agenda. The RPJM identifies the advancement of the welfare of the people as one its three pillars and includes targets for poverty reduction at the national level, reduction of inter-regional differences, and improvement of human capital through increased access to and quality of education and health services. The RPJM sets social targets for 2009, some of which are more ambitious than the MDGs, including: (i) halving the 2004 national poverty rate (from 16.6% to 8.2%); (ii) providing 9 years of compulsory, quality basic education; (iii) reducing illiteracy to 5%; (iv) reducing child mortality to 26 per 1,000 live births; and (v) achieving a decline in maternal mortality to 226 per 100,000 live births. It is recognized

[3] The 2007 MDG report for Indonesia is under preparation.

that a major expansion of the budget allocation for social services is required to increase service coverage and improve quality, particularly for health services (there is a constitutional obligation to allocate 20% of the total Government budget for education services).[4]

13. The MDGs form an overarching framework that places basic human rights and poverty at the center of the development agenda. Indonesia's progress towards meeting the MDG targets has been mixed. While the country has made good progress overall, progress toward several targets is slow. Despite the Government's efforts, vast differences exist across regions and districts and between rural and urban areas, as well as between income groups; there are also some persistent gender disparities. A recent study to assess MDG progress in Asia and the Pacific classified Indonesia as one of the countries of greatest concern, both with respect to the level of deprivation and the level of progress towards the MDGs.[5] Indonesia's performance and progress on the MDGs is provided below.[6] A summary of key indicators measuring progress toward the MDGs and targets is presented in Appendix 2.

14. **Eradicating Extreme Poverty (MDG 1).** Significant progress has been achieved in reducing income poverty. Despite the setback of the Asian financial crisis, income poverty declined steadily from the 1999 level of 23.4% to 16% in February 2005, comparable to pre-crisis levels. However, by March 2006, an additional 4 million people fell into poverty, largely due to the removal of fuel subsidies and increases in the price of rice, resulting in a poverty incidence of about 17.7%; this is far from the MDG target of 7.6% by 2015,[7] or the Government's target of 8.2% by 2009. This level of poverty incidence translates to almost 40 million poor people, with many more (about 49% of the population) living on less than $2 a day, and vast regional differences. While four provinces have less than 10% of their population under the poverty line (with Jakarta at 3.4%), at least 14 provinces have poverty levels of more than 20% (with Papua at about 50%).

15. **Achieving Universal Basic Education (MDG 2).** Indonesia's performance relative to the education-related MDG has been mixed. It has made good progress towards meeting some of the intermediate targets at the national level, however regional disparities are still significant. The Government is aiming beyond the standard MDG 2, as it has included both primary (1 to 6) and junior secondary (7 to 9) education levels in its universal basic education target. While the primary school gross enrolment rate (GER) achieved universal coverage by the early 1980s, and stayed high despite the financial crisis of the late 1990s, the net enrolment rate (NER) has made only small steady increases (from 91.5% in 1995 to 94.0% in 2005). The GER for junior secondary rose from 65.7% in 1995 to 85.2% in 2005, while the NER rose from 51% in 1995 to 63.7% in 2005.[8] The Government target is to raise the GER in junior secondary education to 95% by 2008.

16. Despite the impressive GERs and NERs, disparities in access to education continue to exist (i) within provinces, (ii) between rural and urban areas, and (iii) between the rich and poor. The NER for junior secondary school in 2006 ranged from 43.3% in Nusa Tenggara Timur (NTT) to 77.4% in D.I Yogyakarta, although these have been narrowing over the last decade.

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[4] Amended 1945 Constitution (Amendment 4, 2002) Article 31.

[5] ADB, UNDP, UNESCAP. 2006. *The Millennium Development Goals: Progress in Asia and the Pacific 2006*. Manila.

[6] The analysis does not include MDGs 7 and 8, which are not supported by PRMAP.

[7] Poverty incidence in 1990, using the national poverty line, was 15.1%. In order to reach the MDG target of halving poverty between 1990 and 2015, the proportion of people below the poverty line should be 7.6% by 2015.

[8] Differences in the GER and NER indicate that the school system is catering to underage and over age children within the school population, indicating system inefficiencies. Similarly, gains in NERs have begun to stagnate indicating access barriers and constraints. While the NER is a good measure of entry into school, one of its key limitations is that it does not capture the level of school attendance or completion.

While the gap in the NER at the primary level between the rich and poor is very small, this widens at the junior secondary level. In 2002, only 45.5% of children from the poorest income quintile enrolled in junior secondary education, compared with 76.9% of children from the richest quintile, indicating that access constraints to education are significantly poverty-related.

17. Furthermore, not all Indonesian children enrolled in school complete basic education within the required 9 years. Around 686,000 children drop out of primary school annually, and children who fail to complete primary education are especially at risk of becoming illiterate adults. In 2004/2005, the primary to junior secondary transition rate stood at 82.6%, with 17.4% of students who completed primary education not continuing on to junior secondary. Despite steady achievements in increasing school enrolment, Indonesia's national average educational attainment is low compared to neighboring countries. In 2003, Indonesians aged 15 years and above had an average of 7.44 years of schooling; only 36.2% had an education equal to or above the junior secondary level.

18. **Promoting Gender Equality and Empowering Women (MDG 3).** Indonesia is on track to eliminate gender disparity in primary and secondary education by 2015. The gender gap in terms of the NER at the national level has been eliminated at the primary level, and reversed for the junior secondary level. At the senior secondary level in 2003, the female NER of 37.7% lagged slightly behind the male rate of 38.8%. While the gender gap in adult literacy rates has been narrowing steadily, the literacy rate of women (86%) is still lower than that of men (94%). Women have a mean of 6.5 years of schooling, while the mean for men is 7.6 years.[9]

19. **Reducing Child Mortality (MDG 4).** Indonesia is currently on track to achieve the MDG target of reducing the under-5 mortality rate by two thirds between 1990 and 2015. Between 1990 and 2004 under-5 mortality decreased from 97 per 1,000 live births to 38, which is still higher than similar countries in the region, but close to the MDG target of 32.3. There are still sharp regional and socioeconomic differences in child mortality rates, however, ranging from 23 deaths per 1,000 births in Yogyakarta to 103 in West Nusa Tenggara. The differences between the rich and poor in the under-5 mortality rate are still some of the sharpest observed in Asia, with about 20 deaths per 1000 births among the richest quintile, compared with 75 deaths among the poorest quintile.

20. **Improve Maternal Health (MDG 5).** Although considerable progress has been made toward achieving the target of reducing by three fourths the maternal mortality ratio (MMR), progress to date has not been sufficiently rapid to indicate achievement of this target. The estimated MMR has declined from 390 to 307 per 100,000 live births between 1994 and 2002, which is very far from the 2015 MDG target of 102. During the period 1992 to 2002, the proportion of births assisted by skilled health personnel (an important MDG 5 intermediate indicator) has increased from 40.7% to 72.0%, but is still far from the government target of 90% by 2010. Sharp socioeconomic differences remain, with only 48% of poor women delivering with a trained provider, compared with 90% of wealthy women; regional disparities are also marked, with just 35% of women delivering with a trained provider in NTT, compared with 96% in Jakarta.

21. **Combat HIVAIDS, Malaria, and Other Diseases (MDG 6).** Indonesia is not on track to achieve the MDG targets for HIV/AIDS and malaria, although is on track for tuberculosis (TB). The HIV/AIDS epidemic is concentrated in a few high-prevalence groups (i.e., commercial sex workers and injecting drug users). It is estimated that about 193,000 Indonesians lived with HIV/AIDS and about 5,500 died of AIDS in 2006, while about 18,000 are orphans due to the

[9] ADB. 2006. *Indonesia: Country Gender Assessment*. Manila.

disease. The incidence of condom use with high-risk partners is still low, while comprehensive correct knowledge about HIV/AIDS is still limited to the better educated.

22. Nearly one-half of Indonesia's population lives in malaria-endemic areas, and about 30 million cases are expected to occur every year. Although bed net coverage is reasonably high, use of insecticide-treated bed nets and indoor spraying are still limited. Unless funding for malaria control is increased significantly in the future, it is unlikely that malaria incidence will have begun to decrease by 2015. Indonesia's estimated TB prevalence rate remains high, at 125 per 100,000 people. Although the directly observed treatment—short course (DOTS) treatment success rate has increased sharply during the past few years, reaching 57% in 2005, it is still far from the Government target of 85%.

B. Issues and Opportunities[10]

1. Issues

a. Cross-Sectoral Issues

23. The MDGs will not be achieved unless the poor have better access to, and utilize, affordable and good quality health and education services. Policies and programs are needed that: (i) increase and better target budgetary allocations for health and education services at the district level; (ii) improve the quality and efficiency of these services; (iii) improve public sector governance; (iv) monitor and evaluate outcomes; and (v) develop efficient and transparent accountability mechanisms between national and regional governments, service providers, users and communities to improve performance.

24. Decentralization has posed considerable challenges to the delivery of education and health services, resulting in significant differences in outcomes and performance across local governments. Basic education and health services are obligatory functions of the district government.[11] However, the central government still has a key role in the allocation of resources and the development of policies, legislation and guidelines. In principle, the switch to a decentralized system for the provision of social services should positively affect access, equity and effectiveness of service delivery. However, devolving the responsibility for education and health care to the districts has reduced the Government's capacity to implement and monitor its national policy objectives, including the achievement of the MDGs. Disparities among districts in capacity and per-capita health and education expenditure has led to critical gaps in access and quality of service provision in some districts. Improvements in the mechanisms for allocating funds to the provinces and districts are required to (i) better target poorly performing districts that need additional assistance (so-called "MDG-deficit districts"); and (ii) encourage local governments to improve performance in the health and education sectors, so as to achieve the MDGs.

25. **Need to Improve Fund Allocation for MDG-Deficit Districts.** Local governments have been granted substantial fiscal autonomy through the introduction of an intergovernmental fiscal transfer system that includes elements of revenue sharing, a general development fund (Dana Alokasi Umum, or DAU),[12] and a special development fund (Dana Alokasi Khusus, or DAK).

[10] Appendix 3 includes a summary sector analysis for the health and education sectors, and Supplementary Appendices A and B include detailed analyses.

[11] Law 32 of 2004 gives provincial governors responsibility for assessing district budgets to ensure that districts comply with their obligatory functions. However, the districts retain the main responsibility for the provision of education and health services. The Ministry of Home Affairs (MOHA) is preparing, in 2007, a new government regulation that will further clarify the roles and responsibilities of each level of government.

[12] DAU represents about 80% of local government revenues and is largely allocated for salaries of health and education staff devolved to the districts. The Government is discussing different options for the reform of the DAU

Although these mechanisms are meant to assist local governments without sufficient resources of their own, the current distribution criteria do not allow a focus on the poorest districts, or those not on track to achieve the MDGs. For example, the DAK allocation for education is not linked to enrolment rates in primary or junior secondary schools, and the DAK allocation for health is not related to the use of skilled health personnel.

26. **Uneven Performance by Districts in the Delivery of Health and Education Services.** The PER estimated that 70% of education and health expenditures are made at the sub-national level, mostly by district governments.[13] In most districts the majority of the budget for these sectors is allocated for salary and benefits, and the percentage allocated to development expenditures and other recurrent activities, including maintenance and operations, has been historically very small. Furthermore, there are significant disparities between districts in the per capita public expenditures for health and education,[14] which translate into inequalities in service provision across districts. Many districts need to improve their planning and budgeting systems, fiduciary controls, and education and health expenditure monitoring to make them more efficient, transparent and better targeted to the poor. An increased resource allocation to the social sectors is required to improve health and education outcomes and performance, particularly by poor and MDG-deficit districts. Current transfers from the Government to the districts are not linked to outcomes or performance.

27. **The Reform of the DAK Offers an Opportunity to Provide Additional Resources to districts for MDG Programs and to Improve Performance.** The purpose of the DAK is to (i) address basic services that have not met certain standards, and (ii) support areas requiring accelerated development. DAK allocations are earmarked by the Government to specific sectors and districts. Each year, Parliament establishes the total DAK amount, with the overall level of DAK resources allocated to each of the sectors agreed upon by the (i) Ministry of Finance (MOF), (ii) Ministry of Home Affairs (MOHA), (iii) National Development Planning Agency (BAPPENAS), and (iv) the respective line ministries. Subsequently, the line ministries earmark these resources to specific uses in particular local governments within their sectors. For FY2007, DAK allocations are broken down into seven different sectors, with education and health jointly representing more than 50% of the total DAK.[15] The allocation of DAK resources for health and education to specific districts is not linked to performance or progress on MDG achievement. There is also a high degree of unpredictability regarding the flow of funds, due to annual modifications of the allocation criteria, which distorts district-level plans and budgets. Furthermore, the DAK has remained basically undeveloped until recently, comprising a small percentage of all central government transfers to districts, and of all capital development resources. However, with the significant increases in DAK financing for 2005–2007, there are plans to introduce performance criteria for DAK allocations. The expansion and development of DAK into a more efficient mechanism for funding social sectors also offers an opportunity to direct increased resources to MDG-deficit districts.

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in 2008 to transform it into a more efficient instrument to provide additional funds to the poorest districts. The Local Government Finance and Governance Reform II program, currently under preparation by ADB, is expected to support the Government in these reforms.

[13] In 2004, districts spent about 63% of the total national education budget and 49% of the total national health budget, while the provinces spend about 6% and 18% respectively for education and health.

[14] There is a positive relationship between the level of district revenue and education and health expenditures, with hardly any variation in the share of district spending on health, at about 8%, and small variations for education, at around 33%. This translates into significant discrepancies in per capita allocations.

[15] Districts must provide matching funds of 10% equivalent of the central government contribution (except for the poorest districts) from their own local budgets; they receive quarterly payments after they have demonstrated that they have spent the funds from the previous quarter.

28. **Lack of a Uniform System for Targeting the Poor.** A good quality targeting system is fundamental to making health and education programs for the poor and near-poor more efficient, and requires accurate identification of the poor. Despite government efforts, a recent review of the targeting performance of past programs[16] revealed that only 12% of households in the poorest quintile were covered by scholarship programs, while 22% had access to health cards. Similarly, only 40% of the benefits of scholarship programs went to the poorest quintile, and just 31% of the health cards were distributed to them. Both the BOS and ASKESKIN programs have also identified the difficulty of accurately targeting the poor. The use by each program of different registries of the poor and different targeting criteria[17] has significantly contributed to this. Developing a uniform database of the poor and effective targeting mechanisms, while providing some allowance for local flexibility, is crucial for delivery of education and health programs aimed to address gaps and disparities.

29. **Gender Equality and Empowerment of Women** is central to accelerating achievement of all the MDGs. Without direct improvements in women's health, education, access to formal employment and decision-making, the MDGs are unlikely to be met. A recent household risk and vulnerability assessment[18] shows that poor and near-poor households in Indonesia headed by females have higher maternal mortality, greater risk of experiencing health shocks, less access to pre-natal care, lower levels of school attendance and a higher incidence of child labor. MDG 3 (promoting gender equality and empowerment of women) and MDG 5 (improving maternal mortality) focus directly on women. MDG 2 (focusing on education), MDG 4 (relating to child mortality) and MDG 6 (on communicable disease control [CDC], and especially the HIV/AIDS target), cannot be met without significant economic and social improvements in the lives of women and girls. The achievement of MDG 3 depends on the extent to which actions taken to achieve all the other goals are designed to promote equality between men and women and girls and boys. In other words, the achievement of MDG 3 requires both direct actions and a focus on the interdependence among all the goals. As a crosscutting theme, gender equality and women's empowerment needs to be integrated and mainstreamed across all MDG-related policies, sectors and programs. Sex-disaggregated indicators are required for (i) measuring progress and (ii) improved monitoring of both MDG 3 and the gender equity aspects of all the other goals.

30. **Female Illiteracy**. About 12.8 million Indonesians (8.17% of the population) aged 15 years and above are illiterate. Two-thirds are women from remote or isolated areas with limited access to educational opportunities. In 2005, 12.5% of females aged 10 and above could not read and write, as compared with 5.7% of men. While gender parity in literacy rates has been achieved for those aged 15–24, improving the literacy levels of females, especially those of reproductive age, remains a challenge. Improved female literacy has implications for all the health and education-related MDGs. Literate mothers are more likely to access and utilize education and health services for children. Literate females have fewer children and engage in better birth-spacing practices, reducing the risk of maternal mortality. There is a strong correlation between a mother's literacy level and the life expectancy of a child at birth.

31. **Lack of a Planning Framework for MDG Acceleration.** The lack of a comprehensive roadmap for accelerating achievement of the MDGs has made it difficult for the Government to

[16] Social Safety Net Program for the Health Sector (JPSBK) and Scholarships (BKM) program for the education sector.

[17] World Bank. 2006. *Making the New Indonesia Work for the Poor.* Washington, DC (page 207). Targeting of scholarships was determined by school principals and school committees, while the health cards introduced in 1998 were targeted by district health offices through community identification of the poor.

[18] World Bank. 2006. *Making the New Indonesia Work for the Poor.* Washington, DC.

measure and regularly and accurately report results relating to MDG targets and deficit districts. The division of responsibilities among different government agencies has constrained analyses, and the design and implementation of policy actions to accelerate achievement of the MDGs. The failure to identify appropriate MDG-related indicators and collect accurate data are constraints to the identification of MDG-deficit regions and districts and allocation of resources based on needs and performance across sectors and regions. The lack of a comprehensive and regular mechanism for the compilation, processing and analysis of MDG-related data has contributed to gaps and weaknesses in the preparation of MDG reports. The central and local governments' lack of guidelines and knowledge regarding the implications of adopting MDG targets has made it difficult to mainstream MDGs in the preparation of the annual and medium-term plans and budgets of the ministries and districts, and in the poverty reduction strategies prepared by some regional governments. A comprehensive roadmap is needed to accelerate achievement of the MDGs by holistically addressing the challenges and identifying practical solutions and priority sectors and areas.

b. Education Sector

32. **Unequal Access to Basic Education.** There are about 1.8 million children in the country aged 13–15 who lack access to basic education. Achievement of the education-related MDG targets depends upon a steady increase in both net enrolment and completion rates at both the primary and junior secondary levels. More critically, it depends upon increasing the transition rate from primary to junior secondary schools. Key factors affecting net enrolment and transition rates include (i) substantial cost barriers (e.g. fees, transport cost, textbooks, stationary, and uniforms); (ii) uneven coverage of facilities within and between districts; and (iii) perceptions about the relevance of the curriculum and future employability of school graduates.

33. Poverty is a major barrier to completion of basic education, particularly for junior secondary schools. Children from poor families either fail to enroll or drop out early, due to the physical distance from educational facilities[19] and cost of education, including uniforms, books, stationary and "informal" fees. Financial contributions are still required, and can take creative forms, such as fines imposed on students, and regular requests for voluntary contributions and "seat fees". In 2004, about 44% of the households in the poorest quintile who had children enrolled at the junior secondary level reported difficulties in financing schools fees; they paid about 7% of total household expenditures for each enrolled student. In some cases, the opportunity cost of school attendance is too high, as the children have to contribute to household income.

34. Significant disparities exist in the level of funding received by schools, and in spending per student across districts. In 2005, the Government increased the funding provisions for school operations and maintenance (O&M), through the establishment of BOS, based on student head counts for all schools. BOS is addressing some of these disparities, including indirectly reducing the need for parental contributions to school operating costs through informal "fees". There are also infrastructure development needs, as the large number of primary schools built in the 1970s need rehabilitation, while expansion and rehabilitation is also needed at the junior secondary level.[20] Reducing urban-rural disparities within districts and income-related disparities at the post primary level poses a significant challenge to achievement of the goal of universal basic education.

[19] There are significant regional disparities in the average distance to junior secondary schools, which ranges from 1.9 km in Java to 16.6 km in Papua. On average, transportation is an important cost for junior secondary students in the two poorest quintiles, and represents 17% of their total expenses for education; school fees account for 32% of education expenses.

[20] A survey from MONE in 2004 concluded that 27.3% of the classrooms in secondary schools were damaged.

35. Adoption of the primary and junior secondary integrated school construction strategy constitutes an effective approach to reducing current access barriers, especially those of distance to school and related costs. A clearly defined implementation plan, including targeting and eligibility criteria for integrated school construction, especially in under-served areas, is critical if access policy targets are to be achieved. The introduction of the BOS also represents a cost-effective strategy for indirectly reducing access-related cost barriers and maintaining operations. However, the current BOS funding levels and allocation guidelines are not sufficiently robust. In the case of very poor families, BOS funding may be insufficient to sustain demand and additional scholarships or a conditional cash transfer (CCT) scheme will be required.

36. **Quality, Efficiency, and Effectiveness**. While the country's education and training systems are making adjustments to respond effectively to emerging demographic and labor market demands, Indonesia's national average educational attainment is low compared to neighboring countries. In 2006, pass rates in junior secondary examinations averaged 92% (ranging from 65% to 98%). Student examination performance varies widely across districts, with pass rates in poorer, rural and remote areas consistently below average. Education outcomes, as measured by international programs that assess student skills and learning achievement across countries, confirm the low quality of education.[21]

37. A number of factors contribute to low and uneven quality and standards. In many schools and districts, public spending on education frequently covers only teacher salaries, with non-personnel operational spending accounting for as little as 5%–10% of spending in many districts. Consequently, there are frequent shortages of funds for instructional materials, staff development and routine maintenance of school buildings. Regional differences are exacerbated by the wide variation in provincial and district local revenues and expenditure capacity, often resulting in wide variations in education standards between better and less well-off provinces and districts.

38. The development of national education standards and progressive application of minimum service standards (MSSs) that define the "quality and quantity" of critical education services, linked to clearly defined responsibilities at provincial, district and school levels, are required to improve the quality of basic education. Developing a small number of measurable and achievable MSSs on critical aspects such as teacher training and certification, school facilities and learning materials can help anchor the Government's decentralized strategy to improve access to and quality of education. The MSSs could also be used as a key criterion for budget prioritization and allocation, and the indicators selected for this purpose should be closely linked to the attainment of MDG 2.

39. Another key constraint to quality improvement is the significant proportion of under-qualified teaching staff at all levels. In 2006, it was estimated that only 16.4% of primary school teachers and 59.1% of junior secondary teachers were qualified. Significant problems that need to be addressed to improve the quality of education services include (i) inequitable deployment of existing teachers within districts; (ii) teacher absenteeism (estimated at about 19%); and (iii) weak expertise of teachers in priority subject areas, such as math and science. Special incentive programs need to be developed to attract teachers to remote areas.

[21] In 2003, the Trends in International Mathematics and Science Study (TIMSS), and the Program for International Student Assessment (PISA) revealed deficiencies in the standard of education among 12-year-olds and 15-year-olds, respectively.

40. The challenge is to adopt and implement a systemic approach to addressing these constraints. Strategic options to improve teacher recruitment, qualifications, and incentives for deployment to rural schools, including madrasah, are currently being reviewed. Alternative approaches to expanding cost effective teacher upgrading systems are also being explored, while national standards and MSSs for priority standards are under preparation. While the development of MSSs provides an important basis for defining service standards, any definition of performance needs to make the link between service delivery and the quality of education outcomes at the district and school level.

41. **Governance, Transparency, and Accountability**. Although both the Ministry of National Education (MONE) and the Ministry of Religious Affairs (MORA) are governed by the National Education Law of 2003, each ministry has formulated separate education strategic plans[22] with different financial strategies, due to their different roles under the decentralized administration. Better alignment of these plans, strategies and operations in support of education service delivery at the district level is needed. Fragmentation of education planning and financial management systems has created a number of constraints for districts and schools. The current system of multiple financial allocations—by MONE, MORA, provinces, and districts—makes it difficult to capture all financial resources received by each school, and complicates the preparation by districts of local education plans and budgets, as the districts' total funding cannot be accurately predicted. Disparate policy objectives and priorities, financial management systems, and reporting add to the confusion at the local level.

42. To balance national and local priorities, mechanisms for coordination of local-level budgeting, planning and allocation from multiple sources need to be improved, as does the reliability and predictability of central-local funding transfers; to enable multi-year planning, the criteria for such transfers need to be made more transparent. At the institutional level, there are tremendous opportunities for enhancement of service delivery through organizational restructuring and retraining at all levels of government, in accordance with the Government's decentralization policies aimed at improving the planning, financing and implementation of education services. While the role of MONE as a policy-making, standard-setting, and monitoring and evaluation agency is now being articulated, the ministry has not transformed itself sufficiently to be effective in this new role.

43. Increased resource allocation for the education sector should be accompanied by improved governance, to ensure accountability in the use of these resources, and to reduce corruption. Greater transparency of education outcomes is required to increase the accountability of schools and districts. At the community level, the role and effectiveness of education boards and school committees as governance bodies distinct from management structures is still evolving. Most of these committees in MONE-managed schools meet infrequently—only about 20% meet at least once a month—and women's participation is low. The situation in madrasah is reportedly more encouraging, due to their longer tradition of community participation in school affairs.

c. Health Sector

44. **Limited Access to MNCH and CDC Health Services for the Poor and Women.** Indonesia's health sector has been under-funded for many years, resulting in the gradual erosion of the public health system as a provider of both preventive and curative health services. Despite significant health budget increases in 2003 and 2004, Indonesia remains

[22] MONE. 2005. *Medium Term Plan 2005–2009*. Jakarta; and MORA. 2004. *Madrasah Sector Assessment.* Jakarta.

behind other countries in the region with similar level of development.[23] The central budget allocation to critical MDG-related MNCH and CDC services has been low, and a significant portion of health subsidies have not benefited the poor. De-concentrated expenditure provided by MOH to the regions, which in 2004 represented about 33% of total public health expenditure, did not particularly target the poor or MDG-deficit districts. Furthermore, some local governments, particularly those with weak fiscal capacity, allocate insufficient resources for improving MNCH and CDC services. Limited health-sector spending has resulted in low health facility density, insufficient funds for O&M, limited availability of drugs, and low retention of public health staff.

45. Public health services are underutilized, in particular by the poor and by women, due to: (i) the poor quality of care in government health facilities; (ii) the frequent absence of health staff; (iii) limited availability of drugs and supplies; (iv) high direct and indirect service costs; and (v) the low density of government health facilities, which increases the distance traveled to access care. Most infant deaths occur during the first month after birth, due mainly to poor maternal health and nutrition, the poor quality of MNCH services, and the healthcare-seeking behavior of pregnant women and their families. Only 14% of mothers practice exclusive breastfeeding during the first 6 months after birth. While immunization rates of 12 to 23 month-old children increased in 2004 to about 90%, immunization dropout rates tend to be high among children from poorer households. Limited use of health services for prenatal and postnatal care, family planning, and CDC (for diseases such as malaria, HIV/AIDS and TB) affects progress towards achieving the health-related MDGs.

