INDONESIA – INVESTING IN NUTRITION AND EARLY YEARS (INEY)
PROGRAM-FOR-RESULTS (PforR)
P164686

ENVIRONMENTAL AND SOCIAL SYSTEMS ASSESSMENT REPORT (ESSA)

FINAL DRAFT

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PREPARED BY THE WORLD BANK

ABBREVIATIONS AND GLOSSARY

TERM	EXPANDED TERM/ DEFINITION
ADD	*Alokasi Dana Desa* or Village Funds Allocation
ANC	Ante Natal Care
APBD	*Anggaran Pendapatan, dan Belanja Daerah* or Regional Government Budget
BAPPEDA	*Badan Perencanaan Pembangunan Daerah* or Regional Development Planning Agency
BAPPENAS	*Badan Perencanaan Pembangunan Nasional* or National Development Planning Agency
BCC	Behavioural Change Communication
BLH	*Badan Lingkungan Hidup* or Environmental Agency
BPD	*Badan Permusyawaratan Desa* or Village Council
BPJS	*Badan Penyelenggara Jaminan Sosial* or Social Security Agency
BPNT	*Bantuan Pangan Non Tunai* or Non-Cash Food Assistance Program
BPOM	*Badan Pengawas Obat dan Makanan* or National Agency for Drug and Food Control
BPPSPAM	*Badan Peningkatan Penyelenggaran Sistem Penyediaan Air Minum* or Village-Level Water Board Association
BUMN	*Badan Usaha Milik Negara* or State-Owned Enterprises
Bupati	District Head
CBO	Community Based Organisation
CDD	Community Driven Development
CHS	Complaint Handling System
CLTS	Community Led Total Sanitation
CPASR	Convergence Program to Accelerate Stunting Reduction
DAK	*Dana Alokasi Khusus* or Special Allocation Funds
Dana Desa	Village Funds
DDG	Deputy Director General
DFAT	Australian Department of Foreign Affairs and Trade
DG	Director General
DHO	District Health Office
DLI	Disbursement Linked Indicator
Dusun	Hamlet/s
ECED	Early Childhood Education and Development
EHS	Environmental Health and Safety
ESSA	Environmental and Social Systems Assessment
FGM/C	Female Genital Mutilation/Cutting
Germas	*Gerakan Masyarakat* or Community Action
GIIP	Good International Industry Practice
GOI	Government of Indonesia
GRM	Grievance Redress Mechanism
GRS	Grievance Redress System
GSC	*Generasi Sehat dan Cerdas* or Healthy and Bright Generation
HCF	Health Care Facilities
HDW	Human Development Worker
HIV	Human Immunodeficiency Virus
HRH	Human Resources for Health
INEY	Investing in Nutrition and Early Years
IPC	Inter-Personal Communication
Jampersal	*Jaminan Persalinan* or Maternity Health Insurance
Kadus	Hamlet Heads
Komda PP KIPI	*Komite Daerah Pengkajian dan Penanggulangan Kejadian Ikutan Pasca Imunisasi*
Komnas PP KIPI	*Komite Nasional Pengkajian dan Penanggulangan Kejadian Ikutan Pasca Imunisasi*
MCC	Millennium Challenge Corporation
MOEC	Ministry of Education and Culture

TERM	EXPANDED TERM/ DEFINITION
MOEF	Ministry of Environment and Forestry
MOF	Ministry of Finance
MOH	Ministry of Health
MOHA	Ministry of Home Affairs
MPWH	Ministry of Public Works and Housing
MOSA	Ministry of Social Affairs
MOV	Ministry of Villages
Musrenbangdes	Village Development Planning Deliberation
Musrenbangdus	Hamlet Development Planning Deliberation
NatStrat Stunting	National Strategy to Accelerate Stunting Prevention
NCD	Non-communicable Disease
NGO	Non-governmental Organisation
Nusantara Sehat	Healthy Indonesia Program
OOPE	Out of Pocket Public Expenditure
P3MD	*Program Pembangunan dan Pemberdayaan Masyarakat* or Community Development and Empowerment Program
PAD	Project Appraisal Document
PAMSIMAS	*Penyediaan Air Minum dan Sanitasi Berbasis Masyarakat* or National Rural Water Supply and Sanitation Project
PAUD	*Pendidikan Anak Usia Dini* or Early Childhood Education
PCN	Project Concept Note
PCU	Program Coordinating Unit
PDO	Project Development Objective
Perda	Local Government Regulation
Perpres	Presidential Regulation
PforR	Program-for-Results
PHC	Primary Health Care
PHO	Provincial Health Office
PKH	*Program Keluarga Harapan* or National Social Assistance Program
PMTC	Prevention of Mother to Child Transmission
PMU	Project Management Unit
PNC	Post Natal Care
PNPM	Program Nasional Pemberdayaan Masyarakat or National Empowerment Program
Polindes	*Pondok Bersalin Desa* or Village Level Delivery Post
Poskesdes	*Pos Kesehatan Desa* or Village Health Post
Posyandu	Integrated Health Service Post
PPJK	*Pusat Pembiayaan dan Jaminan Kesehatan* or Center for Financing and Health Insurance
PSC	Program Steering Committee
Puskesmas	Public Primary Health Center
Pustu	Auxiliary *Puskesmas*
RA	Results Area
RCA	Reality Check Approach
Rembuk	A Gathering
RKPD	*Rencana Pembangunan Tahunan Daerah* or Regional Annual Development Plan
RPJMN	*Rencana Pembangunan Jangka Menengah Nasional* or National Medium-Term Development Plan
SOP	Standard Operating Procedure
SOVP	Secretariat of the Vice President
SUN	Scaling Up Nutrition
TBA	Traditional Birth Attendant
Tim Pemantau	Supervision Team
Tim Pembina	Facilitation Team

TERM	EXPANDED TERM/ DEFINITION
TNP2K	*Tim Nasional Percepatan Penanggulangan Kemiskinan* or The National Team for Poverty Reduction
ToT	Training of Trainers
UDB	Unified Data Base
UHC	Universal Health Coverage
UNICEF	United Nations Fund for Children
Wali Kota	Mayor
WASH	Water, Sanitation, and Hygiene
WB	World Bank
WBG	World Bank Group
WHO	World Health Organization

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EXECUTIVE SUMMARY

1. This Environmental and Social Systems Assessment (ESSA) report has been prepared for the World Bank's Investing in Nutrition and Early Years (INEY) to be financed under a Program-for-Results operation (PforR). The ESSA process examines the environmental and social management systems that are applicable to the INEY PforR to assess their compliance with the Bank Policy on PforR Financing. It aims to ensure that the program's environmental and social risks will be managed adequately and that it complies with the basic principles of sustainable development. The scope of the ESSA process includes an assessment of:

a. potential environmental and social risks and benefits;
b. environmental and social systems that apply to the program;
c. implementation experience and capacity;
d. whether system and performance are consistent with key principles of the Bank Policy; and
e. steps required to improve scope of system or capacity.

2. The preparation of this ESSA report is based on a desktop information review, field visits and consultations undertaken at the central and subnational level. Engagement has taken place with government (national, district and villages); development partners; service providers; civil society organisations; private sectors; and affected and beneficiary communities or their representatives. A consultation workshop on the draft ESSA was undertaken on April 09, 2018 with stakeholder representing five districts and national level government. The draft ESSA report circulated prior to the meeting and a summary in Bahasa was also shared.

3. The proposed Program Development Objective (PDO) of the INEY PforR is to increase simultaneous utilisation of nutrition interventions by 1,000-day households in priority districts. The term "1,000-day households" refers to households with pregnant women and/or children aged 0-24 months.

4. The PforR Program will support a subset of interventions of the government's Convergence Program to Accelerate Stunting Reduction ("the Convergence Program" or CPASR) as well as the convergence of instruments that are critical to coordinating the delivery of all priority nutrition-specific and nutrition-sensitive interventions in the priority locations. The overall objective of the Convergence Program is to accelerate stunting reduction within the existing regulatory and institutional framework. The Convergence Program will support achievement of the National Medium-Term Development Plans' (RPJMN) target to reduce the prevalence of stunting from the current prevalence of 37.2% down to 28% by 2019. The Convergence Program will also support achievement of the Scaling Up Nutrition (SUN) Movement 2025 targets.

5. The PforR Program does not have a single system related to environment and social performance. As such, the assessment focused on key systems that impact on the health, particularly sexual and reproductive health of women and girls, water, sanitation and hygiene (WASH), and education service delivery at the household and village level, including the relevant provisions and systems that underpin the Village Law. Similarly, the environment assessment focused on reviewing the adequacy and implementation of relevant national policy, regulations and guidelines related to handling, distribution and storage of supplements and vaccines as well as the safe handling of medical waste (at the primary health care facility).

6. Overall, the risk assessment and screening suggests that the environmental impact of the program is likely to be positive; helping to ensure women and children have access to, and make use of, improved drinking water supply, better sanitation facilities and sanitation conditions.[1] Main environmental issues and risks are expected to be moderate and relate to safe handling of pharmaceutical waste and disposal systems managed by *Posyandu* (Integrated Service Health Post) and *Puskesmas* (Public Primary Health Center),

[1] The INEY PforR will support the coordination of WASH programs at MPWH and the uptake and utilization of water and sanitation facilities, but it will not finance the infrastructure itself.

quality and quantity (continuity) aspects of water supply provision and unsafe construction practices for sanitation facilities. Measures to strengthen system performance for environmental management are: (i) strengthening the relevant institutions to understand and manage pharmaceutical waste including; (ii) watershed management to ensure target beneficiaries have sustainable access to water and sanitation facilities and finally; (iii) promoting hygiene practices.

7. Social effects are likely to arise from the activities associated with Results Area (RA) 4, (Convergence of village service delivery), RA 2 (Strengthen delivery of sector programs) and RA 3 (Strengthen convergence of district activities). The ESSA considered social effects relating to the ability of individuals, households and groups to obtain services in an accessible, safe, and inclusive manner. It also considered whether educational, behavioural change communication, information on nutrition specific interventions, particularly health services, are delivered in a way that takes into consideration local context including literacy, language, and cultural aspects of the beneficiaries. This includes ensuring informed consent and making available a process for raising complaints and concerns. Potential for inequality and conflict will stem from real or perceived differences in how the benefits of the program are distributed which makes the need for an effective grievance system important. If village level systems are inclusive and participatory and managed well the most vulnerable stand to benefit. In this light, it is expected that Indigenous Peoples, if present in the targeted communities, should benefit from the program and vulnerable groups and Indigenous Peoples should not be adversely impacted. Poorer families, lesser educated mothers, young mothers, older mothers, unmarried mothers, single parent families or child headed households, and parents with HIV status are likely to be the most vulnerable. Based on the above assessment, the Program is expected to contribute to addressing equity issues and therefore the risk has been rated as low.

8. The INEY PforR is not currently planning to support infrastructure investments. The infrastructure activities related to Water, Sanitation and Hygiene (WASH) are funded through the National Rural Water Supply and Sanitation Project (*PAMSIMAS*). There are no anticipated adverse impacts to natural habitats, physical cultural property, natural resources, or to assets or livelihoods of people based on the activities supported by the INEY PforR. System assessments with regards to environmental and social risk and impact management emerging from land acquisition, land conversion and infrastructure activities are therefore not within the scope of this ESSA.

9. Communities and individuals who believe that they are adversely affected as a result of a Bank supported PforR operation, as defined by the applicable policy and procedures, may submit complaints to the existing program grievance redress mechanism or the WB's Grievance Redress Service (GRS). The GRS ensures that complaints received are promptly reviewed in order to address pertinent concerns. Affected communities and individuals may submit their complaint to the WB's independent Inspection Panel which determines whether harm occurred, or could occur, as a result of WB non-compliance with its policies and procedures. Complaints may be submitted at any time after concerns have been brought directly to the World Bank's attention, and Bank Management has been given an opportunity to respond. For information on how to submit complaints to the World Bank's corporate Grievance Redress Service (GRS), please visit http://www.worldbank.org/GRS. For information on how to submit complaints to the World Bank Inspection Panel, please visit www.inspectionpanel.org.

A INTRODUCTION

A.1 Objectives

10. The ESSA process is guided by the key policy elements as established by the Bank Policy PforR Financing (December 2017) and as they apply to the assessment of the Government of Indonesia (GOI) systems and the relevant agencies' capacity to plan and implement effective measures for managing environmental and social risks and impacts. The key policy elements with regards to environmental and social management systems of the Bank Policy are:

a. promote environmental and social sustainability in the PforR Program design; avoid, minimize or mitigate adverse impacts, and promote informed decision-making relating to the PforR Program's environmental and social impacts;
b. avoid, minimize or mitigate adverse impacts on natural habitats and physical cultural resources resulting from the PforR Program;
c. protect public and worker safety against the potential risks associated with: (i) construction and/or operations of facilities or other operational practices under the PforR Program; (ii) exposure to toxic chemicals, hazardous waste, and other dangerous materials under the PforR Program; and (iii) reconstruction or rehabilitation of infrastructure located in areas prone to natural hazards;
d. manage land acquisition and loss of access to natural resources in a way that avoids or minimizes displacement, and assist the affected people in improving, or at the minimum restoring, their livelihoods and living standards;
e. give due consideration to the cultural appropriateness of, and equitable access to, PforR Program benefits, giving special attention to the rights and interests of the Indigenous Peoples and to the needs or concerns of vulnerable groups; and
f. avoid exacerbating social conflict, especially in fragile states, post-conflict areas, or areas subject to territorial disputes.

