Project Information Document/ Identification/Concept Stage (PID)

Concept Stage | Date Prepared/Updated: 07-Jul-2020 | Report No: PIDC95627

BASIC INFORMATION

A. Basic Project Data

Project ID	Parent Project ID (if any)	Environmental and Social Risk Classification	Project Name
P162172		Moderate	Women's Voices in the Monitoring and Improvement of Indonesia's Universal Health Care Insurance Services
Region	**Country**	**Date PID Prepared**	**Estimated Date of Approval**
EAST ASIA AND PACIFIC	Indonesia	07-Jul-2020	30-Nov-2016
Financing Instrument	**Borrower(s)**	**Implementing Agency**	
Investment Project Financing	Akatiga Foundation	Akatiga Foundation	

PROJECT FINANCING DATA (US$, Millions)

SUMMARY

Total Project Cost	0.73
Total Financing	0.73
Financing Gap	0.00

DETAILS

Non-World Bank Group Financing

Trust Funds	0.73
Global Partnership for Social Accountability	0.73

B. Introduction and Context

Country Context

The largest economy in Southeast Asia, Indonesia – a diverse archipelago nation of more than 300 ethnic groups – has charted impressive economic growth since overcoming the Asian financial crisis of the late 1990s. Today, Indonesia is the world's fourth most populous nation, the world's 10th largest economy in terms of purchasing power parity, and a member of the G-20. An emerging lower middle-income country,

Indonesia has made enormous gains in poverty reduction, cutting the poverty rate by more than half since 1999, to 9.4% in 2019.

Indonesia's economic planning follows a 20-year development plan, spanning from 2005 to 2025. It is segmented into 5-year medium-term plans, called the RPJMN (Rencana Pembangunan Jangka Menengah Nasional) each with different development priorities. The current medium-term development plan – the fourth phase of the long-term plan – runs from 2020-2024. It focuses on the improvement of human resource quality; mental revolution and development of culture; infrastructure; development of environment and disaster endurance, and dealing with climate change; political, legal, defense and security stability; and transformation of public service.

Indonesia's big bang decentralization, which began in 2001, constituted a tectonic shift in service responsibilities and funding from the center to subnational governments. Subnational governments took over primary responsibility for delivering nearly all public services. The assignment of new functions to local governments was accompanied by massive reallocation of funding to subnational government -- while national GDP per capita is 4.2% of GDP in 2018. Subnational governments now spend over half of the national budget (net of subsidies and interest payments). Much of this spending goes to personnel and administrative expenses. In 2012, district governments spent 52 percent of their budget on personnel and only 3 percent on capital expenditures. Provincial governments did much better (24 percent on personnel and 21 percent on capital) but their spending responsibility is much more limited (34 percent of total transfers to subnational governments in 2013). In general, subnational governments' spending is excessively dominated by spending on administration over productive sectors and on personnel over maintenance and capital spending[1]. I. While the expectation was that decentralization would allow subnational governments to better respond to service delivery needs, the effectiveness of decentralized provision has not yet met expectations.

Considerable challenges remain in achieving Indonesia's goals. Out of a population of around 267.3 million, about 25.1 million Indonesians still live below the poverty line. Based on March 2019 data, approximately 20.6% of the entire population remains vulnerable of falling into poverty, as their income hovers marginally above the national poverty line. While greater efforts are being made to improve basic public services, the quality of health clinics and schools is uneven by middle-income standards, contributing to concerning indicators, particularly in health. Approximately 1 in 3 children under the age of 5 suffer from stunting, which impairs brain development and will affect their future opportunities.[2]

[1] 2016-2020 Country Partnership Framework (CPF) for Indonesia, http://documents.worldbank.org/curated/en/195141467986374707/pdf/99172-REVISED-World-Bank-Indonesia-Country-Partnership-Framework-2016-2020.pdf

[2] The World Bank in Indonesia, April 2020, https://www.worldbank.org/en/country/indonesia/overview

Sectoral and Institutional Context

Health outcomes and outputs in Indonesia have improved in recent years. Life expectancy is 71, which has not increased from 2013 to 2018. Under-five mortality has declined from 29/1,000 live births in 2013 to 25/1,000 live births in 2018 and Indonesia is projected to meet the child-health related to Sustainable Development Goals (SDGs). According to the Susenas-SSGBI 2019, 27.7 percent of Indonesian children under 5 years of age were stunted (almost 8 million children), 16.3 percent of children under five were underweight and 7.4 percent were wasted (low weight-for-height). Although the prevalence of stunting declined significantly from the 2013 (37.2%), the stunting rates remain unacceptably high. However, key challenges remain, including slow progress on maternal mortality and chronic malnutrition, as well as inequalities in health outcomes.