46. A significant reduction in maternal mortality[24] requires a strategic focus on increasing the percentage of facility-based deliveries and births attended by skilled midwives, developing an efficient referral system, and increasing the use of contraceptives.[25] Only 72% of births are attended by skilled personnel, compared with 99% in Thailand and 97% in Malaysia. Women that deliver in health facilities have better access to emergency or referral care in case of complications. However, a majority of deliveries still occur in the home (about 60%). Access to health facilities or professionally trained health personnel varies between regions and across socioeconomic groups. Average distance to a midwife ranges from 12–30 km in Papua to 1.5 km in Java and Bali.

47. HIV/AIDS, malaria, and TB are important communicable diseases in Indonesia, which affect both child and maternal health. The current challenge is to reduce the current HIV epidemic in high-risk groups and to prevent its further spread into the general population. A major barrier to malaria control is the cost of accessing impregnated bed nets. In Indonesia, CDC programs have been organized vertically, resulting in fragmented service delivery. Comprehensive strategies promoting integrated health services that allow for sharing of resources or pooling of funds can support the containment and reversal of the TB and HIV/AIDS epidemics.

48. Even when MNCH and CDC services are locally available, many of the poor still suffer from access constraints due to the high costs of health care. Out of pocket expenditures—including user fees, the cost of drugs, and transportation—are estimated to equal some 70% of

[23] The Philippines spends about 6% of the total government budget and about 3.2% of its GDP, while Thailand spends 13.6% of its budget and 3.3% of its GDP.

[24] The main causes of maternal death include hemorrhaging (25–45%), eclampsia (13%), abortion complications (11%), and post-natal infections (10%). Underlying factors that also contribute to maternal death include: (i) poor maternal nutrition, such as iron-deficiency anemia, vitamin A deficiency, and protein-energy malnutrition; and (ii) infectious diseases, such as malaria, TB, hepatitis and HIV/AIDS.

[25] The Government's continuing policy has limitations, as contraceptives are not available to unmarried women through public channels.

total health expenditures. The opportunity cost for women is higher due to the time spent on obtaining cost-effective health care for themselves and their children. Low education and lack of information about available options also limits utilization of health services by the poor and women.

49. The ASKESKIN program addresses some of these constraints by removing the cost barriers to accessing health services by the poor and near-poor, especially women. The program has two components. The first component provides free healthcare services at public health centers (puskesmas) and the second provides inpatient treatment in "third class" hospitals for the poor. The program is demand-oriented and responds to utilization rates of health services. ASKESKIN benefits are comprehensive (including generic drugs), and there are no deductibles or co-payments. In spite of the initial success of ASKESKIN, further information and evaluation of program impacts are required on (i) utilization rates of health services by type of service, profile of users, and amounts expended by districts to complement the program; and (ii) opportunities to provide feedback to providers on the quality of care rendered through services delivered.

50. **Poor Quality, Efficiency, and Effectiveness of Health Service Delivery.** Government health providers often lack incentives to work in remote areas and to provide services in sufficient quantity and quality, especially for the poor. It is reported that government health workers are frequently absent from their posts.[26] The national aggregate ratios of doctors and midwives to the population are below the 2010 Healthy Indonesia targets, and much lower than found in other countries in the region. There are only 13 doctors and 200 midwives for every 100,000 people. There are also significant variations in the distribution of health personnel per capita between regions. For example, there are 30–40 doctors per 100,000 population in North Sulawesi and Bali, compared with just 6 per 100,000 in Lampung and East Java. Some provinces only have 20 midwives per 100,000 people.[27] MOH has implemented several programs in the past to improve the distribution of doctors and midwives to remote and underserved areas. However, these programs have faced challenges in retaining and motivating health service providers. They have also failed to significantly improve the distribution or retention of providers in poor or remote areas due to insufficient incentives and resulting low levels of remuneration, poor housing, and a lack of water and sanitation facilities.

51. The ASKESKIN program has the potential to modify its reimbursement methods to better motivate providers to deliver key MDG-related services. Under this program, MOH has contracted PT Askes, a parastatal, to reimburse hospitals on a fee-for-services basis for both inpatient and outpatient care. The program also reimburses community health centers, mainly on a capitation basis, without any performance-based incentives.[28] As a third-party, PT Askes could provide a higher capitation to facilities that increase their productivity or achieve other performance targets, especially those linked to MDG-related health services. Public-private partnerships to better manage health services could also help motivate providers through performance-based initiatives, and yield improved access to affordable and quality health care, especially by the poor and women.

52. **Poor Performance and Accountability of Local Governments and Health Providers.** MOH issued a decree in 2003 pertaining to 26 types of MSSs, and including 54 indicators, which

[26] Choudhury, Nazmul, Jeffrey Hammer, Michael Kremer, Karthik Muralidharan, and F. Halsey Rogers. 2005. Missing in Action: Teacher and Health Worker Absence in Developing Countries. *Journal of Economic Perspectives* 20 (1): 91–116. It was reported that about 40% of government health staff in community health centers were absent from facilities for reasons other than off-site duties.

[27] World Bank. 2007. *Indonesia Public Expenditure Review 2007.* Jakarta; and World Health Organization. 2007. *World Health Report 2006*. Geneva (Annex Table 4).

[28] The exception is midwife-attended deliveries and CHC inpatient care.

constitute the minimum level of services local governments must provide to fulfill their obligatory function of delivering basic health services. Significant challenges have been encountered in implementing the MSSs at the local level, however, due to the (i) excessive number of services covered, (ii) type of indicators used, (iii) level at which the standards are set, (iv) lack of clarity about the obligatory functions of each level of government, and (v) lack of guidelines for local governments on how to implement the MSSs. The enactment of Government Regulation No. 65 in 2005, establishing guidelines for the development and implementation of MSSs, and the subsequent MOHA regulation in 2007 providing guidance to line ministries, are positive steps to solve some of these problems. But much work still needs to be done to refine and reduce the number of health-related MSSs, so as to clearly define the "quantity and quality" of health services, and the roles and responsibilities of the various levels of government.

53. Providing increased public funding for health is a necessary step to improve MDG-related performance. But improvements are needed in the way additional resources are channeled to poor and under-performing localities, and to the poor themselves. One method is to channel additional resources through demand-side mechanisms that target the poor, while strengthening accountability between the service provider and client, so as to reduce the large differentials in most MDG-related impact and intermediate indicators, both across regions and between socioeconomic groups. The recently established ASKESKIN program moves in the right direction, because it: (i) targets the poor with substantial additional resources; (ii) channels the resources to a third-party payer (PT Askes), rather than directly to providers; and (iii) expands the range of providers eligible for reimbursement to the non-governmental sector, including village midwives.

54. **Transparency, Monitoring and Evaluation.** Health care in Indonesia is provided by a complex combination of government and private sector entities. Very little information is currently available at the provincial and central levels on the use of local government resources in the health sector, including resources provided by MOH. In such an environment, policy makers need reliable information on the sources and uses of funds to enable (i) better planning, (ii) more accurate financial projections of health sector requirements, and identification of opportunities for improvement. The establishment of a national health accounts (NHAs) program would facilitate analysis and tracking of public health expenditures.

2. Lessons Identified

55. Recent evaluations and lessons from ADB, the World Bank and other development partners active in program lending, including for social sectors,[29] have recommended that: (i) policy frameworks should not be complex or unrealistic, as this makes them difficult to implement; (ii) the program should focus on a few key policy outputs; (iii) the design of policy initiatives should be robust yet flexible enough to withstand a change in government; (iv) policy actions should be specific, measurable, and linked to policy outputs and outcomes; (v) programmatic approaches and program clusters spread along a medium-term framework can be effective in tackling (a) complex policy reform areas and (b) overcoming a scarcity of information; (vi) reforms must be phased and fully aligned with the country's broader medium-term development agenda; (vii)

[29] The relevant evaluation studies include, among others: (i) ADB. 2001. *Special Evaluation Study on Program Lending*. Manila; (ii) ADB. 2006. *Program Performance Evaluation Report for the Health and Nutrition Sector Development Program in Indonesia*. Manila; (iii) ADB. 2006. *Program Performance Evaluation Report for the Social Protection Sector Development Program in Indonesia*. Manila; (iv) Koeberle, Stefan, Harold Bedoya, Peter Silarzky, and Gero Verheyen. 2005. *Conditionality Revisited: Concepts, Experiences and Lessons*. World Bank: Washington, DC; and (v) World Bank. 2005. *Putting Social Development to Work for the Poor: An OED Review of World Bank Activities*. Washington, DC. Lessons identified from social sector programs loans are presented in Supplementary Appendix C.

development partners should work in a harmonized and coordinated manner on policy advice; and (viii) a well-defined monitoring and evaluation system, including specific timeframes, must be established.

56. Reforms in the social sectors are complex, as there are important political and economic considerations, and responsibilities are divided across a number of line ministries, agencies, and national and local government jurisdictions. The evaluation findings for ADB's health and nutrition and social protection sector development programs in Indonesia, which were rated as successful, recognized the complexity of the reforms. A study of the World Bank's experience with social sector program lending revealed that while the overall effectiveness and outcomes of social development projects compares favorably with other sectors, providing integrated attention to social development themes under program lending led to better implementation and more sustainable social benefits. However, reforms may take time and must be undertaken within a medium-term framework.

57. The Government has made accelerated achievement of the MDGs a key pillar of its agenda, and has demonstrated to continue undertaking the necessary reforms. The PRMAP is fully anchored in the Government's RPJM, meaning there is strong ownership by the relevant line ministries and the oversight agencies (e.g. BAPPENAS, the Coordinating Ministry of Social Welfare [Menko Kesra], and MOF). The reform agenda is broad and challenging as it covers several social sectors, emphasizing the need for flexibility in reform implementation. Based on the above considerations, a program cluster modality is proposed for the PRMAP.

3. Coordination with the Development Partners

58. PRMAP has been designed in close coordination with several development partners. The Australian Agency for International Development (AusAID) has provided direct support, actively participated in the design of the program, and will cofinance the TA supporting it. Coordination has been undertaken with the United Nations Development Programme (UNDP) in preparing common approaches to support the Government in establishing a national framework for MDG acceleration. Separate meetings were conducted with the main development partners working in the education and health sectors, particularly the World Bank, to ensure coordination and complementarity of approaches and avoid duplication of efforts. The IMF was also consulted on the macroeconomic impacts of PRMAP. The design of the PRMAP policy reforms was shared and discussed on several occasions with the education sector working group, and with relevant development partners in the health sector to ensure complementarity and agreement, and avoid duplication.[30] The development partners coordination matrix, outlining support in areas related to the PRMAP, is in Appendix 4. The list of external assistance to the health and education sectors is presented in Supplementary Appendix D.

4. ADB Strategy

59. ADB committed to the MDGs in 2002. ADB's Enhanced Poverty Reduction Strategy and the Medium-Term Strategy II for 2006–2008 provide the broad framework for ADB's engagement and support to MDG acceleration and attainment in the region. At an operational level, ADB is committed to assisting its developing member countries integrate the MDGs into

[30] ADB, World Bank, AusAID, Government of the Netherlands, and European Commission are the principal development partners in the education sector while ADB, the World Bank, *Deutsche Gesellschaft fur Technishe Zusammenarbeit* (GTZ), the World Health Organization (WHO), United States Agency for International Development (USAID), AusAID, United Nations Children's Fund (UNICEF), and the Joint United Nations Programme on HIV/AIDS (UNAIDS) are the main partners in the health sector.

their national poverty reduction strategies and to monitor their progress.[31] In 2004, ADB, UNDP 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 achievement of the MDGs. Several regional reports[32] and technical papers have been produced, improvements have been made to the MDG database, and dissemination and advocacy activities have been conducted. ADB's country strategy and program (CSP) for Indonesia 2006–2009[33] identifies MDG acceleration as one of its five strategic areas of engagement. PRMAP will be a key input to the realization of this strategy and the achievement of the objectives under Pillar II: Social development,[34] by supporting improvement of the quantity and quality of social service delivery.

IV. THE PROPOSED PROGRAM

A. Impact and Outcome

60. **Impacts and Outcome.** The PRMAP impacts will be to accelerate progress in achieving the MDGs in education (MDG 2), and health (MDGs 4, 5, 6), and contribute to the Government's poverty reduction (MDG 1) and gender equality (MDG 3) agendas. The program's outcome is improved access, equity, and quality of service delivery in the education and health sectors to accelerate progress toward the MDGs. It will be implemented in accordance with the Government's national priorities, as reflected in the existing RPJM. [35]

B. Policy Framework and Actions

61. The program will assist the Government in reorienting fiscal expenditures to the social sectors and undertaking much-needed policy reforms related to three key areas: access and equity, quality, and governance. PRMAP will include three main pillars with the following policy outputs:

62. **Cross-Sectoral Reforms.** PRMAP will support and enhance strategic government-led reform initiatives, which will result in: (i) increased budget allocations for health and education, focused on MDG-related programs; (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 the poor households; (iv) gender equity in access to health and education services; and (v) a planning framework for MDG acceleration.

63. **Policy Reforms in the Education Sector for MDG Acceleration.** PRMAP will support the Government's objective of universal basic education leading to: (i) improved access to junior secondary schools in under-served areas; (ii) improved O&M support for smaller/remote schools; (iii) increased affordability of education by poor students and/or households; (iv) enhanced quality and equitable deployment of teachers; (v) education service delivery that meets MSSs; (vi) improved planning and implementation of education services; and (vii) greater transparency of education outcomes to enhance accountability.

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[31] ADB. 2004. *Enhancing the Fight Against Poverty in Asia and the Pacific: The Poverty Reduction Strategy of the Asian Development Bank*. Manila (para. 4).

[32] The following reports have been published: (i) ADB, UNDP, UNESCAP. 2005. *A Future Within Reach: Reshaping Institutions in a Region of Disparities to Meet the MDGs in Asia and the Pacific*. Thailand; (ii): ADB, UNDP, UNESCAP. 2005. *Asia Water Watch 2015*. Manila; (iii) ADB, UNDP, UNESCAP. 2006. *Pursuing Gender Equality through the MDGs in Asia and the Pacific*. Manila; and (iv) ADB. 2006. *The MDGs: Progress in Asia and the Pacific*. Manila.

[33] ADB. 2006. *Indonesia: Country Strategy and Program 2006–2009.* Manila.

[34] The CSP includes two pillars: (i) pro-poor, sustainable economic growth, and (ii) social development.

[35] The development policy letter and the policy matrix for the PRMAP cluster are in Appendix 5. The International Monetary Fund's Macroeconomic Assessment for Indonesia is presented in Appendix 6.

64. **Policy Reforms in the Health Sector for MDG Acceleration.** The PRMAP supports the Government's reform agenda, which seeks to expand and improve the equity and quality of MDG-related health services for the poor, in order to (i) increase public financing for MDG-related health programs, (ii) improve targeting of public health financing for the poor, (iii) improve effectiveness of MNCH and reproductive health service delivery by influencing provider behavior, (iv) improve effectiveness of CDC through integrated programs, (v) improve monitoring of MDG-related health performance, and (vi) improve information with regard to MDG-related health expenditures.

1. Cross-Sectoral Policy Reforms

65. **Policy Objective (PO) 1: Increased Budget Allocation for MDG-Related Health and Education.** The Government has recognized the need to increase overall social sector expenditures if it is to achieve its ambitious poverty reduction and MDG acceleration targets. The 2007 PER showed that health and education expenditures have increased significantly. Between 2004 and 2006, real national public expenditure[36] on education increased by 53% (from Rp49.8 trillion [$ 5.5 billion] to Rp76.2 trillion [$8.3 billion], while expenditure on health increased by 50% (from Rp13.2 trillion [$1.4 billion] to Rp19.8 trillion [$2.2 billion]). During the same period spending on education as a percentage of total public expenditure increased from 14.2% to 17.2%, while health spending increased from 3.8% to 4.5%. As a percentage of GDP, spending on education increased from 2.8% to 3.6% of GDP, and on health from 0.73% to 0.95%. Between 2005 and 2006, most of the increases from the central government budget were allocated to programs that benefit the poor, such as the BOS, which increased from Rp5.1 trillion ($543 million) to Rp10.2 trillion ($1.1 billion), and the ASKESKIN, which increased from Rp2.3 trillion ($245 million) to Rp3.6 trillion ($383 million). These programs represented about 25% of the overall central education and health budgets. The budget allocations for these or similar programs are expected to be sustained in the coming years; projected 2007 public expenditures on education and health will represent about 3.9% and 1.09% of GDP, respectively.

Table 1: National Public Expenditure[a]

(Rp trillion)

Education	**2001**	**2004**	**2005**	**2006**[b]	**2007**[c]
Nominal Expenditures	40.5	63.1	79.7	120.2	137.8
Real Expenditures (2001 prices)	40.5	49.8	56.9	76.2	82.2
Annual Growth of Real Expenditures (%)	40.3	(8.4)	14.4	33.8	7.8
As % of Total National Expenditures	11.4	14.2	14.9	17.2	17.5
As % of GDP	2.4	2.8	2.9	3.6	3.9
Health					
Nominal Expenditures	9.3	16.7	22.0	31.5	38.6
Real Expenditures (2001 prices)	9.3	13.2	15.5	19.8	22.8
Annual Growth of Real Expenditures (%)	28.1	(1.8)	19.4	26.7	15.4
As % of Total National Expenditures	2.6	3.8	4.1	4.5	4.9
As % of GDP	0.55	0.73	0.81	0.95	1.09

GDP = gross domestic product, Rp = rupiah.

[a] National public expenditures includes spending by central, provincial and district governments.

[b] Preliminary result and estimates of subnational allocations.

[c] Estimates based on the approved Government budget for 2007.

Source: World Bank, Ministry of Finance, and Badan Perancanaan Pembangunan Nasional; World Bank. 2007. *Indonesia Public Expenditure Review.* Jakarta.

66. **PO 2: Improved Performance Incentives and Geographical Resource Allocation to Districts for Education and Health.** The Government has significantly increased the size and

[36] Includes central, provincial, and district government expenditures.

scope of the DAK targeted for the health and education sectors. From 2004 to 2007, the total DAK allocation for education and health increased sevenfold, with DAK allocations for education increasing from $71 million to $569 million, and health allocations increasing from $50 million to $370 million. These increases will provide additional resources to specific districts for the rehabilitation of schools and health centers and the purchase of equipment and facilities, and are expected to contribute to increased access and quality of services. The modification of the DAK technical criteria for education and health in 2006 offers an opportunity to attract and retain education and health personnel to remote areas, as districts are now allowed to use DAK funds for (i) the procurement of medical and non-medical equipment in health clinics and furniture in schools; (ii) the construction and rehabilitation of water and sanitation facilities; and (iii) housing for school teachers, doctors, nurses, and midwives.

67. Problems remain with the existing DAK allocation formula, however. The current system does not provide operational expenditures for health and education, or incentives for the districts to improve their performance in service delivery, both of which are keys to accelerating MDG attainment. Improvements are also necessary in the horizontal distribution of resources, to ensure districts most in need are targeted. In addition, significant efforts are required to improve monitoring systems to track the use of the DAK at the district level.

68. Reform of the DAK is under way to transform it into a more relevant instrument for earmarking funds to specific districts with insufficient health and education resources. Measures for the improvement of the DAK are included in the National Action Plan on Fiscal Decentralization. MOF and BAPPENAS, in coordination with the Regional Autonomy Advisory Council, are formulating recommendations to strengthen the DAK framework, improve the fund distribution criteria among districts, and promote accountability. The recommendations will include suggestions for vertical and horizontal allocation and development of conditions to successfully support achievement of the MDGs at the local government level. MOHA is also preparing a regulation on performance evaluation of local governments, which could include financial incentives to reward or penalize local governments based on performance. MONE and MOH, in coordination with MOF, will assess options for including mechanisms in the DAK technical guidelines to allocate resources more equitably to districts, and to include incentives to districts to improve performance relative to MDG-related indicators. PRMAP will support initiatives seeking to increase access and equity, and the implementation of performance-based allocation of resources at national and district levels, in order to improve accountability in health and education program implementation.

69. **PO 3: Establishment of a Uniformed System for Targeting the Poor.** BAPPENAS, with the BPS, MOH, and MONE, has prepared guidelines for the establishment of a mass database of poor and near-poor households for a new poverty reduction program, the Program Keluarga Harapan (PKH), which plans to provide conditional cash transfers (CCTs) to 500,000 households in its initial phase in 2007.[37] The database will improve the previous one developed for the former unconditional cash transfers program that used a combination of geographic and household targeting techniques. The focus of the PKH on poverty reduction and on improving access to MDG-related health and education services fosters dialogue among the key stakeholders—BAPPENAS, BPS, MONE, MORA and MOH—and raises the possibility that MOH, MONE and MORA may adopt a uniform targeting system for improving access by the poor to other MDG-related education and health initiatives. Establishment of a uniform targeting system will help improve coverage of MDG-related health and education programs for the poor and reduce

[37] To cover selected sub-districts in seven provinces in its pilot phase, the Government has allocated about $1 billion for this program in 2007. The program will provide cash transfers to the poor, conditional on families enrolling and keeping children in schools and utilizing health services, vaccinations, and other MNCH programs.

leakages to the non-poor. Although the initial costs of developing a uniform database may be significant, in the longer term it will provide savings by avoiding duplication of effort by multiple agencies, and improving transparency.

70. **PO 4: Achievement of Gender Equity in Access to Health and Education Services.** The PRMAP supports the Government's gender mainstreaming efforts pursuant to Presidential Instruction No. 9/2000 and subsequent health and education ministerial regulations and sector action plans. In 2006, BAPPENAS completed an evaluation on the status of gender mainstreaming in nine sectors, including health and education.[38] Recommendations focused on strengthening policies, institutional frameworks, information systems and human resources within each of the sectors to support gender equity. MOH has responded to the evaluation by issuing a Ministerial Decree, which outlines steps to be taken to improve gender mainstreaming within the ministry, including the appointment of directors for gender mainstreaming under each directorate. MONE, in its commitment to implement Education for All, includes a chapter on gender equality,[39] and the topic is featured in other sections on formal and non-formal education. A joint memorandum of understanding was signed in 2006 between MONE, the Ministry of Women's Empowerment (MOWE), and MOHA to increase efforts to lower adult illiteracy rates, particularly for females. The RPJM includes a commitment to lower illiteracy rates to 5% by 2009. This policy action builds on the National Literacy Movement for Indonesia, launched by the President in December 2004, which seeks to strengthen cooperation on literacy within communities and between various levels of government, and promote the importance of literacy through awareness programs.

71. Despite Government efforts to mainstream gender, the lack of information on gender-related MDGs remains a challenge. Sex-disaggregated key health and education indicators are needed to better monitor progress on the gender-related MDGs, and to target resources more efficiently for accelerated attainment of the MDGs. Some health and education indicators that are already disaggregated by sex may require additional proxy indicators to improve monitoring and reporting (e.g., immunization coverage or percentage of births attended by skilled personnel). Additional indicators could be considered, such as: (i) primary completion rates for boys and girls (MDG 2); (ii) under-5 mortality rates for girls and boys (MDG 4); and (iii) percentage of all reproductive-age women and their sexual partners using modern contraceptives (MDG 6). Inclusion of an agreed set of sex-disaggregated indicators in the medium-term development plans of MONE, MORA and MOH would help mainstream gender issues relating to health and education in the planning and budgeting processes.

72. **PO 5: A Planning Framework for MDG Acceleration is Established.** The RPJM and the SNPK include the MDGs as a key element, and recognize the need for mainstreaming MDGs at the local government level. The Government presented the 2005 MDG Progress Report at the UN General Assembly in September 2005. Guidelines need to be developed to assist local governments and sector agencies, such as education and health, to mainstream the MDGs in their development and sector plans and budgets. Plans for the preparation of a comprehensive roadmap for MDG acceleration could include strategies for: (i) developing a flexible institutional framework for the accelerated achievement of the MDGs involving key central government ministries and local governments; (ii) increasing political and public awareness about the MDGs; (iii) involving civil society, private sector and research institutions in efforts to attain the MDGs; (iv) improving data collection, processing and monitoring mechanisms, and reporting of MDG-related indicators; (v) assessing cost and budget

[38] MONE. 2005. *National Action Plan: Education for All.* Jakarta.
[39] BAPPENAS. 2006. *Evaluation on the Implementation of Gender Mainstreaming in Development Sectors.* Jakarta.

implications for the achievement of the MDGs; and (vi) developing sectoral policies for consideration by government ministries in their medium-term development plans.

2. Education Sector Reforms

73. The PRMAP supports education policy reforms to address key access, equity and quality constraints as outlined in MONE's medium term plan (2005–2009) and MORA's strategic plan. The plans respond to the priorities outlined in the RPJM, the SNPK, and Indonesia's international commitments. The MONE and MORA plans organize education strategies, targets, and programs under three main policies: (i) expansion of access and equity; (ii) improvement of quality, efficiency, and effectiveness; and (iii) improvement of governance, transparency, and accountability. Major priorities include (i) achieving the goal of universal access to 9 years of basic education by 2009; (ii) expanding gross enrolment rates in senior secondary education; (iii) raising education standards and relevance at all levels, including through efficient teacher preparation and deployment; (iv) strengthening results-oriented education governance and management systems, especially at district and school/institutional levels; and (v) improved results orientation of sector planning and monitoring systems.

a. Expand Equitable Access to Basic Education Particularly for the Poor

74. The Government's key strategies for enabling equitable access to basic education include (i) an expanded junior secondary school construction program in under-served areas; (ii) reduction of direct and indirect cost barriers through the expansion of school operational budgets; and (iii) expansion of primary and junior secondary school programs for school dropouts.

75. **PO 6: Improved Access to Junior Secondary Education in Underserved Areas.** A number of challenges need to be addressed to reduce access barriers. A priority is the construction of new junior secondary schools and/or madrasah, especially in districts with low enrolment. The introduction of one-roof schools (combined primary and junior secondary schools on the same site) is designed to reduce primary grade dropout and repetition, and increase transition rates to junior secondary education. Implementation of these initiatives will reduce the distance to junior secondary schools and consequent travel costs, which are important obstacles for the poor. Between 2005 and 2007 MONE and MORA allocated Rp 4.252 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. This initiative is also expected to have a positive impact on maintaining or increasing the number of girls attending junior secondary schools and/or madrasah in regions where female enrolment is low. MORA continues to invest in the poorest community-run schools.

76. While considerable investments are planned by both MONE and MORA for school infrastructure, improved targeting and utilization of facilities is also required. Under SP2, local governments will undertake participatory school mapping with local communities to better understand and respond to demand-side issues. Participatory school mapping is a departure from purely technical, geographic information system- (GIS) based school mapping. While GIS-mapping can accurately identify the optimum location of schools, based on demographic and spatial data, it may not alert governments to the underlying socioeconomic factors that prevent children from attending school, despite the provision of physical facilities. Increasing the local ownership of and stake in school construction and rehabilitation will lower construction costs, and improve utilization of facilities. This will yield better returns on the investments made in school infrastructure development under SP3.

