Report Number : ICRR0024692

1. Project Data

Project ID P164277	**Program Name** I-SPHERE
Country Indonesia	**Practice Area(Lead)** Health, Nutrition & Population

L/C/TF Number(s)	**Closing Date (Original)**	**Total Program Cost (USD)**
IBRD-88730	30-Apr-2024	150,000,000.00
Bank Approval Date	**Closing Date (Actual)**	
13-Jun-2018	31-Dec-2024	

	IBRD/IDA (USD)	Grants (USD)
Original Commitment	150,000,000.00	0.00
Revised Commitment	150,000,000.00	0.00
Actual	150,000,000.00	0.00

Prepared by	Reviewed by	ICR Review Coordinator	Group
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2. Program Context and Development Objectives

a. Objectives

According to the Loan Agreement (p. 6) and the Project Appraisal Document (PAD, p. 35), the program's objective was "to strengthen performance of Indonesia's primary health care system." The PAD explicitly defined performance as "the performance of monitoring, quality, and financing of Indonesia's primary health care system." Following the ICR, this Review unpacks "performance" into the three elements specified in the PAD, assessing achievement of three objectives:

- Strengthen the monitoring of Indonesia's primary health care system

- Strengthen the quality of Indonesia's primary health care system
- Strengthen the financing of Indonesia's primary health care system

The objectives remained unchanged throughout program implementation. Some outcome indicator baselines and targets were revised at an April 2020 restructuring, but those changes increased the program's ambition. A split rating is not required.

b. Were the program objectives/key associated outcome targets revised during implementation?
Yes

Did the Board approve the revised objectives/key associated outcome targets?
No

c. Will a split evaluation be undertaken?
No

d. Components
The operation, a Program for Results (PforR), was designed around three results areas (PAD, pp. 24-25), all intended to support key aspects of Healthy Indonesia, the government's flagship health program. Introduced in 2015, Healthy Indonesia aims to improve the health and nutritional status of the community through health and community empowerment efforts, backed by financial protection and the equitable distribution of health services. Coverage of the Bank-financed program was nation-wide, including the three lagging provinces of Nusa Tenggara Timur (NTT), Maluku, and Papua. The three results areas were:

1. **Strengthening performance monitoring for increased local government and facility accountability** was to improve performance monitoring and benchmarking of health care delivery (both primary and referral care), including developing and publishing district-level performance dashboards. Quality of data was to be improved by enabling interoperability of key systems, introducing verification protocols, and making electronic data systems more compliant with a standard data dictionary. Introduction of mobile health (mHealth) was to enable more accountable and efficient frontline service delivery through the "Healthy Indonesia through the Family Approach Program" (PIS-PK), a key national intervention to support improved disease prevention and health promotion.

2. **Improving implementation of national standards for greater local government and facility performance** was to support strengthened implementation of a quality assurance program and accreditation of *puskesmas* (public primary health centers that are the backbone of Indonesia's health system, each covering about 25,000 - 30,000 people, with almost a third having inpatient beds). The intent was to support *puskesmas* to reach higher levels of accreditation, which is associated with more stringent clinical quality and managerial performance standards. Additional focus would also be given to lagging regions in Eastern Indonesia, where *puskesmas* would be supported to achieve basic levels of accreditation. The results area would also cover capacity building of the primary care Accreditation Commission and Ministry of Health (MoH) by introducing better programs to drive clinical quality, community outreach, continuous quality improvement programs, and coverage of the private sector. The Accreditation

Commission would be supported to become independent, make its standards and results more transparent, and implement the necessary improvements to gain International Society for Quality in Health Care certification. Integrated referral information system software was to be rolled out to improve primary and referral care coordination. Capacity development would also be supported in the area of data-driven planning and budgeting, with selected lagging districts given intensive training to improve annual work plans and budgets. Finally, this results area would address human resource scarcity in remote areas by supporting the deployment of teams under the *Nusantara Sehat* (Healthy Archipelago) initiative, launched in 2016 to deploy health workers on special assignment to fill *puskesmas* workforce gaps in targeted locations and for priority programs.

3. **Enhancing performance orientation of health financing for better local service delivery** was to support the introduction of incentives for improved primary health care readiness and availability of frontline health services through both supply-side inter-governmental fiscal transfers and an improved incentive structure governing the purchasing of primary care.

e. Comments on Program Cost, Financing, Borrower Contribution, and Dates

Total planned program cost over five years was US$13.65 billion, supported by an International Bank for Reconstruction and Development loan of US$150 million and government contribution of US$13.5 billion. All Bank funds were fully disbursed. According to the ICR (p. 39), total actual government spending was US$8.896 billion, bringing actual total program costs to US$9.046 billion. The program was structured as a PforR with ten disbursement-linked indicators (DLIs). The PforR financing instrument was intended to leverage a relatively small Bank investment toward substantial systemic change in the overall government health program.