Indonesians have become healthier over the past several decades but are now faced with an unfinished Millennium Development Goal agenda and a growing non-communicable disease (NCD) burden. Between 1960 and 2018, life expectancy increased from 45 to 71.5 years, under-five mortality declined from 222 to 25 per 1,000 live births, and infant mortality declined six-fold to 21 per 1,000 live births. However, a maternal mortality ratio (MMR) of 305 per 100,000 live births (or 1.4 maternal deaths every 1.4 hours) remains high relative to its income level and regional peers. One-third of children under five (8 million children) are stunted – the fifth-highest prevalence in the world. And Indonesia is now the third-largest contributor to the global TB burden, with 842,000 cases reported in 2017. At the same time, NCDs are exploding among the middle-aged due to unhealthy lifestyle choices and health systems that are unprepared to diagnose, treat, and adequately manage chronic conditions. Whereas in 1990 only 37% of morbidity and mortality was due to NCDs, they now account for two-thirds of the burden of disease with stroke, heart disease, depression, and diabetes amongst the most prevalent conditions. Indonesia is also at continued risk from pandemics and natural disasters.[1]

Post-partum hemorrhage (PPH), eclampsia and infections are the key causes of maternal death with underlying lack of continuum of care, young age pregnancies, unsafe abortions and a stagnating family planning program. Thirty-seven percent of children under 5 are stunted and 12% are wasted. Key determinants of malnutrition are inadequate breastfeeding and young child feeding practices, and poor water and sanitation. Large regional and income-related inequalities remain across the country. Infant mortality rates (IMR) differ by two to three times between provinces and IMR in the poorest wealth quintile of households are more than double those in the richest. While overall coverage rates of key maternal health services are high, it varies widely across regions and income: there is a two-fold difference in skilled birth attendance (SBA) across some provinces and home delivery rates are six times higher in the lowest quintile compared to richest quintile. In addition, Institutional capacity of local governments to plan, budget, provide and regulate health care is a key constraint for efficient and effective use of funds. Sub national level health

expenditure accounted for more than 60% of government health spending but major constraints related to funding use and management at sub national level persist.

Indonesia's progress towards universal health coverage (UHC) has been exceptional, however still faces significant gaps in financing and coverage. At 3.3 percent of GDP, Indonesia's total health expenditure (THE) is among the lowest in the world, especially compared with lower middle-income (6.1 percent of GDP) and regional peers (7.4 percent of GDP). In 2016, government budgetary spending was 44.7 percent of THE,[2] followed by Out-of-pocket expenditure (OOP) spending (37.3 percent), external aid (0.4 percent), and other private sources (17.5 percent). Public expenditure on health – at 1.4 percent of GDP, or 7.8 percent of total government expenditure – is half of what countries with a similar level of income spend. This amounts to just US$49 per capita. To put this in perspective, per capita health spending would have to more than double to USD110 to finance a minimum package of essential UHC services. Despite Indonesia's extensive network of public health facilities, the availability and distribution of human resources for health has always been an issue[3] – a problem that has been exacerbated by the introduction of the government's national universal health insurance scheme – Jaminan Kesehatan Nasional (JKN) and the increased demand for services. Front line providers frequently lack drugs, equipment, and medical supplies to deliver services. As a result, while the public sector is more dominant in provision of inpatient services, especially in rural areas, two-thirds of outpatient care is provided by the private sector. This underinvestment in health has led to the implicit rationing of services, a cumulative JKN deficit of IDR 27 trillion (USD 1.9 billion), and a continued high share of OOP expenditures (37 percent) [4]. There are also 50 million Indonesians, mostly among the informal sector, who remain uninsured