77. **PO 7: Improved O&M Support for Smaller and Remote Schools and Elimination of Fees.** The introduction of the BOS in 2005 and its expansion in 2006 and 2007 provides 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. It has covered about 29.5 million students at the primary and 11.7 million at the junior secondary level. The program provides about $25 per year for primary school students and $35 per year for junior secondary students. The provision of funds based on student head count provides incentives to schools to expand their coverage area and overall student numbers. The program has been successful in improving the predictability of school financing, and providing reliable support to schools. Its simple design has rendered the program highly transparent, at least down to the school management level.

78. BOS does need some improvement and refinement, however, if it is to be transformed into a more targeted and efficient instrument, particularly for small, remote schools and for those with many poor students. A key policy action under SP2 will be a comprehensive review of the allocation policy and financing and implementation of BOS and other O&M support programs. The review will consider whether any special assistance programs need to be developed for the poorest districts, taking into account (i) regional differences in costs; (ii) school size differences in fixed and variable costs; (iii) the indirect impacts of BOS in decreasing school fees or other contributions from the poor; (iv) the costs associated with meeting priority MSSs, such as for learning materials and teacher training; and (v) findings from internal audit reports. While the Government recognizes that a more pro-poor allocation policy for O&M assistance needs to be developed for smaller, more remote or poorer schools, preferential allocations under BOS need to be closely monitored and supported under SP2. Under SP3, it is expected that a revised BOS allocation policy for poor and remote districts will be implemented.

79. **PO 8: Increased Affordability of Education by Poor Students/Households.** In 2006, transition scholarships were introduced to improve NERs in junior secondary schools and help poor primary school graduates meet the costs of entering junior secondary. About 147,000 poor students received scholarships. Under SP2, scholarships will be expanded to enable poor students meet the direct and opportunity costs of education. Plans are underway to pilot a CCT scheme to improve demand for education and increase primary to junior secondary transition and retention rates among the poor. Under SP3, these financial support programs to improve enrollments and retention of students will be evaluated to improve the design and targeting of pro-poor programs.

b. Improve Basic Education Quality, Efficiency, and Effectiveness

80. Key government strategies to improve quality, relevance and effectiveness include (i) introduction and implementation of new teacher professionalism and quality assurance standards, through new legislation and organizational reform at central, provincial and district levels; (ii) review of teacher utilization and deployment norms, incorporating potential measures to increase non-salary operational spending, especially on instructional materials and school maintenance; and (iii) expansion of education standards-setting and monitoring systems through the establishment of the Board of National Education Standards (BSNP).

81. **PO 9: Enhanced Quality and Equitable Deployment of Teachers.** Law 14 on Teachers and Lectures was approved in December 2005. The Law makes provision for a doubling by 2015 of teacher remuneration through professional incentive awards. Teachers working in remote areas will also receive a special allowance. Two regulations to implement the provisions of the law for the professional development and incentive structures for teachers and lecturers are currently under preparation. The legislation includes a strategy for providing salary

and non-salary incentives to boost the deployment of teachers to under-served areas. It also includes measures related to management and quality assurance of teachers and other educational personnel, including school directors, and for strengthening teacher performance monitoring and quality assurance systems. Given the scale of teacher upgrading required, the design of cost-efficient and sustainable professional development programs and incentives for deployment in under-served areas are an urgent priority and will be developed under SP2. Under SP3, both MONE and MORA will publish a report on teacher deployment to under-served areas.

82. **PO 10: Education Service Delivery Meeting MSSs.** A number of key regulatory actions have recently been taken to set the foundation for education reform, which will lead to increased accountability of district governments and schools to deliver higher quality education. An independent BSNP was established in mid-2005 through issuance of Regulation 19/2005. BSNP has developed legislation on "Standards on Content" (Regulation No 22/2006), and "Standards on Competence" (Regulation No 22/2006). Regulation No. 24/2006 has been issued to clarify the roles of different levels of government in the implementation of these standards. The development, approval and monitoring of national education standards in eight key areas is expected to be completed under SP2. With TA support from ADB and the European Commission, MONE is also planning to develop MSSs for critical national standards relevant to the achievement of the education-related MDGs, to be applied at the district level. Under SP3, it is expected that MSSs in at least two categories of national standards, especially those related to teachers, facilities, and learning materials, will be implemented by selected districts.[40]

c. Governance, Transparency, and Accountability.

83. **PO 11: Improved Planning and Implementation of Education Services.** The Government has demonstrated high-level leadership and ownership of the education reform program. A joint plan for the achievement of 9-year basic education (Grand Design for Basic Education [2006–2009]) was completed by MONE and MORA in August 2006. Under SP2, an assessment of sector performance, including the roles of different levels of government in delivering education services and progress toward the MDGs, will be undertaken in preparation for the 2010–2015 Strategic Plan for the Education Sector. To accelerate the attainment of the MDGs, specific attention will be paid to the assessment of pro-poor programs for education and possibilities for improvement and expansion. Some analytical work will also be undertaken to assess whether it is possible to adopt a medium-term expenditure framework to help improve the predictability of sector financing in terms of size, flow, and the use of educational expenditures over the medium term. Under SP3, it is expected that a medium-term development plan will be approved to provide good quality services in under-served areas.

84. **PO 12: Greater Transparency of Education Outcomes to Enhance Accountability.** Increased financing of education sector reforms naturally calls for greater efforts to boost governance, transparency and accountability for outcomes (e.g. through the results of national exams, which MONE and MORA now publish). The Center for Educational Assessment has used the results of the junior secondary level national exams, as well as results of the Program for International Student Assessment, and Trends in International Mathematics and Science Studies, to inform government policies for improving accountability and the education quality. A well designed and reliable survey of communities will be conducted under SP2 to obtain feedback on both the positive and negative aspects of basic education service delivery. A citizen report card survey will also be undertaken in three districts under SP2.

[40] A regulation instructing line ministries in the preparation of MSSs was issued by MOHA in 2007. The Ministry is also preparing legislation to guide local governments in the implementation of MSSs developed by line ministries.

85. The technical guidelines for ministerial decree No. 044/u/2002 will be reviewed to increase the proportion of females participating in school committees and district education boards to at least 40%, to ensure the increase of the role of women in the governance of the education system. At the national level, the ministry of education has established a number of measurable anti-corruption performance indicators in the education medium-term plan[41] with the summary of the results to be published on their websites under SP3.

3. Health Sector Reforms

86. Health sector reforms supported under PRMAP include (i) expanding access to health services, especially for the poor and women; (ii) improving quality, efficiency, and effectiveness of health services; and (iii) enhancing governance in health service delivery.

a. Expand Access to Health Services, especially for the Poor and Women

87. **PO 13: Increased Central Budget for MDG-Related Health Programs.** Between 2005 and 2007, MOH increased its budget allocation for MDG-related health programs by more than 50%. In 2007, more than 20% of the MOH budget is expected to be allocated for MNCH and CDC programs. Even with these increases, however, the country's budget allocations in these areas remain far below those of other countries in the region. In the coming years, the Government will need to increase budgetary allocations for health, and the MOH will need to improve budget targeting for (i) MDG-related health programs, such as MNCH and CDC; and (ii) regions with poorer health outcomes. During SP2 and SP3, MOH is planning to increase its budget allocation for programs that would accelerate meeting the health-related MDG targets. Investments in preventive care services and communicable diseases, such as HIV/AIDS and malaria, must be prioritized. These actions are expected to disproportionately benefit the poor, who utilize public sector health services for reproductive and child health care, and suffer from communicable diseases.

88. **PO 14: Improved Targeting of Public Financing for Health Services for the Poor.** In 2005, the Government introduced a new healthcare scheme, the ASKESKIN program, which aimed to: (i) improve targeting of budget resources to health services utilized by the poor, (ii) increase financing for O&M expenses of public sector health facilities, and (iii) increase efficiency of funds management through contracting PT Askes to independently manage the funds and provider contracts. Sixty million poor people were entitled to ASKESKIN benefits, including primary, secondary and tertiary care if provided by public clinics and hospitals. The poor receive free services on presentation of a health (ASKESKIN) card, or a letter from local authorities indicating their poverty status. ASKESKIN's design has evolved since 2005 with the aim of increasing access by the poor to priority health services by allowing reimbursement of services provided by eligible non-government providers (i.e. midwives and select private hospitals).[42] The program provides allocations to public clinics, utilizing a formula to favor those clinics with a higher proportion of the poor within their target areas, and those in remote areas.

89. While the ASKESKIN program has removed some of the key cost barriers preventing the poor from accessing health services, the program has limitations, because it covers only medical care costs, and not non-medical service costs, such as transportation, inpatient meals, and contraceptives. The Government recognizes that there is scope to improve and refine the effectiveness of this program, and is planning under SP2 to conduct a comprehensive analysis

[41] These include targets for: (i) number of corruption charges, (ii) amount of funds subject to corruption investigation, and (iii) amount of funds subject to being reclaimed.

[42] The poor use private service providers, especially midwives, in 57% of cases.

of options for the revision of the ASKESKIN program design and implementation modalities. The evaluation will take into account previous assessments,[43] feedback related to recent program adjustments, and the longer-term development of a national health insurance policy. Under SP3, MOH will utilize the analysis to revise the program's design and implementation strategy, in order to: i) improve targeting of benefits to the poor; ii) increase access and utilization of primary care services; iii) improve integration of primary care services delivery (e.g., family planning, antenatal, delivery and postnatal MNCH services); and iv) increase program management efficiency to increase incentives for health service providers. The ASKESKIN program could also modify its reimbursement methods to better motivate providers to deliver key MDG-related services.

b. Improve Quality and Efficiency of Health Services

90. **PO 15: Improved Effectiveness of MNCH/RH Services through Influencing Provider Behavior.** In May 2006, the Government modified the program for recruiting and contracting temporary doctors and midwives by including additional financial incentives to attract them to remote areas. The program will provide an additional monthly salary of Rp.7.5 million ($828) to specialist doctors; Rp. 5 million ($552) to doctors, and Rp. 2.5 million ($276) to midwives working in remote areas. The program is expected to improve the quality of MNCH services. Provider payment mechanisms introduced through ASKESKIN that influence financial incentives will also affect provider location choices and influence provision behavior. Since 2006, district governments can also use DAK funds to construct water and sanitation facilities and housing for doctors, nurses and midwives in remote areas, so as to attract and retain health personnel. These actions are expected to increase the availability and quality of MNCH services in remote areas.

91. A systematic review of provider payment modalities in Indonesia is needed to inform evidence-based policy development with respect to improving availability of health personnel in remote and underserved areas. Under SP2, MOH plans to commission an assessment to comprehensively document all the methods used to attract and retain health personnel in remote and underserved areas. The assessment will analyze how the different alternatives have influenced the distribution of health personnel, and the provision of health services and health outcomes, with particular attention to increasing provision of integrated primary health services for women and children. In the process, MOH will be improving its database on health personnel. During SP3, MOH will utilize the findings and recommendations of the assessment in revising provider payment mechanisms.

92. **PO 16: Improved Effectiveness of CDC through Integrated Programs.** The Government is developing comprehensive strategies for CDC (especially for HIV/AIDS, malaria and TB), including elaboration of the roles and responsibilities of various ministries, and mechanisms for coordination of efforts across ministries. In 2006, MOH developed a National Policy and Strategy for Reproductive Health that elaborates 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. In addition, MOH is developing more detailed ministerial-level strategies to strengthen CDC, including provision of integrated preventive and curative health care at the community and health-center level. For example, MOH has endorsed national guidelines for mitigating TB that

[43] An initial rapid assessment of the program in six provinces was undertaken by the Government between March and June 2006, with ADB and World Bank support. The assessment identified the need to improve targeting of beneficiaries, provide public information about the program among the poor to increase demand for health services, develop a complaint resolution mechanism, and strengthen M&E.

specify strategies and plans for TB control for the period 2006 to 2010, including guidelines for development of public-private partnerships in TB case detection and treatment. MOH is also supporting provision of information, education, and communication activities through the Center for Health Promotion, so as to enhance the knowledge, attitudes and practices of individuals, households and communities to prevent the contraction and spread of communicable diseases.

93. During SP2, the National AIDS Commission has finalized the national strategy for HIV/AIDS mitigation for 2008 to 2012, including the roles and responsibilities of all relevant ministries, the private sector and civil society. In support of national efforts to mitigate HIV/AIDS, MOH will approve the Strategic Plan for HIV/AIDS Mitigation in Indonesia, 2008 to 2012, that integrates HIV/AIDS control efforts in all relevant MOH programs. HIV/AIDS strategies will reflect surveys findings related to the distribution of the disease and existing evaluations related to the effectiveness of current HIV/AIDS strategies and programs. In addition to surveillance, voluntary testing and treatment, national and MOH strategies will include actions to strengthen the knowledge, attitudes and practices of individuals, households and communities in relation to HIV/AIDS prevention. HIV/AIDS strategies will be coordinated with TB control efforts. Under SP3, MOH will complete and present to the National AIDS Commission an analysis of the costs and available sources of financing for the MOH component of the Government's response to the HIV/AIDS epidemic. [44]

94. **PO 17: Improved Monitoring of MDG-Related Health Performance.** MOH has prepared a revised list of district MSSs and indicators. The list contains 8 types of MSSs with 28 indicators. The need to monitor local government progress and performance in achieving the MDGs were key criteria in developing the revised list of indicators. Of the 28 indicators, 10 refer directly to MNCH services, while several 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.

95. MOH plans to refine the health-related MSSs and endorse them through a ministerial decree. The MSSs prepared by MOH will be first reviewed by the National Consultative Team,[45] and submitted for approval to the Regional Autonomy Advisory Council. The updated MSSs decree will include health-related MDGs and identify intermediate indicators for child nutrition, maternal and child health, HIV/AIDS, and TB. To the extent appropriate and feasible, MOH will identify intermediate indicators that are harmonized with health-related MDG indicators. MOH will undertake to modify their health information system to track the performance of MSSs indicators and link the allocation of human, material and financial resources to performance at the national and sub-national levels. These actions will benefit strategy development and resource management related to achievement of the health-related MDGs. The introduction of performance-based contracts, and incentives for public and private sector service providers to better manage district level health services, based on a short list of measurable MSSs, could increase their motivation and yield improved access to affordable and quality health care, especially by the poor and women.

[44] A recent survey, which focused in particular on two high-risk groups (intravenous drug users and commercial sex workers and their partners), was undertaken to estimate the distribution of HIV/AIDS. The Coordinating Ministry for People's Welfare (Menko Kestra) issued a Ministerial Decree in 2007 to coordinate multisectoral efforts to reduce HIV/AIDS transmission by use of intravenous drugs. The MOH has issued a Ministerial Decree on the Appointment of Referral Hospitals for HIV/AIDS and Service Standards that details standards required for select public and private sector hospitals to provide HIV/AIDS testing and treatment services.

[45] Consisting of ministers, directors general and related directors under Bappenas, MOF, MOHA, and the state apparatus minister.

c. Enhance Governance in Health Service Delivery

96. **PO 18: Improved Financial Information with Regard to MDG-Related Health Expenditures.** The PER, carried out by BAPPENAS and MOF with World Bank support, provides an analysis of overall health expenditures by central, provincial and district governments. It presents a review of health financing issues that contributes to the understanding of MDG-related expenditures. However, the PER did not include detailed analysis of public sector health expenditure by program, especially at the national and sub-national levels, as such information is not readily available.

97. To improve the completeness, quality of information and analysis of total and public expenditures for health under SP2, BAPPENAS will lead efforts to develop a plan for institutionalization of a NHAs program, including specification of the responsible agencies and terms of reference for conduct of the NHAs; the plan will be used by the Government to establish the program. NHAs detail how resources are used, and if implemented on a regular basis, can track health expenditure trends. NHAs can also be used to make financial projections of health system requirements and identify opportunities for improvement. Health accounts can help track use of resources to achieve the MDGs and other global initiatives. Under SP3, NHAs will be produced for at least one year between 2008 and 2010, based on the plan developed. MOH is also planning to retrospectively analyze public expenditure for health for the period 2003 to 2006, based on the initial analysis prepared by the PER. These actions will contribute to improving the transparency of health expenditures and programmatic and geographic allocations. Such information will improve the targeting of public expenditures to health-related MDG programs and to districts with poor performance with respect to the MDG indicators.

C. Linkages with Other Assistance

98. The design and implementation of the PRMAP have been closely coordinated with ongoing ADB programs and projects. ADB's Development Policy Support Programs I and II included several crosscutting reforms that are related to social sector services delivery.[46] These programs have focused on (i) creating fiscal space for further investment in social sectors; (ii) the improvement of budget and financial reporting and accounting mechanisms to improve governance and reduce corruption; (iii) the reform of the civil service, through the design of a new job classification and remuneration policy; (iv) the development of a program for conditional cash transfers to the poor, and monitoring of the effectiveness and fiduciary assessment of this program. The Local Government Finance and Governance Reform Sector Development Program[47] supported measures that had positive impacts on the financing of decentralized social service delivery, such as (i) the revised Law on Fiscal Balance and its implementing regulations; and (ii) the clarification of the roles and responsibilities of each level of government for social services, such as the establishment of the Regional Autonomy Advisory Council and preparation of the National Action Plan for Fiscal Decentralization. PRMAP will build on these reforms by supporting the reform of DAK, the development of MSSs for the education and health sectors, and the improvement of incentives for teachers and health personnel.

[46] ADB has adopted a dual-track approach to enhance the linkage and synergy between cross-cutting macroeconomic reforms and deeper sector-level reforms. This dual-track approach is outlined in ADB. 2005. *Report and Recommendation of the President to the Board of Directors on a Proposed Loan to the Republic of Indonesia for the Development Policy Support Program.* Manila (Loan 2228-INO, para. 7).

[47] ADB. 2005. *Report and Recommendation of the President to the Board of Directors on Proposed Loans to the Republic of Indonesia for Local Government Finance and Governance Reform Sector Development Program*. Manila.

99. Several other ADB projects complement PRMAP in key sectors relevant for achievement of the MDGs. The Decentralized Health Services I and II[48] projects support the strengthening of district capacity in planning, performance-based budgeting for the health sector, and the development of incentive schemes for redistributing staff to remote and underserved areas in 200 districts. The Decentralized Basic Education Project[49] provides support to schools and districts for the preparation of school development plans, and for developing and improving the functioning of school committees. It also supports capacity-building activities at the district level to improve planning, management and budgeting of education services. The Madrasah Education Support project[50] will provide quality education services for the poor in underserved areas. The Community Water Services and Health Project,[51] which supports access to safe drinking water and sanitation, will have a positive impact on the reduction of child mortality rates in rural areas. The Nutrition Improvement Through Community Empowerment Project[52] will contribute to improved maternal and child health through promotion of better nutrition, breast-feeding, and other community-based initiatives. TA will also be provided to develop and implement MSSs in the education sector at the district level. The PRMAP reforms will enhance the sustainability of these projects and assist in the development of an improved policy framework for implementing them.

D. Important Features

100. PRMAP's overall design directly supports the Government's medium-term development vision, as articulated in the RPJM, and the medium-term plans for the health and education sectors. It is anchored in the Government's policy reform agenda and actions and emphasizes government leadership and ownership. The program recognizes recent key policy actions, while establishing a medium-term framework to continue the complex reform process at a flexible pace. The design of PRMAP as a program cluster consisting of three subprograms provides the flexibility needed by an emerging middle-income country such as Indonesia, which is undergoing a governance and fiscal transition, to build consensus for reforms among stakeholders with competing interests.

101. The PRMAP is the first program loan from ADB focused on the MDGs. The program tackles the multidimensional aspects of poverty with particular attention to non-income MDGs, especially the lack of access by the poor to quality health and education services. It also recognizes cross-sectoral linkages and supports the development of interagency networks to develop and implement a complex reform agenda. PRMAP complements other interventions by ADB and its development partners through projects and programs for specific sectors and multisectoral development policy loans. It will provide an overall framework and develop a roadmap for the accelerated achievement of the MDGs.

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[48] ADB. 2000. *Report and Recommendation of the President to the Board of Directors on a Proposed Loan to the Republic of Indonesia for Decentralized Health Services.* Manila; and ADB. 2003. *Report and Recommendation of the President to the Board of Directors on a Proposed Loan to the Republic of Indonesia for Second Decentralized Health Services.* Manila.

[49] ADB. 2001. *Report and Recommendation of the President to the Board of Directors on a Proposed Loan to the Republic of Indonesia for Decentralized Basic Education Project.* Manila.

[50] ADB. 2006. *Report and Recommendation of the President to the Board of Directors on a Proposed Loan to the Republic of Indonesia for Madrasah Education Development Project*. Manila.

[51] ADB. 2005. *Report and Recommendation of the President to the Board of Directors on Proposed Loans to the Republic of Indonesia for Community Water Services and Health Project.* Manila; and ADB. 2003. *Report and Recommendation of the President to the Board of Directors on a Proposed Loan to the Republic of Indonesia for Community Water Services and Health Project.* Manila.

[52] ADB. 2006. *Report and Recommendation of the President to the Board of Directors on a Proposed Loan to the Republic of Indonesia for Nutrition Improvement Through Community Empowerment Project*. Manila.

102. The program and the supporting TA will strengthen capacity in the Government's education and health ministries with respect to strategic, policy oversight, M&E and supervisory functions. It will also assist the Government in developing incentive mechanisms for local governments to improve efficiency and accountability. This approach aims at addressing the challenge of improving health and education public service delivery within a progressively decentralized framework, while ensuring rapid acceleration of progress towards meeting the MDG targets.

E. Financing Plan

103. The PRMAP adopts a program cluster approach with three back-to-back subprograms, each supported by a single-tranche loan and a specific loan agreement. Intervals of about 2 years each are envisaged between the subprograms. Thus, subject to adequate progress and approval of Subprogram 1 (SP1) around October 2007, Subprogram 2 (SP 2) could be considered for approval in 2009, and Subprogram 3 (SP 3) in 2011.

104. For SP1, the Government has requested a loan from ADB of $400 million, to support the reforms and policy actions outlined in the development policy letter and policy matrix. The loan size has been determined by the strength of the policy package and its development impact, the importance of the sectors covered and investment needs in the education and health sectors. Some adjustment cost arising from the establishment of new programs, such as BOS or ASKESKIN, the implementation of surveys and development of a database to identify the poor, and the preparation of MSSs for education and health services were also considered. The reform agenda for SP2, and especially for SP3, will be refined to reflect the progress made and evolving circumstances. The Government envisages support from ADB of $200 million each for SP2 and SP3. The amounts will be reconfirmed during the PRMAP review and the processing of each subprogram.

105. In terms of overall financing requirements in 2007, the Government has requested $2.1 billion[53] in program loans from ADB, Japan and the World Bank. This reflects a significantly higher fiscal deficit of around 1.6% of GDP, due to increased spending in health and education and other investment and reconstruction efforts. In 2007, total national expenditures for the education sector are expected to increase by approximately $1.928 billion and for the health sector by $778 million. The central government has allocated an additional $852 million for education and $406 million for health, with the remaining funds provided by local governments. Without PRMAP support, sustaining these necessary increases in education and health expenditures may not be possible.

106. The program loan of $400 million for SP1 will be funded from ADB's ordinary capital resources, and will have (i) a 15-year term, including a grace period of 3 years; (ii) an interest rate determined in accordance with ADB's London interbank offered rate (LIBOR)-based lending facility; (iii) a commitment charge of 0.75% per annum; (iv) conversion options that may be exercised in accordance with the draft loan agreement, the loan regulations, and ADB's conversion guidelines; and (v) such other terms and conditions as set forth in the draft program loan agreement. The Government has provided ADB with (i) the reasons for its decision to borrow under ADB's LIBOR-based lending facility, and (ii) an undertaking that this choice was its own independent decision and not made in reliance on or any communication or advice from ADB.

[53] This comprises (i) from ADB, $400 million for the PRMAP, $200 million for the Development Policy Support Program 3, and $300 for the Capital Market Development Cluster Program; (ii) from the World Bank, $600 million through its Development Policy Loan 4 and $200 million for the Infrastructure Reform Sector Development Program; and (iii) from the Government of Japan, $200 million through cofinancing of the Development Policy Loan 4 and the $200 million Infrastructure Reform Sector Development Program.

F. Implementation Arrangements

1. Program Management

107. A Program Steering Committee (PSC) and a program technical committee will be established to oversee implementation of the program cluster. Both committees will be chaired by Deputy Human Resources and Cultural Affairs, BAPPENAS, and include representatives from all relevant ministries (MOF, MOH, MONE, MORA, MOWE,MOHA and BPS) with responsibilities related to the attainment of the MDGs. BAPPENAS will be the executing agency for coordinating the implementation of the PRMAP and will establish an executive secretariat. The line ministries responsible for the various sectors will be the implementing agencies and will establish sectoral technical committees and secretariats for the education and health sectors.

2. Implementation Period

108. The implementation period for SP1 is from 1 April 2005 to 31 March 2007. All actions included in the policy matrix under SP1 have been implemented during this time frame. The program period for SP2 is from 1 April 2007 to 30 March 2009, while that of SP3 will cover the period from 1 April 2009 to 31 March 2011. The timeframe of SP1 and SP2 is consistent with the implementation period of the RPJM and the recently approved education and health medium-term development plans. This time frame is also consistent with the ADB CSP 2006–2009, which includes MDG acceleration as one of its core areas of support. SP3 will build on the results of SP1 and SP2 and will be revised to support the new RPJM, which is to be prepared by the Government in 2009. The duration of the program loan is considered appropriate to reach the policy reform objectives of PRMAP.

3. Procurement and Disbursement

109. The proceeds of the program loan will be disbursed to the Borrower in accordance with the provisions of ADB's *Simplification of Disbursement Procedures and Related Requirements for Program Loans*.[54] The SP1 loan of $400 million will be released in a single tranche upon loan effectiveness. The loan proceeds will be 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 (Appendix 7) and imports financed by other bilateral and multilateral sources. In accordance with the provisions of ADB's *Simplification of Disbursement Procedures and Related Requirements for Program Loans*, the proceeds of the program loan will be disbursed to the Borrower. No supporting import documentation will be required, if the value of Indonesia's total imports minus imports from nonmember countries, ineligible imports, and imports financed under other official development assistance is equal to or greater than the amount of the loan disbursed during the given year. The Government will certify its compliance with this formula with its withdrawal request. Otherwise, import documentation under existing procedures will be required. The PRMAP will provide for retroactive financing for expenditures incurred by the Government 180 days prior to loan effectiveness. The Borrower has been informed that the approval in principle of the retroactive financing does not commit ADB to finance this program.