The program was approved in June 2018, became effective in October 2018, and held a mid-term review in April 2021. It was restructured twice:

- April 2020: *Puskesmas* in Eastern Indonesia achieved unexpectedly high levels of accreditation, despite initial expectations that they would struggle to meet even basic standards. As a result, the definition and wording of DLIs 3 and 4 were adjusted to allocate these *puskesmas* to DLI 4, which had a higher unit price point than DLI 3. The baseline and target values for both these DLIs were changed to reflect the actual number of accredited *puskesmas* and the adjusted definitions. In addition, the wording of an intermediate results indicator for DLI 8 was modified to clarify the requirement for a joint agreement between MoH and the National Social Health Insurance Agency (BPJS-Health) on performance-based capitation.
- February 2024: The program's closing date was extended by eight months, from April 30, 2024, to December 31, 2024, mainly to accommodate a revised timeline for DLI 5 (after a government regulation issued in January 2023 required international recognition of MoH accreditation standards for primary care) as well as delays caused by the COVID-19 pandemic.

The program closed on December 31, 2024.

3. Relevance

a. Relevance of Objectives

Rationale

The program's objectives were highly relevant to country context and government strategy. At the time of appraisal, health outputs and outcomes in Indonesia had been experiencing improvement. Life expectancy had increased from 67 in 2002 to 69 in 2015, and under-five mortality had declined from 46/1000 live births in 2002 to 32/1000 in 2017. Landmark legislation passed in 2004 and 2011 had set the stage for progress toward universal health coverage, with the single-payer social health insurance program (*Jaminan Kesehatan Nasional, JKN*) having improved health insurance coverage from around 27 percent in 2004 to 73 percent in 2017; it was expected that coverage would reach 100 percent by 2019. Key challenges, however, remained. There were geographical and income-related inequities in access to quality care and health outcomes. Provinces in Eastern Indonesia performed considerably below national levels on indicators like under-five mortality and chronic malnutrition. The three prioritized provinces—Maluku, Papua, and INT—had the lowest outpatient and inpatient utilization rates in the country. The infant mortality rate in the poorest wealth quintile of households was more than double that in the richest quintile. Moreover, Indonesia was facing a dual burden of disease, with both persistent levels of communicable diseases and a rising prevalence of non-communicable diseases (NCDs). NCDs' share of the disease burden stood at 66 percent in 2017, almost double the share in 1990.

The government was committed to addressing these challenges through the Healthy Indonesia program's three pillars: promoting a health paradigm (strengthening of preventive and promotive efforts), strengthening health care services, and implementing the national health insurance scheme (JKN). The achievement of universal health coverage was foundational to this program, but three key constraints required attention: health financing, governance, and access to quality service delivery. Health financing was marked by low public health expenditures, high out-of-pocket payments, and a complex and fragmented intergovernmental fiscal transfer system. In 2014, public health expenditure was 1.5 percent of gross domestic product (GDP)—among the lowest in the world—and constituted only 41 percent of total health expenditure. Out-of-pocket payments stood at 46 percent of total health expenditure and 1.2 percent of GDP. The performance of primary health care suffered from lack of performance monitoring and accountability in a decentralized setting (frontline health workers and facilities reported to local government, not to the MoH), underdeveloped ability to enforce clinical and managerial standards at the facility and district levels, and poor performance orientation of intergovernmental fiscal transfers and the social health insurance program. District health spending was funded from multiple sources with different conditions for allocation and use. Referral systems were weak, and primary care providers did not play a meaningful gate-keeping role in accessing higher levels of health care. Health information management was characterized by high fragmentation, poor compliance, low levels of data verification, and underutilization of data for decision making. Decentralization had strained the capacity of local governments to do more integrated health planning and budgeting. The MoH had developed a training course on planning and budgeting, but it had been rolled out in only a limited number of districts.

After two decades of experience with hospital accreditation, Indonesia established a primary care Accreditation Commission in 2015, designed to improve the quality of primary care services by ensuring not only that the necessary inputs (such as infrastructure, equipment, and human resources) were in place, but also that both clinical and managerial processes were improved. MoH established a policy that accreditation of primary health care facilities would, by 2021, become a prerequisite for their empanelment by BPJS-Health as a JKN provider. In order for this policy to work, however, the credibility of the primary care

Accreditation Commission and its processes needed to be strengthened. In addition, although JKN—which financed 42 percent of the total amount of district health budgets in 2015—was a potentially potent financial lever to improve health outcomes and supply-side readiness, it needed to be targeted better to the poorest population quintiles and to improve collection among non-poor informal workers. Strategic purchasing under JKN, involving strengthening of performance-based capitation payments for primary care providers, presented an opportunity for increased efficiency and accountability in primary care service delivery.

The objectives were also highly relevant to Bank strategy. The Country Partnership Framework (CPF) at appraisal (2015-2020) had an engagement area on delivery of local services, with pillars on strengthening the decentralization framework to support local service delivery and supporting the delivery of quality health services. The project remained relevant to the CPF at closing (2021-2025), which contained an engagement area on nurturing human capital and an objective to strengthen quality and equity in nutrition and health. The CPF cited this project as a key intervention toward achievement of that objective.