Indonesia's national health insurance *Jaminan Kesehatan Nasional*, or JKN, was launched in January 2014 with an initial roadmap that stated a goal of achieving universal health coverage (UHC) by 2019. The central purpose of the JKN scheme is to address existing inequities in access to and quality of health care in Indonesia, ensuring that all citizens, especially the poor and near-poor, can access quality care without facing financial hardship. JKN offers a generous health services benefit package and promotes the enrollment of vulnerable populations in the scheme. Under JKN, the Government of Indonesia (GOI) is spending considerable resources on fully subsidizing the contribution payments for the poor and near-poor (known as the segment *Penerima Bantuan Iuran* or *PBI*). [5] At present, the National Health Insurance scheme or JKN has reached 83% of the population or over 220 million Indonesians. The share of out-of-pocket health expenditures (in total health expenditure) has reduced considerably- from 47% to about 32%.

Despite progress, implementation of UHC still faces several challenges. The most critical ones are: i) unequal distribution of health services in outer islands; ii) delays in capitation payments due to decentralization regulation; iii) lack of information availability for beneficiaries, iv) coverage issues in the informal sectors, and v) uncertain financial sustainability. Moreover, according to a survey form Kompas, one of the most prominent mass media groups in Indonesia, 42.9% of the members of are not satisfied with the services. Some of the most common complaints are that patients cannot get a room in hospitals or that they are unnecessarily referred to services that are not covered by UHC.

Indonesia's health sector has experimented with various forms of social accountability that have shown promising results. Social accountability can reinforce programmatic gains by strengthening institutional mechanisms for problem solving. Several initiatives led by health sector agencies and by CSOs -supported by donors such as the World Bank, USAID and AusAID, among others- have introduced mechanisms aimed at improving health users' access and satisfaction with health services. Lessons from these initiatives point to the need to (i) employ inter-linked, systems-based interventions that consider the health system as a whole and the linkages across the delivery, policy making and implementation chains. Some of these interventions encompass community risks communications and education, collaborative interfaces between health users and healthcare staff and decision-makers, grievance redress mechanisms, and feedback loops between sub-national and central decision-making agencies. Evidence from the independent evaluation of the GPSA-supported project led by Wahana Visi Indonesia (2014-2018) found that the introduction of collaborative social accountability mechanisms changed local power relations through transparent platforms for collective opinion, by empowering women; and by bringing different types and levels of decision-makers into the process. The health system was strengthened through improved relationships, increased information, resource flows and positive feedback loops.[6]

[1] World Development Indicators database

[2] This includes 17.3 percent through the national health insurance scheme (JKN).

[3] Only 8 districts (out of 492) had at least 1 doctor per 1,000 population, 165 districts had at least 1 midwife and 215 districts at least 1 nurse per 1,000 population.

[4] Previous analytics from Indonesia Public Expenditure Review, 2020

[5] Teplitskaya L, et al, Healthcare Utilization Trends and Determinants since the Implementation of National Health Insurance in Indonesia, 2018

[6] See https://gpsaknowledge.org/indonesia-how-social-accountability-changed-power-dynamics-and-strengthened-the-health-system/

Relationship to CPF

In terms of alignment with the World Bank's Country Partnership Framework (CPF) FY16-FY20, the project contributes to the implementation of Engagement Area 4, which focuses on strengthening the delivery of "local services and infrastructure", by generating information on the access and the quality of health services for poor and vulnerable group. More specifically, the project will support the development and implementation of tools for citizens to monitor health services.