4. Anticorruption

110. ADB's *Anticorruption Policy* (1998, as amended to date) was explained to and discussed with the Government and all relevant ADB guidelines, including the *Procurement Guidelines* (2007, as amended from time to time)*, Guidelines on the Use of Consultants* (2007, as amended from time to time), and the loan regulations, was specifically brought to the notice of

[54] ADB. 1998. *Simplification of Disbursement Procedures and Related Requirements for Program Loans*. Manila.

the Government. Consistent with its commitment to good governance, accountability, and transparency, ADB reserves the right to investigate, directly or through its agents, any alleged corrupt, fraudulent, collusive, or coercive practices relating to the Program. To support these efforts, relevant provisions of ADB's *Anticorruption Policy* are included in the loan regulations and the bidding documents for the Program. In particular, all contracts financed by ADB in connection with the Program shall include provisions specifying the right of ADB to audit and examine the records and accounts of the Executing Agency and all contractors, suppliers, consultants, and other service providers as they relate to the Program. The Government has considerably strengthened its anticorruption efforts since late 2004. The reforms adopted as part of PRMAP will reduce the risk of corruption in the health and education sectors by increasing government transparency in the allocation of resources and improving accountability by service providers, local governments and central government ministries. Some of the reforms contributing to the reduction of corruption include: (i) the publication of the summaries of the MONE and MORA inspectors general audit reports in their websites; (ii) socialization of ASKESKIN programs to communities to inform them on available services and entitlements; (iii) increased transparency in the allocation of DAK funds for health and education; (iv) strengthening of the schools committees with increased women's participation; and (v) increased availability and transparency on health expenditures though the preparation of NHAs.

5. Accounting, Auditing, and Reporting

111. ADB retains the right to audit the use of loan proceeds and to verify the accuracy of the Government's certification for the withdrawal application. Prior to the withdrawal, the Government will open a deposit account at Bank Indonesia to receive the loan proceeds. The account will be managed, operated, and liquidated on terms satisfactory to ADB.

6. Performance Monitoring, Evaluation, and Program Review

112. MOF and BAPPENAS will be continuously monitoring implementation of the PRMAP and its impact. Reporting on progress will be made by the line ministries, as implementing agencies, to the PSC through regular quarterly meetings. BAPPENAS will submit to ADB semi-annual reports until the completion of the program cluster. With ADB TA support, the line ministries reporting system on progress will be strengthened and technical coordination will be provided to resolve problems and facilitate implementation of pending or delayed actions. ADB will be closely involved in the process through TA as well as policy dialogue, and its inputs will be conveyed to the Government. BAPPENAS and ADB will jointly assess the impact and evaluate the benefits of SP1 within 12 months after completion. Findings from the consultations and reviews will be utilized in ensuring continuity and sustained progress of SP1 reforms under SP2 and SP3.

V. THE TECHNICAL ASSISTANCE

113. The impact of the proposed technical assistance (TA) is to strengthen social service delivery at the national level through the implementation of national policy reforms in health and education. The TA outcome will be to sustain the reforms introduced under SP1, and refine and assist the Government to achieve the national policy reforms included under SP2. It will support BAPPENAS, MONE, MORA, MOH, and MOWE to implement these reforms. The TA is designed to be flexible, allowing the Government to develop outputs, terms of reference, and budgets for individual components based on current needs and demand. The TA will coordinate and complement ADB and other donor-supported decentralized programs in poverty, gender, education and health, to ensure that lessons can be applied to the TA for accelerating MDG achievement in a holistic way.

114. The TA will result in 10 outputs grouped under three components. Component 1 will support cross-sectoral policy reforms by assisting Government agencies to: (i) develop recommendations for strengthening the 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 will support 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, and (ii) demonstrating the use of the "Citizens Report Card" (CRC) for education, used for surveying parents on their satisfaction with service delivery to improve accountability and education quality. Component 3 will support 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, including in particular their impact on the distribution of providers in poor and remote areas, and (b) utilization of MNCH and CDC services, particularly by women; (iv) assisting in the revision of a ministerial regulation regarding health-related MSSs; and (v) contributing to developing a NHAs program.

115. The TA will be implemented in parallel with the PRMAP and will cover a period of 20 months, from 1 January 2008 to 31 August 2009. The total cost of the TA is estimated at $2,700,000. ADB will finance $1,500,000 from its TA funding program, and the Government will provide counterpart support in the amount of $200,000 equivalent. AusAID will provide about $1,000,000 parallel cofinancing to support health sector reforms. BAPPENAS will be the executing agency and the line ministries responsible for the various sectors will act as the implementing agencies. The PSC established for PRMAP will also coordinate implementation of the TA. A team of international specialists (46 person-months) and national experts (31 person-months), supported by ADB, will be recruited in accordance with ADB's *Guidelines on the Use of Consultants*, following the quality- and cost-based selection method and using a full technical proposal. A team of international specialists (total 30 person-months) and national experts (40 person-months), supported by AusAID on a parallel basis, will be recruited on an individual basis. The TA is presented in Appendix 8. The terms of reference for consulting services are in Supplementary Appendix E.

VI. PROGRAM BENEFITS, IMPACTS, AND RISKS

A. Expected Impacts

116. The key benefits expected from PRMAP are (i) the acceleration of the attainment of the MDGs; (ii) sustained progress in meeting the Government's medium-term poverty reduction and social development objectives, as articulated in the RPJM, the SNPK, and the national sector strategies for the health and education sectors; (iii) reorientation of public expenditure to the social sectors; (iv) an improved decentralization framework for provision of social services; (v) reduction of regional disparities; and (vi) increased access to and enhanced quality, efficiency, and accountability of education and health services for the poor.

117. **Institutional Impacts.** The PRMAP will strengthen the institutional framework for the social sectors and assist in developing inter-sectoral linkages and networks to overcome traditional institutional barriers across ministries, and between central and local government agencies. Within the education sector, institutional coordination between MONE and MORA will improve due to the preparation of a joint strategic plan (the Grand Design for Basic Education). In the health sector the role of PT Askes as a provider of health insurance will be enhanced. At the

district level, the roles and responsibilities of local governments with respect to social sector delivery will be clarified. The increased role of women in district education boards and school committees is expected to increase institutional capacity at the community level.

118. **Policy Impacts.** PRMAP will assist in raising public awareness regarding the MDGs, promote study and debate around the development challenges facing the country, forge stronger alliances among diverse groups, renew political commitment and help the Government and its development partners create deeper and better-financed partnerships. It will help focus the national debate on specific development priorities related to the poor and vulnerable, which in turn will trigger action in terms of policy reforms, institutional change and resource allocation. The program will also provide for policy continuity and consistency in areas in which ADB has been actively involved.

119. **Social Impacts.** The PRMAP supports improved access and equity of social services for the poor and women. The program will contribute to reducing sharp regional and socioeconomic differentials in selected education and health indicators. It will also contribute to a reduction in maternal mortality by improving access to comprehensive emergency obstetric care, antenatal care, and family planning services, and lower infant and child mortality rates by increasing immunization coverage. Improved CDC (targeting, for example, HIV/AIDS, malaria, and TB) will also contribute to lowering maternal and child mortality. In education, better access to schools and the removal of fees will likely result in improved transition rates to junior secondary education. Higher enrollment and transition rates will result in reduced child labor as children delay their entrance to the labor market to obtain more education. A summary poverty reduction and social strategy is in Appendix 9.

120. **Gender Impacts.** Accelerating progress towards the achievement of the MDGs will directly benefit women through the promotion of gender equity. An increased focus on achieving the MDGs requires designing interventions that target improvements in women's health and education (e.g., achieving universal primary education, reaching gender parity in primary and secondary education, reducing maternal and infant mortality, and reducing HIV/AIDS). The policy measures under PRMAP will improve (i) girls access to junior secondary education through, among others, integrated schools and scholarship schemes; and (ii) access by females to affordable maternal and reproductive health services through increased financing and technical improvements to the ASKESKIN program. PRMAP also supports policy changes to increase the proportion of female representatives on district education boards and school committees to 40%. Improved and more efficient delivery of basic education and health services will result in reducing the opportunity cost of women's time, improving the health and nutrition status of families, lowering fertility, and reducing future gender disparities.

121. **Economic and Poverty Impacts.** The nature of PRMAP, as a policy reform program, does not lend itself to a quantitative financial and economic analysis. Nevertheless, it is evident that major economic benefits will accrue to the entire population through measures that aim to expand the scope and improve access to and the quality and governance of basic social sector services, particularly for the poor. Improved access to basic education will increase productivity and personal income of poor families in the long run. Access to affordable health services and to health insurance will increase productivity and protect the poor from catastrophic health risks, which can exacerbate poverty. PRMAP will contribute to the development of human resources to better equip the population to seize the opportunities generated by rapid economic growth. It will also have a positive impact on employment by increasing the number of healthcare providers (e.g., midwives) through improved reimbursement procedures of the ASKESKIN program and improving recruitment and deployment of teachers. The introduction of MSSs and

performance-based allocation of resources will make social services more responsive to local preferences, and service providers more accountable to their clients, increasing efficiency.

122. **Social and Environmental Safeguards.** A desk review was undertaken to assess the impact of the PRMAP policy measures and the TA on land acquisition and resettlement, the environment, and ethnic groups, in accordance with ADB's social and environmental safeguard policies (i.e., the *Involuntary Resettlement Policy* [1995], *Policy on Indigenous Peoples* [1998], and *Environment Policy* [2002]). The PRMAP and TA are unlikely to have any adverse impacts on ethnic groups, resettlement or environment.

B. Risks and Mitigating Measures

123. The PRMAP is subject to the following risks:

(i) **Limited impact on education and health outcomes.** Overall increased public expenditure in the sectors may have limited effect in improving education outcomes if the funds are not utilized efficiently or fail to reach the intended beneficiaries. Increased budget allocation for education and health from the Government may encourage local governments to reduce their own allocations. The introduction of performance-based allocation mechanisms and improved systems for monitoring outcomes will mitigate these risks.

(ii) **Corruption and poor governance.** PRMAP may face constraints in the form of weak governance and corruption. However, the Government has considerably strengthened its anti-corruption efforts in recent years. The profile and visibility of the anti-corruption commission and other law enforcement agencies have now been considerably enhanced to deal with corruption. The strengthening of school committees and increased transparency and accountability mechanisms introduced under the ASKESKIN program will improve governance in the education and health sectors.

(iii) **Resistance to the policy reforms by local governments and lack of capacity.** 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. Recent steps taken to further clarify these responsibilities through the establishment of minimum services standards is expected to mitigate this risk. There is also a risk that local governments will fail to support reforms that increase their accountability and impose further monitoring of their policies and actions. Lack of capacity by local governments to implement reforms is also a risk. Current support provided to districts by ongoing ADB projects to improve capacity for implementation of health and education programs is expected to reduce these risks.

(iv) **External and domestic economic shocks may affect the sustainability of the reforms:** Increased oil prices or other adverse regional or domestic events that have a contagion effect could reduce the fiscal space available for the implementation of the reforms. Efforts taken by the Government to balance the budget and improve economic management have reduced this risk.

(v) **Government commitment to MDGs.** A lack of government commitment could reduce the momentum for policy reforms focused on accelerated achievement of the MDGs. However, Government actions indicate strong commitment to poverty reduction and the MDG acceleration agenda in the medium term.

VII. ASSURANCES AND CONDITION

A. Specific Assurances

124. In addition to the standards assurances, the Government has given the following assurances, which are incorporated in the legal documents:

(i) Counterpart funds generated from the proceeds of the program loan will be used to finance the development needs as outlined under the PRMAP implementation arrangements.

(ii) The policies and actions taken prior to the date of the PRMAP loan agreement, as described in the development policy letter (including the policy matrix), will continue to be in effect for the duration of the PRMAP and subsequently.

B. Condition for Loan Effectiveness

125. All reform actions and measures, as specified in the Policy Matrix for Subprogram I, have been carried out.

VIII. RECOMMENDATION

126. I am satisfied that the proposed program cluster and loan would comply with the Articles of Agreement of the Asian Development Bank (ADB) and recommend that the Board approve

(i) the program cluster to the Republic of Indonesia for the Poverty Reduction and Millennium Development Goals Acceleration Program;

(ii) the loan of $400,000,000 to the Republic of Indonesia for Subprogram 1 of the Poverty Reduction and Millennium Development Goals Acceleration Program Cluster, from ADB's ordinary capital resources, with interest to be determined in accordance with ADB's London interbank offered rate (LIBOR)-based lending facility; a term of 15 years, including a grace period of 3 years; and such other terms and conditions as are substantially in accordance with those set forth in the draft Loan Agreement presented to the Board; and

(iii) the provision of technical assistance not exceeding the equivalent of $1,500,000 on a grant basis to the Government of Indonesia for Strengthening Social Services Delivery.

Haruhiko Kuroda
President

4 October 2007

DESIGN AND MONITORING FRAMEWORK

Design Summary	Performance Targets/Indicators	Data Sources/ Reporting Mechanisms	Assumptions and Risks
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% • Net enrolment ratio of 95% in primary education and 80% in junior secondary • Ratio of girls to boys in basic education: 100% • Under-5 mortality rate per 1000 births: 32 • Maternal mortality rate per 100,000 live births: 102 • Malaria prevalence rate per 100,000 people: less than 1000 • HIV prevalence among pregnant women: less than 0.04 • Tuberculosis prevalence rate per 100,000 people: less than 200	Central Board of Statistics (BPS) data MOF Data from the Program Steering Committee (PSC) MONE and MORA MOH	**Assumption** • Macroeconomic and political stability **Risks** • Lack of effective coordination between the concerned line ministries and local governments • External and domestic economic shocks may affect the sustainability of the reforms
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% • Difference in per capita expenditure for health and education between the poorest and the richest quintile of districts reduced by 10% • Proportion of funds from education and health programs reaching the poor increased by 20% • 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%	PSC reports BPS data MONE and MORA MOH and PT Askes Local government reports	**Assumption** • Low corruption and good governance **Risk** • Increased government expenditures have limited impact on outcomes

Design Summary	Performance Targets/Indicators	Data Sources/ Reporting Mechanisms	Assumptions and Risks
Outputs **I. Cross sectoral policy reforms** • Increased budget allocation for health and education, especially focused on MDG-related programs. [MDGs 1–6] • Improved performance incentives and geographical resource allocation to districts for education and health. [MDGs 1–6] • Uniform system for targeting the poor for achieving the MDGs in health and education established. [MDGs 1–5] • Gender equity in access to health and education services achieved [MDGs 1–6] • Planning framework for MDG acceleration established [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. • At least 20% of DAK funds for education and health are allocated based on performance. • A uniform database of the poor is established and utilized by MONE, MORA and MOH (at least one program each). • At least four health and education sex-disaggregated indicators collected in 30% of districts. • MDGs included in the medium-term plans of 20 districts and five provinces, and the medium-term plans of MOH, MONE and MORA.	PSC reports Budget approval documents Asian Development Bank (ADB) review missions Local government reports PSC reports Budget approval documents ADB review missions Local government reports Surveys	**Assumption** • Government commitment to MDGs and poverty reduction is sustained **Risks** • Conflict between central and local governments • Lack of clarity about roles and responsibilities of local governments • Resistance to the policy reforms by local governments and lack of capacity
II. National policy reforms in the education sector • Improved access to junior secondary schools in under-served areas [MDGs 1–3] • Improved O&M support for smaller/remote schools [MDGs 2, 3] • Increased affordability of education by poor students/ households [MDGs 1–3] • Enhanced quality and equitable deployment of teachers [MDGs 2, 3] • Education service delivery meets MSSs [MDG 2]	• Average distance to junior secondary schools reduced in 70 selected districts • 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 • At least 40% of the eligible poor receive scholarships for junior secondary education, and 70% of scholarships go to the poor • At least 30% of teachers are qualified, and about 10,000 additional teachers per year are working in remote areas • At least 10 districts implement the MSSs established by MONE	PSC reports Budget approval documents ADB review missions Local government reports MONE and MORA data Surveys	

Design Summary	Performance Targets/Indicators	Data Sources/ Reporting Mechanisms	Assumptions and Risks
• Improved planning and implementation of education services [MDGs 2, 3]	• At least 20 of districts prepared joint plans for MONE and MORA schools		
• Greater transparency of education outcomes to enhance accountability. [MDGs 2, 3]	• Annual surveys on parents' satisfaction with basic education services are institutionalized • Inspector general audit report includes cases analyzed on corruption • At least 40% of school board members are women in 100 surveyed schools		
III. National policy reforms in the health sector		PSC reports	
• 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	Budget approval documents ADB review missions	
• Improved targeting of public financing for health services for the poor [MDGs 1, 4–6]	• At least 40% of the poor have health cards, and 60% of benefits from ASKESKIN go to the poor	Local government reports MONE and MORA data	
• Improved effectiveness of MNCH/RH service delivery through provider behavior [MDGs 4–6]	• Absenteeism of health personnel from community health centers reduced, and all provinces have at least 30 midwives per 100,000 population	Surveys	
• Improved effectiveness of CDC through integrated programs [MDGs 3–6]	• TB detection rate of 80% and treatment success rate of 85% • HIV/AIDS: 80% of people most at risk reached by prevention programs		
• Improved monitoring for MDG-related health performance [MDGs 1, 3–6]	• At least 20% of districts implement the MSSs established by MOH		
• Improved financial information with regard to MDG-related health expenditures [MDGs 1, 3–6]	• NHAs are institutionalized and have been produced at least twice.		

Activities with Milestones	Inputs
SP1 (by 31 March 2007) • Between 2004 and 2007, the national budget for the education sector increased from 2.8% to 3.9% of GDP, and for the health sector from 0.7% to 1.1% of GDP • BOS increased to Rp. 10.2 trillion and ASKESKIN increased to Rp. 3.6 trillion in 2006 • Annual DAK allocation for health and education increased sevenfold from 2004 to 2007, reaching Rp. 5.3 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 9 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 with 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 Rp. 4.252 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 between 2005 and 2007 by 50% in real terms. • 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. **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 for at least 40 selected districts, identifying poor households, completed by BPS. • Sex-disaggregated indicators for the health and education MDGs (at least 4 indicators) finalized by BAPPENAS, with MONE, MORA, MOH and MOWE.	• 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 loans to support SP2 and SP3 • Periodic review of progress under each subprogram • Reports from the Program Steering Committee • Technical assistance reports

Activities with Milestones	Inputs
• Comprehensive roadmap for accelerating attainment of the MDGs prepared by BAPPENAS and Menko Kesra (the Coordinating Ministry of Social Welfare) and approved by the Government. • Guidelines directing local governments to mainstream the MDGs when preparing district medium-term development plans and district poverty reduction strategies issued by the Government. • 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 junior secondary students. • 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 a 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 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.	

Activities with Milestones	Inputs
• 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 MTDP 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 the 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), BSNP = National Education Standards Board, BOS = Bantuan Operational Subsidi, DAK = Dana Alokasi Khusus, GDP = gross domestic product, HIV/AIDS = human immunodeficiency virus/acquired immunodeficiency syndrome, MNCH/CDC = maternal neonatal and child health care/communicable diseases control, MDG = Millennium Development Goal, MOF = Ministry of Finance, MOH = Ministry of Health, MONE = Ministry of National Education, MOHA = Ministry of Home Affairs, MORA = Ministry of Religious Affairs, MSS = minimum services standard, MTDP = medium-term development plan, NHA = national health account, O&M = operation and maintenance, PKH = Program Keluarga Harapan, RPJM = Medium-Term Development Plan, PRMAP = Poverty Reduction Millennium Development Goal Acceleration Program, PSC = project steering committee, PT Askes = a third party parastatal, SP1 = subprogram 1, SP2 = subprogram 2, SP3 = subprogram 3, TB = tuberculosis.

PROGRESS TOWARD THE MILLENNIUM DEVELOPMENT GOALS AND TARGETS

Target	Goal	Indicators	Earliest Value (1990–1994)	Latest Value (2002–2006)	Target in 2015
	Goal 1: Eradicate Extreme Poverty and Hunger				
1	Halve, between 1990 and 2015, the proportion of people whose income is less than $1 a day.	Proportion of population below national poverty line	15.1 (90)	17.7 (06)	7.6
		Proportion of population living below $1 per day	20.6 (90)	7.2 (02)	10.3
2	Halve, between 1990 and 2015, the proportion of people who suffer from hunger.	Prevalence of underweight children (% of children under 5 years old)	36.6 (90)	28.2 (03)	18.3
	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)	88.7 (92)	94.8 (06)	98
		% of grade 1 cohort reaching grade 5	75.6 (90)	82.2 (02)	98
		Net enrolment ratio in junior secondary education (% of children aged 13–15 years)	41.9 (92)	63.7 (05)	98
		Literacy rate, 15–24 years old (%)	96.6 (92)	98.7 (02)	
	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 education no later than 2015.	Ratio of girls to boys: primary education, 7–12 years (%)	100.6 (92)	100.1 (02)	100
		Ratio of girls to boys: junior secondary education, 13–15 years (%)	101.3 (92)	102.6 (02)	100
		Ratio of literate females to males, 15–24 years (%)	97.9 (92)	99.8 (02)	100
	Goal 4: Reduce Child Mortality				
5	Reduce by two thirds, between 1990 and 2015, the under-5 mortality rate.	Under-5 mortality rate (per 1,000)	97.0 (90)	38.0 (04)	32
		Infant mortality rate (per 1,000 live births)	57.0 (94)	35.0 (02)	
	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 (94)	307.0 (02)	102
		Proportion of births attended by skilled health personnel (%)	40.7 (92)	72.0 (05)	90

Target	Goal	Indicators	Earliest Value (1990–1994)	Latest Value (2002–2006)	Target in 2015
	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 (02)	
		Proportion of contraceptive users (married women ages 15–49 years) reporting condom use (%)	1.3 (92)	0.4 (02)	
		Number of children orphaned by HIV/AIDS		18,000 (02)	
8	Have halted by 2015, and begun to reverse, the incidence of malaria and other major diseases.	Malaria prevalence rates, per 100,000 people		1,000 (01)	
		Tuberculosis prevalence rates, per 100,000 people	440 (90)	125 (05)	
	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 (90)	2.3 (00)	
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 (94)	50.0 (02)	
		% of population with sustainable access to basic sanitation	30.9 (92)	63.5 (02)	
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 (92)	83.5 (01)	

HIV/AIDS = human immunodeficiency virus/acquired immunodeficiency syndrome.
Sources: Central Board of Statistics (BPS). *2005 Socio Economic Survey*. Jakarta; BPS. Ministry of Health. 2004. *Demographic Health Survey*. Jakarta; and World Health Organization.

SUMMARY EDUCATION AND HEALTH SECTOR ANALYSES

A. Basic Education Sector Analysis

1. Current Status of Education MDGs

1. Indonesia's performance relative to the education-related Millennium Development Goal (MDG) 2 of universal basic education by 2015 is mixed, although it has made good progress with respect to some intermediate indicators at the national level. Indonesia, which has one of the largest school-going populations in the world (Table A3.1), has been more ambitious than most countries striving to meet the international target of universal basic education. Indonesia has defined basic education as including a total of 9 years: 6 years of primary education (7–12 year olds) and 3 years of junior secondary education (13–15 year olds). In an impressive achievement, access to education, as measured by gross enrolment rates (GERs) and net enrolment rates (NERs), has improved nationally at all levels. In 2005, the GER and NER at the primary level were 114.6% and 94.0% respectively, while those for junior secondary level were 82.9% and 63.7% (Table A3.2). These enrolment rates, especially at the primary level, compare favorably with enrolment rates in East Asian countries with much higher per capita incomes.

Table A3.1: Population of School Aged Children (million)

National Population	Population 0–6 Years Old	Population 7–12 (Primary)	Population 13–15 (Junior Secondary)	Population 16–18 Senior Secondary
220	28.5	25.60	13.03	12.66

Source: Ministry of National Education. 2005. *Indonesia Educational Statistics in Brief 2004/2005.* Jakarta.

Table A3.2: Enrolment Trends 1995–2005 (%)

Item	1995	2000	2001	2002	2003	2004	2005
GER[a]							
Primary	107.0	107.7	107.2	106.0	105.8	107.1	114.6
Junior Secondary	65.7	77.6	78.1	79.9	81.1	82.2	82.9
NER[b]							
Primary	91.5	92.3	92.9	92.7	92.7	92.5	94
Junior Secondary	51.0	60.3	60.5	61.7	63.5	65.2	63.7

GER = gross enrolment rate, NER = net enrolment rate

[a] Gross enrolment ratio (%). Number of pupils in primary school, regardless of age, expressed as a percentage of the population in the theoretical age group for primary education.

[b] Net enrolment rate (%). Number of pupils in primary school, falling within the theoretical age group for primary school education, expressed as a percentage of the population in the theoretical age group for primary education.

Source: UNESCO Institute for Statistics.

2. One of the key limitations of NERs, however, is that they do not translate automatically into school attendance or completion. Additionally, even if a cohort analysis of those that complete basic education is undertaken, focusing on those who remain in school and complete a certain level of education fails to take into account overall system inefficiencies resulting from repetition and dropouts. Moreover, a recent study[1] shows that even in those countries that are on track to meet the MDGs, the majority of youth do not meet minimal competency levels, let alone the level of competency required in a globalized environment.

[1] Filmer, Dan, Amer Hasan, and Lant Pritchett. 2006. *A Millennium Learning Goal. Measuring Real Progress and Education*. Working Paper No. 97. Center for Global Development. Available: http://www.cgdev.org.

3. This analysis is very relevant for Indonesia. Despite impressive GERs and NERs, only about half of Indonesian children enrolled in school complete basic education within the required 9 years. A recent study[2] shows that the dropout rate for primary school level students was 1.68% in secular schools and 2.26% for madrasah. At the junior secondary level, the rates increased to 2.65% and 3.55% for secular and religious schools, respectively. GER-disaggregated data reveal higher dropout rates for male students as the level of education increases; dropout rates for male students are higher than for females, particularly at the junior secondary level. (See Table A3.3).

Table A3.3: Dropout Rates (%)

Level and Type of School	Drop-Out Rate Grade I–VI		
	Male	Female	Total
Primary School (secular)			
Urban	1.26	0.99	1.16
Rural	2.28	1.90	2.09
Subtotal	**1.82**	**1.48**	**1.68**
Primary School (religious)			
Urban	2.70	3.11	2.89
Rural	3.18	3.31	3.25
Subtotal	**2.64**	**2.65**	**2.65**
Junior Secondary (secular)			
Urban	2.09	1.36	1.74
Rural	4.13	2.90	3.58
Subtotal	**3.09**	**2.12**	**2.65**
Junior Secondary (religious)			
Urban	4.41	2.53	3.34
Rural	5.86	3.16	4.85
Subtotal	**4.43**	**2.43**	**3.55**

Source: Ghozali. 2004. *Studi Putus Sekolah, Mengulang Kelas, dan Tidak Melanjutkan Sekolah Pada Jenjang Pendidikan Dasar*. Balitbang: Ministry of National Education.