The program was a logical next step in the Bank's engagement with Indonesia's health sector and was based on a rigorous analytic foundation. Although the MoH had not had an operation with the Bank since 2008, the Bank had been supporting the government to achieve universal health coverage through analytical and advisory work on health financing, service delivery, and governance (including, for example, *Indonesia Health Financing System Assessment: Spend More, Right, and Bette*r, 2016; and *Is Indonesia Ready to Serve? An Analysis of Indonesia's Primary Health Care Supply Side Readines*s, 2018). This program followed a clear sequence from diagnostics to analytic work to lending. Following the 2015 Systematic Country Diagnostic's identification of the need to improve health facilities' readiness for service delivery, the cited 2018 study assessed service readiness and highlighted disparities across public and private providers, geographic areas, and other factors. These analytic efforts directly informed program design. This program also complemented ongoing engagements managed through the Governance Practice, including a Programmatic Advisory Services and Analytics on decentralized service delivery. The PforR instrument provided an opportunity for relatively small external financing to leverage larger systemic changes, building on ongoing dialogue with MoH and the Ministry of Finance, shifting focus to results at the central and local levels, and allowing for scale-up of successful interventions.

Rating
High

b. Relevance of DLIs

DLI 1
DLI
Districts covered in MoH's published performance dashboard

Rationale
Prior to the operation, health information management was characterized by high fragmentation, poor compliance, weak data verification, and underutilization of data for decision making. The MoH had developed a standard data application for *puskesmas*, but it was being used in only about ten percent of facilities.

Another 20-30 percent of *puskesmas* were using other electronic systems, and the rest were using paper-based systems. There was lack of consistency in the use of data terms, facility and patient identifiers, and treatment codes. This DLI measured the development of a performance dashboard using the District Health Information System-2 (DHIS2) to consolidate and standardize agreed performance indicators from the various information systems already in place. The dashboard would help benchmark performance across districts, shedding light on the kinds of capacities, resourcing, and incentives needed to improve service delivery, and making the results public to improve the performance orientation and accountability of districts.

Rating
High

DLI 2

DLI
Puskesmas using mHealth application to support enhanced PIS-PK

Rationale
Prior to the operation, data quality in the health sector was uneven, with challenges related to the reporting burden for facilities (using different systems for different directorates of MOH, BPJS-Health, and development partners) and high levels of error and confusion (when the same information would appear in different systems as different data). This DLI was to measure the development and use of mHealth as an innovation to support PIS-PK as well as specific service delivery interventions. The use of mHealth would support the nationwide rollout of a "Healthy Family Index," based on twelve indicators, to capture the preventive and promotive aspects of PIS-PK. Design and use of the mHealth application at the *puskesmas* level would enhance frontline health worker productivity, improve service delivery for the priority PIS-PK program, and improve data quality and consistency across primary care.

Rating
High

DLI 3

DLI
Puskesmas that have received higher levels of accreditation

Rationale
There were four levels of accreditation for primary care facilities based on scores achieved across nine major standard areas: basic, intermediate/middle, main/prime, and excellent/high. This DLI measured the number of *puskesmas* receiving accreditation at main/prime or excellent/high levels, as certified by the primary care Accreditation Commission. These higher levels require strict adherence to outreach, managerial, and clinical protocols, all of which are crucial for delivering quality health services. The DLI included both *puskesmas* receiving accreditation for the first time and those receiving re-accreditation.

Rating
High

DLI 4

DLI
Puskesmas that have been accredited (for basic levels) in Eastern Indonesia

Rationale
This DLI was to measure the number of *puskesmas* receiving accreditation at the basic or intermediate/middle levels, as certified by the primary care Accreditation Commission, in the three provinces of Eastern Indonesia: Maluku, Papua, and NTT. It included *puskesma*s receiving accreditation for the first time and those receiving re-accreditation. By focusing on the two most basic accreditation levels, this DLI sought to ensure that these underserved areas were supported to meet minimum health care standards, addressing disparities in quality and access to primary health care services. The DLI was also a direct response to a 2015 ministerial regulation requiring all *puskesmas* to become accredited by the end of 2024 to qualify as service providers under the JKN program.

Rating
High

DLI 5

DLI
Primary care accreditation body functioning as an independent commission

Rationale
Prior to the operation, the primary care Accreditation Commission for Primary Health Care Facilities (KAFKTP) was still in its infancy, having been established under a Minister of Health decree in 2015. Its capacity was limited, it was reliant on the MoH across multiple dimensions, and it was in the early stages of developing credible quality assurance and validation mechanisms. Its standards and results were not yet fully consistent and transparent. This DLI measured the planned expansion of its national capacity in terms of surveyors, its local capacity in terms of district-level facilitators to assist with the accreditation process, and its overall ability fo manage the accreditation process impartially for both public and private facilities. KAFKTP was financially dependent on MoH at the time of program appraisal, but it was intended to become an independent entity.