The Bank's support is aligned with GOI's national development plan (RPJMN) and the Healthy Indonesia Program's efforts to accelerate and sustain progress towards UHC. This includes the GOI's ambition to ensure JKN sustainability as high level national priorities. The recent activities which included the lending operations and programmatic analytical and advisory services (PASA) are follows:

1. **Indonesia's Supporting Primary Health Care Reform (I-SPHERE) (P164277)** is the GOI's 1st lending operation in the health sector in 10 years. The development objective is to strengthen the performance and quality of Indonesia's primary health care nationally, with an additional focus on Eastern Indonesia. It is $150 million PforR with a focus on supporting primary care reform by improving data use and accountability, strengthening clinical and managerial capacity at the district and provider level, and introducing performance-based financing through JKN and *Dana Alokasi Khusus* (*DAK*) -Special Allocation Fund – a fiscal transfer from central to district governments that is earmarked for health.
2. **ID-Supporting reforms to accelerate UHC or the UHC PASA (P166489**) supports the GOI's efforts to accelerate and sustain progress towards UHC by strengthening reforms related to governance, health financing, and service delivery. This includes TA to address specific JKN implementation and sustainability issues around targeting and enrollment, governance arrangements, provider payment options, and better use of claims data. It also provides TA to support I-SPHERE (e.g. local government capacity building, information systems and data use, accreditation commission strengthening, and performance-based financing). The total budget is $3.17 million, funded mainly by the Global Fund for AIDS, TB, and Malaria ($2.82 million) through the "Integrating Donor Funded Health Programs" multi-donor trust fund (MDTF)[1] and bank budget (350K).

The project will generate information on the access and quality of health services and improve the quality of JKN implementation programs. Subsequently, it will support the development and implementation of tools for citizens to monitor health services.

[1] The main contributors for this MDTF have been the Department of Foreign Affairs and Trade (DFAT), Government of Australia, and the Global Fund for AIDS, TB, and Malaria (GF ATM).

C. Project Development Objective(s)

Proposed Development Objective(s)

The Project Development Objective (PDO) is to contribute in improving access and quality of health services delivery for poor and vulnerable population in selected districts of Indonesia through collaborative social accountability mechanisms among stakeholders, which include: (i) Poor communities, defined as those who are eligible to receive Indonesian health card, and assisted by CSO Fatayat NU; (ii) Health providers affiliated with the National Health Insurance network; (iii) National Health Insurance policy makers at local and national level.

The Project Development Objective (PDO) will be achieved via:

a) Establishing a citizen volunteer-based accompaniment and monitoring process aimed at increasing poor primary health care facility (PBI) targeted health users' access to and effective utilization of the public health insurance

system,
b) Developing an information system on patients' experiences in using health services that will be regularly analyzed and followed up by AKATIGA and Fatayat NU.
c) Engaging collaboratively with health service providers and public health institutions for problem-solving in health service delivery.

Key Results

The key results of this project are:

- Percentage of problems experienced by target beneficiaries that are identified and followed up through the project's collaborative social accountability mechanism
- Percentage of direct beneficiaries assisted by the project that have increased access and utilization of health services[1]

- [1] Cumulative target in this indicator will be adjusted if necessary after the baseline

D. Preliminary Description

Activities/Components

The initial project design draws from the proposal submitted by Akatiga to the GPSA third global competitive call for proposals, which was evaluated by an independent roster of experts and selected by the GPSA Steering Committee on February 25, 2016. Adaptive development emphasizes the importance of clearly identifying and understanding the nature of the problem being addressed as well as its political economy factors, and taking small, incremental steps and adjustments towards a long-term goal. The project's design makes the presumption that not every facet of the project can be planned, and no implementing partners can accurately forecast at the beginning what will happen.

The GPSA promotes this approach across its project portfolio as it seeks to operationalize adaptive principles, with the measure of success often being the extent to which projects have helped implementers solve problems that they have discerned themselves, using collaborative social accountability mechanisms. By carrying out interventions through a collective identification of clear locally relevant problems, collaborative social accountability mechanisms developed under GPSA grants seek relevance, legitimacy and practicality.

In addition, the project's design has also been enhanced by taking into consideration the GPSA's theory of change, tailored in this case to Indonesian health context. By engaging multiple stakeholders, including the GoI and subnational governments, – under the coordination of Akatiga and Fatayat NU- to cooperate in order

to better leverage the existing health delivery system, the project attempts to contribute to addressing problems of lack of collaborative governance and the capacities needed for collective problem solving.