4. Disparities in access to education continue to exist at the post–primary level among provinces, among rural and urban areas within provinces, between those children attending religious schools and those attending public schools, and between the rich and the poor (Table A3.4). Key factors affecting enrolment and transition rates include substantial cost barriers (e.g. fees, transport cost, textbooks, stationary, and uniforms), uneven coverage of facilities, and perceptions about the relevance of the curriculum and future employability of school graduates.

Table A3.4: NER by Income Quintile

	Q1(poorest)	Q2	Q3	Q4	Q5(richest)	Q5/Q1
Primary						
1993	86.7	90.7	92.5	93.3	93.0	1.07
1997	90.3	93.0	93.4	93.5	92.4	1.02
2002	91.4	93.6	93.8	93.2	91.4	1.00
Junior Secondary						
1993	22.6	37.5	45.7	61.3	72.5	3.21
1997	37.7	52.2	60.0	69.2	75.1	1.99
2002	45.5	57.9	65.1	72.0	76.9	1.69

Source: Ministry of Education. 2004. *Education Sector Review.* Jakarta.

[2] Ghozali. 2004. *Studi Putus Sekolah, Mengulang Kelas, dan Tidak Melanjutkan Sekolah Pada Jenjang Pendidikan Dasar.* Balitbang: Ministry of National Education.

5. Therefore, meeting the MDG 2 target of universal basic education[3] by 2015 depends not only upon the steady increase in NERs at both the primary and junior secondary levels, but also on completion rates at these levels. Existing urban-rural disparities within districts and income-related disparities at the post–primary levels pose significant challenges to the attainment of MDG 2. Children who do not complete primary education are especially at risk of becoming illiterate adults.

6. Indonesia is on track to meet the MDG 3 target of eliminating gender disparity in primary and secondary education by 2015. An impressive achievement for Indonesia is that the gender gap in terms of NER has been eliminated at the primary level and reversed for the junior secondary levels,[4] where there were more girls enrolled than boys (64.5% vs. 62.6%) in 2003 (Table 3.5). At the senior secondary level, the NER for girls (40.6%) in 2003 was almost the same that for boys (40.5%). In addition, the general observation—that the poorer the family, the lower the proportion of girls enrolled in school and the higher the dropout rate for girls—does not hold true for Indonesia at all levels of schooling.

Table A3.5: Net Enrolment Rates, by Gender, Urban and Rural 2003

Education Level	Male			Female		
	Urban	Rural	Total	Urban	Rural	Total
Primary	92.3	92.6	92.5	92.0	93.0	92.6
Junior Secondary	72.5	56.2	62.6	73.0	58.8	64.5
Senior Secondary	56.9	28.5	40.5	55.2	29.0	40.6
Tertiary	16.0	2.2	8.8	14.9	2.1	8.3

Sources: Central Board of Statistics (BPS). 2003; and National Socioeconomic Survey (SUSENAS). 2003.

7. While the gender gap in terms of adult literacy rates has been narrowing steadily, due to faster improvements in the literacy rates of females than those of males, the literacy rate of women (86.2%) is still lower than that of men (93.5%). Women also have lower mean years of schooling (6.5 years) than do men (7.6 years). The Government is promoting female literacy through non-formal education programs. In addition, increasing completion of basic education will by default lower illiteracy levels in the future.

2. Analysis of Institutional Capacity, Resource Allocation and Governance for Education Sector Development in support of MDGs

a. Institutional Capacity

8. Decentralization has led to changed and still-evolving roles for education sector management. The political and administrative decentralization undertaken within Indonesia in 2001 has posed some challenges for policy formulation and service delivery for the education sector. While general public education service delivery has been made the obligatory function of local governments, with the Ministry of National Education (MONE) responsible for policy development and resource allocation, the Ministry of Religious Affairs (MORA), a central level agency, continues to be responsible for delivering religious education. In addition, the role and coordination among different agencies—such as Badan Perancanaan Pembangunan Nasional (the National Development Planning Agency, BAPPENAS) in policy formulation, the Ministry of Home Affairs (MOHA) in regulation, the Ministry of Finance (MOF) in performance based resource allocation, as well as the Board of National Education Standards (BSNP)—are still

[3] While internationally, the MDG for basic education refers to 5 years of education, Indonesia has been more ambitious in defining its basic education to include both primary (grades 1–6) and secondary (grades 7–9).

[4] ADB. 2006. *Indonesia Country Gender Assessment.* Manila; and World Bank. 2004. *Education in Indonesia. Managing the Transition to Decentralisation*. Vol.1. MONE's Renstra 2005–2010.

evolving. Increased clarity with respect to the role of each agency in the education sector will lead to improved management and sector performance.

9. **Managing Education Initiatives.** Positive initiatives are underway for improving education quality, efficiency, and effectiveness, but need to be managed well. The Government is acutely aware of the need to establish standards of education and raise attainment levels for these standards through improved teacher qualifications as well as the provision of adequate textbooks and other learning materials. While additional teachers will be needed to replace retirees, the deployment of teachers within districts and the weak expertise of teachers in priority subject areas such as math and science are much greater problems.

10. While the establishment of BSNP and the development of national education standards and minimum service standards (MSSs) has been long overdue, there is a danger that districts be overwhelmed if all MSSs are implemented simultaneously, if the number of MSSs is excessive, and if the effort to impose standards is too ambitious. It is therefore important that implementation of the MSSs be well sequenced. Proper implementation of the national education standards would require (i) sufficient funding; (ii) understanding of what needs to get done at the school level; and (iii) cooperation between MONE, MORA, MOHA, BAPPENAS, MOF and local governments.

11. The Government is also aware of the need to improve the efficiency and effectiveness of education service delivery. In the aggregate, government financing for education is allocated efficiently, as funds are directed primarily to improve enrolment levels and the quality of outcomes at the primary and junior secondary levels. The allocative and technical efficiency of primary and junior secondary spending could be further enhanced through (i) the reassignment of teachers across geographic areas, and (ii) adjustment of the Bantuan Operasional Sekolah (BOS) formula to take into account school size. Technical efficiency could also be improved by meeting education standards for average class size and average hours of instruction. In addition, decisions related to investments in teacher quality would also need to be reflected in the technical quality of education.

12. **Aligning MONE and MORA Policies.** Central MONE and MORA policies and strategies need to be better aligned to support the RPJM as well as district education development plans. The Government's Medium-Term Development Plan for 2005–2009 (RPJM) is characterized by a strong focus on policies and programs for social justice, equity and quality of basic social services. Recognizing the need for urgent policy reform, MONE and MORA have conducted comprehensive sector performance assessments and developed medium-term plans.[5] Although both ministries are governed by the National Education Law of 2003, they formulated separate education strategic plans. Recent measures have sought to better align their policies, strategies and operations in support of education service delivery at the district level, and include the development of a joint strategic plan for basic education. In addition, these agencies need to support district governments in developing comprehensive education development plans based on an assessment of performance in terms of education outcomes and strategies to reduce disparities.

13. There continue to be tremendous opportunities for organizational restructuring within the central government and retraining at all levels of government for improved planning, financing and implementation of education services, in accordance with the Government's decentralization policies. Local government capacity for service delivery remains particularly weak. While the provision of basic education services is now an obligatory function of district

[5] MONE. 2005. *Medium-term Development Plan 2005–2009.* Jakarta; and MORA. 2004. *Madrasah Sector Assessment*. Jakarta.

governments, it is quite evident that management capacity, in terms of the systems and personnel in place at the district level, is inadequate to perform the expected functions. A number of development partners, including ADB, are currently providing technical assistance (TA) to raise the managerial, technical and financial management capacities at the district and school levels.

14. **Revival of Management Information Systems.** One detrimental aspect of decentralization in the short term has been the breakdown in data flows from local to central level, and the loss of skilled personnel to manage information systems. These weaknesses have greatly impeded sector-level planning for and performance monitoring of education services. Similarly, information management systems at the district level are insufficiently user friendly and not results-oriented, which undermines the operational planning and service management functions of local governments. These systems need to be revived and made functional to direct increasing education sector resources to MDG-deficit areas. In addition, school mapping needs to be made more participatory to allow for greater understanding of the socioeconomic and cultural factors that promote or impede the use of education facilities, and to promote greater responsibility for the use of school services by communities.

b. Education Sector Resources

15. **Medium-term Education Expenditure Framework.** Government spending on education is rising, but an overall medium-term expenditure framework with clear roles for the Government and other stakeholders in education financing is needed. In order to implement the education reform program, national public expenditure on education is projected to rise from Rp42.3 trillion to around Rp131 trillion (in nominal terms) over the period 2005–2007. Approved centrally managed education expenditure is projected to rise from Rp24 trillion to Rp65 trillion over 2005–2009. In order to avoid any fiscal gap, regional budgets for education will need to increase from around Rp40 trillion to Rp51 trillion over the same period. Community spending is projected to remain roughly constant at around Rp10 trillion over the same period, with a rapidly increasing share at post-basic levels.

16. Central expenditure for formal basic education is projected to rise from Rp12.1 trillion in 2005 to Rp19.7 trillion by 2009, including (i) school operational budgets, (ii) infrastructure rehabilitation and (iii) scholarships for the poor. Consistent with Government priorities, expenditure on teacher management and quality assurance will rise from Rp3.2 trillion to Rp9.6 trillion over the same period. Central expenditure on non-formal education is projected to increase from Rp0.3 trillion to Rp4.6 trillion by 2009.

17. The new education financing strategy is expected to increase the volume and share of central government education expenditure within the poorest and currently underserved areas of Indonesia. A critical financing policy issue is to ensure that increased levels of central government spending on education (e.g. due to the teachers law and BOS) does not lead to lower levels of spending on basic education by local governments.

18. It is now necessary, however, to shift from simply increasing education financing to a greater focus on increasing efficiency and effectiveness. Improving allocative and cost efficiency is of particular importance in the context of Indonesia, where the Constitution mandates that 20% of the national budget will be allocated for (non-salary) education expenditures. Financial investments to increase student retention and transition and reduce dropouts can lead to greater effectiveness but lower education system efficiency. These critical issues need to be explored by the Government to inform policies for financing education.

19. **Increasing Education Access and Transition Rates.** Infrastructure development is being designed to help increase access to as well as transition rates among different levels of

education. Achieving the MDGs requires getting the last 2.6% of primary (7 to 12 years old) and 16% junior secondary (13 to 15 years old) school-aged children into school. The large stock of primary schools built in the 1970s needs to be rehabilitated, while expansion and rehabilitation is needed at the junior secondary level. In order to increase transition rates, the Government has adopted the policy of "one roof" or integrated schools, under which primary schools will be upgraded and/or expanded to enroll children at junior secondary levels.

20. **Linking Remuneration and Outcomes.** Considerable investments are planned for upgrading the skills of and incentives for teachers and education personnel, but these need to translate into improved practices and performance at the school level. The implementation of the new Teachers and Education Personnel law, approved in December 2005, will have significant medium- to long-term implications for education financing. In broad terms, the legislation provides, by 2016, for a doubling of the remuneration of teachers through incentive awards, and for professional upgrading through education and certification. The challenge will be to ensure that any increases in teacher remuneration are linked to gains in (i) efficiency, (ii) teacher performance, and (iii) subsequent improved student outcomes and standards. Upgrading of teacher skills will need to be managed carefully in integrated schools to ensure a balance between increased work loads and professional development requirements.

21. **Results of Operational Funding Support.** Recent operational support funding programs for schools by the central Government have had mixed results. Provision of resources for recurrent expenditures at the school level—including student activities, maintenance of infrastructure and equipment, and other administrative expenses—are the responsibility of district governments. However, the budget allocated by districts for these activities has historically been very small, averaging less than 5% for public primary schools, and less than 10% for public junior secondary schools. This was a primary reason why almost all public schools needed to solicit parental contributions to close the gap between funding requirements and the resources made available from the district government. Poorer communities with limited resources to contribute therefore ended up with poorly funded schools.

22. The situation has been improving, however. The reduction in fuel subsidies in 2005 led to the launching that year by the Government of a school operational support program, based on the number of students per school (the BOS program). An early assessment of the program highlighted implementation challenges, and the risk that increased central-government spending could result in further spending reductions by districts. As a result there could be limited growth in total public sector resources, with negative consequences for policy implementation, especially in terms of quality and standards improvement.

23. While the BOS program has increased overall resources for schools accessed by very poor communities, and allows school principals the discretion to offer financial support to poor students, this may be negated by other solicitations for financial support from parents. Some communities are still being asked to make financial contributions which take creative forms, such as "seat" fees and fines imposed on students, with negative consequences for the students' access to and retention within the education system. The Government is therefore piloting a conditional cash transfer (CCT) scheme, to stimulate demand for basic education by the poor and complement current programs.

c. Education Sector Governance and Accountability for Outcomes

24. **Education Quality.** Education outcomes, as measured by international programs that assess student skills and learning achievement across countries, confirm the low quality of

education in Indonesia.[6] Even with the low graduating standard currently in use (i.e. a 42.25% pass score), many students do not pass. In the 2006 national exam, 8.6% of vocational high school and 7.43% of senior high school students did not pass, although there was a marked improvement in the average scores of those that did pass. Student examination performance varies widely across districts. In 2006, pass rates in junior secondary examinations averaged 92%, with a provincial range of 64.7% to 94.3%. Pass rates in poorer, rural and remote areas were consistently below average. These results call for measures to improve the student assessment and learning techniques employed in schools.

25. There is strong evidence of high-level leadership and ownership of the education reform program in Indonesia that seeks to improve these sector outcomes. The minister of national education has led the formulation of the new education reform program for MONE (RENSTRA 2005–2009), and a joint strategy between MONE and MORA was completed in 2006. The reforms are based on an extensive and inclusive public consultation process in five regions during 2005, as well as intensive consultation with the parliamentary working group on education. Vice President Yusuf Kalla has indicated strong government commitment to ensuring that all primary schools and madrasah are repaired and renovated within the current Government's mandate. Consistent with President Susulo Bambang Yudhoyono's commitment to governance reform, the ministry of education has set a number of measurable anti-corruption performance indicators in the education RENSTRA.[7]

26. While the support given to reforming education services, which includes vital financial support, makes it considerably easier to examine the systemic weaknesses and devise strategies to address these, there is currently no regular process within the government for monitoring the effectiveness of education policies and strategies. The Government has embarked on a program to encourage district education development planning as well as school development planning, with regular reporting on the use of funds being submitted to the school committees and the district education boards, along with annual budget hearings at district and national legislatures. Despite these initiatives, none of these bodies are yet evaluating the appropriateness of legislation, regulations and policies independently of the executive, which should be their primary role in a decentralized environment. Regular budget hearings that examine progress towards achievement of national and international targets such as the MDGs would make the process truly results–oriented, and help the executive focus on the outcomes for which they are ultimately accountable.

27. Another challenge for improving education sector governance is the lack of clear delineation of responsibilities among the central, provincial and local governments; although the National Education Law 20/2003 provides some broad assignment of responsibility, it remains open to interpretation, which has led to a plethora of implementing regulations from different central government agencies, as well as district governments.

B. Health Sector Analysis

1. Current Status of the Health MDGs

28. **MDG 4.** The MDG 4 target on infant and child mortality is on track. Indonesia is currently on track to achieve the MDG 4 target. The under-5 mortality rate has already decreased,

[6] International Association for Evaluation of Education Achievement. 2003. *Third International Mathematics and Science Study.* Boston. For 14-year olds, Indonesia ranked 35th, out of 39 countries, in mathematics, and 33rd in science. OECD. 2003. *Program for International Student Assessment.* Manila for 15-year olds. Indonesia ranked 39th in reading and mathematics, and 38th, out of 41 countries, in science.

[7] These include targets for: (i) number of anticorruption charges, (ii) amounts of funds subject to anticorruption investigation, and (iii) amount of funds subject to reclaim.

dropping between 1970 and 2004 from 97 to 38 deaths of children under 5 per 1,000 live births. Many factors, both within and outside the health sector, explain Indonesia's progress during this period in reducing child mortality. However, sharp regional and socioeconomic differentials remain in child mortality, and progress could be more rapid with improved performance in immunization, malaria control, water and sanitation and maternal-child nutrition, and with improved quality and accessibility of maternal neonatal and child health (MNCH) services.

29. **MDG 5.** The MDG 5 target on maternal mortality is not likely to be achieved by 2015 given current progress. Although considerable progress appears to have been made toward achieving the MDG 5 target, progress to date has not been sufficiently rapid to indicate that this target is likely to be achieved by 2015. The estimated maternal mortality ratio (MMR) has declined from 390 to 307 maternal deaths per 100,000 live births between 1991 and 2002. During the period 1992 to 2005, the percentage of births assisted by skilled health personnel (an important MDG 5 intermediate outcome indicator) has increased from 40.7% to 72.0%. However, there are still sharp regional and socioeconomic differentials in this indicator, and 42% of rural births are still assisted by traditional birth attendants. If Indonesia is to attain the targeted decline in the MMR, and achieve significant decreases in child mortality (MDG 4), more emphasis is needed on delivering in health facilities (hospitals, primary health centers or private maternity clinics) instead of in homes; home births currently account for at least 59% of all births.

30. **MDG 6. Several** targets on communicable disease control—of HIV/AIDS and malaria—are not likely to be achieved by 2015 given current progress. Indonesia is not on track to achieve the communicable disease control MDG targets. Currently, the HIV epidemic is concentrated in a few high-prevalence groups (i.e., commercial sex workers and injected drug users). The challenge is to prevent its further spread into the general population. Condom use with high-risk partners is still low, while comprehensive correct knowledge about HIV/AIDS is still limited to the better educated, including among youth. Unless more effective measures are taken in the future, it is unlikely that Indonesia will have halted and begun to reverse the spread of HIV/AIDS by 2015.

31. Reliable information about malaria incidence is currently unavailable in Indonesia because of the poor condition of the national health information system and, more importantly, because up to 90% of malaria cases are treated outside health facilities (for example, using drugs purchased over the counter). Nearly one-half of Indonesia's population currently lives in malaria-endemic areas. Although bed net coverage is reasonably high (40% of children under 1 year of age were reported to have slept under a bed net in 2000), use of insecticide-treated bed nets and indoor spraying are still limited. Unless funding for malaria control is increased significantly in the future, it is unlikely that malaria incidence will have begun to decrease by 2015.

32. Indonesia currently has one of the highest estimated rates of TB prevalence in the world. Although the directly observed treatment—short course (DOTS) success rate is currently at the targeted 85%, the DOTS detection rate was only 57% in 2004. Unless the DOTS detection rate is increased dramatically in the future, it is unlikely that TB prevalence will have begun to decrease by 2015.

2. Health Resources

33. **Underfunding of the Health Sector**. Indonesia's health sector has been under-funded for many years, both by the Government and by households. Government-financed health expenditures averaged less than 3% of total central government expenditure and about 0.5% of gross domestic product (GDP) during the period 1985 to 2002. Per capita public health expenditure (i.e., central government plus donor-financed health expenditure) ranged between

$2 and $6 during this period. Household-financed health expenditure is estimated to account for about 68% of total health expenditure, implying that per capita total health expenditure averaged only about $12 during this period. Despite recent efforts by the Government to increase public expenditure in the health sector, total public health expenditure remained low, at about 17% of GDP in 2006.

34. **Health Sector Government Budgets**. Because of the non-transparent government budgeting and reporting system, there is little information currently available on the allocation of resources within the government health system, either at the central level or in the provinces and districts. However, the available data suggest that there is substantial variation among provinces in per capita levels of public health expenditure that is unrelated to high MMR or infant mortality rates. The available data also indicate that the allocation of central health funding among provinces tends to exacerbate rather than reduce inequalities between provinces in public health spending.

35. **Shortages and Misallocation of Health Personnel.** Due to chronic under-funding and a government-wide freeze on civil service employment during the 1990s, the Indonesian health sector faces an acute shortage of personnel compared to other countries in the region. Moreover, there is a serious misallocation of health personnel (and especially of doctors) within the government health system. The available evidence suggests that the quality of Indonesia's health personnel is rather poor, due to the poor quality of education and training institutions, and the absence of re-licensing and re-certification requirements and effective continuing education programs. Another problem is the mismatch, particularly at the central level, between the skills needed to manage a modern health system and the narrow, mostly medical qualifications of existing MOH staff.

36. **Sparse Government Health Infrastructure.** There are relatively few hospital beds per capita, and primary health centers serve relatively large populations. However, the limited government health infrastructure is fairly equally distributed among regions. There is little information available on the current condition of government health infrastructure, which is still maintained, renovated and replaced through centrally managed transfers, such as the DAK.

3. Health Processes

37. **Low Health System Productivity.** Productivity of health services is relatively low in Indonesia. In addition, productivity levels vary considerably among government health facilities, reflecting personnel allocations that are unrelated to actual workloads and generally low levels of service utilization. However, productivity is also low in the government health system because personnel are poorly motivated and supervised. In one recent study, for example, it was found that 40% of government health staff in primary health centers were absent from their facilities for reasons other than off-site duties. Possible solutions to low productivity include the introduction of performance-based incentives by third-party payers (for example, PT Askes) and increased accountability of health facilities to the communities they are designed to serve.

38. **Low Health Service Utilization.** Utilization rates at most government health facilities are low. Community health centers (CHCs) are in competition with many providers (including self treatment, other government providers, and even with the private practices of CHC staff) for both curative and preventive care. The CHC is not the preferred source for many types of health services. The quality of care in government health facilities is considered by the population to be poor (with, for example, limited access to doctors), staff are frequently absent, and drugs and supplies are frequently out of stock. In a 2004 household survey in 32 districts of eight provinces, non-poor households were more than twice as likely to prefer to visit a private doctor if seriously ill than to visit a CHC.

39. **Weak Accountability to Communities.** Local accountability to the communities served is still weak within the government health system. Limited community oversight of health facilities exists at the district level. Although there is a national policy to have community oversight at the sub-district level (i.e., at the level of community health centers), this policy has not yet been widely implemented.

4. Health Outputs

40. Health services include not only curative and preventive services delivered to individuals, but also important "collective" services, such as health education, disease surveillance and vector control that are delivered to communities. Outputs are generally measured at the facility level through routine reporting systems. However, because routine reporting systems are weak in Indonesia and because of the important role of the private sector, it is necessary to rely on household survey data for assessments of both service quality and quantity.

41. **Health Services Obtained from Public and Private Providers.** Several types of preventive care are critically important to the achievement of the health MDGs, including immunization (affecting child and maternal mortality, and TB infection among young children), antenatal care (affecting maternal and child mortality), obstetric delivery care (affecting maternal and neonatal mortality), and family planning (affecting maternal and child mortality). In Indonesia, all of these services are obtained from both public and private providers, although most immunization is done by public providers.

42. **Varying Quality of Care.** Primary health care is provided by a wide range of providers in Indonesia, with important differences in access to many types of providers between urban and/or suburban and rural areas. In terms of curative care, many Indonesians, especially the poor, rely on self treatment using drugs purchased over the counter. Self treatment is a serious problem not only because the quality of care is believed to be poor but also because the inappropriate use of drugs contributes to the development of resistant strains of diseases such as malaria and TB. Access to medical doctors for primary curative care is mainly limited to urban and upper-income Indonesians. Although there is no systematic information available on the quality of either primary or referral curative care in Indonesia, the available evidence suggests that it is rather poor, apart from that obtained from qualified medical doctors.

43. **Immunization Coverage.** Immunization coverage remains high but seems to have been decreased recently from 90% in 1991 to 85% in 2005. There are still sharp regional and socioeconomic differences in immunization rates, stemming in part from higher immunization dropout rates among poorer children.

44. **Percentage of Obstetric Deliveries in Health Facilities.** Obstetric delivery care is currently obtained from a range of providers, including traditional birth attendants, with 72%of deliveries assisted by nurses or midwives. The best delivery care is provided in hospitals, health centers or in private maternity clinics (usually operated by private midwives). Poorer quality delivery care is available in women's homes, where at least 60% of deliveries still occur. In recent years, many home births have been assisted by professionally trained village midwives, who are gradually replacing traditional birth attendants in providing home delivery care. Further reductions in maternal and neonatal mortality require that an increasing percentage of deliveries occur in health facilities, where services are better and where referral care can be obtained relatively quickly, should the need arise.

45. **Poor Availability and Quality of Family Planning Services.** Antenatal care and family planning services are also mainly provided by nurses or midwives. Village midwives currently

provide about 20% of family planning services. The available evidence (based on information provided by respondents in household surveys) suggests that the quality of both antenatal and family planning services is poor. Providers tend not to follow standard treatment protocols, especially for less well-educated clients (and probably also for poorer clients). The poor also have reduced access to relatively expensive sterilization services, which are not subsidized by the national family planning program.

46. **Limited Access to Diagnostic Services in Rural Areas.** Little information is available regarding the quality or accessibility of public and private diagnostic services. However, access to diagnostic services is limited in rural areas, as indicated by the fact that only about half of reported malaria cases are confirmed through laboratory testing. It is also known that government laboratories frequently experience shortages of reagents and other materials, while quality assurance systems have not been implemented in most laboratories.

47. **Some Public Health Services are Ineffective.** Public health services, including health education, disease surveillance and vector control, have been provided by Indonesia's public health system for many years. There has been some success with health education, particularly in family planning, but there are also many examples where increased knowledge has not translated into changed behavior. The available evidence indicates that recent efforts to inform the population (including youth) about HIV/AIDS have not been very effective. Average levels of knowledge are low, and there are sharp differences between people with different education levels. Disease surveillance also needs strengthening in relation to HIV/AIDS, malaria and TB.

5. Institutional Capacity

48. **Need for Stewardship Role by Central MOH.** Sector management includes health policy, regulation, information and research functions. Overall health policy in Indonesia appears to be on the right track (i.e., recognizes a need to focus scarce public resources and to develop strong public-private partnerships). However, it is proving difficult to implement. The two most important health policy changes in recent years have been the 2001 decentralization and the establishment of the ASKESKIN (health fund for the poor) program. In the case of decentralization, the MOH has not been very successful to date in shifting its main focus from service delivery (which is now mainly the responsibility of districts) to overall sector stewardship.

49. **Linking Regulatory Capacity and Policy.** Health sector regulation has received some attention for many years. However, the development of regulatory capacity and its use as an effective policy tool has not been a priority within the health sector. Little use has been made of licensing, certification and other regulatory tools to improve facility and personnel standards.