Rating
High

DLI 5 REVISION 1

Revised DLI
Ensuring credibility and reliability of the primary care accreditation process

Revised Rationale

In January 2023, a national regulation mandated that MoH accreditation standards for primary care be recognized by international institutions in order to enhance the health care system's credibility. The accreditation framework therefore no longer required KAFKTP to become an independent commission as initially planned, but instead mandated that MoH standards and accreditation bodies and processes be recognized at the international level. The wording of the DLI was therefore changed to remove the requirement that KAFKTP become a standalone commission. The revised DLI could have been more specific in the requirement for recognition by an international accrediting institution.

Revised Rating
Substantial

DLI 6
DLI
Lagging districts that have produced improved annual plans and budgets

Rationale
Prior to the operation, local governments had limited capacity in the areas of annual planning and budgeting. District health offices rarely engaged in planning processes aimed at addressing gaps in inputs for health facilities with focus on facilities and populations in greatest need. The accreditation process at the facility level provided a useful framework for investment planning, but MoH required support to upgrade training modules and redesign pedagogical methods to strengthen local government capacity in lagging districts (defined based on relevant health system indicators). The DLI was to measure the number of lagging districts that conducted workshops on integrated planning and budgeting and, as a result, produced improved annual plans and budgets in accordance with MoH guidance. This improved capacity would allow districts to strategically allocate resources to priority areas, leading to better health care service delivery, and to incorporate monitoring and evaluation processes into the preparation of planning documents, ensuring alignment with district health priorities and identifying areas for further enhancement.

Rating
High

DLI 7
DLI
Special health worker teams deployed

Rationale
Prior to the operation, human resources for health were a challenge across Indonesia's health sector. Key issues included unequal distribution, a shortage of specialists, and poor quality of workers. Poor and remote areas were disproportionately affected by shortages of doctors (particularly specialists), nutrition staff, dentists, and laboratory technicians. Attracting qualified staff to remote areas required not only financial incentives, but also good management and facilities in those areas. This DLI measured the number of special health worker teams deployed in response to annual demand in lagging, border, and island areas. A special MoH program—*Nusantara Sehat*—was designed to deploy health worker teams to fill workforce gaps in

underserved regions. Adequate health worker coverage was critical to ensuring accreditation of primary health care facilities in underserved areas.

Rating
High

DLI 8

DLI
Primary care providers that are implementing performance-based JKN capitation

Rationale
Prior to the operation, capitation within the JKN system functioned primarily as a cost containment tool. This DLI supported the enhancement of the performance-based capitation mechanism to strengthen JKN's role in promotive and preventive health interventions, as well as health system and provider performance improvement, in addition to its ongoing use as a cost containment instrument. The goal was to increase the number of performance-based capitation indicators and the quantum of the financial penalty to providers for non-compliance, incentivizing primary care providers to deliver higher-quality care and to focus on preventive measures.

Rating
High

DLI 9

DLI
Districts showing improvement on at least half of the performance indicators in the enhanced DAK non-fisik

Rationale
Indonesia's health care financing is complex and fragmented. Demand-side financing is primarily through the JKN. Supply-side financing takes place through several intergovernmental fiscal transfer mechanisms (from the Ministry of Finance to local governments): general allocation funds, revenue sharing, and social allocation funds (*Dana Alokasi Khusus*, DAK). DAK is the country's largest conditional transfer and serves as an important lever for the national government to influence subnational service delivery outcomes across all sectors. There are two forms of DAK: (1) *DAK fisik*, which in health is focused mainly on infrastructure, equipment, and medicines; and (2) *DAK non-fisik*, which in health largely finances operational expenditures. Neither form of DAK has traditionally been strongly linked to results, though that changed for *DAK non-fisik* in 2018 with the introduction of some basic performance elements largely tied to process indicators (local government financial realization and reporting compliance). This DLI satisfied the desire of both MoH and the Ministry of Finance to expand the performance indicators for *DAK non-fisik* to focus district and health facility effort more directly on health service delivery performance. It measured the introduction and implementation of performance-based elements into *DAK non-fisik* allocations, rewarding local governments that achieved results with additional allocations the following year. The performance-based indicators were to cover promotive and preventive health service interventions and system improvements.

Rating
High

DLI 10
DLI
Provinces that are using an integrated referral information system (IRIS)

Rationale
Prior to the operation, Indonesia's health care referral system (which transfers patients between primary care providers and higher-level health care facilities) suffered from weak coordination, inadequate follow-up, a shortage of specialists, and poorly equipped facilities. As a result, patients were often turned away or referred to unsuitable facilities, increasing inefficiencies and costs and reducing quality of care. This DLI measured the development and use of an integrated referral information system (IRIS) that would connect *puskesmas* and hospitals, enabling timely and appropriate referrals as well as integrated patient care, and improving case management and resource utilization.

Rating
High

OVERALL RELEVANCE RATING
Rationale
The program's objectives were strongly aligned with country context, government strategy, and Bank strategy. The DLIs were highly relevant individually (with the exception of the revised DLI 5), and the DLIs would have worked collectively to incentivize achievement of the objectives. Data to measure each DLI were readily available. Overall relevance is rated High.