11. The objectives of the ESSA are to assess:

a. potential environmental and social risks and benefits;
b. environmental and social systems that apply to the program;
c. implementation experience and capacity;
d. whether system and performance are consistent with the key principles of the Bank Policy; and
e. steps to be taken to improve the scope of system or capacity.

A.2 Approach to the ESSA

12. The ESSA process focused on the systems to address the following effects identified through screening:

a. Environmental considerations: supply, distribution, and storage of vitamins/supplements. Particular issues on disposal of expired vitamins, and storage of oversupplied vitamins; supply, distribution, and storage of vaccines, and disposal of pharmaceutical waste (expired/damaged/unused vaccines, vaccine vials, used syringes); access to improved drinking water (quality and quantity), including water testing/sampling, safe distance from water pollution sources, watershed management, water collection and distribution; and, access to improved sanitation facilities, including safe distance from water pollution sources, and provisions of water supply to toilets.
b. Social considerations: lack of participation by women, young women, and vulnerable groups in village level decision making; challenged to program benefits for remote communities and Indigenous Peoples; limited decision-making power and access to and control over resources at the household level by mothers; education, water and sanitation and health service delivery not accessible, inclusive nor context specific (i.e. do not take into account literacy, including health literacy, language, gender, and cultural aspects); behavioural change communication not context specific and only aimed at mothers or pregnant

women; distribution of services not based on needs; poorly functioning systems for raising and addressing complaints and concerns; and poorly applied informed consent processes.

13. Review of the Environmental and Social systems relevant to the Program. The assessment focuses on the adequacy of the relevant systems, including implementation and the GOI's capacity to enforce. The system review is approached in two parts:

a. Identification of relevant systems that are pertinent to the ESSA will be addressed in **Section D** on Review of Policy, Regulatory, and Institutional Frameworks; and
b. Analysis on the implementation of the systems, including capacity and enforcement of certain environmental and social measures, will be addressed in **Section F**.

14. The ESSA was informed by a review of relevant information on the environmental and social systems underpinning the program, as well as engagement and field visits to understand the operationalization of those systems, including the infrastructure in place to support and the capacity to implement them. The ESSA process thus far has included:

a. Information review of relevant environmental and social management procedures, standards institutional responsibilities that will apply to the INEY PforR:
    - Social: National guidelines on *PAUD* (Early Childhood Education, ECED), *Posyandu* (i.e. outreach, facilitation, community engagement), administration of vaccines (i.e. consent, safe handling, counselling), village laws and guiding regulations (e.g. community participation, use of village funds, access to information). National instruments with provisions for Indigenous Peoples were also reviewed. Understanding implementation of previous projects such as Healthy and Bright Generation (*GSC*), National Community Empowerment Program (*PNPM*), *PAMSIMAS* was also used to inform system capacity under the ESSA.
    - Environment: National guidelines issued by Ministry of Health (MOH) on handling, distribution and storage of supplements (roles, responsibilities and oversight); Minister of Health Regulation (PMK No. 12/2017) regarding the implementation of immunizations which include provisions for the supply, distribution and storage of vaccines; procedures for handling and disposal of medical waste including: used syringes, expired/damaged/unused vaccines, and empty vaccine vial (Minister of Environment and Forestry (MOEF) Regulation no 56 year 2015 on procedure and technical requirement for management of hazardous waste from health service facility); MOH Regulation no 27 year 2017 on Guidelines for prevention and control infection in health service facility; *Posyandu* management system overall (including manuals for midwives and cadres with regards to community engagement, consent, and grievance handling, or the lack thereof); existing technical guidelines/code of practice for the construction of community level water supply facilities (developed through *PAMSIMAS* and *PNPM* Rural); and Provisions of the program/subject within the existing *PAUD* curriculum and *PAUD* manuals.

b. Field assessments:
    - Social: Site-visits were conducted to the Island District of Talaud, South Sulawesi (13-17 November, 2017) and Ketapang District of West Kalimantan (12-15 February, 2018) to conduct a preliminary environmental and social systems assessment for INEY PforR. The Talaud mission was jointly-organized with *GSC* team from the Ministry of Villages (MOV). The safeguards team visited 5 Sub-Districts in total, 3 in the larger Karakelong Island (Beo, Rainis and Esang Selatan) and 2 in the smaller Kabaruan Island (Kabaruan and Damau). In Karakelong, the team visited 3 villages, Desa Bantik in Beo, Desa Ensem in Essang Selatan and Desa Rainis in Rainis. In Kabaruan, the team visited 2 villages, Desa Damau Bawone in Damau and Desa Pangeran in Kabaruan. During the Ketapang mission the safeguards team visited 2 Sub-Districts (Delta Pawan and Muara Pawan) in total, and 3 villages. In Delta Pawan, the team visited Desa SukaBangun and in Muara Pawan, Desa SukaMaju and Desa Ulak Medang.

- Environment: A site visit to Cianjur District was conducted on 8-9 February 2018 and included a visit to the Environmental Sanitation unit of District Health Office in Cianjur District, a *Puskesmas* in Cikalong, and a *Posyandu* in Desa Kamurang to gather information related to *Puskesmas* and *Posyandu* operations/activities related to stunting prevention and medical waste handling. A visit to the Environmental Agency at Cianjur District was also conducted to collect information relating to the implementation of regulatory provisions on medical waste management.

15. Consultations for the Project including for the ESSA included:

- Social: Consultations at the community level, with relevant district agencies, and with ministries at the central level, including Ministry of Education and Culture (MOEC), and MOH.
- Environment: Consultations at district level with relevant district agencies (*BLH* and Dinkes); in sub-districts and villages (*Puskesmas* and *Posyandu*); and in national/central level including MOH, MOEF and MOEC.

16. A consultation workshop on the draft ESSA was undertaken on April 09, 2018 with representatives from central ministries, including MOHA, MOEF, MPWH, MOH as well as representatives from Central Maluku District, Gorontalo District of Gorontalo Province, Cianjur District of West-Java, Central Lombok District of NTB and Ketapang District of West Kalimantan. The draft ESSA report was circulated prior to the meeting and a summary in Bahasa was also shared. Observations from the workshop have been incorporated into the ESSA report and a complete list of participants and a summary of their comments is included in Annex 3. The final draft of the ESSA report will be disclosed publicly through the World Bank external website and public comments will be solicited during a period defined and reserved for comments.

B PROGRAM DESCRIPTION

B.1 Government Program

17. The overall objective of the Convergence Program to Accelerate Stunting Reduction ("the Convergence Program" or CPASR) is to accelerate stunting reduction within the existing regulatory and institutional framework. The overall objective of the Convergence Program to Accelerate Stunting Reduction is to accelerate stunting reduction within the existing regulatory and institutional framework. This objective will be achieved by:

a. Ensuring stunting reduction is a priority for all leaders at all levels of government and society, from the President to Village Heads;
b. Increase public awareness of stunting, its impacts and causes as well as its solutions;
c. Expand the coverage and improve the quality of programs that deliver priority nutrition-specific and nutrition-sensitive interventions;
d. Improve access to nutritious food; and
e. Encourage monitoring, evaluation and learning.

18. The Convergence Program will support achievement of the National Medium-Term Development Plans' (RPJMN) target to reduce the prevalence of stunting from the current prevalence of 37.2% down to 28% by 2019.The Convergence Program will also support achievement of the SUN Movement 2025 targets.

B.2 Investing in Nutrition and Early Years (INEY) Program for Results (PforR)

19. The proposed PDO of the INEY PforR is to increase simultaneous utilization of nutrition interventions by 1,000-Day Households in Priority Districts.

20. The PforR Program will support a subset of interventions of the government's Convergence Program as well as the convergence of instruments that are critical to coordinating the delivery of all priority nutrition-specific and nutrition-sensitive interventions in the priority locations. Building on the experience of Peru and other multi-sectoral efforts to reduce stunting, the government's National Strategy to Accelerate Stunting Prevention (NatStrat Stunting) acknowledges both the need to improve the delivery of individual priority sector interventions as well as the planning, budgeting, monitoring, evaluation and citizen engagement systems that can drive coordination, public participation, accountability and performance across all interventions. The government has requested that the PforR Program support both aspects of the Government Program.

21. The PforR Program will focus on four Result Areas (RAs):

a. Results Area 1: Strengthen national leadership. This RA will support activities that are critical to securing the commitments of subnational leaders (*Bupati* and *Wali Kota*) to converge district programs and activities, improving expenditure systems for monitoring and assessing the performance of national spending on nutrition interventions, and ensuring stunting remains politically salient and accelerating learning on what works and what doesn't. Key activities include Annual Stunting Summits (SOVP/*TNP2K*), National Expenditure Tagging and Performance Reviews (*BAPPENAS* & MOF), and implementation of an annual mini-anthropometric module in *SUSENAS* (*BPS*).
b. Results Area 2: Strengthen delivery of sector programs. RA 2 will support improvements to activities that will increase the capacity of ECED teachers to deliver nutrition-sensitive services to parents and 0-2-year-old children, enhance the nutrition-sensitivity and implementation quality of the *BPNT* (Non-Cash Food Assistance Program), and increase capacity of districts to design and *Puskesmas* to deliver locally-adapted IPC (interpersonal communication) activities. Key Activities include implementation of the ECED teacher professional development program with nutrition-sensitive modules (MOEC),

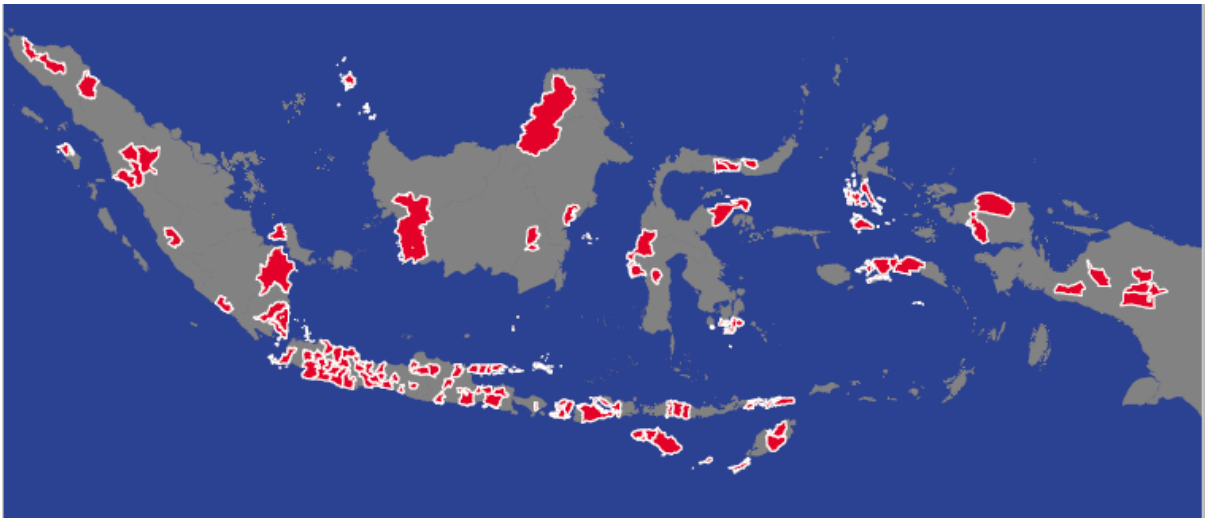
implementation of the nutrition-sensitive *BPNT* (MOSA) and implementation of the Interpersonal Communication (IPC) capacity development for districts (MOH).

c. Results Area 3: Strengthen convergence of district activities. This RA will support activities that will strengthen evidence- and results-based budgeting at the district-level, incentivize districts to spend more on nutrition interventions and monitoring systems (including behavioural change programming), and improve alignment of district and village plans and budgets. The main activity is implementation of an annual performance assessment to measure districts' implementation of the convergence program, incentivized by a Programmatic *DAK* for Stunting Convergence (*BAPPENAS* and MOF), which together will support districts to implement district-level Convergence Actions including local stunting surveillance, local Behaviour Change Communication (BCC) activities, and mobilization of Human Development Workers (HDWs).

d. Results Area 4: Village delivery convergence. This RA will support activities that will converge delivery of priority interventions on all 1,000-day households in villages, incentivize villages to allocate more *Dana Desa* (*DD*) to priority nutrition-specific and nutrition-sensitive interventions, and increase participation in community-based growth promotion activities. Key Activities include village-level Social Mapping of 1,000-day households, Village Convergence Scorecards and Height-based Community Growth Promotion (MOV, MOH and MOF). The RA will benefit from the HDW activates financed under the Programmatic *DAK* for Stunting Convergence (RA 3).