50. **Health Information System Strengthening**. Government health information systems have been a weak link in the public health system for many years and have become even weaker since the 2001 decentralization. Consequently, Indonesia has had to rely on household surveys to provide information on health status and on health service utilization. Unfortunately, this does not meet the needs of programs such as malaria and TB, which need timely local area data on disease incidence in order to allocate their resources effectively. The most promising opportunity to strengthen health information systems is probably through increased reporting by health insurers, especially if health insurance schemes increasingly cover the services of private providers.

C. Conclusions

51. **Revise Incentives to Redirect Provider Behavior.** Indonesia is unlikely to achieve all of the health MDGs by 2015 if the past approaches are not changed. The key challenge is to improve the efficiency of the health system. At this time, the effective use of incentives for both

providers and the population is the key to achieving the health-related MDGs. Additional provider incentives would probably not be necessary in an effective public health system, but Indonesia's public health system has become essentially a "privatized" system, in which personnel respond mainly to material incentives (including those afforded by their part-time private practices). In this situation, revised incentives are needed to channel provider behavior in directions that contribute to accelerated achievement of the health-related MDGs.

52. **Supporting Pro-Poor Health Programs**. Since there are large differentials, both regionally and among various socioeconomic groups, in most of the MDG-related impact and intermediate outcome indicators, a key part of any strategy to ensure achievement of the health MDGs must include finding ways to direct additional resources to poor, under-performing localities, as well as to the poor regardless of where they reside. However, these additional resources should not be channeled directly to providers, as has been done in the past. Instead, the additional resources should be channeled to the target population (i.e., to the demand side) so that accountability between providers and clients is strengthened. ASKESKIN represents the culmination of several years of testing various approaches to providing targeted health financing for the poor. Although the program still has some limitations, ASKESKIN is likely to accelerate the achievement of the health MDGs by improving access by the poor to health services.

53. **Providing Incentives to Redirect Consumer Behavior**. Conditional cash transfers (CCTs) are needed to compensate poor women for the time they spend obtaining cost-effective health care for themselves and their children. Time is often a poor person's only productive resource, and women's time is particularly scarce. CCTs are an effective way to overcome the opportunity cost of women's time as a barrier to health-care utilization. They can also be used to provide additional incentives for particularly critical types of health care (for example, to ensure that all children are fully immunized or to promote birthing in health facilities). Plans are currently being made to pilot CCTs in Indonesia. Scaling up the pilots will be an important additional measure to accelerate achievement of the health MDGs.

DEVELOPMENT PARTNERS COORDINATION MATRIX

Sectors Covered in PRMAP	ADB Support for Policy Reforms	Support from Other Development Partners
A. Education	• Earlier projects with support for policy reform aspects included in the Basic Education Project, Junior Secondary Education Project, Private Junior Secondary Education Project, Second-Junior Secondary Education Project • The Social Protection Sector Development Project, designed and implemented in response to the 1997/98 economic crisis, supported reforms in the provision of basic social services, including enhancing the decentralization and improving the efficiency of education management, and adopting a block grant mechanism to support schools • The ongoing Decentralized Basic Education Project supports decentralized management of basic education, including the improvement of school-based management by establishing school boards and strengthening community participation • Support under the ongoing EC and UNICEF-cofinanced Basic Education Support Capacity Sector Program aims to building capacity of MONE to implement strategic changes that promote an equitable, effective and efficient decentralized education system • Support under the proposed Madrasah Education Development Project aims at enhancing quality and coverage of 9-year compulsory education through madrasah	• AusAID: several initiatives under ongoing Indonesia-Australia Partnership in Basic Education aimed at service delivery of basic education and school-based management including community participation; capacity building through long-term academic scholarships • CIDA: Islamic higher education capacity building in Jakarta, Yogyakarta and Banda Aceh • JICA: school-based management with community participation to improve junior secondary education under Regional Education Development Improvement Program; various technical and technological capacity building initiatives in mathematics, science, engineering • GTZ: improving primary school science education; • USAID: education management at district level, school-based management, planning and budgeting capacity building • World Bank: primary and junior secondary education projects in Sumatra, Sulawesi and Eastern Islands; early childhood development; distance learning teacher quality improvement • EC and Government of the Netherlands: support basic education management at central level, mainstreaming good practices, strengthen capacity of information system, improve governance, transparency, budget process, financial management and accounting, strengthen capacity of policy dialog.
B. Health	• Earlier support for policy reform aspects under various projects such as Rural Health and Population Project, Family Health and Nutrition Project, and Intensified Communicable Disease Control Project • The Social Protection Sector Development	• EC: Support to Community Health Services in Jambi, South Sumatra and Papua, to improve health and nutrition status of poor people through community health system development at the district and sub-district levels • GTZ: policy support for creating social health insurance and developing a qualification system for health sector

Sectors Covered in PRMAP	ADB Support for Policy Reforms	Support from Other Development Partners
	Project designed and implemented in response to the 1997/98 economic crisis, supported reforms in the provision of basic social services, including enhancing decentralization of essential health, nutrition, and family planning services, and adopting a block grant mechanism to support health centers and village midwives • The Health and Nutrition Sector Development Project, designed and implemented in response to the 1997/98 economic crisis, supported fundamental reforms to develop pro-poor health services, structures, and systems that were more responsive to local needs • Ongoing support under Decentralized Health Services Project and Second Decentralized Health Services Project to better coordinate public and private health service provision at the regional level, to improve clinical and managerial skills of health personnel, and to involve civil society in planning and monitoring of service provision	management; district health service improvement, policy advisory support, and piloting in NTT; HIV/AIDS prevention and public education on STDs; family planning • KfW: Health Care in NTT, HIV/AIDS Prevention • USAID: Health Services Project covering Banten, West Java, East Java, North Sumatra, and Jakarta • World Bank: Provincial Health Projects 1 and 2, with 1 focusing on reforms for effective health sector decentralization in the provinces of Lampung and Yogyakarta and support to MONE to become an effective, analytical, advisory, and advocacy agency, and 2 focusing on North Sumatra, West Java, and Banten, and support to MOH and Social Welfare to carry out its roles in a decentralized system; Health Workforce and Services Project supports health sector decentralization in Jambi, East Kalimantan, West Kalimantan, and West Sumatra focusing on client-centered delivery of health services and redefining the roles of MOH, MONE, and the Indonesian Medical Association vis-à-vis health workforce policy, planning and management

AusAID = Australian Agency for International Development, CIDA = Canadian International Development Agency, EC = European Commission, GDP = gross domestic product, GTZ = *Deutsche Gesellschaft fur Technishe Zusammenarbeit*, HIV/AIDS = human immunodeficiency virus/acquired Immunodeficiency syndrome, JICA = Japan International Cooperation Agency, KFW = *Kreditanstalt fuer Wiederaufbau* (KfW Bankengruppe Development), MOH = Ministry of Health, MONE = Ministry of National Education, NTT = *Nusa Tenggara Timur,* USAID = United States Agency for International Development.
Source: Asian Development Bank estimates.

STATE MINISTER OF NATIONAL DEVELOPMENT PLANNING/CHAIRMAN OF BAPPENAS
MINISTER OF FINANCE
GOVERNMENT OF INDONESIA

Reff: No. 0300/M.PPN/09/2007
S-441/MK.08/2007

Jakarta, Indonesia
September 25 , 2007

Mr. Haruhiko Kuroda
President
Asian Development Bank
Manila
Philippines

Subject : Development Policy Letter on Poverty Reduction Millennium Development Goals Acceleration

Dear Mr. Kuroda:

1. This Development Policy Letter highlights the Government of Indonesia's (the Government) commitment to reduce poverty and accelerate the achievement of the Millennium Development Goals (MDGs) through ongoing reorientation of public expenditure towards the education and health sectors and the implementation of reforms to improve access and equity, quality, and performance of social service delivery in the medium term.

2. Our Medium Term Development Plan (RPJM) for 2004-2009 focuses on three broad objectives: a safe and peaceful Indonesia; a just and democratic Indonesia; and a prosperous Indonesia to improve people's welfare. Increased access to quality education and health services are two of the key priorities identified in the RPJM. Health and education have also been identified as key priorities under the Government's Annual Work Plans (RKP) for 2006 and 2007. We recognize that poverty alleviation does not merely require high economic growth, but also necessitates a quality of growth that reaches all levels of society, particularly the poor. At the Millennium Summit in September 2000, the Government committed to meeting the MDGs by 2015 and at the UN General Assembly in September 2005, we reiterated this commitment and presented Indonesia's 2005 MDG progress report. The Government gives priority to the allocation of resources to education and health to ensure the quality of growth and the achievement of the MDGs. This Development Policy Letter builds on these priorities.

3. Since early 2005, the Government has undertaken major reforms that created sufficient fiscal space to allow increased investments in the health and education sectors. Debt management and steady economic growth combined with the creation of additional fiscal space has provided us the confidence to increase public expenditures for tackling

poverty reduction and investments in health and education. A significant portion of savings generated by removal of the fuel subsidy was utilized for this purpose through the Fuel Subsidy Reduction Compensation Program (PKPS-BBM). We have also implemented important reforms to improve access, equity, and quality of service delivery in the education and health sectors to accelerate progress toward the MDGs.

4. This Development Policy Letter is in support of our request that ADB approve the Poverty Reduction and Millennium Development Goals Acceleration Program (PRMAP) cluster comprising three subprograms with Subprogram I loan of $400 million, to be disbursed in fiscal year 2007, to support the first phase of these key reform initiatives. This loan will maintain the momentum of implementing the RPJM for 2004–2009, the RKP for 2007, the National Poverty Reduction Strategy (SNPK), and commitments to achieving the MDGs by 2015. These plans have set development goals which, in some cases, are more ambitious than the MDGs. It is these plans and the commitment to achieve Indonesia's development goals that underpin this Development Policy Letter. The Letter should be read in conjunction with the Policy Matrix (Attachment 1) and together they constitute the Government's medium term reform commitment in the education and health sectors to accelerate achievement of the MDGs.

I. PROGRESS TOWARDS THE ACHIEVEMENT OF THE MDGs AND DECENTRALIZATION CHALLENGES

5. Indonesia's progress towards meeting the MDG targets has been mixed. Despite Government efforts, disparities exist in achievements across regions and income groups. While solid progress is noted in many areas, accelerated improvements are needed if Indonesia is to meet the international and national MDG targets. Almost 40 million people are still poor and more than half of the population live on less than $2 a day. Some of the health-related targets are particularly off-track. Maternal mortality rates remain stubbornly high; malnutrition and child mortality rates are higher than many of our neighboring countries; and about half million new cases of tuberculosis are recorded every year. The poor suffer disproportionately from the lack of access to quality education and health services and have lower health and education outcomes. For example, infant mortality rate is three times higher for the poorest fifth of the population than for the richest fifth and about 50% of children from poor households do not enroll in junior secondary school. We recognize that the MDGs will not be achieved unless the poor have better access to and higher utilization of affordable and good quality health and education services.

6. Decentralization has posed considerable challenges to the delivery of health and education services, resulting in significant differences in outcomes and performance across local governments. Basic education and health services are obligatory functions of the local government. In principle, the switch to a decentralized system for the provision of social services should positively affect access, equity and effectiveness of service delivery. However, devolving the responsibility for education and health to local governments has constrained central Government's capacity to implement and monitor our national policy objectives, including the achievement of the MDGs.

7. The reforms implemented in the education and health sector are framed within the above context, of Indonesia entering into a second generation of fiscal reforms and reorientation of public resources towards the achievement of the MDGs in a stable macroeconomic framework. This context is characterized by the Government's objectives of: (i) enhancing the quantity and quality of social public expenditures; (ii) improving local government accountability, without stifling the basic principles of regional autonomy; and

(iii) adopting sound and sustainable resource allocation mechanisms to target poverty reduction and MDG acceleration, especially in areas that lag behind.

II. CROSS SECTORAL REFORMS

8. Recognizing the need to transform economic growth into sustainable broad-based development, the Government has gradually increased expenditures for the social sectors to meet our ambitious poverty reduction and MDG acceleration targets. Several critical measures were initiated to expand and reorient public expenditures towards the education and health sectors, improve efficiency of health services for the poor, and expand access, equity and quality of basic education.

9. **Increasing budget allocation for health and education, especially focused on the poor.** We have recognized the need to increase overall expenditure for the social sectors if it is to achieve its ambitious poverty reduction and MDG acceleration targets. The 2007 Public Expenditure Review showed that health and education expenditures have significantly increased. Between 2004 and 2006, real national public expenditure increased by 53%, from Rp. 49.8 trillion to Rp. 76.2 trillion for education and by 50%, from Rp. 13.2 trillion to Rp. 19.8 trillion for health. As a percentage of total public expenditure, during the same period, education increased from 14.2% to 17.2% and health from 3.8% to 5.4%. In GDP terms, this represents increases from 2.8% to 3.6% of GDP for education and from 0.73% to 0.95% for health. Between 2005-2006, most of the increases from the central Government budget were allocated to programs which benefit the poor such as the Bantuan Operasional Sekolah (BOS), which increased from Rp. 5.1 trillion to Rp. 10.2 trillion and the Basic Health Care and Insurance for the Poor program (ASKESKIN), which increased from 2.3 trillion to Rp. 3.6 trillion. These programs represented about 25% of the overall central budgets for education and health. Budget for these programs or similar ones is expected to be sustained in the following years. In 2007, it is estimated that public expenditure in education and health will represent about 3.9% and 1.1% of the GDP respectively.

10. **Improving performance incentives and geographical resource allocation to districts to education and health.** We recognize that disparities among districts in capacities and in per-capita expenditure on health and education have led to critical gaps in access and quality of service provision in some districts. In this context, the Government has significantly increased the size and the scope of the special development fund (*Dana Alokasi Khusus*, or DAK) targeted for the health and education sectors to assist these districts. Between 2004–2007, the total DAK allocation for education and health increased sevenfold, and now represents Rp. 5.195 trillion for education and Rp.3.380 trillion for health. These increases will provide additional resources to specific districts for the rehabilitation of schools and health clinics. Since 2006 districts can also use these funds to purchase equipment in health centers and furniture in schools, and for the construction and rehabilitation of water and sanitation facilities and housing for school teachers, doctors, nurses and midwives, which offers an opportunity to attract and retain education and health personnel in remote areas. As part of PRMAP the Government is committed to introduce performance criteria for the allocation of the education and health DAK and improve targeting of resources to MDG-deficit districts.

11. **Developing of a uniform system for targeting the poor.** Accurate identification of the poor and a good quality targeting system are fundamental to making health and education programs for the poor and near-poor more efficient. Targeting the poor in health and education programs has been difficult. The use of different registries of the poor and different targeting criteria by individual education and health program have

significantly contributed to this. Developing a uniform database of the poor and effective targeting mechanisms, while providing some allowance for local flexibility, is crucial for delivery of education and health programs aimed to address gaps and disparities. In 2007, guidelines were prepared for the establishment of a mass database of poor and near-poor households for a new poverty reduction program, the Program Keluarga Harapan (PKH), which will provide conditional cash transfers to 500,000 households in its initial phase. This initiates the possibility of adopting a uniform targeting system for improving the poor's access to MDG-related education and health initiatives and reduce leakages to the non-poor.

12. **Achievement of gender equity in access to health and education services.** In 2006, BAPPENAS completed an evaluation of gender mainstreaming in nine sectors, including health and education. The Ministry of health (MOH) has responded to the evaluation by issuing a Ministerial Decree, which outlines steps for better gender mainstreaming, including the appointment of directors for gender mainstreaming under each Directorate. The Ministry of Education (MONE), in its commitment to implement *Education for All*, includes a chapter on gender equality. A joint memorandum of understanding was signed in 2006 between MONE, Ministry of Women's Empowerment, and the Ministry of Home Affairs (MOHA) to step-up efforts aimed at decreasing adult illiteracy rates, particularly for females, to be 5% in 2009. Despite GOI efforts, lack of information on gender-related MDGs remains a challenge. Sex disaggregated key health and education indicators are necessary to better monitor progress of gender-related MDGs, and to target resources more efficiently for MDG acceleration. Inclusion of an agreed upon set of sex-disaggregated indicators in the medium-term development plans of MONE, MORA and MOH will help mainstream gender issues in health and education in the planning and budgeting processes.

13. **Establishment of a planning framework for MDG acceleration.** The Government's RPJM and the SNPK included MDGs as a key element. We recognize the need for monitoring and mainstreaming MDGs at the local government level. Under PRMAP, we are planning to develop guidelines to assist local governments to mainstream MDGs in their medium term and annual development plans, annual budgets and poverty reduction strategies. Guidelines will also be useful for ministries responsible for MDG-related sectors, such as health and education. We are also planning to prepare a comprehensive road map for MDG acceleration that could include strategies for: (i) developing a flexible institutional framework for MDG acceleration involving key central government ministries and local governments; (ii) increasing political and public awareness about the MDG; (iii) involving civil society, private sector and research institutions in efforts for attaining the MDGs; (iv) improving data collection, processing and monitoring mechanisms, and reporting of MDG-related indicators; (v) assessing cost and budget implications; and (vi) developing sectoral policies for consideration by central ministries in their medium term development plans.

III. EDUCATION SECTOR REFORMS

A. Expand equitable access to basic education particularly for the poor.

14. **Improving access to junior secondary education in underserved areas.** A number of challenges need to be addressed to reduce access barriers to basic education. We have given priority to construction of new junior secondary schools/madrasah, especially in districts with low enrolment. The introduction of one-roof schools (combined primary and junior secondary schools on the same site) is designed to reduce primary grade dropout and repetition, and increase transition rates to junior secondary education. These initiatives will reduce distance to junior secondary schools and consequent travel

costs, which are important obstacles for the poor. Between 2005 and 2007 MONE and MORA allocated Rp 4.2 trillion for the establishment of integrated schools, and the construction of new junior secondary schools and new classrooms in existing junior secondary schools. Our goal is to prepare a plan to guide local governments to undertake participatory school mapping with local communities to better understand and respond to demand side issues. Participatory school mapping will also be used to understand the underlying socio-economic reasons preventing children from attending school even after the physical facilities have been provided.

15. **Improving O&M support for smaller and remote schools and elimination of fees.** The introduction of the BOS in 2005 and its expansion in 2006 and 2007 provides funds to cover O&M of schools 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 count. It covered about 29.5 million students at the primary level and 11.7 million at the junior secondary level. The provision of funds based on student head count provides incentives to schools to expand the coverage area and overall student numbers. The program has been successful in improving predictability of school financing, and provided reliable support to schools. Its simple design has rendered the program highly transparent, at least down to the school management level. However, we will have to review the allocation policy, financing and implementation of BOS to introduce some improvements and refinements to transform it into a more targeted and efficient instrument.

16. **Increasing affordability of education by poor students/households.** In 2006, the transition scholarships were introduced to improve net enrolment ratios in junior secondary schools and help poor primary school graduates meet the costs of entering junior secondary. About 447,000 poor students received scholarships. We are planning to implement program to enable poor students meet the direct and opportunity costs of education. In 2007 we ara piloting a conditional cash transfer scheme to improve demand for education and increase the primary to junior secondary transition and retention rates among the poor. We will need to evaluate these financial support programs to improve their design and targeting and assess their impact on enrollments and retention of students. For 2008, the Government has also planned to provide scholarship for poor students at primary and junior secondary levels both at general and religious schools, and at public and private schools.

B. **Improve quality, efficiency and effectiveness of basic education.**

17. **Enhancing quality and equitable deployment of teachers.** Law 14 on Teachers and Lectures was approved in December 2005. The Law makes provision for a doubling of teacher remuneration through award of professional incentives by 2015. Teachers working in remote areas will also receive a special allowance. Two regulations to implement the provisions of the Law for the professional development and incentive structures for teachers and lecturers are currently under preparation. The legislation includes a strategy for providing salary and non-salary incentives to boost the deployment of teachers to under-served areas. It also includes aspects related to the management and quality assurance of teachers and other education personnel, including school principals, and for strengthening teacher performance monitoring and quality assurance systems. Given the scale of teacher upgrading required (for around 2.7 million teachers), the design of cost efficient and sustainable professional development programs and incentives for deployment in under-served areas are an urgent priority for the Government.

18. **Education service delivery meeting minimum service standards (MSS).** A number of key regulatory actions have recently been taken to set the foundation for

education reform, which will lead to increased accountability of district governments and schools to deliver higher quality of education. The independent Board of National Education Standards (BSNP) was established in mid 2005 through issuance of Regulation 19/2005. BSNP has developed legislation on "Standards on Content" (Regulation No 22/2006), and "Standards on Competence" (Regulation No 22/2006). Regulation No. 24/2006 has been issued to clarify roles of different levels of government in the implementation of these standards. The development, approval and monitoring of national education standards in eight key areas is expected to be completed soon. MONE is also planning to develop MSS for critical national standards relevant to the achievement of the education MDGs to be applied at district level. Our priority is to develop MSS in a few key categories of national standards, especially those related to teachers, facilities, and learning materials, to be implemented by selected districts.

C. Governance, transparency and accountability in the delivery of education services

19. **Improving planning and implementation of education services.** A joint plan for the achievement of nine year basic education (Grand Design for Compulsory Basic Education (2006–2009)) was completed by MONE and the Ministry of Religious Affairs (MORA) in August 2006. We are planning to initiate an assessment of sector performance, including the roles of different levels of government in delivering education services, and progress toward the MDGs, in preparation for the 2010–2015 Strategic Plan for the Education Sector. Specific attention will be paid to the assessment of pro-poor programs for education and possibilities for improvement and expansion. We will also assess the possibility of adopting a medium-term expenditure framework to help improve the predictability of sector financing in terms of size, flow, targeting and use of educational expenditures. This work will be useful for the preparation of a new medium term development plan focused on the provision of good quality services in under-served areas.

20. **Greater transparency of education outcomes to enhance accountability.** Increased financing of education sector reforms naturally calls for greater efforts to boost governance, transparency and accountability for outcomes. The national exams results are now published by MONE and MORA and are used to inform government policies for improving accountability and the quality of education, in conjunction with results from other international examinations. Our objective is to continue obtaining feedback from parents and communities on both the positive and negative aspects of basic education service delivery through Citizen Report Card surveys and other mechanisms. To improve accountability of service education providers, it is also necessary to strengthen the role of the school committees and district education boards. We are also planning to review legislation to increase female participation in these committees and the boards. To promote good governance, a number of measurable anti-corruption performance indicators are included in the education medium strategic plan, which will be widely published and tracked by the offices of the Inspectors General in MONE and MORA.

IV. HEALTH SECTOR REFORMS

A. Expand access to health services especially for the poor and women

21. **Increasing central budget for MDG-related health programs.** Between 2005 and 2007, the MOH increased its budget allocation by more than 50% for MDG-related health programs. In 2007, more than 20% of the MOH budget is allocated for maternal, neonatal and child care (MNCH) and control of communicable diseases (CDC) programs. We need to further increase budget allocations and improve budget targeting for MDG-related health programs, such as MNCH services and CDC, to regions with poorer health outcomes. We

are planning to prioritize investment in preventive care services and emerging diseases such as HIV/AIDS. These actions are expected to disproportionately benefit the poor.

22. **Improving targeting of public financing for health services for the poor.** In 2005, we introduced a new healthcare scheme, the ASKESKIN program aimed to: (i) improve targeting of government budget resources to finance health services utilized by the poor, (ii) increase financing for O&M expenses of public sector health facilities, and (iii) increase efficiency of funds management through contracting a parastatal (PT ASKES) to independently manage the funds and provider contracts. The program has two components. The first component provides free health care services at public health centers (Puskesmas) and the second provides in-patient treatment in third class hospitals for the poor. Sixty million poor people were entitled to ASKESKIN benefits including primary, secondary and tertiary care if provided by public clinics and hospitals. The poor receive free services on presentation of a health card (ASKESKIN card) or a letter from local authorities indicating their poverty status. The second component of the program is demand-oriented that responds to utilization rates of health services. ASKESKIN's design has evolved since 2005 with the aim of increasing the poor's access to priority health services through allowing reimbursement of services provided by eligible non-government providers (i.e., midwives and select private hospitals).

23. The ASKESKIN program has removed some of the key cost barriers to accessing health services by the poor and near-poor, especially women. However, we recognize that there is scope to improve and refine the effectiveness of this program. We are planning to conduct a comprehensive analysis of options for the revision of the ASKESKIN program design and implementation modalities. We will utilize the analysis to revise the program's design and implementation strategy to: i) improve targeting of benefits to the poor, ii) increase access and utilization of primary care services, iii) improve integration of primary care services delivery (e.g., family planning, and antenatal, delivery and postnatal MNCH services), and iv) increase efficiency in program management to increase incentives for health service providers. The ASKESKIN program could also modify its reimbursement methods to better motivate providers to deliver key MDG-related services.

B. Improve Quality, Efficiency, and Effectiveness of Social Service Delivery

24. **Improving effectiveness of MNCH/RH services through influencing provider behavior.** In May 2006, the Government modified the program for recruiting contractual temporary doctors and midwives (PTT) to include additional financial incentives to attract them to remote areas. The program is expected to improve the quality of maternal, neonatal and child services. Provider payment mechanisms introduced through ASKESKIN that influence financial incentives will also affect provider location choices and influence provision behavior. However, systematic review of provider payment modalities is needed to inform evidence-based policy development with regard to improving the availability of health personnel in remote and underserved areas. We plan to commission an assessment to comprehensively document all of the modalities used to attract and retain health personnel in remote and underserved areas. The assessment will analyze how the different alternatives have influenced the distribution of health personnel, provision of health services and outcomes, with particular attention to increasing provision of integrated primary health services for women and children. We will utilize the findings and recommendations of the assessment to revise provider payment mechanisms.

25. **Improving effectiveness of CDC through integrated programs.** The Government is developing comprehensive strategies for CDC, especially for HIV/AIDS,

malaria and tuberculosis (TB), including elaboration of the roles and responsibilities of various ministries and mechanisms for co-ordination of efforts across ministries. In 2006, MOH developed a National Policy and Strategy for Reproductive Health that integrates various elements of reproductive health under one coordinating strategy, including maternal health, child health, family planning, prevention and treatment of sexually-transmitted infections, and HIV/AIDS. The MOH has endorsed National Guidelines for Mitigating TB that specify strategies and plans for TB control for the period 2006 to 2010. The National AIDS Commission has finalized the national strategy for HIV/AIDS mitigation for 2007–2010. The MOH will approve the Strategic Plan for HIV/AIDS Mitigation in Indonesia, 2008 to 2012, that integrates HIV/AIDS control efforts in all relevant MOH programs. The national and MOH strategies will include actions to strengthen individuals, households and communities' knowledge, attitudes and practices related to HIV/AIDS prevention. HIV/AIDS strategies will be coordinated with TB control efforts. MOH will also complete and present to the National AIDS Commission an analysis of the costs and available sources of financing for the MOH component of the response to the HIV/AIDS epidemic.