Rating
High

4. Achievement of Objectives (Efficacy)

OBJECTIVE 1
Objective
Strengthen the monitoring of Indonesia's primary health care system

Rationale

The theory of change governing this objective centered around development of a performance dashboard based on various monitoring systems with the MoH, Ministry of Finance, and BJPS-Health, the use of which would promote transparency and accountability by publicly disclosing local government and health facility performance, creating incentives for improved service quality. The development of that dashboard, as well as overall health system information systems and data use, would be facilitated through the publication of a standard data dictionary, automation of data sharing, and the introduction of mHealth applications at the local level.

Outputs and intermediate outcomes

- MoH's Center for Data and Information developed and rolled out data verification protocols, with ongoing training on those protocols at the provincial level.
- BPJS-Health, MoH, and the Ministry of Finance issued a joint circular for data sharing between those institutions.
- The share of *puskesmas* using electronic data reporting systems with complete and compliant data, according to MoH's data dictionary, increased from zero at baseline to 99 percent in 2023, surpassing the target of 80 percent of *puskesmas*.
- The number of *puskesmas* using the mHealth application increased from zero at baseline to 1,535 in 2024, meeting the target of 1,500 *puskesmas* (DLI 2). The application offers an array of features, including full intervention management, case management, mLearning, and birth/date notifications, with robust verification and monitoring mechanisms. However, there were some challenges with integrating mHealth data with the national Identification Number, stemming from issues with collaboration with the Civil Registration office.

Outcomes

- The number of districts covered in MoH's published performance dashboard increased from zero at baseline to 92 percent in 2024, meeting the target of 90 percent (DLI1). The ICR (p. 41) notes that the dashboard integrates multiple datasets, enabling data-driven decision-making at national and district levels. It provides customizable views for government users, incorporating indicators on maternal and child health, nutrition, tuberculosis, HIV/AIDS, malaria, and adherence to service standards, supporting program planning and performance management. It aligns with the "One Indonesian Data" policy, enhancing data standardization and benchmarking across districts. Remaining challenges, however, include "significant" shortcomings in data interoperability "that affect the performance dashboard's effectiveness" (ICR, p. 18), with multiple data applications still in use at the *puskesmas* level and high staff turnover limiting realization of the full potential of information technology to enhance patient care. The ICR further notes that the COVID-19 pandemic diverted resources and attention from resolving these interoperability issues.

According to the ICR (p. 11), the use of these data and reporting systems has led to better tracking and management of health services, facilitating more informed decision-making and resource allocation. The ICR attributes progress on service delivery to improved monitoring, noting that the number of people receiving essential health, nutrition, and population services, which the project equated to the number of deliveries attended by skilled health personnel, reached 26.1 million in 2023, surpassing the target of 23.4 million people. However, no baseline data were provided for this indicator, and in any event, it is likely that many

additional factors beyond the DLIs supported under this objective contributed to the reported outcome on HNP service delivery.

Nonetheless, performance monitoring at the primary health care level was strengthened, meeting or surpassing targets for use of electronic data systems with complete and compliant data, use of mHealth, and use of integrated performance dashboards. Recognizing continuing challenges with data interoperability, achievement of this objective is rated Substantial.

Rating
Substantial

OBJECTIVE 2
Objective
Strengthen the quality of Indonesia's primary health care system

Rationale
The theory of change governing this objective held that the implementation of national standards for local government and facility performance, verified through strengthened accreditation procedures, would, by definition, improve the quality of primary health care. Strengthening of accreditation procedures would be facilitated through KAFKTP's achievement of status as an independent commission and an increase in the number of trained surveyors and accreditors. Support for *puskesmas* to achieve accreditation at initial or higher levels would be facilitated through improved referral systems, deployment of qualified health sector personnel to underserved and remote areas, and improved health planning and budgeting capacity in local governments.

Outputs and intermediate outcomes

- The MoH and Ministry of Finance allocated additional budget to allow the KAFKTP to increase the capacity and quality of accreditors and surveyors.
- The MoH introduced financial management training and a funds utilization monitoring system as part of its ongoing *puskesmas* management training.
- The number of lagging districts that produced improved annual plans and budgets reached 141 in 2024, surpassing the target of 120 districts (DLI 6).
- The number of special health worker teams deployed increased from 439 in 2017 to 1,040 in 2023, meeting the target of 1,039 deployed teams (DLI 7). These deployments addressed personnel shortages in remote and underserved areas. The ICR (p. 44) notes that collaboration with local governments supports the sustainability of these deployments by supporting the basic needs and safety of the health teams, and incentives (scholarships and career advancement opportunities) help with retention.
- Five provinces began using an integrated referral information system (IRIS) by 2023, meeting the target of five provinces (DLI 10). The system enhanced coordination among health care providers, improved data integration by consolidating information from various applications, and increased accessibility to referral services that guided patients to the correct level of care.