22. The Convergence Program identified 100 priority districts of high stunting prevalence and incidence for 2018, and proposes an ambitious scale up for 2019 and beyond. The priority locations were selected by overlaying MOH's data with areas of high stunting prevalence, in addition to MOSA and *TNP2K* data on poverty.[2] In 2018 it includes districts in all 34 provinces, in which there is at least one district in each province, and which covers 1,891 sub-districts, 21,888 villages and approximately 3.1 million stunted children. Full national coverage is expected in 2021. The term "priority districts" refers to those with highest prevalence and incidence of stunting as identified in the NatStrat Stunting.

Figure 1: Priority Locations (2018-2019).

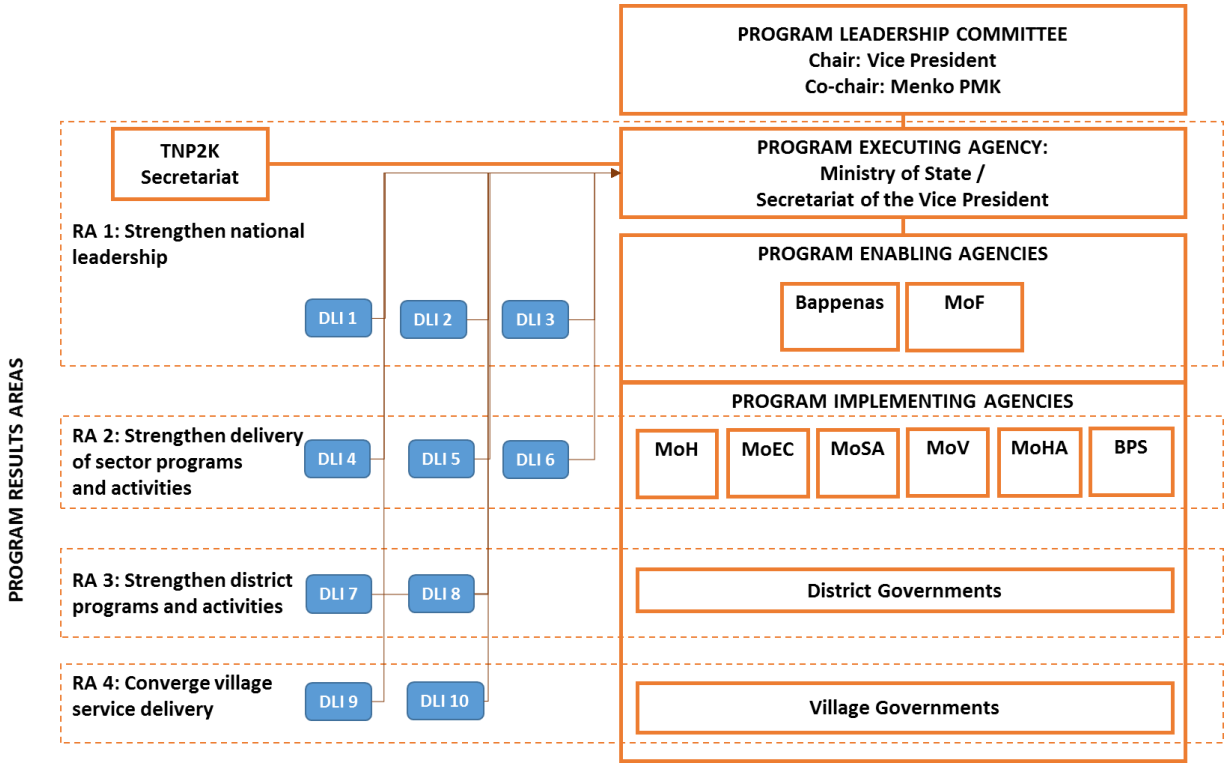


Source: NatStrat Stunting Document, TNP2K, 2017

[2] Potential priority districts were highlighted and visited to verify the data. The team who was led by the Kemenko PMK carried out mapping of the areas to flag the high stunting prevalence villages. Teams also advocated for the importance of stunting reduction on their mission, to ensure the commitment and support of provinces and district governments.

23. The institutional arrangements, as shown in the diagram below, consist of a steering committee, executing agency, enabling agencies, implementing agencies and district and village level governments.

Figure 2: Proposed INEY PforR Institutional Arrangements



B.3 Social and Environmental Risks and Benefits

24. The environmental and social screening assessment (Annex 2) indicated that potential social and environmental risks and impacts associated with the activities supported by the PforR are moderate, with environmental risks, in particular, requiring further measures.

25. The screening exercise of the five priority packages indicated that key environmental risks mainly relate to safe-handling of pharmaceutical waste and disposal systems managed by *Posyandu* and *Puskesmas*, quantity and quality aspects of water supply provision and unsafe construction practices for sanitation facilities.

Table 1: Summary of Key Risks for the Five Priority Packages

Five Priority Service Packages	Potential Environmental and Social Issues and Risks
1.b. Taking iron tablets during pregnancy	**Environment: Public health issues relate to** supply, distribution and storage of vitamins/supplements. Particular issues relate to the disposal of expired vitamins, and storage of oversupplied vitamins.
1.a. Four prenatal care visits for pregnant women **1.b. Taking iron tablets during pregnancy** **1.c. Growth monitoring** **1.d. Three postnatal care visits**	**Social:** Access to services (to be framed within the overall access to healthcare), information, and consent needs to be sensitive to social, religious, cultural and other beliefs and values.
1.e. Complete childhood immunizations	**Environment:** Supply, distribution and storage of vaccines; and disposal of pharmaceutical waste (expired/damaged/unused vaccines, vaccine vials, used syringes). **Social:** Access to immunization services (to be framed within the overall access to health services), consent and access to information need to be sensitive to social, religious, cultural and other beliefs and values.
2. Nutrition, Hygiene and Parent Counselling (including 2.a and 2.b)	**Social:** Access to counselling, cultural appropriateness of counselling delivery and social acceptability, community engagement.
3.a. Access to improved drinking water	**Environment:** Access to improved drinking water: Quality and quantity (continuity) of water supply provision, weak implementation of water quality control, weak construction supervision of the implementation of the technical guidelines for the construction of community level water supply facilities. **Social:** Access to water for all and includes participation of girls, women and vulnerable groups in provisioning.
3.b. Access to improved sanitation facility	**Environment:** Access to improved sanitation facility: Improper design practices on sanitation facilities including non-compliance with the safe distance requirements and the lack of provisions for water supply to toilets. **Social:** Needs to take into account the needs of girls and women. Since the model adopted is Community Led Total Sanitation (CLTS) risks are low. Facilitation skills could be an important determinant for social outcomes.
5. a. Participation in *PAUD* for early learning/stimulation	**Environment:** Hand-washing program will benefit the early years learning towards improved personal hygiene for school children. **Social:** Access to *PAUD* services for all, including poor and vulnerable families previously supported by *GSC*, appropriateness of service delivery.
5.b. Introducing Parenting Education through *PAUD* teachers	**Social:** Access to marginalized and vulnerable groups that do not reside in a village/and mothers and fathers that do not place their children in *TK*/*PAUD*. Men should also be involved. Potential for reaching out to adolescent girls and boys should be explored.

26. The program activities are not expected to have a significant adverse environmental footprint, but will provide an opportunity to enhance systems related to ensuring safe, clean and sustainable public health provisions. Overall, the risk assessment and screening suggests that the environmental impact of the program is likely to be positive. The program is expected to deliver a number of environmental benefits, such as access to improved drinking water supply, access to better sanitation facilities and improved sanitation conditions. This may reduce the disease burden associated with these factors and improve the quality of life.

27. Main environmental issues and risks are expected to be moderate and will relate to safe handling of pharmaceutical waste and disposal systems managed by *Posyandu* and *Puskesmas*, quality and quantity (continuity) aspects of water supply provision and sanitation. Potential environmental risks are identified as follows: (i) disposal of expired vitamins and storage of oversupplied vitamins; (ii) supply, distribution and storage of vaccines as well as disposal of pharmaceutical waste (expired/damaged/unused vaccines, vaccine

vials and used syringes); (iii) quality and quantity (continuity) aspects of water supply provision and sanitation.

28. The activities of the INEY PforR are intended to improve outcomes for families of 1,000-day households in priority districts through converging delivery of priority nutrition-specific and nutrition-sensitive interventions. The overall effect of the investments is socially beneficial. Social effects assessed for the ESSA mainly relate to Result Area 4; prioritizing convergence of village service delivery.

29. At the household and community level the program specifically targets children and their caregivers, who are likely to be their mothers. Women and girls tend to predominately carry the burden for childcare. Further, their status may limit their access to and control over resources (direct or indirect); which means less decision-making power in the household and at the village level; impacting their ability to access services and their own health and that of their children. These constraints to access to resources, voice and agency impact on children's survival, health and nutrition. For the program to be effective these considerations need to be reflected in the delivery of activities. The interventions will also need to consider how men can be involved at the household and village level in terms of knowledge, attitudes, and practice to enable them to positively impact on nutrition and stunting.

30. The delivery of services for nutrition specific and nutrition sensitive interventions is focussed on outreach, education, BCC, immunization, home visits, and provision of supplements. To some degree, these are reliant on household and village level decision-making, which may benefit some and exclude others. There could be potential for complaints and conflict if there are disparities or perceptions that some benefit more than others and it is not based on needs. There is also potential for elite capture.

31. The INEY PforR is not currently planning to support infrastructure investments. The infrastructure activities related to WASH are funded through PAMSIMAS and are therefore are not within the INEY PforR boundaries. There are no anticipated adverse impacts to natural habitats, physical cultural property, natural resources, or to assets or livelihoods of people based on the activities supported by the INEY PforR. System assessments with regards to environmental and social risk and impact management emerging from land acquisition, land conversion and infrastructure activities are therefore not within the scope of this ESSA.

C STAKEHOLDER ENGAGEMENT

32. This section provides a summary of the engagement activities undertaken for the INEY PforR and specifically for the ESSA as well as future engagement activities for the disclosure of the ESSA.

33. Stakeholder groups consulted with and details of consultations are provided in Annex 3.

a. **Potentially affected and beneficiary communities or their representatives**: 36 villages across 8 districts.
b. **Village Governments**: Village Heads, *Posyandu* cadres, *PAUD* teachers, Village Level Water Board Associations (*BPPSPAM*) cadres, community leaders and religious figures from 36 villages across 8 districts.
c. **District Governments:** *Bupatis*, district planning departments (*BAPPEDA*), district financial management offices (*DPKD*), district sector departments (Health, Public Works, Education, Social Affairs, Environment and Village Development and Community Empowerment) in eight districts from seven provinces between November 2017 and February 2018. It also included consultations with *Camat* (sub-district heads), *Puskesmas* heads and technical staff in 18 sub-districts.
d. **Central Government Agencies**: Echelon I, II and III as well as technical staff from the SOVP, *BAPPENAS*, MOF, MOH, MOEC, MPWH, MOSA, MOHA, MOEF, and MOV.
e. **Civil Society Organisations:** SUN Movement[3] Secretariat, Nutrition International, University of Indonesia, Survey Meter, and Tanoto Foundation as part of the preparation process.
f. **Development Partners**: DFAT, UNICEF and MCC/MCA-I, Towards a Strong and Prosperous Indonesia (*MAHKOTA*), Indonesia Governance for Growth (*KOMPAK*), and Empowering Indonesian Women for Poverty Reduction (*MAMPU*).
g. **Private Sector:** Engagement with the private sector was more limited given the nature of the Convergence Program, and included only Indofood[4] and the SUN Business Network.

34. Engagement methods included one-to-one meetings, formal presentations, *Rembuk*, focus group discussions and the sharing of project documentation. A consultation workshop on the draft ESSA was undertaken on April 09, 2018 with representatives from central ministries, including MOHA, MOEF, MOH as well as representatives from Central Maluku District, Gorontalo District, Cianjur District of West-Java, Central Lombok District of NTB and Ketapang District of West Kalimantan. The draft ESSA report was circulated prior to the meeting and a summary in Bahasa was also shared. Observations from the workshop have been incorporated into the ESSA report and a complete list of participants and a summary of their comments are also included in Annex 3. The final draft of the ESSA report will be disclosed publicly through the World Bank external website and public comments will be solicited during a period defined and reserved for comments. Grievance redress is discussed as part of the systems assessment and proposed actions.

35. Poorer families, lesser educated mothers, young mothers, older mothers, unmarried mothers, single parent families or child headed households, and parents with HIV status are likely to be the most vulnerable. However, they are not expected to be adversely impacted as a result of the INEY PforR. Indigenous Peoples who may have specific needs will need to be consulted meaningfully to ensure their participation. The HDW and social mapping will be key to ensure the needs of the groups mentioned are captured in the planning and implementation of the desired interventions and that no barriers exist to their participation. The HDW training will also include materials that emphasise women's empowerment, men's participation in parenting as well as risk of early marriage and adolescent pregnancy and hygiene best practice.