26. **Improving monitoring of MDG-related health performance.** The MOH has prepared a revised list of MSS and indicators for districts to monitor progress and performance. The list contains eight types of MSS with 28 indicators. Of these, ten refer directly to MNCH services and several others will monitor CDC-related aspects, such as TB detection rates, cases of diarrhea treated, or number of villages in the district that receive timely response to disease outbreaks. The MOH plans to refine the health-related MSS and endorse it through a ministerial decree. The updated MSS decree will include health-related MDGs and identify intermediate indicators for child nutrition, maternal and child health, HIV/AIDS, and TB. The MOH will work towards modification of their health information system to track performance related to the selected indicators for the MSS, and to link the allocation of human, material and financial resources to performance at the national and sub-national levels. The introduction of performance-based contracts and incentives with service providers to better manage health services at the district level could help increase motivation and yield improved access to affordable and quality health care, especially for the poor and women.

C. Enhance Governance in Health Service Delivery

27. **Improving financial information with regard to MDG-related health expenditures.** The Public Expenditure Review (PER), carried out by the BAPPENAS and the Ministry of Finance , with World Bank support, provides an analysis of overall health expenditures by central, provincial and district governments. It presents a review of health financing issues that contributes to the understanding of MDG-related expenditures. However, the PER did not include detailed analysis of public sector expenditure for health by program, especially at the national and sub-national levels, as such information is not readily available. To improve the completeness and quality of information and analysis, BAPPENAS will lead efforts to develop a plan for a national health accounts (NHA) program. Based on this plan, an NHA program will be established, including specification of the responsible agencies and terms of reference for conduct of the NHA. The NHA will help us to track health expenditure trends, make financial projections, and track use of resources to achieve the MDGs. We are confident that NHA for at least one year between 2008 and 2010, will be produced. These actions will contribute to improving transparency of programmatic and geographic allocations and targeting of public expenditures to health-related MDG programs and to districts with poor performance on MDG indicators due to insufficient public financing.

V. CONCLUSION

28. The Government remains committed to an ongoing reform agenda that reorients public expenditure towards the education and health sectors and increasing the quality of social services as laid out in the PRMAP and as part of the RPJM. We believe these reforms will accelerate progress towards achieving the MDGs in education (MDG 2), and health (MDGs 4, 5 and 6) and contribute to the Government's poverty reduction (MDG 1), and gender equality (MDG 3) agendas. The support and assistance of the Asian Development Bank has been instrumental to our success during the two-year period of Subprogram 1 and we look forward to working with you again during the next Subprogram period.

29. Let us, Mr. President, thank you for your support and express the hope that the Poverty Reduction and Millennium Development Goals Acceleration Program will be considered favorably by the ADB Board at an early date.

Sri Mulyani Indrawati
Minister of Finance

Paskah Suzetta
Minister for National Development
Planning/Chairman of BAPPENAS

Table A5: Policy Matrix[a]

No.	Policy Objective/Output	Policy Actions	SP1	SP2	SP3	Responsible Ministry/Agency
A. Cross-Sectoral Policy Reforms						
1.	Increased budget allocation for health and education, especially focused on MDG-related programs. [MDGs 1–6]	1.1.1. 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)	✓			• MOF • MONE • MOH
		1.1.2. BOS increased from Rp 5.1 trillion in 2005 to Rp. 10.2 trillion in 2006 and the ASKESKIN program increased from Rp 2.3 trillion in 2005 to Rp. 3.6 trillion in 2006.	✓			• MOF • MONE • MORA • MOH
		1.2. Financial allocations for BOS and ASKESKIN (or equivalent program) sustained.		✓	✓	• MOF • MONE • MORA • MOH
2.	Improved performance incentives and geographical resource allocation to districts for education and health [MDGs 1–6]	2.1. Annual DAK financial allocation in the national budget for health and education sectors increased sevenfold from 2004 to 2007.	✓			• MOF • BAPPENAS • MOH • MONE
		2.2. 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.		✓		• MOF • BAPPENAS • MOH • MONE • MORA • MOHA
		2.3. 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 2.2.			✓	• MOF • BAPPENAS • MOH • MONE/MORA
3.	A uniform system for targeting the poor for achieving the health and education MDGs is established. [MDGs 1–5]	3.1. The Government issued guidelines on establishing a survey-based database to identify poor households,[b] enabling their improved access to MDG-related health and education services, as part of a new poverty reduction program, the Program Keluarga Harapan (PKH).	✓			• BAPPENAS • BPS
		3.2. BPS has completed a survey-based database for selected districts, identifying poor households that lack access to key MDG-related health and education services.		✓		• BPS
		3.3. 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.			✓	• BPS • MOH • MONE • MORA

No.	Policy Objective/Output	Policy Actions	SP1	SP2	SP3	Responsible Ministry/Agency
4.	Gender equity in access to health and education services achieved [MDGs 1–6]	4.1.1. BAPPENAS completed an evaluation of gender mainstreaming implementation in 9 sectors (2006), including health and education.	✓			• BAPPENAS • MOH • MONE • MORA • MOWE
		4.1.2 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 with Gender Equality* (2005).	✓			• MOH • MONE • MORA
		4.1.3. 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.	✓			• MOHA • MONE • MOWE
		4.2. 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.		✓		• BAPPENAS • MOH • MONE • MORA • MOWE
		4.3. Sex-disaggregated indicators for the health and education MDGs are reflected in the medium-term development plans of MONE, MORA and MOH.			✓	• MOH • MONE • MORA
5.	A planning framework for MDG acceleration is established. [MDGs 1–6]	5.1. MDGs were included as a key element in the national medium-term development plan (RPJM) and the national poverty reduction strategy.	✓			• BAPPENAS •MENKO KESRA
		5.2.1. A comprehensive roadmap for accelerating attainment of the MDGs, prepared by BAPPENAS and Menko Kesra, is approved by the Government.		✓		• BAPPENAS • MENKO KESRA
		5.2.2. The Government issues guidelines directing local governments to mainstream the MDGs when preparing district medium-term development plans and district poverty reduction strategies.		✓		• BAPPENAS • MOHA
		5.3. The medium-term development plans of the national government, MONE, MORA, MOH, and MOWE include MDGs and targets as key priorities.			✓	• BAPPENAS • MONE • MORA • MOWE • MOH

No.	Policy Objective/Output	Policy Actions	SP1	SP2	SP3	Responsible Ministry/Agency
B. Policy Reforms in the Education Sector						
1. Expand access to basic education, particularly for poor and vulnerable children						
6.	Improved access to junior secondary schools in under-served areas [MDGs 1–3]	6.1. MONE and MORA have 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 priority districts, and have allocated funds in the 2005, 2006, 2007 approved budgets.	✓			• MONE • MORA
		6.2. 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 in remote and/or underserved areas in the 70 priority districts.		✓		• MONE
		6.3. 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, and relevant demographic and education data.			✓	• MOF • MONE • MORA
7.	Improved O&M support for smaller and/or remote schools [MDGs 2,3]	7.1. Funds have been allocated for a school subsidy program for O&M, i.e., Bantuan Operasional Sekolah (BOS), for basic education schools including madrasah (religious schools), eligible pesantrens (Islamic boarding schools), and non-Islamic religious schools.	✓			• MONE • MORA
		7.2. BAPPENAS, MONE and MORA have finalized an allocation policy for BOS or developed other programs for poor and remote districts.		✓		• MONE • MORA • BAPPENAS
		7.3. The Government has allocated resources for BOS based on the revised allocation policy and the programs for poor and remote districts.			✓	• MOF • MONE
8.	Increased affordability of education by poor students and/or households [MDGs 1–3]	8.1. The Government has introduced transition scholarships to boost junior secondary enrollments for the poor and provided funds in the 2006 budget.	✓			• MONE • MORA
		8.2. 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.		✓		• MONE • MORA
		8.3. BAPPENAS and Balitbang have conducted 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.			✓	• MONE • MORA •BAPPENAS
2. Improve the quality, efficiency and effectiveness of basic education service delivery						
9.	Enhanced quality and equitable deployment of teachers [MDGs 2,3]	9.1. Parliament approved Law 14/2005 on Teachers and Education Personnel, which reflects improvements in teacher deployment, qualification, competency, and professional status.	✓			• MONE • MORA
		9.2. MONE and MORA have initiated implementation of programs for professional development and incentives for deployment of formal basic education teachers in underserved areas.		✓		• MONE • MORA

No.	Policy Objective/Output	Policy Actions	SP1	SP2	SP3	Responsible Ministry/Agency
		9.3. MONE and MORA have published a report demonstrating deployment of teachers to underserved areas.			✓	• MONE • MORA
10.	Education Service Delivery meeting Minimum Service Standards (MSS) [MDG 2]	10.1. 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.	✓			• MONE
		10.2. BSNP has developed eight national standards of education, and developed a plan to monitor adoption of national standards.		✓		• BSNP • MONE • MORA
		10.3. The Government has implemented minimum service standards in at least two categories of national standards in selected geographic areas.			✓	• BSNP • MONE • MORA
3. Enhance governance, transparency and accountability in the delivery of education services						
11.	Improved planning and implementation of education services [MDGs 2,3]	11.1. MONE and MORA developed a Grand Design for Nine Year Basic Education in Indonesia in 2007 to work collaboratively in achieving the national education goals for completion of basic education.	✓			• MONE • MORA
		11.2. 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.		✓		• BAPPENAS • MONE • MORA • MOWE
		11.3. The Government approved the new medium-term development plan with a focus on provision of good quality basic education services for boys and girls in underserved areas.			✓	• BAPPENAS
12.	Greater transparency of education outcomes to enhance accountability. [MDGs 2,3]	12.1. MONE and MORA have published national exam results to enable a nationwide comparison of performance of rural and urban schools.	✓			• MONE • MORA
		12.2.1. BAPPENAS has 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 multi-media.		✓		• BAPPENAS
		12.2.2. The Government has issued technical guidelines for the district education boards and school committees explicitly requiring that at least 40% of members on each district education board and school committee be women.		✓		• MONE
		12.3. Summary of MONE and MORA Inspectorate General Audit Report on the implementation of major basic education programs such as the BOS posted on MONE and MORA websites.			✓	• MONE • MORA

No.	Policy Objective/Output	Policy Actions	SP1	SP2	SP3	Responsible Ministry/Agency
C. Policy Reforms in the Health Sector						
1. Expand access to health services, especially for the poor and women						
13.	Increased central budget for MDG-related health programs [MDGs 4–6]	13.1. MOH has increased the central budget allocation for MDG-related programs between 2005 and 2007 by 50%.	✓			• MOH
		13.2. 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
		13.3. MOH has increased the total central budget allocation in real per capita terms for MDG-related programs (MNCH/CDC) between 2009 and 2011.			✓	• MOH
14.	Improved targeting of public financing for health services for the poor [MDGs 1, 4–6]	14.1. 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
		14.2. MOH has published annually a 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.		✓		• MOH
		14.3. 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 provision of prenatal, postnatal, obstetric delivery services and contraceptives).			✓	• MOH
2. Improve the quality, efficiency and effectiveness of basic health service delivery						
15.	Improved effectiveness of MNCH/RH service delivery by influencing provider behavior [MDGs 4–6]	15.1. MOH has 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
		15.2. 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
		15.3. MOH has revised their strategies related to contract provider payment schemes (for physicians and midwives) and is conducting on-going monitoring and evaluation.			✓	• MOH
16.	Improved effectiveness of communicable disease control through integrated programs [MDGs 3–6]	16.1.1. MOH has developed and approved the National Policy and Strategy for Reproductive Health (2006) that specifies multisectoral approaches for reproductive health, including prevention and treatment of sexually transmitted infections and HIV/AIDS.	✓			• MOH
		16.1.2. MOH has endorsed national guidelines for mitigating tuberculosis that specify the MOH plan and strategy for TB control for the period 2006	✓			• MOH

No.	Policy Objective/Output	Policy Actions	SP1	SP2	SP3	Responsible Ministry/Agency
		to 2010, including guidelines for development of public-private partnerships in TB case detection and treatment.				
		16.2. 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 to 2012).		✓		• MOH
		16.3. MOH has completed and presented to the National AIDS Commission an analysis of the costs and available sources of financing for the MOH component of the Government's response to HIV/AIDS epidemic.			✓	• MOH • National AIDS Commission
17.	Improved performance and monitoring for health-related MDGs [MDGs 1, 3–6]	17.1. MOH has refined the minimum service standards (MSSs) to more effectively emphasize health-related MDGs (i.e., MNCH/CDC).	✓			• MOH
		17.2 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.		✓		• MOH
3. Enhance governance, transparency and accountability in the delivery of health services						
18.	Improved financial information with regard to MDG-related health expenditures [MDGs 1, 3–6]	18.1. BAPPENAS and MOF have endorsed and published the Public Expenditure Review (2007), including an analysis of government spending for the health sector.	✓			• BAPPENAS • MOH • MOF
		18.2. A plan for a national health accounts (NHAs) program has been developed.		✓		• BAPPENAS • MOH
		18.3. The NHAs 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.			✓	• BAPPENAS • MOH

ADB = Asian Development Bank, ASKESKIN = Basic Health Care and Insurance for the Poor Program, BAPPENAS = Badan Perancanaan Pembangunan Nasional (National Development Planning Agency), BSNP = National Education Standards Board, BOS = Bantuan Operational Subsidi, DAK = Dana Alokasi Khusus, GDP = gross domestic product, HIV/AIDS = human immunodeficiency virus/acquired immunodeficiency syndrome, MENKO KESRA = Coordinating Ministry of Social Welfare, MNCH/CDC = Maternal Neonatal and Child Health Care/Communicable Diseases Control, MDG = Millennium Development Goal, 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, RPJM = Medium-Term Development Plan, PRMAP = Poverty Reduction Millennium Development Goal Acceleration Program, SP1 = subprogram 1, SP2 = subprogram 2, SP3 = subprogram 3, TB = tuberculosis.

[a] SP1 = 1 April 2005–31 March 2007, SP2 = 1 April 2007–31 March 2009, and SP3 = 1 April 2009–31 March 2011.

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

Source: Asian Development Bank.

MACROECONOMIC ASSESSMENT LETTER FROM THE INTERNATIONAL MONETARY FUND: INDONESIA

August 28, 2007

Staff Assessment of Developments and Policies

Recent Developments and Short-Term Prospects

Economic growth reached 5½ percent in 2006 as the dip in activity following the late 2005 fuel price and interest rate hikes proved shallow. Strong exports compensated for weak domestic demand. Notwithstanding heightened risks to the outlook from a possible slowing of U.S. growth, staff still projects GDP growth at around 6 percent in 2007 with some shift from external to domestic demand. Inflation has fallen in recent months to around 6 percent—the middle of the 2007 target range of 5–7 percent—allowing Bank Indonesia (BI) to lower its policy rate further to 8¼ percent. The external current account surplus is projected to narrow from 2¾ percent of GDP to around 1¾ percent in 2007 as lower global growth and commodity prices reduce exports. The central government deficit increased modestly to 1.0 percent of GDP in 2006. For 2007, staff projects a somewhat higher deficit of around 1.6–1.8 percent of GDP.

Along with other emerging markets, Indonesia's equity and bond markets were hit by the recent turmoil in global financial markets. The extent of the sell-off was relatively high in a regional comparison, but it followed a prolonged period of increases, driven by the abundant global risk appetite as well as domestic factors such as declining interest rates and perceptions of reduced vulnerability and improving economic prospects. Portfolio capital flows mirrored these developments as foreign investors increased their positions in Indonesian securities during most of 2007, then reduced exposure since mid-July. After appreciating in May vis-à-vis the U.S. dollar in response to portfolio inflows, the rupiah has subsequently fallen by around 7 percent (3½ percent since the Article IV consultation in mid-July), but remains within a range consistent with external competitiveness and macroeconomic stability.

Banking sector indicators have strengthened, although the impact on balance sheets from the recent market turmoil has yet to be fully assessed. Over the past year, bank profitability has improved. The banking system is well capitalized and nonperforming loans are low for private banks. State banks' non-performing loans have fallen significantly but still remain higher. Overall, with the improving indicators, the banking system appears to be in a relatively good position to weather the recent global financial market turmoil. Direct exposure to collateralized debt obligations (CDOs) or other structured credit products appears minimal and Indonesian financial markets have so far remained sufficiently liquid during periods of market pressure.

Similarly, external vulnerability indicators have improved over the past year, helping the economy to weather recent volatility. Fiscal deficits are modest and public debt is 2 declining, the external current account is in surplus, and the exchange rate is broadly market determined, with some symmetric market intervention to smooth volatility and automatic purchases of the government's foreign exchange receipts. The ratio of total external debt to GDP is expected to decline to less than 20 percent of GDP by 2012, from 35 percent in 2006, while government debt (including domestic debt) is projected to decline from 39 percent of GDP to 26 percent over the same period. A steady build-up of reserves and lower external borrowing have increased the ratio of reserves to short term debt to more than 150 percent.

Nonetheless, downside risks remain to the positive outlook, in particular related to the global financial market turmoil and its impact on global growth. While reduced vulnerabilities have put the Indonesian economy in a good position to weather moderate external shocks (see adverse macro scenarios in the 2007 Article IV staff report), a sharper than expected slowdown in global economic growth and a sustained reduction in risk appetite could have a significant negative impact on the Indonesian economy. The main risks arise from potentially lower export demand and commodity prices, reduced access to financing and higher financing costs, and possible balance sheet impacts of lower asset prices and a depreciated rupiah.

Macroeconomic and Structural Policies

The government continues to implement its comprehensive reform agenda to boost growth over the medium term. Key elements of the strategy include policies to strengthen financial intermediation, improve the business climate, and increase infrastructure investment. While substantial progress has been achieved, including passing of a new investment law and several fiscal reforms, other measures, particularly with respect to the labor market, have encountered resistance.

- **With respect to monetary policy, Bank Indonesia (BI) has responded flexibly to shocks to inflation and output, while building the credibility of its newly established inflation targeting framework.** The latest policy meeting saw a pause in the current rate-cutting cycle, in response to the recent weakening in the rupiah and uncertainty over the fall-out from the global financial turmoil. Staff judge that room for further rate cuts will remain limited, particularly since the full effect of recent rate cuts is likely still to be felt and the currency has shown some renewed weakness in recent months.
- **In the staff's view, the recent relaxation of prudential regulations to encourage lending is not likely to have much impact on lending growth.** At the same time, the steps represent a departure from international standards and risk having an adverse signaling effect on supervisors and banks alike. With bank lending already increasing, in the staff's view BI should reconsider the appropriateness of the measures as soon as possible. Moral suasion to encourage banks to lend to specific 3 sectors could result in credit misallocation and should also be avoided. Instead, staff has encouraged the authorities to strengthen efforts to promote the development of capital markets and instruments of longer-term financing and to develop a strategy on the future role of state banks.
- **The authorities' projected fiscal stance is appropriate.** The modest relaxation in deficit targets for 2007 and 2008 provides some room for additional development spending while ensuring further declining debt ratios. Further improvements in tax administration, some new tax measures, and the streamlining of expenditures, including through greater flexibility of energy prices, could create additional space for priority spending, such as infrastructure, health, and education. Enhancing the implementation capacity of local government would also contribute to this effort.
- **The authorities have made good progress in fiscal reform.** Recent achievements include the restructuring of the tax agency and the adoption of a key tax reform bill. The planned introduction of a fiscal risk statement and the medium-term fiscal framework in the 2008 budget should help to further strengthen fiscal management.

- **Structural reforms have advanced with the recent passage of the investment law and the presentation of a new economic policy package.** While publication of the negative list for foreign investors raised some concerns in the foreign business community, the law retains a broadly open investment regime and clarifies existing ownership limits, which were previously opaque. The privatization process has also been restarted, with the sale of a minority stake in a major state owned bank in July. However, progress on the difficult issue of labor market reform remains limited.

Status of IMF Relations

- The 2007 Article IV consultation was completed on July 18, 2007.
- The next Fund mission is scheduled for November/December, 2007. The next Article IV mission is scheduled for mid-2008. Technical assistance missions from the Fiscal Affairs Department, covering tax and treasury administration, and from the Monetary and Capital Markets Department, covering banking supervision, will be in the field in the interim.

LIST OF INELIGIBLE ITEMS

No withdrawals shall be made in respect of:

(i) expenditures for goods included in the following groups or sub-groups of the United Nations Standard International Trade Classification, Revision 3 (SITC, Rev. 3), or any successor groups or sub-groups under future revisions to the SITC, as designated by the Asian Development Bank (ADB) by notice to the Borrower:

Table A7: Ineligible Items

Chapter	Heading	Description of Items
112		Alcoholic beverages
121		Tobacco, unmanufactured; and tobacco refuse
122		Tobacco, manufactured (whether or not containing tobacco substitute)
525		Radioactive and associated materials
667		Pearls, precious and semi-precious stones, unworked or worked
718	718.7	Nuclear reactors and parts thereof, fuel elements (cartridges), nonirradiated for nuclear reactors
728	728.43	Tobacco processing machinery
897	897.3	Jewelry of gold, silver, or platinum-group metals (except watches and watch cases); goldsmiths' or silversmiths' wares (including set gems)
971		Gold, nonmonetary (excluding gold ores and concentrates)

(ii) expenditures in the currency of the Borrower or of goods supplied from the territory of the Borrower;

(iii) expenditures for goods supplied under a contract that any national or international financing institution or agency will have financed or has agreed to finance, including any contract financed under any loan or grant from ADB;

(iv) expenditures fro goods intended for a military or paramilitary purpose or for luxury consumption;

(v) expenditures for narcotics;

(vi) expenditures for environmentally hazardous goods, the manufacture, use or import of which is prohibited under the laws of the Borrower or international agreements to which the Borrower is a party; and

(vii) expenditures on account of any payment prohibited by the Borrower in compliance with a decision of the United Nations Security Council taken under Chapter VII of the Charter of the United Nations.

PROPOSED TECHNICAL ASSISTANCE FOR STRENGTHENING SOCIAL SERVICES DELIVERY

A. Introduction and Background

1. The Poverty Reduction and MDG Acceleration Program (PRMAP) supports the Government of Indonesia (the Government) in its commitment towards the achievement of the Millennium Development Goals (MDGs) in education (MDG 2) and health (MDGs 4, 5, 6), and contributes to the Government's poverty reduction agenda (MDG 1), and gender equality (MDG 3). National level progress in meeting the MDG targets obscures vast differences across regions and districts, rural and urban areas, and income groups, and between men and women. The PRMAP provides financial resources to support the Government in implementing its MDG-related public expenditure programs more effectively, through policy, institutional, legal and regulatory reforms in the education and health sectors. It builds on and enhances implementation and effectiveness of existing government programs and Asian Development Bank (ADB)-supported assistance in poverty reduction, gender mainstreaming, and health and education.

2. The proposed technical assistance (TA) complements the PRMAP by directly supporting the achievement of national policy objectives aimed at improving access to and efficiency and performance of government programs. TA is provided to support achievement of key health and education-related actions in subprogram 2 (SP2, April 2007–March 2009). Specific SP2 policy actions have been identified for TA support, based on their strategic impact and added value for the Government in accelerating MDG outcomes in health and education. The following criteria were applied in prioritizing TA support for SP2 actions: (i) requests by government agencies to implement PRMAP reforms, (ii) alternative financing sources available to support inputs leading to SP2 actions, and (iii) the size of TA budget support for PRMAP. The TA complements ongoing ADB-supported initiatives that aim to expand access, improve the quality of services, and enhance governance and accountability in both health and education.[1] Concerted efforts have been made to synergize activities with other donor-assisted programs to ensure complementarity in advancing achievement of the MDGs (see Supplementary Appendix E).

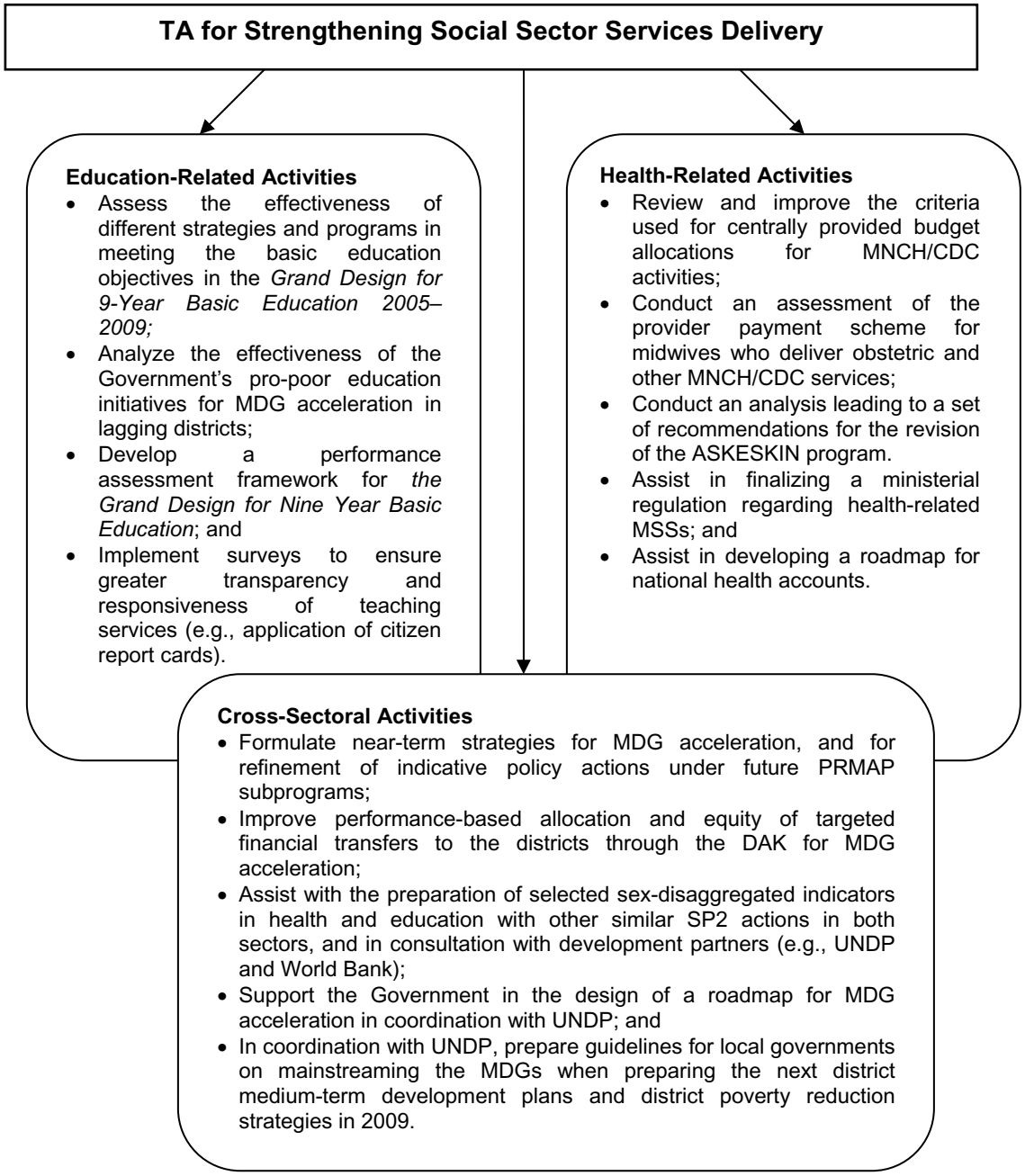
B. The Proposed Technical Assistance

1. Impact and Outcome

3. The impact of the proposed TA is to strengthen social service delivery within a framework for accelerated achievement of the MDGs ("MDG acceleration") at the national level. The TA supports the decentralization process through national policy reforms in health and education. The TA complements the PRMAP, and supports improvements for more efficient public spending in health and education.