- Indonesia's national accreditation body (KAFKTP) received international accreditation from the International Society for Quality in Health Care External Evaluation Association in April of 2024, signifying that the primary care accreditation process is credible and reliable (DLI 5). KAFKTP provided capacity-building initiatives for health care staff and local officials, equipping them to meet accreditation requirements and sustain quality care. The ICR (p. 43) further reports that cost reductions in the accreditation process have increased accessibility to accreditation for more facilities.

Outcomes

The PAD and ICR present sufficient information on accreditation processes and standards to confirm that receiving accreditation, or moving up in levels of accreditation, is in itself an acceptable indicator of improved quality of health care. Specifically, KAFKTP's international accreditation through the International Society for Quality in Health Care External Evaluation Association—which accredits independent national external evaluation bodies for dozens of countries at all levels of development—confirms that national accreditation through KAFKTP is a reliable marker of strengthened quality of the primary health care system.

- The number of *puskesmas* receiving higher levels of accreditation increased from 495 in 2017 to 2,265 in 2024, exceeding the original target of 1,496 and revised target of 1,995 *puskesmas* (DLI 3).
- In Eastern Indonesia, the number of *puskesmas* accredited at any level increased from 197 in 2017 to 646 in 2023, exceeding the target of 597 *puskesmas* (the baseline and target were adjusted upward at the 2020 restructuring from a baseline value of 66 and target value of 466 *puskesmas*) (DLI 4).

The project contained one additional outcome indicator under this objective, the percentage of pregnant women delivering at a health care facility. There was little progress on this indicator, with deliveries at health care facilities increasing from 78 percent in 2017 to 80 percent in 2024, not reaching the target of 90 percent. The ICR notes, however, that the DLIs did not focus specifically on maternal or reproductive health care, meaning that this indicator was not an appropriate measure of outcomes directly incentivized by the DLIs.

The ICR provided evidence of quality improvements, with accreditation taking place at levels meeting or surpassing targets. However, there is a lack of evidence on the extent to which progress in accreditation translated into progress along more direct measures of quality of care. The ICR (p. 34) reports that, for the second semester of 2024, 97.4 percent of patients reported being satisfied with *pukesmas* services, but no data for other years/time periods are provided, making it impossible to determine whether this is an improvement that may have resulted from the program's incentives. Achievement of this objective is therefore rated Substantial.

Rating
Substantial

OBJECTIVE 3
Objective
Strengthen the financing of Indonesia's primary health care system

Rationale

The theory of change governing this objective held that strengthening and expanding performance-based financing would incentivize providers and districts to improve health outcomes. There were no intermediate outcome indicators under this objective.

Outcomes

- The percentage of primary care providers implementing performance-based JKN capitation reached 93 percent, surpassing the target of 60 percent (DLI 8). Primary care providers were incentivized to enhance service quality through the linkage of their financial compensation to performance, especially on promotive and preventive care. The emphasis on disease prevention and healthier behaviors was intended, in the medium and longer terms, to improve overall health outcomes.
- DLI 9 measured strengthened financing by tracking the percentage of districts showing improvement on at least half of the performance indicators in the enhanced DAK *non-fisik* program. 70 percent of districts achieved this threshold, surpassing the target of 60 percent of districts. Prioritizing promotive and preventive health services, the enhanced performance indicators motivated districts to invest in these areas. The initiative aligned financing with results, optimizing resource allocation.

These results provide evidence of improvement in the performance orientation of health care financing. With both outcome indicators exceeding targets, achievement of this objective is rated High.

Rating
High

OVERALL EFFICACY

Rationale
With the financing objective fully achieved, and the monitoring and quality objectives substantially achieved, the program almost fully achieved its intended outcomes. Overall efficacy is therefore rated Substantial.

Rating
Substantial

5. Outcome

With High relevance and Substantial overall efficacy, outcome is rated Satisfactory, indicating that there were only minor shortcomings in the program's preparation, implementation, and results.

Outcome Rating
Satisfactory

6. Risk to Development Outcome

The government remains highly engaged with the reform processes supported under the program. This is to be expected, as the program's objectives and DLIs were all set in response to ongoing government policies and priorities. All program-supported activities are still financed by the government, and in some cases, by regional governments as well (for local capacity building and health facility staffing in remote areas). International accreditation of the Primary Care Accreditation Commission highlights Indonesia's ongoing commitment to maintaining and increasing standards in service provision. The MoH has requested the Bank's technical assistance to develop a system of checks and balances for the accreditation process, bolstering its credibility and accountability. The ICR (p. 10) notes that the government is continuing the performance-based transfers supported by DLIs 8 and 9, which should contribute to sustainable health care financing and continued improvements in the primary health care sector. Accreditation of *puskesmas* at increasingly higher levels remains a government priority. The government continues to recognize and address data interoperability challenges with dashboards and mHealth (ICR, p. 23).