[3] The Government's commitment and initiatives to reduce stunting are a part of the Global SUN Movement which was launched in 2010, with a basic principle that all citizens have the right to gain access to sufficient and nutritious food. Indonesia joined the movement in 2011 upon delivery of a letter of participation by the Minister of Health (MoH) to the United Nations Secretary-General. The movement is now endorsed by 57 developing countries, including Indonesia, and over a hundred partners and nearly 3000 community service organizations.

[4] Indofood is a major Indonesian company involved in the food industry.

D POLICY, REGULATORY AND INSTITUTIONAL FRAMEWORKS

D.1 Policy, Legal, and Regulatory Frameworks

D.1.1 Environment

36. Environmental management for INEY program aims to strengthen capacities needed to manage environmental risks associated with the Program; and provide support to the Program to help achieve its desired results sustainably. Within this context, the ESSA assessed whether the management system mitigates impacts, provides transparency and accountability, and generally performs effectively in identifying and addressing environmental risks. The table below describes policies, regulations and guidelines related to provisions in managing the potential environmental issues and risks:

Table 2: Policies, Regulations and Guidelines Related to Environmental Risk

Potential Environmental Issues and Risks	Policies, Regulations and Guidelines
Program's Priority Services: Maternal and Child Health Services	
1. Supply, distribution, and storage of vitamins/supplements. Particular issue related to the disposal of expired vitamins, and storage of oversupplied vitamins.	The MOH Guidelines (2016) regarding: The Integrated Management for Vitamin A Supplement. **Provisions:** Planning, supply, storage and distribution of Vitamin A. **(a). Planning:** Number of supplies is calculated and prepared based on data derived from the district health offices of the MOH. This process aims to avoid either under-supply or over-supply of vitamins. Data for targeted beneficiaries were taken from the Health Development Program (*Program Pembangunan Kesehatan*). (**b) Supply:** Vitamins are supplied by Directorate General of Public Pharmaceutical and Health Supplies *(Direktorat Tata Kelola Obat Publik dan Perbekalan Kesehatan)* through a pharmaceutical facility at the district level. At the same time, buffer stocks are kept at the provincial level of the pharmaceutical facility. **(c) Storage and Distribution:** Vitamins are kept safely at the pharmaceutical facility according to procedure regulated by MOH. Distribution is handled by pharmaceutical facility at the district level to *Posyandu through Puskesmas.*
2. Supply, distribution, and storage of vaccines, and disposal of pharmaceutical waste (expired/damaged/unused vaccines, vaccine vials, used syringes).	MOH Regulation No. 12 Year 2017 on The Implementation of Immunizations. **Provisions:** Planning, supply and distribution, storage and maintenance, waste disposal, and monitoring and evaluation (M&E). **a) Planning:** The central government, in collaboration with the local governments, conduct regular planning on the implementation of immunizations. Local governments are responsible for the operation of immunizations, including the maintenance of cold chain equipment. Number of supplies is calculated and prepared based on local government's annual proposal (to the central government) on target beneficiaries. **(b) Supply:** The central government is responsible for the supplies, including Vaccines, Auto Disable Syringe), Safety Box, Anaphylactic equipment, Cold Chain equipment, and Record-keeping of immunization services. In relation to Cold Chain

Potential Environmental Issues and Risks	Policies, Regulations and Guidelines
	equipment, it includes storage (cold room, freezer room, vaccine refrigerator, freezer), vaccine transportation (cold box, vaccine carrier, cool pack), and supporting equipment (thermometer, alarm, etc.). Supplies of vaccines are managed by state-owned enterprises (*BUMN*), appointed by the Health Minister. (**c) Distribution:** Central Government distributes Vaccine, ADS and Safety Box to *Puskesmas* through the provincial and district governments, whereas Cold Chain is delivered directly to the targeted locations. Other logistics distributed directly by the Provincial and District Governments. **(d) Storage and Maintenance:** Governments at the provincial and district levels are responsible for the storage and maintenance of the equipment and logistics of immunization programs, as well as provisions for trained/qualified human resources to manage and implement the program. **(e) Waste Disposal:** For immunization conducted in *Posyandu*, staff who conduct immunizations are responsible for collecting ADS waste (vial and/or vaccine vial) into the Safety Box. The Safety Box is then delivered to *Puskesmas* to handle and dispose the waste. *[Note: Puskesmas will be the key actor in pharmaceutical waste disposal. Assessment on their capacity is crucial]* **(f) Monitoring and Evaluation:** Central government, provincial and district governments are responsible for M&E. [*Note: Although the instruments are well-planned, M&E on the implementation of waste management and disposal at Puskesmas is not included]*.
	Ministry of Environment and Forestry (MOEF) Decree No. 56 Year 2015 on Procedures and Technical Requirements of Hazardous Waste Management from Health Care Facility. **Provisions:** - As part of *Puskesmas* Accreditation requirements, Health Care Facilities (HCFs) are required to develop Standard Operating Procedures (SOPs) in the handling of medical waste (solid and liquid) and pharmaceutical waste. - Environmental agencies at the district level are responsible for the provision of permits on handling hazardous (solid) waste. - For transportation, handling and disposal the permit is from MOEF Jakarta. - *Bupatis* can only issue permit for temporary hazardous waste storage at the district level (if *Puskemas* has one).
	MOH Regulation No. 27 Year 2017 on the Guidelines for Prevention and Control of Infection in Health Care Facility. **Provisions:** Safe handling and disposal of used syringes, including the method of waste disposal (use of incinerator).

Potential Environmental Issues and Risks	Policies, Regulations and Guidelines
Program's Priority Services: Water and Sanitation	
3. Access to improved drinking water: quality and quantity (continuity) of water supply provision, weak implementation of water quality control, weak construction and supervision on the implementation of the technical guidelines for the construction of community level water supply facilities.	Government Regulation No 2/2018 r.e. Minuimum Standard Services (SPM) to achive the universal acess target 100-0-100. Technical guidelines for the construction of community level water supply facility (developed through *PAMSIMAS* and *PNPM* Rural). MOH guidelines on parameters for water quality.
4. Access to improved sanitation facility: Improper design practices on sanitation facilities including non-compliance with the safe distance requirement and the lack of provisions for water supply to toilets.	Technical guidelines for the construction of community level water supply facility (developed through *PAMSIMAS* and *PNPM* Rural).

D.1.2 Social

37. There is no one system related to social performance. The assessment has focused on the relevant provisions of the Village Law (Law No. 6 of 2014) and the key instruments that impact on the health, in particular, sexual and reproductive health of women and girls, WASH, health and education service delivery at the household and village level.

38. The Village Law: The new Village Law was issued in January 2014, replacing the previous Law No. 32 of 2004 on Regional Autonomy. The Village Law incorporates a number of key Community Driven Development (CDD) principles and institutions, including participatory village planning, implementation of village-level projects, inter-village collaboration, community facilitation and community oversight. Under the Village Law, village governments are responsible for administering village funds (*Dana Desa* and *Alokasi Dana Desa*)[5] and accommodating community needs through democratic processes (hamlet and village deliberations). The Village Law introduces an additional function of Village Councils (*BPD, Badan Permusyawaratan Desa*) to supervise the performance of Village Heads (Article 55).

39. Reproductive and Sexual Health: Action to reduce stunting requires improvements not only in food and nutrition security, education, access to water and sanitation, access to health services, but also in poverty reduction and the status of women including on sexual and reproductive rights:

a. **Early Marriage:** The Marriage Law of 1974 establishes the legal minimum age for marriage at 16 for girls and 19 for boys. In an attempt to increase the minimum age for girls to 18, this age difference was recently challenged. However, the measure was rejected by the Constitutional Court in 2015. The Commission on Violence against Women reported that the number of discriminatory national and local regulations targeting women had risen to 422 in 2016 (from 389 at the end of 2015).[6]
b. **Female genital mutilation/cutting (FGM/C)** is condemned by many international treaties and conventions as a violation of girls' and women's human rights. In Indonesia, the MOH issued a circular in 2006 prohibiting female circumcision by medical professionals. However, in 2010, a new regulation (PMK No. 1636/2010) permitted the practice (with the exception of "grave types of FGM/C"), if done

[5] Explanation of village funds *Dana Desa* and *Alokasi Dana Desa*

[6] Human Rights Watch (2017). "World Report 2017: Events of 2016."

by medical professionals and based on the request or approval of a parent or guardian. The Women's Commission in Indonesia and Committee on the Rights of the Child consistently advocated against this regulation and it was repealed in February 2014. However, there are no sanctions for individuals who continue to conduct FGM/C and the practice remains widespread.[7]

40. Indigenous Peoples: The second amendment to the 1945 Indonesian Constitution enshrines state recognition and respect for communities living by the customary law (*Adat*) and traditional value systems. Subsequent laws, such as the Basic Agrarian Law No.5/1960 and the Forestry Law No. 41/1999 (with recent revision through Constitutional Court Ruling No.35/2013) provide recognition to the rights of *Adat* communities. However, these sectoral laws, including implementing presidential and ministerial regulations are focused on land and natural resources, as such they are not relevant to the ESSA. The recent enactment of the Village Law No.6/2014 also provides opportunities for *Adat* communities to strengthen their participation, including managing development that addresses their needs and aspirations through support from the village funds. However, guiding regulations with regards to *Adat* communities are still being developed and further facilitation support is currently being provided to some degree by MOV at the village level that corresponds to the needs of these communities. The Program seeks to strengthen village facilitation through the HDW.

41. Indonesian laws use various terms to refer to Indigenous Peoples, including *masyarakat suku terasing* (isolated tribal communities), *masyarakat tertinggal* (lagging communities), masyarakat terpencil (remote communities), *masyarakat hukum adat* (customary law communities), and more simply *masyarakat adat* (communities governed by custom). These communities usually live in forests, mountains and coastal areas, and some are nomadic and sedentary and are dependent on natural resources. Since the program aims to target 1000-day households, screening of these communities to determine whether or not they are indigenous peoples becomes irrelevant and entails high transaction costs. The ESSA approach on Indigenous Peoples has been very much informed by the imperatives for social inclusion and Indigenous Peoples' ability to participate in program interventions in a meaningful and informed way. Therefore, the challenges foreseen with regards to Indigenous Peoples are not related to the legal framework pertaining to the rights of Indigenous Peoples, but more on technical aspects within the Program to ensure that the approach and engagement suits the needs and aspirations of these communities as well as the ability of the Program interventions to reach these communities, who may live in remote areas or still live in a nomadic and sedentary fashion, and therefore are hard to access. This will be further discussed in the section on findings.

42. Complaints handling: There is no one system for receiving and addressing any feedback or complaints and that covers the five intervention packages:

a. **Village level system:** generally, the assumed rates of grievances with regards to the use of village development funds and their use for the delivery of basic services show a lower rate of complaints than expected in comparison to the earlier *PNPM*. There is no single channel for complaints handling at the village level, but rather spread across multiple channels depending on the types of complaints, perceptions of reliable mediation, relevance and severity of complaints against aggrieved parties. Complaints at the individual agency tends to be more likely an ad-hoc affair and generally handled without reference to standard procedures and without the allocation of resources (human and financial) to manage complaints (World Bank Consultant Report, 2017). In an earlier study by the World Bank in 386 districts, the Village Community Empowerment and Development Agency (*DPMD*) was the primary institutional unit for handling complaints related to village governance, followed by the district inspectorate and secretariat (World Bank, 2016a). Misuse of village development funds dominates complaints about village governance, followed by village boundary disputes, misuse of authority by village officials, and village head elections.

[7] UNICEF (2016). "Statistical Profile on Female Genital Mutilation/Cutting."

In the current facilitation support provided by the MOV, complaints handling does not appear to form part of the responsibilities of Village Law Facilitators. It was generally understood that these facilitators are expected to report problems that they become aware of, but there is no specific assignment or involvement in the actual dispute settlements for fear that they may damage their relationships with villages. In the case of corruption, perpetrators are usually given an opportunity to return funds prior to a case being processed in the court. Returns of funds would generally result in the case being closed although social liability may remain (World Bank Consultant Report, 2017).