The project combines (i) flexible funding for civil society-led coalitions to work with government to solve problems that local actors have prioritized with (ii) sustained non-financial support to meaningful engagements, including implementation support, capacity building, facilitation, and brokering. The aim is to contribute to improved health delivery through the use of collaborative social accountability mechanisms to address obstacles to improving targeted service delivery.

Component 1: **Capacity-Building and Development of Collaborative Social Accountability Mechanisms.** The objectives of this component are: (i) to develop a citizen feedback mechanism for the systematic collection of poor health users' feedback on service access and quality, (ii) to discuss and validate this mechanism with relevant health sector institutions, and to agree on a collaborative framework for its implementation; and (iii) to build project partners' capacities to carry out the monitoring of health services

The main component activities will consist of:

a. Review data, mapping targets, problems & recruitment of cadres: (i) checking data on poor people registered in targeted districts' BPJS; (ii) mapping of targets, problems, and cadres' recruitment; and (ii) assessment of BPJS' existing complaints mechanism of BPJS and identification of gaps and challenges for the poor
b. Elaboration of information, education and communication materials: the type of pedagogical materials and means of communication with poor health users will be determined based on existing materials disseminated by BPJS. IEC materials will guide cadres in assisting patients in accessing health facilities. Activities in preparing IEC materials will include but not be limited to: (i) identifying information needs, users' experiences and frequent problems experienced with BPJS; (ii) coordination and agreement about materials with BPJS and state district hospitals; and (iii) dissemination activities.
c. Information system development and equipment: setting up an information system using data coding in line with BPJS health management information systems (e.g. identity card users' identification numbers), but independent from it. This information system will become a platform for cadres to input data and stories about target users' experience on accessing health services
d. Developing standard operating procedures (SOP) and training implementation for Fatayat Cadres: Elaborating and delivering a capacity-building plan for volunteer cadres to monitor users' experiences (take notes and input to information system) and to communicate with health centers and hospitals; including other necessary local stakeholders. Consent from health users to be involved in this project will be included in the SOPs.
e. Piloting during and after capacity building training.

Component 2: **Collaborative Social accountability Mechanisms to improve targeted service delivery**. The objective of this component is to generate systematic health users' feedback on health services' access and

quality that may contribute to introducing improvements along the service delivery chain and increase utilization and quality of services for poor and vulnerable health users.

The main component activities will consist of:

At the district/city level:

a. Data collection: (check and collect data in various relevant institutions on direct beneficiaries and health care facilities level 1 and level 2 affiliated with the National Health Insurance) in BPJS, Ministry of Social Affairs, Regional Government, Puskesmas, and local hospitals (RSUD).
b. Patients' assistance, data collection, and data input: (i) identifying health users in poor situation and assisting them through their experience in accessing curative health services; (ii) inputting data into information system; (iii) identifying solutions to service bottlenecks and joint monitoring of follow-up actions with service providers (Local Governments, primary healthcare centers and hospitals), district health agencies and central-level stakeholders. Data will comprise information about gaps between health insurance operational procedures compared to actual services delivered as experienced by direct beneficiaries.
c. Organizing periodic policy dialogues to problem solve and/or establish, strengthen and sustain mechanisms for problem solving around deficits in access and use of health care services or its causes with key health stakeholders at the local level

At the national level:

a. Implementing a collaborative framework at the inception phase with health institutions (Social Security Administration Agency –BPJS-, Ministry of Health (MoH), and National Development Planning Agency (Bappenas) by regularly sharing health users' data and jointly monitoring follow-up actions to improve the service delivery chain and policy. The collaborative framework will consist of (but not limited to) (a) information sharing (e.g. access to health data provided by government counterparts, information about the project's progress, etc.), (b) agreement on the feedback and response channels that will be used at the local and national levels, and (c) joint activities, such as problem-solving, training, etc. that might be co-organized between the project partners and government counterparts. The content of the framework will be agreed upon at the inception phase and periodically adjusted throughout implementation.
b. Organizing periodic policy dialogues about the findings related to gaps in JKN services with key health stakeholders (e.g. Indonesian Association of Doctors, Indonesian Hospital Association, JKN Monitoring Forum, donors, etc.) to share the projects' progress and to strengthen the projects' networking and coalition-building capacities.