7. Assessment of Bank Performance

a. Quality-at-Entry

The program was organically derived from government strategies and priorities in the health sector. At the time of project appraisal, at the request of the Minister of Finance, the Bank made specific recommendations to improve the quality of public spending on health, many of which were reflected in this program's objectives: better use of budgetary resources and intergovernmental fiscal transfers to achieve results; strengthening monitoring systems and use of health performance scorecards; fostering innovations to improve access; and improving the strategic purchasing function of JKN. The PforR instrument was relatively new for Indonesia, leading the Bank to spend time orienting MoH and Ministry of Finance to the approach, including on DLIs, verification protocols, and associated procurement, financial management, and social and environmental assessment requirements. As noted earlier (Section 3a), program preparation and design were informed by extensive analytical work, reports, and assessments. The program effectively complemented (but did not duplicate) interventions being undertaken by development partners, primarily the United States Agency for International Development (JKN financial sustainability and strategic purchasing), the Australian Department of Foreign Affairs and Trade (preparation for Indonesia's graduation from Global Fund to Fight AIDS, Tuberculosis, and Malaria support), the Global Alliance for Vaccines and Immunization (new vaccine introduction and strengthening of immunization management and surveillance), and the World Health Organization (technical assistance in support of multiple programs).

At the time of appraisal, institutional arrangements for project implementation were in place, anticipating likely coordination and execution challenges due to the program's scope and complexity. These arrangements included a national Program Steering Committee (MoH, BPJS-Health, Ministry of Finance), MoH implementing units, and a working-level Technical Committee to provide overall technical guidance. The head of the MoH Bureau of Planning was to be Director of the Program Coordinating Unit. The PforR instrument facilitated constructive dialogue between the MoH, Ministry of Finance, and Ministry of National Development Planning. It was envisioned that the Bank would provide needed technical

assistance on international experience with performance monitoring systems, mHealth applications, quality assurance mechanisms, methodologies for health sector planning and budgeting, and performance-based health financing.

Risk assessment found substantial risks in several area. Political and governance risks pertained to local governments' varying levels of commitment to health, mitigated through strengthening of planning and budgeting capacity of lagging districts as well as the use of performance-based fiscal transfers to the districts. Risks related to sector strategies and policies stemmed from the extent to which details and implementation regulations and guidelines for the Healthy Indonesia strategy were still being put into place. To address these risks, the Bank allocated technical assistance resources to generate awareness and commitment, and to help design, implement, and monitor systems that would incentivize improved use of resources to implement Healthy Indonesia. Technical design and stakeholder risks were related to the program's work across ministries and agencies and with decentralized local governments, mitigated through inter-agency collaboration via institutional arrangements like the Program Steering Committee, as well as the incentive structure created by scalable DLIs. Institutional capacity and fiduciary risks were to be addressed through the participation of central and local-level staff in capacity building.

The M&E framework and arrangements were overall sound. However, as noted elsewhere (Section 8a), there were some shortcomings in the specification of outcome indicators.

Quality-at-Entry Rating
Satisfactory

b. Quality of supervision
The Bank's contributions extended beyond financial assistance. The Bank team provided crucial technical expertise, capacity development, and policy guidance throughout the program's implementation period, particularly in the areas of health care financing, human resources, and service delivery. Training was provided on data collection and analysis, and on the implementation of new technologies and practices. The Bank team worked with the government to maintain funds flows and progress toward achievement of the objectives during the COVID-19 pandemic, when many activities, including the facility accreditation process, were suspended. The ICR (p. 18) notes that the Bank was "instrumental" in verifying and ensuring the integrity of DLIs to support the effective disbursement of funds.

However, issues related to disagreements on DLI verification protocols were not identified until the mid-term review in April of 2021 (see Section 8b). According to the ICR (p. 20), these questions were never fully resolved, sometimes creating bottlenecks and delays.

Quality of Supervision Rating
Satisfactory

Overall Bank Performance Rating

Satisfactory

8. M&E Design, Implementation, & Utilization

a. M&E Design

The program contained as well-articulated results chain outlining the intended links between the DLIs and outcomes. It was designed with five outcome indicators and ten DLIs. Ambitious targets were selected to vary in accordance with the level of difficulty of each DLI. DLIs were verified by the national government's Finance and Development Monitoring Agency (BPKP) on an annual basis. BPKP had experience in the role of verification agent for other Bank-financed projects but required capacity building on technical issues related to health.

Existing MoH systems were used to monitor the results framework, but it was recognized that additional data collection and independent verification would be needed. Indonesia had many national data collection and reporting systems for the health sector. These systems were fragmented and had incomplete coverage. Data were rarely verified. Rather than add additional systems to this landscape, the program sought to work closely with the MoH's data center and relevant Directorates General to develop desk and field-based protocols to check and enhance existing data quality. These processes were then used to model methods that the government could adopt for routine data verification and validation across all health information systems.