[1] The TA complements ongoing ADB-supported initiatives: ADB. 2001. *Report and Recommendation of the President to the Board of Directors on a Proposed Loan to the Republic of Indonesia for Decentralized Basic Education Project*. Manila; ADB. 2001. *Report and Recommendation of the President to the Board of Directors on a Proposed Loan to the Republic of Indonesia for Decentralized Health Services Project*. Manila; ADB. 2003. *Report and Recommendation of the President to the Board of Directors on a Proposed Loan to the Republic of Indonesia for Second Decentralized Health Services.* Manila; ADB. 2006. *Report and Recommendation of the President to the Board of Directors on a Proposed Loan to the Republic of Indonesia for Madrasah Education Development Project*. Manila; and ADB. 2005. *Technical Assistance to the Republic of Indonesia for Pro-Poor Planning and Budgeting Project.* Manila. The TA also incorporates lessons from previous ADB-supported initiatives: ADB. 1998. *Report and Recommendation of the President to the Board of Directors on a Proposed Loan to the Republic of Indonesia for the Social Protection Sector Development Program*. Manila; ADB. 2004. *Technical Assistance to the Republic of Indonesia for Gender Responsive Public Policy and Administration Project.* Manila; ADB. 2000. *Japan Fund for Poverty Reduction Grant Assistance to the Republic of Indonesia for Assisting Girl Street Children at Risk of Sexual Abuse.* Manila; and ADB. 1998. *Technical Assistance to the Republic of Indonesia for Capacity Building for Decentralized Social Services Delivery*. Manila.

Figure A8.1: Activities of the Proposed Technical Assistance



ASKESKIN = Basic Health Care and Insurance for the Poor Program, DAK = Dana Alokasi Khusus (special development fund), MDG = Millennium Development Goal, MNCH/CDC = maternal neonatal and child health/communicable disease control, MSS = minimum services standard, PRMAP = Poverty Reduction and Millennium Development Goals Acceleration Program, TA = technical assistance, UNDP = United Nations Development Programme.
Source: Asian Development Bank.

2. Components and Outputs

4. The TA will support ministries primarily responsible for achieving PRMAP SP2 (April 2007–March 2009) policy reforms by 2009. The TA includes three sets of outputs at the national level to support: (i) Badan Perancanaan Pembangunan Nasional (BAPPENAS) and the Ministry of Finance (MOF) in achieving PRMAP SP2 cross-sectoral policy actions; (ii) BAPPENAS, the Ministry of National Education (MONE) and the Ministry of Religious Affairs (MORA) in achieving PRMAP SP2 education-related policy actions; and (iii) BAPPENAS and Ministry of Health (MOH) in achieving PRMAP SP2 health-related policy actions. Additional support might be provided to other line ministries, as identified during implementation. Figure 1 above captures suggested activities under each output.

a. Support for Cross-Sectoral National Policy Reforms for MDG Acceleration

5. Component 1 will support three policy actions under SP2: (i) recommendations for strengthening the technical guidelines of the Dana Alokasi Khusus (DAK), (ii) finalization of selected sex-disaggregated MDG health and education indicators, and (iii) development of a MDG roadmap and preparation of general guidelines on mainstreaming the MDGs into district medium-term development plans and district poverty reduction strategies.

6. **Improved DAK Technical Guidelines for the Education and Health Sectors.** The DAK is one of the instruments available to the Government to transfer financial resources to districts for sector-specific investments. The DAK remained undeveloped until recently; however, in recent years, the Government has significantly increased the size and the scope of the DAK allocated for the health and education sectors. The TA will support MONE, MOH and BAPPENAS in evaluating the current patterns of allocation and utilization of the education and health DAK by district governments. The TA will also assist in the design and evaluation of different options to transform the sectoral DAK into a more relevant instrument for (i) targeting funds to specific districts with insufficient resources for health and/or education, (ii) improving district performance in those sectors at the district level, and (iii) encouraging districts to increase the quantity and efficiency of their own resource investment in MDG-related areas. The various dimensions of the education and health DAK (i.e., allocation levels to each district, conditionalities and monitoring systems) will be further developed in order to transform the program, and to ensure that funding for MDG-related education and health expenditures is provided in an efficient, equitable, transparent and stable manner.

7. **Sex-Disaggregated MDG Indicators.** Achieving gender equity in accessing health and education services is an important aspect of accelerating achievement of the MDGs. Two MDGs focus directly on women—MDG 3 (promoting gender equality and empowerment of women) and MDG 5 (improving maternal mortality). Indicators selected to measure progress in achieving MDG 3 and 5 do not require data to be disaggregated by sex, but achievement needs to be placed within a wider gender context. The TA will support BAPPENAS in coordinating the finalization of key indicators among MONE, MORA, MOH, and the Ministry of Women's Empowerment (MOWE) for selected MDGs in health and education. These selected indicators could be used to monitor MDG-related progress within their respective sectors, and help target resources more efficiently for accelerating MDG achievement. Support for this policy action will need to be coordinated closely with support provided by the TA for other policy actions.

8. **Establish a Planning Framework for MDG Acceleration.** In coordination with the MDG TARGET program supported by the United Nations Development Programme (UNDP) and ADB's TA 6762-INO: Pro-poor Planning and Budgeting, the TA will assist BAPPENAS prepare guidelines to (i) encourage and assist local governments to mainstream the MDGs in their

medium-term and annual development plans, budgets and poverty reduction strategies; and (ii) encourage MONE, MOHA, MORA and MOWE to include MDG and targets in their medium term and annual plans. The TA will also support BAPPENAS and Menko Kesra (the Coordinating Ministry of Social Welfare) in the preparation of a comprehensive roadmap for accelerating attainment of MDGs. The roadmap could include strategies for: (i) development of an institutional framework for acceleration of the MDGs, involving key central government ministries and local governments; (ii) increasing public awareness about the MDGs; (iii) approaches to increase the involvement of civil society, the private sector and research institutions in efforts to attain the MDGs; (iv) improving data collection, processing and monitoring mechanisms, and reporting of MDG-related indicators; (v) assessing cost and budget implications for achievement of the MDGs; and (vi) developing sectoral policies for consideration by Government ministries in their medium-term development plans.

b. Support for National Policy Reforms in Education for MDG Acceleration

9. Component 2 will support MONE and MORA in reaching two policy actions under SP2: (i) assessment of the effectiveness of different strategies and programs in meeting the basic education objectives in the Grand Design for Nine Year Basic Education 2005-2009, and (ii) demonstration of use of the "Citizens Report Card (CRC) for Education" for surveying mothers and fathers (or guardians) on their satisfaction with the service delivery of local school systems.

10. **Education Sector Performance Assessment and Monitoring.** MONE and MORA completed a joint-plan (the "Grand Design") in 2007 for the completion of 9-year basic education that presents a combined vision from both ministries aimed at achieving national education objectives, including basic education. The TA will support activities to assess education sector performance prior to development of the new medium-term plan for national education in 2009, and related investment plans of MONE, MORA and district governments.

11. **Piloting the Citizens Report Card for Education.** The CRC approach and survey methodology was developed with ADB assistance, on the premise that feedback from communities that use public services provides reliable and relevant information, which is needed to improve governance and delivery of public services. Based on CRC survey results, recommendations for improvement may not necessarily entail additional financial costs. The TA will support efforts to enhance local accountability in the delivery of basic education services by adapting the CRC approach to the Indonesian context. A research institute will be recruited to undertake the planning, administration, and analysis of the survey. The institute will be required to submit time-bound reports on findings at different stages.

c. Support for National Policy Reforms in Health for MDG Acceleration

12. Component 3 will support MOH in strengthening policy, strategies and financing aimed to improve access to and efficiency and quality of health-related MDG services (e.g., maternal and child health, reproductive health, and HIV/AIDS). The TA will support MOH in undertaking five policy actions under SP2, and initiate background assessments to implement SP3 including: (i) review and improve the criteria used for centrally provided budget allocations for maternal neonatal and child health (MNCH) and communicable disease control (CDC) activities; (ii) support an analysis leading to a set of recommendations for the revision of the ASKESKIN program design and implementation modalities; (iii) support an evaluation of contract provider payment-schemes, especially (a) the impact of such schemes on the distribution of providers in poor/remote areas; and (b) utilization of health-related MDG services (i.e. MNCH and CDC), especially by women; (iv) assist in finalizing the revision of a ministerial regulation regarding health-related minimum service standards (MSSs); and (v) assist in the development of a national health accounts (NHAs) program.

13. **Improved Budget Allocation for MNCH/CDC Programs.** The Government needs to increase future health funding, and MOH will need to improve targeting of budget allocations so as to benefit (i) MDG-related health programs and (ii) areas with poorer health outcomes. The TA will assist MOH in reviewing the current criteria used for centrally provided budget allocations for MNCH/CDC, and will help formulate possible mechanism(s) whereby a portion of the central MOH budget may be used to improve the level and allocation of direct and operational budgets for health programs and activities at local government levels. Further, the TA will assist in analyzing MOH budget and expenditures allocations for MDG-related health programs to better estimate central budget resources required to meet MDG-related health outcomes. In addition, the TA will assist in analyzing options for improving the efficiency and equity of MDG-related health services delivery through development of: (a) formulae to allocate central government budget for each MDG program among provinces and from the provinces to the districts; (b) mechanisms to utilize central government budget to leverage additional local government allocations; and (c) mechanisms to link central government budget allocations to improved local government reporting on utilization of supported services. The criteria that MOH develops would be coordinated with the cross-sectoral efforts under the PRMAP TA to develop allocation formula options for the health DAK based on the identification of MDG-deficit districts (i.e., those which lag behind in achievement of the selected MDG-related indicators).

14. **Recommendations for ASKESKIN Program Improvements.** The ASKESKIN program was introduced by MOH in 2005 to (i) improve targeting of government budget resources to finance health services utilized by the poor, (ii) increase financing for operational and maintenance expenses of public sector health facilities, and (iii) increase the efficiency of funds management by contracting a third-party agency to independently manage the funds and provider contracts. Since 2005, the program has evolved by allowing fee-for-service payment with both public and eligible nongovernment providers (i.e. midwives and select private hospitals). The TA will support MOH in developing a set of recommendations for the revision of the ASKESKIN program design and implementation modalities, including appropriate provider payment mechanisms, reimbursement levels for specific services that directly impact on MDG outcomes. This analysis will take into account evaluations of ASKESKIN and other appropriate health-related MDG efforts, feedback related to recent program adjustments, and the longer-term development of Indonesia's national health insurance policy and design.

15. **Increasing Health Providers in Remote Areas.** The ratios of physicians, midwives, and nurses to the population are below the "2010 Healthy Indonesia" targets, and there are significant variations in the distribution of health personnel per capita between provinces and among districts.[2] MOH uses a number of means to attract primary healthcare providers (e.g., physicians and midwives) to remote and underserved areas. For instance, MOH has adopted mixed provider payment mechanisms through ASKEKSIN that influence financial incentives affecting provider location choices and service provision behavior. The TA will support MOH in conducting an evaluation of the contract provider payment-schemes on: (i) their effectiveness in reaching women and those in poor and/or remote areas, (ii) the impact of the scheme on utilization of MNCH/CDC services, and (iii) the impact of the scheme on the distribution of primary healthcare providers across provinces and districts. This TA will also review international experience regarding alternative options used to reduce inequities in provider distribution, and the impact on service use and MDG reduction targets. This will require documentation of the different modalities currently used to attract and retain health personnel in remote and underserved areas, with particular attention to increasing the provision of integrated primary health services for women and children in the community. TA input will complement rather than duplicate studies under development by World Bank involving health-related human resource issues in Indonesia.

[2] Ministry of Health. 2006. *Subnational Health System Performance Assessment*. Jakarta.

16. **Meeting National Standards in MNCH/CDC.** GOI has advised all ministries to define a standard set of indicators estimating the minimum services standards (MSS) to be met countrywide. The establishment of MSS for the health sector is expected to help meet national priorities, including attainment of the MDGs. The MOH ministerial decree of 2003 related to MSSs is currently being revised. The updated MSSs decree is expected to identify intermediate indicators, for child nutrition, MNCH, HIV/AIDS, malaria, and tuberculosis. The fundamental principles and objectives of MSS need to be clarified and a methodology developed in formulating its implementation and monitoring. The TA will work closely with MOH and MOHA to clarify objectives and to improve health-related MSS to ensure that health-related MDG services are included. The TA will assist MOH to formulate criteria for inclusion of relevant programs and indicators for the health-related MSS. It will also assist MOH to ensure that central and local government obligations are clearly identified in the MSS, including financial obligations. The TA will support the finalization of the ministerial decree and complement ongoing efforts by Deutsche Gesellschaft fur Technishe Zusammenarbeit (GTZ) related to the MSS.

17. **Institutionalizing a National Health Accounts Program.** NHAs provide data and analysis of total public and private expenditure for health by payer, financing intermediary, and provider. NHAs may also provide analysis of expenditure by program, type of input, and geographic area. Institutionalization of NHAs in Indonesia may be used to improve targeting of public expenditures on health-related MDG programs and on those districts with poor achievement related to MDG indicators. NHAs data collection and analyses will help improve monitoring of health public expenditure against specific outcomes (e.g., access and equity of allocation, and allocation and technical efficiency). To improve the quality of information and analysis of total and public expenditures for health, BAPPENAS plans to institutionalize a NHAs program in Indonesia. The TA will support BAPPENAS, MOH and other stakeholders in the development of a roadmap for a NHAs program for Indonesia. The roadmap will consider the devolution to the district level of decision-making authority over public health spending and independent implementation of district health accounts analyses, so as to improve the evaluation by districts of allocation and the technical efficiency of resource use. The roadmap will explore ways in which district-level health accounts can be undertaken and institutionalized to facilitate an ongoing program. Pilot district health accounts analysis will be supported nationwide to ensure that common methodological approaches are used.

3. Implementation Arrangements

18. The TA will be implemented in parallel with the PRMAP and will cover a period of 20 months, from 1 January 2008 to 31 August 2009. Implementation arrangements for both the proposed TA and the PRMAP will be the same, so as to ensure synergy between the program loan cluster and the TA. BAPPENAS will be the executing agency and the line ministries responsible for the various sectors will act as the implementing agencies. The steering committee established for PRMAP will be the same for the TA. It will be chaired by BAPPENAS and include representatives of MOF, MOWE, MOH, MONE, MORA, and MOHA. The proposed TA is estimated at $2.7 million, of which ADB will finance $1.5 million as a grant, with the Government providing counterpart support equal to $200,000 equivalent. The Australian Agency for International Development (AusAID) will provide $1 million in parallel co-financing. Table A8.1 contains the cost estimates and financing plan.

19. A team of international specialists (total 46 person-months) and national experts (31 person-months), supported by ADB, will be recruited in accordance with ADB's *Guidelines on the Use of Consultants* (2007, as amended from time to time) following the quality- and cost-based selection method and using a full technical proposal. A team of international specialists (total 30 person-months) and national experts (40 person-months), supported by AusAID on a parallel basis, will be recruited individually. A research institute with significant experience working with governments on governance and public service delivery issues will be recruited

through direct selection to undertake the Citizen Report Card satisfaction survey for basic education. The outlined terms of reference (TOR) and person-months for each specialist are found in Supplementary Appendix E.

20. BAPPENAS will be supported by an international MDG advisor in the development of a general framework for MDG acceleration. This advisor will also act as the team leader for the TA. BAPPENAS, MONE, MORA and MOH will also be supported by specialists and experts with expertise in gender, data management, financial management, education performance monitoring and assessment, learning assessments, health financing and insurance, and health systems support. They will be responsible for submitting reports to ADB, the Government, and AusAID. Emphasis will be on technical content rather than administrative aspects, describing the advice provided to the Government in simple terms. Technical briefs will be prepared by consultants on a needs-basis. Individual output reports from each sector will be submitted to BAPPENAS and other relevant ministries, ADB, and AusAID for review and comments prior to finalization. Each report will be finalized after incorporating the comments received.

Table A8.1: Indicative Cost Estimates and Financing Plan
($'000)

Item	Total Cost
A. ADB Financing[a]	
1. Consultants (Cross-Sectoral)	
a. Remuneration and Per Diem	
i. International Consultants	920.0
ii. National Consultants	130.0
iii. Research Institute	50.0
b. International Travel	55.0
c. Local Travel	30.0
d. Reports, Workshops, Surveys and Communications	90.0
2. Contingencies	225.0
Subtotal (A)	**1,500.0**
B. AusAID Financing[b]	
1. Consultants (Health Sector)	
a. Remuneration and Per Diem	
i. International Consultants	600.0
ii. National Consultants	160.0
b. International Travel	40.0
c. Local Travel	30.0
d. Reports, Workshops, Surveys and Communications	70.0
2. Contingencies	100.0
Subtotal (B)	**1,000.0**
C. Government Financing[c]	
1. Office Accommodation and Transport	50.0
2. Remuneration and Per Diem Of Counterpart Staff	150.0
Subtotal (C)	**200.0**
Total	**2,700.0**

ADB = Asian Development Bank; AusAID = Australian Agency for International Development.
[a] Financed by ADB's technical assistance funding program.
[b] Financed by the Government of Australia's Overseas Aid Program.
[c] Contribution by the Government of Indonesia.
Source: ADB estimates.

SUMMARY POVERTY REDUCTION AND SOCIAL STRATEGY

A. Linkages to the Country Poverty Analysis

Is the sector identified as a national priority in country poverty analysis?	☒ Yes ☐ No	**Is the sector identified as a national priority in country poverty partnership agreement?**	☒ Yes ☐ No

Contribution of the sector or subsector to reduce poverty in Indonesia:

The Government of Indonesia (the Government) aims to (i) enhance the quantity as well as quality of public expenditures; (ii) improve local government accountability, while maintaining the basic principles of regional autonomy; and (iii) adopt sound and sustainable resource allocation mechanisms to target poverty reduction and accelerated achievement of the Millennium Development Goals (MDGs) ("MDG acceleration") in areas that lag behind. In recent years, fiscal consolidation has been at the center of the Government's macroeconomic management. Since the Asian financial crisis of 1997, the Government has instituted a number of structural reforms across different sectors to remove the distortions that led up to the crisis in 1997. However, in the past the Government has been unable to maintain its development expenditures, especially on education and health.

The Government's National Poverty Reduction Strategy (SNPK) has identified a lack of access to key basic services (e.g., health and education) and to economic opportunities as factors contributing to poverty. The SNPK aims to: (i) establish Indonesia's commitment to poverty reduction, (ii) build consensus on poverty eradication, (iii) underline the commitment to achieving the MDGs, and (iv) synchronize poverty reduction activities. It is incorporated into the Government's Medium-Term Development Plan (RJPM) 2004–2009. To implement the SNPK, the Government is preparing a national poverty reduction action plan in consultation with relevant stakeholders. The current draft is in-line with the priority areas of the 2007 budget.

The proposed impact of the Poverty Reduction and MDGs Acceleration Program (PRMAP) is to accelerate progress towards achieving the MDGs in education (MDG 2), health (MDGs 4, 5, 6) and contribute to the Government's poverty reduction agenda (MDG 1), and gender equality (MDG 3). The program will be implemented in accordance with the Government's national priorities as reflected in the existing RPJM. The PRMAP is aligned with the Government's systems and assistance, and supports the Government's efforts to increase spending directed to attainment of the MDGs. The proposed TA for strengthening social sector services delivery supports these actions and reforms in the health and education sectors.

B. Poverty Analysis **Targeting Classification:** Targeted intervention (non-income MDGs)

Indonesia spans an archipelago of over 17,000 islands, of which about 7,000 are inhabited by approximately 235 million people, living in about 440 districts in 33 provinces. An estimated 742 ethnic groups and languages are found in Indonesia, and many Indonesians identify themselves with a specific language and/or island. Based on household survey data, poverty incidence has fallen from 23% in 1999 to 16% in 2005. According to the international poverty line ($1/day), poverty incidence is estimated at 7% based on purchasing power parity. About 49% of the population lives on $2 per day (2005). By 2009, the target is to reduce poverty (with respect to the national poverty line) to about 8.2%. However, in March 2006, poverty incidence increased to 17.7%, following the fuel subsidy reductions and an increase in the price of rice in 2005.

Lack of access to key social sector services such as health and education is one of the main causes of poverty in Indonesia. Lack of access to basic education significantly decreases productivity and personal income. Lack of access to affordable health services affects the health status of individuals and poor health decreases productivity and personal income. The poor are more vulnerable to health shocks due to high medical expenses for treating diseases, lost school and work days for recovery, high transportation costs, and other access barriers. The opportunity cost of completing basic education is also greater for children, especially girls, from poor households.

National-level progress in achieving the MDGs obscures vast differences across regions and districts, rural and urban areas, income groups and genders. The *Human Development Report* (2006)[1] ranked Indonesia 108th (HDI value of 0.71) among 177 nations in terms of the human development index (HDI). In 2002, the HDI value for Indonesia was 0.66, but across regions, the HDI ranged from 0.76 in Jakarta to 0.47 in the Jayawijaya district in Papua. Indonesia's national gender-related development index (GDI) for 2002 shows the male adult literacy rate to be 93.5%, while the female rate was 85.7%. Variations among provincial and district GDIs are also evident. In 2002, the GDI in DKI Jakarta was 66.7, in Bangka Belitung 47.7, in Nanggroe Aceh Darussalam 55.5, and in North Maluku 31.2.

During program preparation, the Policy Matrix for PRMAP was reviewed from the perspective of assessing (i) the potential for adverse poverty and social impacts, if any, of the policy actions and/or reforms; (ii) areas for gender mainstreaming and/or enhancement through (a) additional actions, if any, or (b) rephrasing of actions that are more conducive to mainstreaming efforts; and (iii) areas for enhancing collection of regional and district-level information to inform future policy actions. The policy actions in the Policy Matrix were also assessed to determine potential adverse impacts on deepening social and regional disparities. As a result of the assessment, some policy actions were refined and/or better explained in the accompanying sector write-up.

C. Participation Process

Is there a stakeholder analysis? ☒ Yes ☐ No

The program and the TA have been prepared based on extensive consultations with a wide range of government officials, development partners and other concerned stakeholders. Sector specialists have shared the policy matrix with respective development partners in health and education sector forums. BAPPENAS and other concerned line ministries have provided direction and suggestions, which have fed into the design of the PRMAP and TA. Continued

[1] United Nations Development Programme (UNDP). 2006. *Human Development Report 2006.* New York.

policy dialogue with the Government, development partners, and other concerned agencies is required to achieve the subprogram 2 and 3 actions and overall program outputs.

Is there a participation strategy? ☒ Yes ☐ No

A participation strategy has been integrated into the policy actions framework. It identifies the lead line ministries responsible for achieving each policy action. The policy measures aimed at improving governance and monitoring systems focus on enhancing the potential benefits of decentralization by making social sector services more responsive to local preferences and making service providers more accountable to their clients. Civil society, private sector and research institutions will participate in the preparation of the roadmap for MDG acceleration under SP2.

D. Gender Development

Strategy to maximize impacts on women:

The joint-donor Country Gender Assessment for Indonesia (2006)[2] and meetings with key informants in the Ministry of Women's Empowerment, National Development Planning Agency, Ministry of National Education, Ministry of Religious Affairs, and Ministry of Health, and partner agencies, provided the context for assessing the affects of the policy matrix on gender issues within the health and education sectors. Policy actions in the matrix were refined according to the methodology described in section B. The disaggregation of information by sex, and consideration of specific gender challenges in health and education are basic requirements for effective monitoring of policy conditions, achievement of SP2 policy actions, and more equitable allocation of budgetary resources.

Has an output been prepared? ☒ Yes ☐ No

A policy output for gender mainstreaming has been included under the cross-sectoral section of the policy action matrix (PO.4). Specific actions in health and education cater to the specific non-formal education and maternal/reproductive health needs of women. For instance, the PRMAP includes a policy action that mandates that 40% of representatives on district education boards and school committees be female (Policy actions 12.22). Similarly, the PRMAP includes policy actions aimed at increasing the supply of health providers in underserved areas through reimbursements for midwives on a fee-for-services basis for comprehensive obstetric care and antenatal care (Policy action 15.3). A gender specialist will also be recruited under the TA to support gender mainstreaming efforts in achieving SP2 policy actions. A summary of gender impacts is included in the main text of the RRP (para. 120).

E. Social Safeguards and Other Social Risks

Item	Significant/ Not Significant/ None	Strategy to Address Issues	Plan Required
Resettlement	☐ Significant ☐ Not significant ☒ None	The PRMAP and TA facility are not expected to require or cause any land acquisition or resettlement.	☐ Full ☐ Short ☒ None
Affordability	☐ Significant ☒ Not significant ☐ None	Policy actions in the matrix aim at strengthening national policy reforms in health and education. For example, policy actions aim at providing affordable health services by improving delivery mechanisms for health financing and insurance through a third party (PT Askes), and improving access to education by implementing a general subsidy for school operational support.	☐ Yes ☒ No
Labor	☐ Significant ☒ Not significant ☐ None	The PRMAP, through its policy reforms, is not expected to adversely affect the labor market and/or displace individuals from their jobs. Through policy support and TA support, the PRMAP will contribute to better recruitment and deployment of teachers. The PRMAP will also help to increase the number of healthcare providers through reimbursement, through ASKESKIN, of emergency obstetric and antenatal health services for the poor.	☐ Yes ☒ No
Indigenous Peoples	☐ Significant ☒ Not significant ☐ None	The PRMAP is not expected to adversely affect the ethnic population through the implementation of policy actions or the TA. The PRMAP aims to address regional and social disparities that are recognized as slowing MDG achievement. National policy actions and reforms have been assessed for their impact on poverty, gender and ethnic groups.	☐ Yes ☒ No
Other Risks and/or Vulnerabilities	☐ Significant ☐ Not significant ☒ None	None.	☐ Yes ☒ No

[2] ADB. 2006. *Indonesia: Country Gender Assessment.* Manila.