The role of the Village Council as a potential arbiter for complaints handling is also not clear; concerns may arise regarding their public perception of reliability, limited authority and capacity to address and accommodate complaints effectively.

b. **Water and Sanitation**: Since the INEY PforR is concerned over people's access to water and sanitation services, it can be reasonably assumed that multiple channels exist for people to lodge their complaints with regards to water distribution, user fees, access to sanitation facilities, use of water resources, etc. For central government programs implemented through the district agencies, such as *PAMSIMAS* with the district Public Works Agency, a centralized Grievance Redress Mechanism (GRM) has been created through SMS and/or online submissions (i.e. 081808952148/ www.*PAMSIMAS*.org) or alternatively direct submission through the program facilitators. For WASH facilitation support provided by the District Health Office (DHO), such as the CLTS, inquiries and complaints may be addressed to program facilitators, cadres and/or sanitarians at the *Puskesmas*. Whether or not complaints handling for WASH investments financed by village funds follows the same trajectory as village level complaints handling systems remains arguable. One reason is attributed to the low rates of complaints on WASH issues in villages visited for the assessment. If there are issues raised, e.g. unfair water distribution, extra user fees, etc., resolution is likely to be an ad-hoc affair.

c. ***PAUD***: Similar to WASH, division of authority in relation to complaints handling likely exist but enforcement would vary. Level of interest in complaints handling related to *PAUD* services is low in all villages visited. Complaints were usually not related to the services provided, but rather the amount (or different amounts) of fees *PAUD* teachers/cadres received. Those who have been registered in the District Education Agency, would usually receive slightly higher amounts compared to those recruited locally by village governments although responsibilities are often the same. Complaints by *PAUD* teachers are usually managed on an ad-hoc basis if at all.

d. ***Posyandu***: There is no specific complaint handling mechanism for the delivery of *Posyandu* services. Issues and complaints are treated to be ad-hoc affairs. Only in rare circumstances where such services led to serious adverse events such as illness post vaccination, would complaints be directed to Puskesmas staff or through their midwives or directly to the District and Provincial Health Offices (DHOs and PHOs) or to a higher level, such as MOH. Communities are encouraged to report to administering health facilities and/or DHOs and PHOs in the event of maltreatments and/or adverse impacts leading to fatalities and/or serious side-effects following vaccination (Chapter 41 of MOH Regulation 12/2017). Independent committees, namely *Komda PP KIPI* at the provincial level and *Komnas PP KIPI* at the central level, are established by respective governments (Minister and Governors) to investigate post-immunization adverse events and/or incidents. Each commission is comprised of relevant medical specialists. Respective health facilities are responsible to investigate and report the results to the heads of DHOs and PHOs, who will then pass the investigation results to *Komnas KIPI* and *Komda KIPI* for further examination and reporting to MOH. By rule, the government shall bear the costs for investigation and remedial measures in the event of maltreatments (Chapter 42 of MOH Regulation 12/2017).

43. Consent processes for administration of vaccines: parents and caregivers have the right to refuse vaccines provided by the government. Every health facility, including *Puskesmas*, is required to ensure that communities in their catchment areas are well-informed (Chapter 5 of Government Regulation 32/1996)

about the use of vaccines, possible side-effects, possible effects for not administering vaccination as well as necessary mitigation measures. Following socialization, enrolment of families and caregivers at the time of vaccination can be construed as approval and there is no requirement for written consent (Chapter 2 of MOH Regulation No 290/PER/III/2008).

D.2 Institutional Responsibilities

44. The key institutions involved in the delivery of the INEY PforR are presented in the table below:

Table 3: Key Institutional Stakeholders for the Program.

Interventions	National	District	Village
Nutrition-Specific Interventions	- Ministry of Health (MOH - DG-P&MD, DG-PH)	- District Health Offices (DHOs) - *Puskesmas* (sub-district)	- *Posyandu* - Village Governments - *BPD* - Frontline service providers
Nutrition-Sensitive Interventions	- MOH (DG-PH) - Ministry of Education and Culture (MOEC – DG-ECED) - Ministry of Social Affairs (MOSA – DG-PFM)	- District Education Offices (DEOs) - District Social Agencies	- *PAUD* - Village Governments - *BPD* - Frontline service providers

D.2.1 Environment

45. Under the INEY PforR, the main institutions involved with environmental management include MOH, MOHA, and MOEF. The table below describes roles and responsibilities of the institutions in managing the potential environmental risks.

Table 4: Institutional Roles and Responsibilities for Environmental Performance.

Institutions	Institutional Roles and Responsibilities
Ministry of Health (MOH): - **Directorate of Primary Care** - **Directorate General of Community Health** - **Directorate General of Public Pharmaceutical and Health Supplies**	*Posyandu* or *Pos Pelayanan Terpadu (an integrated service centre for maternal and child health related services*) is a monthly clinic for children and pregnant women; a volunteer-led community health services in Indonesia. The centre aims to provide basic health services such as family planning, mother and child health, nutrition (including vitamin and mineral supplementation), immunization and disease control (diarrhoea prevention). The centre is operated by volunteers who are called village health workers or cadres (*Kader)* who are selected from community members and trained by medical doctors or midwife from *Puskesmas* (*Pusat Kesehatan Masyarakat* or primary health centre*)* – a sub-district representative of the MOH to perform basic health care services needed. Implementation of *Posyandu* requires inter-sectoral collaboration between MOH and MOHA.
Ministry of Home Affairs (MOHA)	MOHA provides supports to *Posyandu*.

Institutions	Institutional Roles and Responsibilities
Ministry of Environment and Forestry (MOEF)	In coordination with local government (environment agencies of the province and district) to monitor the implementation of regulation related to medical/pharmaceutical waste management; to issue the permit for medical waste handling companies; to provide guidance and advise on medical waste management

D.2.2 Social

46. Village Government: The key stakeholders for addressing social performance are the village government, and the village and household level healthcare and early years education providers.

a. The structure of village governments is comprised of village heads who are democratically elected every five years and is assisted by a village secretary and section heads of village governance, welfare and basic services. At the hamlet level, the village governments are supported by hamlet heads (*Kadus*) in the running of village government affairs and community mobilization. Outside the village government system, the role of the *BPD* mirrors legislatures to represent communities and advocate their aspirations. The *BPD* are responsible to 1) discuss and agree on village regulations with village heads, and 2) collect and extend community aspirations so that they are accommodated in village planning and budgeting processes.
b. Village governments play a critical role to ensure availability of nutrition-specific and sensitive interventions at *Posyandu* and *PAUD*. Under the Village Law, village governments are responsible to administer village funds (*Dana Desa* and *Alokasi Dana Desa*)[8] and accommodate community needs through democratic processes (hamlet and village deliberations). The role of village governments in mainstreaming health and education into village development plans (*RKPDes*) and village development budget plans (*APBDes*), including in determining budget allocation and/or directing how allocated budget is spent, is critical and may continue to become stronger in the coming years.

47. WASH: Under *PAMSIMAS*[9], the delivery of improving access to water, sanitation and hygiene at village level is in two parts; infrastructure instalment (simple water treatment systems, pipeline, toilets and hand-washing facilities) and community led behaviour change around good hygienic practices. Although district governments assist in identifying the poorest villages, village communities must provide funding to purchase program benefits. Villages must elect members to form the BPPSPAMs and *PAMSIMAS* facilitators that are responsible to facilitate sessions on good hygiene practices in collaboration with frontline health and education providers. Village-level BPPSPAMs will represent at the district level BPPSPAMs to share knowledge and best practices. Under the INEY PforR, the Convergence Program will focus on convergence of non-infrastructure WASH investments, specifically improving behaviour change to increase uptake of hand washing programs and achieving Open Defecation-Free status.

48. Frontline health services: Nutrition-specific interventions supported by the Program (see Annex 6, Social) are administered by *Puskesmas* (public primary health centres)[10] and their auxiliary and outreach services. The public primary care system also includes 23,000 auxiliary *Puskesmas* (*Pustu*) for outreach activities in remote regions, village-level delivery posts (*Polindes*, often the home of the village midwife) and village health posts (Poskesdes). Frontline service delivery in the more than 75,000 villages across Indonesia is also undertaken through *Posyandu* and by village midwives (who are formally part of the health

[8] Explanation of village funds *Dana Desa* and *Alokasi Dana Desa*

[9] PAMSIMAS is moving towards the achievement of its development objective. As of February 2017, the larger Project has provided around 1.8 million people with access to improved water facilities and access to improved sanitation in around 2,251 villages. About 56% of target communities have reached an open defecation free (ODF) status, about 72% have adopted hand washing programs, and more than 87% of targeted schools had improved their sanitation facilities and hygiene programs. 81% of villages had efficiently managed and financed water supply facilities. DFAT Grant has supported the project to strengthen capacity building and sustainability as well as disability inclusion.

[10] There are approximately 2,400 hospitals in Indonesia and about two-thirds of them are private. The public health care system is decentralized to the district level with about 9,767 Puskesmas forming the backbone of Indonesia's health system.

system). *Posyandu* is a monthly event manned by at least five types of community health workers that cater to the five essential services: registration, weighing and monitoring children's growth, recording of child growth in health cards, counselling and education; immunization and ante and post-natal care (ANC and PNC) as part of outreach services of *Puskesmas*. Cadres - who work on a voluntary basis - are not part of the formal health system and do not receive monthly salaries (only minimum transport allowance from DHOs or village governments)[11].

49. Midwives and nurses are important frontline service providers due to their placement and/or operations at the village level and therefore, are more accessible compared to doctors who are mainly based in *Puskesmas* at the sub-district level[12]. In addition, midwives and nurses are usually permanent workers with monthly pay-rolls or paid by villages. Following the roll-out of the *Program Nusantara Sehat* (Healthy Indonesia Program)[13], it is anticipated that the number of midwives will increase, however distribution remains an issue. Since many of the midwives met are being assigned to multiple villages, their level of engagement with village governments is more limited compared to their cadre counterparts. However, they may have more power to influence due to their technical expertise.

50. ***PAUD*:** The delivery of ECED is administered by village-level *PAUD* centres for children aged 0-6 years[14] (MOEC Ministerial Regulation No 137/2014). These centres are run by *PAUD* teachers who serve on a voluntary basis. *PAUD* teachers who are registered with the Education Agency are entitled to financial incentives of 500k IDR per month and opportunities to participate in training. If *PAUD* teachers are recruited by the village, they are entitled to a lesser fee of 200k – 300k IDR (varies between villages) from village funds that is paid every 6 months depending on village funds withdrawal. This gap in fees exists despite the same work responsibilities. *PAUD* cadres work in 3-4 half-day sessions per week. *PAUD* services are demand-driven and there could be a lack of incentives for *PAUD* teachers to outreach to tend to children due to existing burdens. Although the prescribed ideal ratio for *PAUD* teachers to children is 1:15 (one teacher is responsible for 15 children), this ratio is often considered unrealistic and too high. With regards to capacity building, *PAUD* teachers are entitled to receive 200 hours of training from the Education Agency per year, and gain access to peer support learning on a monthly basis, facilitated by *Kelompok Kerja Guru* (Teacher Peer Support Group) from the sub-district. Classroom materials are funded and provided by the Education Agency, or through *Dana Desa.* Parents do not usually contribute funds or payments to *PAUD* services. There have been instances when a community voluntarily contributes small amounts to *PAUD centres* to support their activities however this is not common.

Box 1: Perceptions of *PAUD*

In Talaud, *tendik PAUD* explained that many parents were not convinced by the benefit of *PAUD*, adding that it is perceived as playtime and children are sent to attend *PAUD* so that mothers have the household to themselves for a couple of hours and to *"keep them out of trouble"*.

Some *tendik* requested small contributions for extra classroom materials. However, parents did not comply because they did not bring the children in every day and could not see the benefit.

[11] These cadres usually consist of village volunteers who work in collaboration with Puskesmas staff at the village health posts (Posyandu). Posyandu runs monthly check-ups and health promotion activities, usually for pregnant mothers, infants and the elderly.

[12] Frontline health services are mainly delivered at the Puskesmas and village health posts (Pustu). However, these centers suffer from absenteeism. Doctors do not stay in rural areas and only 70% of midwives remain in villages, and the remaining 30% migrate to cities (the National Research Council 2013).

[13] Following the discontinuation of the PTT program (temporary deployment of doctors, midwives, and dentists), the Ministry of Health (MOH) launched the Nusantara Sehat Program (Healthy Indonesia Program) in 2016 to deploy health workers on special assignment (two years on a rolling basis) to fill health workforce gaps in Puskesmas in targeted locations, particularly in remote, lagging or border areas, and locations facing health issues within the four priority areas of the NSP. The NSP deploys two types of health workforce (i) team based special assignment consisting of at least five health worker categories, albeit with varying combination in response to local needs, and (ii) individual health workers.

[14] *PAUD* centers are also referred to as Taman Kanak-Kanak (TK), Taman Kanak-Kanak Luar Biasa (TKKLB), Kelompok Bermain (KB), Taman Penitipan Anak (TPA) and Satuan *PAUD* Sejenis (SPS). TK are for children aged 4-6 years; TKKLB are for 4-6 years with priority to 5 and 6; KB are for 2-6 years with priority to 3 and 5 years; TPA are for 0-6 years; SPS are for 0-6 years (Article 1 Ministerial Regulation No 84/2014).