***Component 3*: Improving Knowledge and Learning on Social Accountability in the Indonesian Health Sector, and project management**. The objective of this component is to establish a monitoring, evaluation and learning (MEL) system, which will include an internal adaptive management and learning process to regularly

adjust project implementation based on experience and contextual circumstances. In addition, the system is intended to generate knowledge and learning for targeted external dissemination amongst key stakeholders.

The main component activities will consist of:

a. Setting up the project's MEL system, including, but not limited to, contracting an independent evaluator (or evaluation firm) at the onset of the project to conduct the project's evaluation (including baseline, midterm and final evaluation), inform the production of quality bi-annual technical reports as well as provide support to the project team to develop capacities to adaptively manage the project.
b. Conducting regular internal project MEL sessions focused on adjusting the project's social accountability strategy and operations, including, but not limited to, using an organizational self-assessment measurement within Fatayat and internal groups, and "reality check" discussions with public health sector stakeholders.
c. Developing and implementing a plan for disseminating the project's Knowledge and Learning products to key target audiences, with a focus on the uptake of relevant aspects and elements of the collaborative social accountability process and mechanism (implemented by the project) that may be sustained or scaled up and/or inform substantive policy decisions in local or national level related to changes based on the use of social accountability mechanisms.
d. Contribute to the GPSA's mandate to facilitate and promote knowledge and learning about collaborative social accountability, the local adaptation of the GPSA's theory of change and feeding back lessons that may inform practitioners and the Global Partnership.

Environmental and Social Standards Relevance

E. Relevant Standards

ESS Standards		Relevance
ESS 1	Assessment and Management of Environmental and Social Risks and Impacts	Relevant
ESS 10	Stakeholder Engagement and Information Disclosure	Relevant
ESS 2	Labor and Working Conditions	Relevant
ESS 3	Resource Efficiency and Pollution Prevention and Management	Relevant
ESS 4	Community Health and Safety	Relevant
ESS 5	Land Acquisition, Restrictions on Land Use and Involuntary Resettlement	Not Currently Relevant
ESS 6	Biodiversity Conservation and Sustainable Management of Living Natural Resources	Not Currently Relevant
ESS 7	Indigenous Peoples/Sub-Saharan African Historically	Not Currently Relevant

	Underserved Traditional Local Communities	
ESS 8	Cultural Heritage	Not Currently Relevant
ESS 9	Financial Intermediaries	Not Currently Relevant

Legal Operational Policies

Safeguard Policies	Triggered	Explanation (Optional)
Projects on International Waterways OP 7.50	No	The project activities will not impact any international waterways.
Projects in Disputed Areas OP 7.60	No	There is no disputed area in the project location.

Summary of Screening of Environmental and Social Risks and Impacts

The overall environmental and social risk rating is Moderate. The project seeks to contribute to improving access and quality of health services delivery for poor and vulnerable population in selected districts of Indonesia through collaborative social accountability mechanisms among stakeholders, which includes: (i) Poor communities; (ii) Health providers affiliated with the National Health Insurance network; (iii) National Health Insurance policy makers at local and national level. The overall project outcome is expected to be positive to the poor and vulnerable groups (defined as those who are eligible to receive subsidized health card) in accessing health care facilities under BPJS. ESS1 Assessment and Management of Environmental and Social Risks and Impacts, ESS2 Labor and Working Conditions, ESS3 Resource Efficiency and Pollution Prevention and Management, ESS4 Community Health and Safety, and ESS10 on Stakeholder Engagement and Information Disclosure were assessed applicable for the proposed operation. The project?s nature is a small investment intended as a way to demonstrate success in improving the access and delivery of services to the poor and vulnerable in the National Health Insurance scheme (BPJS) through accountability mechanisms. The project type and nature itself constitutes a low social risk but considering the context in which the project will be implemented during and after the Covid-19 pandemic, the environmental and social risk rating has been justified to be moderate. The main project risks are on the social side, however there are environmental risks related to occupational and community health and safety, which need to be addressed. Under the current contextual risk, as the project will involve public meetings, training, hospital visit, there is the potential risk for project workers/volunteers to be exposed to Covid-19. There is also the risk of social stigmatization against people perceived to have been in contact with the virus. Potential adverse effects to human health and/or the environment will be mitigated through a tailor made procedure for addressing social stigma associated with Covid19, conducting public meeting under Covid19 constraints and implementation of strict occupational health and safety (OHS) protocol based on relevant GOI, WB and WHO guideline. In addition to the Covid-19 risk, there is also the risk of exposing personal health-related data, which may include the experiences of BPJS?s patients in accessing and/or receiving health care services. A Standard Operating Procedure (SOP) will include provision for a code of conduct on using health data or patient medical record, including requirement to get consent and restriction on use of data by third parties or for purposes beyond project objectives. For the purposes of public meetings/dialogues, the project will only use aggregate data that has been compiled into a data summary with no information on the identity of the health users (anonymous). The issue on vulnerable groups being excluded from the project is not envisaged as the project main beneficiaries are those who are eligible to participate in the BPJS scheme. The