The ICR (p. 19) insightfully notes that the DLIs functioned entirely from the supply side (improvements in accreditation, capitation, etc.). While this was not an inappropriate choice, given the framing of the program's objectives, some of the outcome indicators on health services utilization also depended critically on demand-side factors that were not directly addressed by the program. In order words, the outcome indicators on people receiving essential HNP services and deliveries attended by skilled health personnel lay outside the program's control. Better outcome indicators could have more directly measured improvements in primary health care service quality.

b. M&E Implementation

The Bank team provided valuable technical M&E implementation support to the MoH and other stakeholders, including capacity development for the primary care accreditation agency to implement the M&E system for accreditation. M&E extended beyond tracking DLI achievement. Several evaluations, studies, and analytical works were conducted across the program implementation period, including the piloting of an assessment methodology for regional organizational work plans in 34 districts, a case study on deployment of special health worker teams to remote and underserved areas, training and workshops to enhance the capacity of surveyors and accreditors, and technical assistance for performance-based capitation payment monitoring.

The ICR (p. 20) notes, however, that there was some controversy throughout implementation on the exact interpretation of DLI conditions and their verification. These issues were not identified until the mid-term review mission in early 2021. The issues stemmed from perceived ambiguity in the DLI verification protocol outlined in the PAD. Although DLI payments continued as targets were confirmed as reached or exceeded, these disagreements persisted across the program's lifetime and were never fully resolved.

c. M&E Utilization

M&E data and analysis were used to inform strategic decision-making across the program's lifetime. They also facilitated peer learning opportunities, including webinars on international best practice in performance-based financing. The ICR (p. 20) confirms that "the continuous evaluation process allowed for necessary adjustments to the program, ensuring it remained aligned with its goals and delivered its intended results."

M&E Quality Rating

Substantial

9. Other Issues

a. Safeguards

In its "Environmental, Social, and Fiduciary Compliance" section, the ICR (p. 21) states that "environmental and social is rated as Satisfactory." The program was environmental assessment category "C" and did not trigger any of the Bank's safeguard policies. Potential risks were identified, however, in the areas of safe handling of medical waste, the health and safety of health service providers, patient and public safety, consent processes, and grievance systems. As the program did not support infrastructure investments, there were no anticipated impacts to natural habitats, physical or cultural property, natural resources, or assets or livelihoods of people. Through its focus on accreditation of primary health care facilities, the program supported improvements in hazardous waste management, tracking of medical waste, and grievance redress. The ICR (p. 21) notes that "all planned activities related to environmental and social safeguards [were] successfully executed."

b. Fiduciary Compliance

In its "Environmental, Social, and Fiduciary Compliance" section, the ICR (p. 21) states that "fiduciary is rated as Satisfactory." Fiduciary risk at appraisal was assessed as Substantial. About two-thirds of the program was to be implemented by *puskesmas* and local governments, which varied widely in their financial management capacity. The PAD (p. 45) recommended allocation of sufficient budget for continuous training of *puskesmas* staff, MoH preparation of guidelines for more effective internal control of funds at the *puskesmas* level, and enhancement of monitoring mechanisms. A robust financial reporting system was developed to ensure sound financial management practice. The program's financial statements were prepared as part of overall MoH financial statements, and annual audits followed the government's audit arrangements. The Bank monitored financial management implementation and the implementation of technical assistance to the local levels as a result part of supervision.

c. Unintended impacts (Positive or Negative)

None reported.

d. Other

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10. Ratings

Ratings	ICR	IEG	Reason for Disagreements/Comment
Outcome	Satisfactory	Satisfactory	
Bank Performance	Satisfactory	Satisfactory	
Quality of M&E	Substantial	Substantial	
Quality of ICR	---	Substantial	

11. Lessons

The ICR (pp. 23-25) presents a series of insightful lessons and recommendations with which IEG concurs. Among the most important are:

In the health sector, a PforR can drive systemic change and enhance accountability by linking resource allocations to measurable improvements in health spending effectiveness. This program established measurable DLIs that were aligned with national health priorities on preventive and promotive care, to incentivize performance at the central, local, and health facility levels. The integration of monitoring, financial, and quality DLIs meant that multiple incentive streams were encouraging actors in the health system to behave in desired ways.

Systematic integration of data analytics into health financing, resource allocation, and decision-making processes can enhance the effectiveness and efficiency of health reform programs. In this case, data collection and analysis processes were enhanced through standardized entry protocols, quality assurance mechanisms, and advanced analytical tools, but the data interoperability challenge was not fully resolved. Although meaningful progress was made, significant work still remains in standardizing data formats and application programming interfaces.

12. Assessment Recommended?

No

13. Comments on Quality of ICR

The ICR is coherent, internally consistent, candid, and evidence-based. It follows established guidelines. It provides data of sufficient quality and quantity to assess program performance. Its lessons are insightful, though many of them are accompanied by lists of short recommendations rather than clear explanations of the ways that the stated lessons emerged from this program's experiences. In addition, the ICR is somewhat repetitive in places, and in others—particularly the "Key Factors during Implementation" section—it frames the discussion in terms of generic lessons or observations rather than specific descriptions of actual events during program preparation and implementation, making it sometimes difficult to discern exactly what happened and when. On balance, ICR Quality is rated Substantial.

a. Quality of ICR Rating

Substantial