E EXPERIENCE FROM PREVIOUS PROJECTS

51. The World Bank has been supporting the GOI to expand access to basic health and education services under the *GSC*. The program was previously part of the *PNPM*, executed by MOHA. Following the establishment of the MOV, the program has been implemented by MOV. The program previously provided small-grants to communities to support availability and access to basic health and education services. Following the enactment of the Village Law in 2014, the program was re-designed to provide technical assistance and capacity building support to *GSC* villages to help them better use village funds for basic health and education services. The program's transition from MOHA to MOV presented challenges in program implementation and ensuring proper oversight, including safeguards. As a new ministry, MOV has been tasked with a critical responsibility to manage village funds across villages in Indonesia. This has consequently impacted the level of coordination and quality of program implementation. The Person-in-Charge for safeguards at the PMU (Project Management Unit) has changed multiple times and the program's GRM was only recently reactivated in 2016. Given the program's planned phase-out in the end of 2018, the program is currently undergoing a restructuring to support a HDW pilot, which aims to provide capacity building support to frontline development workers to mobilize communities around stunting interventions whilst supporting integration of GSC activities into village planning and budgeting. It is envisioned that the HDW will be the main mechanism through which the Convergence Program will, via districts, support village governments to identify, implement and monitor intervention delivering to "first 1,000-day households" in each village.

52. A review of then PNPM Generasi (now GSC) found that even though it has a strong focus on women and children, it missed opportunities for well-rounded gender integration. One omission has been the absence of fathers in PNPM Generasi interventions. By focusing so exclusively on the role of women as mothers and by excluding fathers from the process, important roles that fathers can play are missed. The assessment also highlighted women's low status within the community and their lack of confidence to make active and well-informed health choices as key concerns. In summary, issues of men's participation and women's empowerment (rather than numeric participation) are key gaps for PNPM Generasi.

53. Crucial to effective service delivery under the Convergence Program, will be effective prioritisation and allocation of village funds to health and education services at village level. To support village planning processes and governance over village funds, the World Bank is supporting MOV in implementing Village Innovation Project. This program is supporting the transition from PNPM to Village Law systems, and will be increasingly important to facilitate documenting and monitoring of village spending.

54. Other previous and on-going government programs supported by the WB relevant for the INEY PforR would include PAMSIMAS and PNPM Rural and Urban. Lessons learned on the implementation of environmental management systems through these projects indicate substantial provision on practical tools in managing and mitigating potential environmental risks and impacts. These tools were instrumental to assist community facilitators and village governments in integrating environmental considerations into village-level development. Under PAMSIMAS, grants are transferred directly to communities for local water and sanitation infrastructure and technical assistance. PAMSIMAS program activities will continue until December 2020. The Convergence Program will consolidate and implement lessons learnt from these interventions.

55. Under the umbrella of PNPM Rural, PNPM Green was developed and implemented by MOHA. The project enabled the implementation of an environmental management strategy aimed at achieving more sustainably managed natural resources. The strategy included mainstreaming environmental considerations into village level investment choices which led to activities (or sub-projects) that are not only environmentally benign but that also proactively improve the environmental conditions in and around project villages. Maintaining and improving the natural capital is an important component for maintaining and improving natural resource related livelihoods, rural economies and the security of rural communities.

56. The World Bank has also supported GOI to expand and strengthen access to social assistance under PKH (National Social Assistance Program). These conditional cash transfers are tied to specific requirements that incentivize communities to utilise health and education services[15] in the villages thereby increasing demand for these services and improving education and health outcomes in the long-run. In 2017 the World Bank provided finance for this program to strengthen program delivery, improve inclusivity and support expansion from 3.5 million to 15 million by 2020. The program is implemented by MOSA in collaboration with other line ministries at national and local level.

[15] In the area of health, PKH's indicators focus on improving mothers' attendance to village health nters (Posyandus), which provides basic health check-ups and counseling by midwives and occasional distribution Fe tablets and supplementary feeding. In the area of education, PKH aims to stimulate school children's attendance and such an intervention.

F CAPACITY AND PERFORMANCE ASSESSMENT

F.1 Environmental Considerations

57. Institutional capacity to implement the environmental management system for the INEY PforR is highly dependent upon the level of assessment on the following criteria. Annex 5 provides the overall assessment of capacities in implementing the relevant policies:

a. *The provision of policy and legal framework.* It is crucial that such provision is in place within the government's legal framework. National guidelines, policies and regulations related to mitigation measures and management of environmental related issues and risks are available. These provisions are critical in setting the institutional boundaries for policy implementation.
b. *Institutional arrangement:* Availability and capacities of human resources are crucial in ensuring relevant policies and regulations are well implemented. Consultations with relevant ministries and agencies indicate that policies and regulations on environmental management are broadly understood and recognised. However, capacities to implement remain an issue.
c. *Budget for improved capacity:* Availability of budget provision for training, monitoring supervision of the implementation of the policies is instrumental in ensuring policies and regulations are well implemented. The training budget for midwives is proposed by District MOH to be allocated by BKPPD (*Badan Kepegawaian Pendidikan dan Pelatihan Daerah*) at district level. ESSA team has encouraged the national level stakeholders to ensure availability of budget within current respective program for the purpose of capacity building.
d. *Monitoring and supervision:* Level of monitoring and supervision plays a major role to ascertain the implementation of the guidelines, policies and regulations (i.e. Quality Control). Consultations with relevant ministries and agencies highlighted that there is a need to improve and strengthen the monitoring and supervising roles of the relevant agencies, in particular at the district level.

58. Potential environmental adverse impacts and health hazards to staff, patient and public/community from primary healthcare (PHC) providers such as Puskesmas and Posyandu that will support INEY program have been identified and regulated to be equivalent with Good International Industry Practice. The immunization activities and provision of food supplement, medicine/vaccine could produce hazardous medical waste such as infectious waste, sharps/needles, expired vaccines/medicines and other solid and liquid waste. Ministry of Environment and Forestry Decree no 56/2015 regarding Medical Waste Management of PHCs clearly regulates the management of medical waste such as the separation system, labelling, storage, transportation, disposal and permitting requirement including the efforts in waste reduction and competency/capacity building. This decree is comprehensive and equivalent with the World Bank Environmental Health and Safety (EHS) Guidelines for Health Care Facilities. Ministry of Health Decree 46/2014 regarding PHC accreditation and Decree 75/2014 about Puskesmas regulate these aspects in more detail.

59. Government regulations stipulate pharmaceutical/medical waste as hazardous waste due to its infectious characteristics. Licenses are required for any activities relating to temporary storage, transportation, utilizing and disposal/treatment of waste. Within this regulatory framework, the sub-national governments have only the authority to issue permit for temporary storage while other activities are managed by the MOEF at the national level. With regards to licensed hazardous waste disposal facilities, the Government of Indonesia has one facility which is located in Cileungsi Bogor, operated by PT. PPLI – a joint ownership between private company and MOEF and operated since 1994. In particular for medical waste handling and treatment, at current there are only 6 (six) medical waste treatment service companies in Indonesia, mainly are located in Java island. In 2017, MOEF established a pilot medical waste treatment facility in South Sulawesi in efforts to cover eastern Indonesia region.

60. A site visit to a certified Puskesmas in Cikalong, a consultation with environmental health staff at DINKES Cianjur district, and a discussion with the local environmental agency (BLH) revealed that; (i)

special bins for medical waste and expired medicines/chemicals, disposal boxes for sharps/needles with proper handling for labelling, including storage and transportation are sufficiently supplied; (ii) dedicated staff are available and competent in providing training to primary care providers on the implementation of the relevant regulations; (iii) there is close collaboration between DINKES and BLH in implementing the regulations including problem solving when abnormal conditions arise; (iv) the procurement of auto-disable syringes has been promoted by DINKES to primary care providers; and (v) the provision of Circular Letter No 861/2017 from the National Accreditation Committee stipulates the requirement from International Society for Quality in Health Care. This has been adopted by the Accreditation Committee to implement an absolute requirement to have a permitted medical waste treatment facility in hospital. If during certification the permit/facility was not found, the certificate award will be deferred for 3 months for evaluation (Circular Letter No 861/2017).

61. The site visit identified several challenges with regards to the implementation of the above regulations at village level. Posyandu and Puskemas are not equipped with proper transportation devices as regulated in MOEF Decree 56/2015. In some cases, the mid-wifes or sanitarian use personal car, motorcycle, or local ambulance to bring medical waste from Posyandu to Puskemas or to a permitted waste storage facility. They are all aware of such risks and based on the information from the workshop the strict adherence to the regulation from the staff is still lacking and need to be continuously reminded. . The program will support coordination and converging efforts to all relevant activities under INEY Program along with other existing program related to Puskesmas and Posyandu such as the Puskemas Accreditation program under I-Sphere PfR, DAK Penugasan Kesehatan, Dana Desa etc.

62. A site visit in Kamurang village, where stunting was found, suggests that water and sanitation facilities remain a significant issue. The lack of available facilities means that some people use their backyards (or nearby creeks) as an alternative to the use of toilet. And in some cases, it extends to the use of local creeks where community members collect their drinking water supply. The DAK allocation for water and sanitation is also very low, approximately 2-3% as compared to education and family planning allocation. The issue with the sustainability and the operations and maintenance of the facility was also discussed during the worhsop with representatives from 5 districs (see Annex 3).

63. It is highly recommended that several waste reduction efforts and an integrated solution and coordination for medical waste management handling (among relevant agencies at district level) is initiated under the INEY program in cooperation with I-Sphere program. The use of needle destroyer or needle cutter can be implemented to reduce the generation of medical waste from Posyandu/Puskemas. Also, the training on how to implement a proper burial technique for remote Puskesmas as per PermenLH 56/2015 was also discussed during the workshop (Annex 3). From the discussion with BLH staff, a draft PERDA is being prepared to regulate waste management in Cianjur including hazardous waste management. The mission suggested that early consultation with relevant agencies (such as primary care providers (including private clinics/hospitals), MOEF, development partners, waste transporter companies including civil society organizations and expertise/academics in this field) should be undertaken prior to the enactment of the PERDA. However, it is important to note that INEY intervention has its own limitation and boundaries that shall be further carefully assessed before getting involved with such types of coordination efforts.

F.2 Social Considerations

64. Social effects to be assessed were informed by the INEY program objective of increasing simultaneous utilization of nutrition interventions by 1,000-Day Households in priority districts. The social considerations were: community participation; inclusion of targeted beneficiaries including interventions that consider beneficiaries' specific context, vulnerability and marginalisation to enable them to understand and participate in an informed manner; complaint and feedback handling; and informed decision-making and consent processes.

F.2.1 Role of Village Government, Posyandu, PAUD and Community Participation

65. The role of village governments in mainstreaming health and education into *RKPDes* and *APBDes*, including in determining budget allocation and/or directing how allocated budget is spent, is critical and may continue to become stronger in the coming years as observed in Talaud. Such an increase may have a linear correlation with a combination of advocacy, facilitation, enabling regulatory and policy environments on the use of village funds, and sustained community demand for basic services. However, there is often a lack of presence of BPD in the running of village governance. Although the current law positions BPD in a strategic position to advance community aspirations, initial findings from the World Bank-supported Sentinel Village Study (SMERU, 2017) indicate that BPD's limited capacity to engage in village planning and budgeting, despite their physical presence in these processes, limits their intended roles and functions.

66. As part of the ESSA, the World Bank visited Talaud District. Across Talaud, villages, especially where GSC operates, have steadily increased their allocation of village funds for health and education services especially (see Table 5). Such an increase may have a linear correlation with a combination of advocacy, facilitation, enabling regulatory and policy environments on the use of village funds, and sustained community demand for basic services. The assessment observed that the role of village governments was more articulated in directing the "hardware" of basic services, such as construction of basic infrastructure and/or procurement of equipment needed to run such services. Their role tends to diminish and/or become less articulated in managing the "software" of these services, such as capacity building, targeting of beneficiaries, spending on specific inputs for services, such as food supplements. The current guideline for *PAUD* dictates that village governments and community representatives are responsible to guide and oversee the implementation of *PAUD* through oversight and advisory committees (*Tim Pemantau* and *Tim Pembina* respectively). This raises questions whether this role is effectively enforceable within the current divisions of responsibilities.

Table 5: Share of Health and Education-related Activities in APBDes in the District of Talaud.