project design is essentially an inclusion project. Although the volunteer cadres will all be Moslems (i.e. Fatayat NU), the targeted poor and vulnerable health users will be anyone within the volunteer?s neighborhood community regardless of gender, race, or religion. Indigenous Peoples are not present in the project location as the project will only operate in Fatayat NU network of areas in the targeted provinces, where most Fatayat NU branch offices are located in urban and peri urban areas, and none in remote areas. Involvement of stakeholders is an important part of the project design. A stakeholder engagement plan (SEP) will be developed during project preparation along with a Labor Management Procedure (LMP), which will provide information on the specific activities that are assigned to direct project workers and community workers/volunteers or cadres, the nature of the potential risks and impacts to those workers, the terms of conditions on which the direct project workers and community laborers will be engaged, amount and method of payment for services, provision of health insurance for the workers (if applicable), working times, and provision of proper working conditions for volunteers when working in the field. A Grievance Redressed Mechanism (GRM) for direct project workers and community workers (volunteers) to raise grievances in relation to the project will be included in the SEP. The SOP for project workers/volunteers will be developed to manage the project risks that includes information on OHS protocols such as wearing the proper PPE, social distancing measures, prevention and addressing social stigma associated with Covid-19, rules in using health data, and guidelines on conducting public meetings. The project implementing agencies will secure sufficient allocation of budget for PPE provisions and for a properly volunteers training on the SOP. The SOP preparation and training will be included in the ESCP. AKATIGA has prior experience working with the World Bank mainly on community driven developments and is aware of the World Bank safeguards requirements. Although AKATIGA and Fatayat NU do not have direct experience in applying the ESF requirements in projects, AKATIGA?s past experience working with the World Bank will bring them to be committed to ESF requirements, especially on stakeholder engagement, and OHS management. To support this commitment, environmental and social focal points will be appointed at AKATIGA and Fatayat NU to oversee implementation of the environmental and social guidelines, protocols and procedure. The TORs for the environmental and social focal points will be prepared by AKATIGA and approved by the World Bank. The TOR and capacity building/training on the relevant ESF requirements will also be provided for AKATIGA and Fatayat NU and will be specified in the ESCP.

CONTACT POINT

World Bank

Contact :	Ann-Sofie Jespersen	Title :	Senior Governance Specialist
Telephone No :	473-0143	Email :	
Contact :	Elvina Karjadi	Title :	Senior Health Specialist
Telephone No :	5781+3326 /	Email :	

Borrower/Client/Recipient

Borrower :	Akatiga Foundation		
Contact :	Titik Hartini	Title :	Program Manager
Telephone No :	6281317628598	Email :	Thartini2012@gmail.com

Implementing Agencies

Implementing Agency :	Akatiga Foundation		
Contact :	Titik Hartini	Title :	Program Manager
Telephone No :	6281317628598	Email :	Thartini2012@gmail.com

FOR MORE INFORMATION CONTACT

The World Bank
1818 H Street, NW
Washington, D.C. 20433
Telephone: (202) 473-1000
Web: http://www.worldbank.org/projects