Year	Health related activities*	Education related activities*
2015	1.98%	-
2016	8.40%	4.26%
2017	8.62%	6.15%

*as a share of village funds in *APBD*es, specific expenditure items were not known. source: *GSC*'s profile in Talaud

67. On village planning, *Musrenbangdus* (hamlet deliberation) was perceived to be more participatory and receptive to proposals from various community groups. Through this deliberation process, a long list of proposed activities will be produced by each hamlet and subsequently short-listed and will subsequently compete with other hamlets during *Musrenbangdes* (village deliberation). The winning proposals will form the basis for the development *RKPD*es led by a team named Tim 11[16]. Following the finalization of *RKPD*es, *APBD*es (village budget plans) will be developed once indicative ceilings of village funds from *Dana Desa* and *Alokasi Dana Desa* are known. A relevant question would be how community participation influences final allocation of village funds into specific expenditures rather than to what extent village planning processes are participatory. Several potential determinants were identified including:

a. As *Musrenbang Desa* is often understood by community members as a ranking exercise for hamlet proposals, the running of the *Musrenbang Desa* would likely resemble a negotiation rather than a consultative process. This perception has implications with regards to what extent community members can change or add to existing proposals. Cadres and *GSC* beneficiaries met during the assessment explained that although activities around maternal health, education and nutrition were prioritized

[16] Often dubbed as Tim 11, this team is a think-tank team established by community members through a democratic election to formulate village plans and budget allocation. The figure 11 is usually associated with the PNPM's TPMD (village community empowerment team) although by law the minimum composition is 7 representatives.

during *Musrenbang Dusun*, final decisions were often steered by men and respective figures during *Musrenbang Desa*;

b. Observations indicate that inclusion of spending on basic services in the *APBD*es by village governments may be influenced by peer-pressure or advocacy by certain individuals (e.g. cadres, midwives, or facilitators) rather than the voices of citizens;
c. Regulatory obedience could be a stronger determinant than community participation. Given the recent signing of an MOU between the MOV and the Police and Military to monitor village funds, such paranoia may worsen;
d. Instructions by higher level governments, for instance *Bupati*, tend to be more effective in mobilizing efforts around certain priorities than generating community demand for services. District heads may mobilize their power through district agencies that facilitate or verity *RKPD*es and *APBD*es to influence village decisions on village funds.

68. A case in point is that community participation indicators per-se may not necessarily reflect how decisions are made at the village level. However, fostering community participation in hamlet and village planning processes may increase communities' awareness about their rights and subsequently citizens' demand for basic services and therefore, could help hold village governments accountable. Integration of social mapping tools in *Musrenbang Dusun* and *Musrenbang Desa* spearheaded by the *GSC* is one of the examples how this can be done.

69. The social mapping tools introduced by the *GSC* to the village planning processes present opportunities for villages to prioritize spending on their community members who are considered poor or in need for support. However, translating community needs for basic services identified in these social mapping processes into unit costs could be challenging, let alone projecting financial requirements for specific expenditures (e.g. support to high-risk pregnancy and malnutrition) and negotiating these during *APBD*es formulation, which was often developed by the Tim 11 in a closed space. In addition, the success of this social mapping exercise may be dependent on the facilitation skills of facilitators. The transition from the *GSC* facilitation to possibly the village law facilitation (P3MD) may present risks, not only in terms of shortages of skills, but also lack of prioritization since the current P3MD facilitators are likely to be occupied by administrative support to village governments or simply not available due to high attrition and/or absenteeism. A focus on identifying the poor in these social mapping processes may also risk excluding stunting cases in families and/or households who may be perceived to be well-off. Alternatively, there may be potential for elite capture and if processes are not transparent there is the potential for inequalities in the distribution of services in particular nutritional products. The social mapping tools will focus on 1,000 day households regardless of their socio-economic, ethnicity, indigenous, religious and cultural status.

70. For programs managed by *Puskesmas*, such as vaccination, nutrition interventions for malnourished infants, or sanitation programming (e.g. CLTS, Community-led Total Sanitation), targeting would rely on midwives and *Puskesmas* staff who usually collect data from *Posyandu* cadres and/or in some instances, village governments. *Posyandu* is particularly an important platform for village-level targeting processes since cadres would usually report to midwives and *Puskesmas* staff if malnutrition cases or mothers with high-risk pregnancy are found and/or reported. Such targeting may be more accurate and updated than the UDB (Unified Data Base)[17] or any government targeted database since village community members themselves provide the information in a more regular basis. However, there could be a limit with regards to

[17] The UDB is an electronic data system containing social, economic and demographic information on around 24.7 million households or 96.4 million individuals in the poorest 40 percentiles across Indonesia. Households' welfare status was ranked using the variables of household welfare obtained during PPLS (Data Collection for Social Protection Programs) Survey 2011 conducted by the Central Bureau of Statistics (BPS) and using proxy means testing (PMT) models to determine the relative poverty of households for each district/municipality. The PMT models predicted households' income by collecting simple information about the assets they own and were tailored to each district and municipality to accommodate variable differences (TNP2K 2015). The consumption index generated by the PMT models was used as the basis to rank households based on their welfare status. To date, the UDB is considered to be the most comprehensive targeting database in the country.

what extent and types of information relevant to stunting that can be generated through *Posyandu* growth monitoring indicators.

71. During the mission to Ketapang, the World Bank joined the Ministry of Health's Monitoring and Evaluation Mission to Ketapang, where national, provincial, district agencies and village governments gathered to share statistics and analysis on stunting in the district, it was revealed there were discrepancies in stunting data held by village governments and district agencies, whereby data on stunting cases held by *Posyandu* did not accurately reflect the reality in the village. This may be due to a gap in knowledge over how to measure stunting (infant and child height) at *Puskesmas* and *Posyandu* level. With an inaccurate picture of stunting statistics in villages, this runs the risk of inaction or wrong action towards solving the problem. In order to increase transparency over this and thus correct action by village governments and service providers, it would necessitate further capacity building for cadres and *Puskesmas* staff, development of simple measurement tools/methods for stunting, monitoring protocols and improved communication between village governments and district agencies.

72. The functioning of *Posyandu* varies in terms of levels of efforts and quality of outreach services. Households in higher income brackets tend to show lower participation in *Posyandu* activities (Nazri et. al 2016). Several factors may explain such behaviour, including 1) mobility patterns where wealthier mothers and/or caregivers are more likely working outside home; 2) limited incentives to access *Posyandu* services due to their association of being poor; and 3) ability to access other options, including private health services. Perceptions of reliability and benefits of *Posyandu* services influences mothers and/or caregivers' attitude to *Posyandu*. This suggests that a combination of improvements of service quality and social marketing (supply and demand side) has the potential to increase use of *Posyandu* services.

73. Outside the recognized health system, the assessment also found that Traditional Birth Attendants (TBAs) still play an important role in the delivery of basic services, particularly in counselling, assistance to delivery (now increasingly performed by midwives) and post-natal care. Since the current regulations outlaw the practice of TBAs in performing delivery, their roles are diminishing. Some of the trained TBAs are given new responsibilities to assist midwives in delivery and provide post-natal care for mothers, with incentives from *BPJS*/*Jampersal* (maternity health insurance) claims agreed with respective midwives. In some of the villages visited, some of these ex-traditional birth attendants assume a new role as *Posyandu* cadres and therefore their presence is recognized by formal health service providers and could access training. Community perceptions around changes associated with mainstreaming modern medical practices and how this could create social tension and/or conflicts with service providers outside the formal system will be monitored as part of the INEY PforR.

Box 2: Births Attended by TBAs

Occasional incidences of births assisted by TBAs were reported in Talaud. However, the frequency could be higher due to various reasons, such as:

- Pregnant women may feel more comfortable since traditional birth attendants are believed to have more experience and possess spiritual powers and knowledge of traditional medicine;
- Village midwives are sometimes young and lack experience so are not trusted. Some of these midwives may come from outside the village and therefore may not be familiar with the culture and local languages;
- Services are provided at home and therefore cheaper, especially in places far away from *Puskesmas*; and
- Some TBAs offer extra services by doing household chores while mothers recover.

74. In terms of the possibility for *PAUD* being used as a counselling platform for parents around nutrition and child rearing, the assessment observed that there could be some resistance from *PAUD* teachers if parents stay during the sessions. It would, therefore, be necessary to find optimal times for *PAUD* teachers to host sessions which parents could join. Given that teachers will be doing extra outreach to target and invite priority families, and host parenting and practical learning sessions, their workload will increase quite significantly, and this would necessitate appropriate compensation and incentives. Teachers would usually encourage parents to leave to foster independence of their children and efforts to invite families should be supported by village governments, service providers and facilitators.

75. Water and sanitation: No infrastructure in supported under the program boundary and the Village Convergence Scorecard is aimed to understand peoples access to water and sanitation.

F.2.2 Inclusion and Behaviour Change

F.2.2.1 Gender

76. It will be critical to understand how gender roles and relations interact with interventions to influence child health and nutrition outcomes and to consider how to involve men and adolescent girls as well as well as pregnant women and mothers in interventions. Programs to combat or reduce stunting in children should focus on both men and women, as responsible caregivers and decision-makers. Additionally, involving adolescent girls in interventions will be key to generating desired behaviours for later stages of life.

77. Informed women who have greater influence in decision-making and agency in access to and control over information, incomes, and resources (including food) are statistically less likely to have malnourished or stunted children (UNICEF, 2011). If women are the caregivers, then the decision-making power and access to and control over resources are key as they form the basis of women's bargaining power within the household. There is correlation between stunting and wealth of the household. There is evidence that a mothers' ability to seek treatment for children is closely related to her ability to access resources (including food) both independently and from others within the household. Generally decision-making on resources is made by men and senior household members including mothers-in-law, as well as deciding about well-being of the child and the need to seek assistance from outside the home. A mother's ability to pay for costs and treatment, herself, may also influence the decision-making. Divisions of labour can present a heavy burden on women with potentially negative impacts for child health and nutrition outcomes.

78. Poorer families, lesser educated mothers, young mothers, older mothers, unmarried mothers, single parent families or child headed households, and parents with HIV status are likely to be the most vulnerable. Reduced stunting and malnutrition is positively correlated with women's empowerment.

79. In the poorest households in Indonesia, it is likely that more money is spent on tobacco than on education and health care combined. Smoking exacerbates the effects of poverty, as expenditures for tobacco may divert household income from food, clothing, housing, health and education (Semba et al, 2006). In 2013, smoking prevalence among males was 66%, while among females was 6.7%. Smoking prevalence among children ages 10–14 in 2013 was 3.7%, twelve times higher than in 1995 (IAKMI, 2014; Ahsan, 2015).

80. Education status of mothers is also a key factor in preventing stunting. There is a strong evidence base on the link between women's education and child survival generally and this also is shown to be the case in Indonesia where there is a link between the mother's education level and stunting. It would also be interesting to understand how or why education makes such a difference for example education may enable ability to better negotiate systems for healthcare or village level decision making. It is also likely that a woman with higher education may have greater direct access to resources through improved income earning potential and increased indirect access to resources and decision-making power through improved status in the household as well as the community level. It would be useful to understand if there are differences with education level of mother and stunting based on urban and rural areas. Urban versus rural settings may have different structural and traditional expectations of women. There is also potentially a gap in the information on paternal education and effect on child health and nutrition.

81. Child marriage in Indonesia has plateaued, but it remains persistently high with over one in four girls currently marrying before reaching adulthood. Marriage of girls under the age of 16 and 15 has declined since 2008 to 3.5% and 1.1%, respectively; however, marriages among girls aged 17 and 16 has remained roughly the same (20.2% of marriages in 2008 and 19.3% of marriages in 2015) (UNICEF, 2016). One of the key drivers of child marriage is rigid gender norms (Plan International, 2015). Poverty makes girls more

vulnerable to child marriages, but social and cultural acceptance of the practice permeates all economic levels. In 2015, nearly one in eight girls who married before the age of 18 were from households with the highest levels of expenditure in Indonesia (UNICEF, 2016). Child marriage in Indonesia is estimated to have caused a loss of at least 1.7% of GDP in 2014 (UNICEF, 2015). Discriminatory laws, customs and practice such as early marriage result in inequalities that can affect nutrition and stunting. When girls marry early this results in early pregnancy, often in malnourished mothers, and low weight births (UNICEF, 2011). Married girls tend to have poorer educational, economic, and health prospects. This limits their ability to lift themselves out of poverty and increases the likelihood of passing on similar circumstances to future generations. Undernourished girls have a greater likelihood of becoming undernourished mothers.

82. Various forms of female genital mutilation/cutting (FGM/C) continue to be practiced in Indonesia. In 2013, nationally representative data on FGM/C were collected through a survey of nearly 300,000 households in 33 provinces and 497 districts. This Basic Health Research Survey (RISKESDAS) was implemented by the MOH's National Institute of Health Research and Development and asked questions to caregivers or guardians of each female household member up to 11 years old. Findings from the survey indicate that nearly half of girls under the age of 12 have undergone some form of FGM/C, the majority of whom were under 6 months of age at the time (3 out of 4). This is high in comparison with other countries, and just below Mauritania (54%) and the Gambia (56%). In 8 out of 10 cases, it was reported that parents had suggested that their daughters undergo FGM/C because of religious and cultural beliefs. In urban areas, the majority of cases of FGM/C were performed by a midwife while in rural areas, TBAs are the most common practitioners of FGM/C. Girls from the poorest quintile were most likely to have FGM/C performed by TBAs while those from the richest quintile most often experienced the practice at the hands of midwives (UNICEF, 2016b). As part of the program midwives and TBAs will be pivotal in delivering program-related activities specifically in relation to antenatal and postnatal care.

83. Observations from Ketapang showed FGC[18] was commonly practiced in 3 villages, however variations existed on who administered the procedure. Most commonly was TBAs, *kampong dukun* (village shaman) or grandmothers who have decision making influence (*nenek moyang*). One village reported that circumcision for females and males were held at *Posyandu* by *Posyandu* cadres whilst the other two reported these were done at the family household.

F.2.2.2 Indigenous Peoples

84. The current understanding of the locations of Indigenous Peoples is based on database produced by MOSA based on the following criteria: small homogenous community; remote and or limited exposure to other communities; subsistence livelihoods; reliance on natural resources; limited access to socio-economic and political services; clan based (Bappenas, 2013). However, this represents a small subset of communities and the data is not up-to-date. Other possible ways to identify communities include use of maps such those developed by the Indonesia Network for Participatory Mapping. These also have limitations.

85. Estimating the precise population size of Indigenous Peoples has been constrained by limited population census data disaggregated based on agreeable indigeneity indicators/criteria. Civil society groups, notably AMAN, estimates that there are roughly 50 to 70 million individuals (out of a total country's population of 260 million) who belong and/or identify themselves as *Adat* in some way or the other. While such claims represent a major portion of the country's population, information with regards to health or stunting issues affecting this population category is largely unknown and would warrant further in-depth assessments. As a result, due to the limitation of existing analytics and information, analysis presented in the ESSA remains anecdotal and it can only be assumed that there could potentially be a large size of

[18] In Ketapang FGC is performed on young girls between 0-6 months. This entails cutting the hood of the clitoris with a small and sharp blade. Usually this blade is passed down from generation to generation creating concern over health and hygiene if the blade is rusted and unsterilized.

Indigenous populations that may be affected by stunting issues due to their level of poverty which appears to be higher than the national average[19] as well as other socio-economic factors.

86. Issues around indigenous communities' ability to access basic services can be observed amongst remote and isolated communities elsewhere in Indonesia. Such issues include lack of mobility, limited availability of basic services, poor access to information, high illiteracy rates, high logistical costs, slow responses to emergencies, etc. All of these factors combined are often attributed to poorer health outcomes amongst remote communities, which are not unique to indigenous communities and apply to many communities that may be considered not indigenous. A recent measles outbreak due to severe malnutrition in the Asmat Region of Papua Province that killed 66 children (Tempo, 2018) may only reveal underlying systematic issues in service delivery affecting remote communities.

87. Some features such as social structures and languages may likely present more constraints to effective service delivery to indigenous communities compared to other communities. The relatively amorphous social structure characteristics of many indigenous communities often present a challenge to external parties attempting to engage with them, whether from the government, NGOs, private sector and other groups. In addition, language barriers, despite prevalent use of Bahasa Indonesia as a lingua franca, tend to limit engagement with indigenous communities, particularly the elderly and those who have not experienced formal education. In some cases, indigenous communities choose to exclude themselves from the broader society, such as the *Baduy*, *Sedulur Sikep* or *Samin* people who have resisted integration into the mainstream society to a varying degree, and subsequently acceptance to government services. Health service providers are often ill-prepared to respond to cultural preferences amongst these communities. For instance, in various places in Nusa Tenggara Timur provinces, local government policies on birthing which prohibit TBAs practicing birthing services and traditional practice of giving birth beside a fire (known as "mother roasting") do not address issues of rapport between health workers and local women, as well as TBAs. Such limited engagement often results in lack of compliance and lack of trust to health service providers, who are mostly come from outside the region (World Bank unpublished report, 2017).

88. Engagement with these communities would therefore require tailored approaches and possibly use of local facilitators and frontline workers to foster social acceptance and rapport. For any services and interventions planned there will be a need to understand context, accessibility, belief systems and preferences to inform the appropriateness and uptake of the planned service or intervention. For example, some of the indigenous communities are matriarchal which may have women and men having different status and performing different gender roles in the area of child-care, nutrition and decision-making. Ideally the frontline workers should be from the communities from themselves and will be equipped to ensure participation of men, women and youth as appropriate. A Social Inclusion Specialist will form part of the Coordinating Unit under TNP2K and will have specific experience on Indigenous Peoples, gender and adolescent girls.

F.2.2.3 Behaviour Change

89. Key to developing effective behaviour change communication to address stunting will be understanding how the relations of power between men and women affect household dynamics (and their respective level of control over decision-making about resource allocation including food) and the division of labour (MCA, 2015). The MCA report suggest the need to develop behaviours will that support the following kinds of changes and outcomes:

a. improved understanding about family nutrition, including stunting;

[19] Various World Bank analyses indicate that forest-dependent communities – assumed to be largely indigenous peoples - have far higher rates of poverty and vulnerability than mainstream Indonesians, and account for about one fifth of Indonesia's poor. Thirty-two million people live in forest areas and, of these, 6.3 million are poor, giving a poverty rate of 20 percent compared with a national average poverty rate of around 12 percent. It is therefore estimated that the poverty rate of many indigenous peoples in Indonesia is twice the national average (World Bank Indigenous Peoples Study in Indonesia 2017, unpublished).

b. improved family hygiene and sanitation behaviours (including hygienic bottle feeding) to reduce incidence of diarrhoea and enteropathy;
c. better allocation of HH budget for buying nutritious food;
d. reduction of smoking (predominantly males), particularly in the presence of children and pregnant women;
e. effective breastfeeding, weaning, and parenting practices for boy and girl children;
f. better time use planning so that more nutritious meals can be prepared and eaten;
g. improved access to and use of quality health services for pre- and post-natal care and for delivery.

90. People's appetite for change towards healthy behaviour varies and similarly understanding of being sick and healthy. A Reality Check Approach (RCA, 2015) study found that baby sicknesses such as diarrhoea, coughs, fever and running noses are often not understood as an issue and considered as normal and part of child's development. The study also observed that household and individual decisions around food intakes and preferences are often informed by convenience and availability rather than what is healthy. Sugar intake and habits of snacking and drinking instant sweet drinks are particularly prevalent among children. The ability to buy packaged snacks is also associated with some level of social status. Under such circumstances, availability and affordability of packaged snacks and sweet drinks at schools, combined with the pervasiveness of packaged food advertising has exacerbated dietary patterns amongst children and reduced demand for local food options, which could be healthier and more nutritious.

91. Understanding and practices around nutrition and child rearing are often passed down from parents and caregivers, such as practices of early-feeding and perceptions of colostrum as 'dirty milk' (Mercy Corps, 2014). Public information around nutrition and sanitation is limited and often not useful. People rarely noticed posters, which tend to tear under the elements. In the ESSA assessment and *GSC* mission locations, the team observed that television has become an important means for people to get entertainment and information. Addressing perceptions and attitudes towards nutrition would require concerted efforts, possibly through popular mass-media in simple, aspirational, contemporary and clear rather than instructive formats. This needs to be combined with empowering frontline health providers with accurate information, appropriate engagement and simple communication materials to encourage change in behaviours. Furthermore, it will also be beneficial to regulate television advertisements to ensure messages are not distorted and/or encourage unhealthy practices.

F.2.3 Complaints and Feedback Handling

92. Learning from the *GSC's* online Complaint Handling System (CHS) (http://generasi.web.id/chs), which was re-activated in early 2017, the system has been used to handle complaints associated with the program's governance, in particular on aspects related to financial management, procurement and program administration. Such an increased use of online CHS for a typical CDD program with vast coverage could foster good governance, transparency, and responsiveness in addressing program management issues on the ground and therefore could prevent program mismanagement from worsening. However, the use of the system to solicit citizens' voice around service delivery, particularly on issues related to social inclusion, safe medical practices, and participation, would continue to be challenging. Unless there is a major case (e.g. food poisoning), such grievances are usually low-key and do not normally attract people's attention and therefore are easy to be forgotten.

93. Generally, the assumed rates of grievances with regards to the use of village development funds, in comparison to the *PNPM*, shows a lower rate of complaints than expected[20]. An earlier World Bank survey (2016a) reported that following the field assessments, complemented with an earlier study by the World Bank (2016) provide several explanations:

[20] In comparison to the PNPM, the number of complaints estimated to the implementation of the Village Law is roughly half of the annual rate of complaints submitted to the PNPM complaints handling system although the data is not sufficiently robust to enable firm conclusion to be drawn.

a. Limited knowledge of entitlements and rights amongst citizens. This may be caused by lack of citizen demand for basic services, as observed in relation to education and sanitation. Permissive attitudes with regards to the misuse of village development funds by village officials were observed in some locations to a varying degree (World Bank, 2016; Kompak, 2016);
b. Lack of access to grievance redress mechanisms due to geographic, financial, or information barriers as well as legal services. In addition, the ability of village governments or program facilitators or cadres in addressing complaints or the lack thereof also influences citizens' trust to the existing channels;
c. Issues being perceived trivial and subjective and not worth reporting;
d. Unwillingness to articulate grievances due to fear of retribution, collective action issues and perverse incentives. As observed during the PNPM (World Bank, 2012), villages may risk of losing project funds in the event of corruption. For allocation of resources under village funds, there could be understanding that little can be changed once decisions made during village deliberations (*Musrenbangdes*) are final; and
e. Perceptions of lack of reliability of existing channels, particularly in circumstances where suspected cases implicate certain individuals who are in the position of power.
f. Since the allocated budget for basic services are usually comparably smaller than other priorities (except for infrastructure related to basic services e.g. *PAUD* or *Posyandu* building), there could possibly be less incentives to complain.

94. Misuse of authority by district and sub-district governments is more difficult to address for two possible reasons. First, although the overall impact of such misuse of authority may be significant, its impacts on any particular village are likely small and therefore, represent collective action issues (World Bank's consultant report, 2017). Secondly, there could be low level of institutional credibility if complaints are expected to be addressed by agencies who are themselves suspected to a complaint. That said, district-level corruption and/or misuse of authority with regards to the provisions of basic services will not only be difficult to be tracked due to lack of citizens' demand to articulate complaints, particularly if it involves petty corruption, but also difficult to be addressed.

95. Based on the institutional experience of the earlier *PNPM* program (World Bank, 2016), larger cases involving individuals in the position of power such as village heads or sub-district heads, could be less susceptible to social sanction and law enforcement due to their political and financial resources. Fear of retaliation, particularly against whistle blowers, could also discourage people from articulating their complaints. Only when cases exceed local norms of acceptability and there are no constraining factors and there is a mechanism and/or channel to report cases (often motivated by political factors e.g. village head elections), citizens are more likely to report it to the higher-level government and/or law enforcement authorities (e.g. the police). However, as it may be expected, when cases are serious enough for people to complain, they are more likely dealt with by law enforcement rather than government administrative procedures.

96. A relevant question would be how to first generate a greater number of complaints so that systemic issues can be better understood, particularly those involving the delivery of basic services using village funds. It may be worth further exploration beyond the ESSA, but key considerations would include: a) strengthening rights awareness and community oversight of the delivery of basic services would be important to increase exposure of certain issues e.g. use of social media; b) it is also equally important to ensure that there is an effective accountability mechanism to ensure village governments and/or individual agencies are effectively pressured to address certain issues (e.g. village service audits, inspections, etc.)

97. When services are provided for free (e.g. subsidised by village funds), there is less likelihood for people to complain about the performance of teachers and the quality and appropriateness of their services. However, when there are extra charges required for people to able to access services, there could be a higher interest for people to understand where their contributions are being spent and demand some level of accountability.

98. Based on previous experiences with the *GSC* and *PNPM*, and currently with the Village Law, complaints related to basic service availability and/or delivery or the management of the program are usually captured through direct communication with facilitators, cadres, midwives, village heads and this largely depends on the issues, people who get implicated in the issues, and trust-levels. This suggests that empowering key actors to handle complaints or liaise with relevant stakeholders who may hold the authority or possess the resources would be beneficial to enable issues to be resolved locally and quickly. At the same time, there could be benefits to raise citizens' awareness of various avenues/means to file complaints to foster check and balances. Alternative mechanisms such as satisfaction surveys or strengthening engagement on the existing grievance mechanisms may need to be considered to understand how well the INEY PforR is meeting its desired objective.

F.2.4 Informed Decision Making and Consent

99. Ensuring informed decisions prior to administering vaccines to parents and/or caregivers would rely on the ability and inter-personal skills. The RCA study (2015) observed that knowledge about vaccinations varies and often little information is provided to parents and/or caregivers. Common perceptions perceive vaccinations as mandatory, however if babies suffered fevers following vaccinations people tend to discourage others from taking it.

100. Distribution of food supplements at *Posyandu* is often associated with perceptions of being poor and mothers and/or caregivers' lack of ability to provide for their children. Praise for weight gain at the *Posyandu* may also encourage people to feed their babies with solid foods early and tend to incriminate those with skinnier children (RCA 2015). Alternatives can be sought by empowering frontline health workers to provide culturally and socially sensitive services that avoid stigma, including tailoring services to specific needs (e.g. home-based care). Providing trusted cadres and other carers, such as TBAs with appropriate incentives and support should also be built into the overall basic health service system.

G ENVIRONMENTAL AND SOCIAL ACTIONS.

G.1 Environmental Measures

101. Based on capacity assessment mapped out by the ESSA team (see Annex 5) and consultation workshop was conducted on April 9, 2018 (Annex 3), strengthening institutional capacity ranges from providing relevant training to implement policies and technical guidelines to equipping related staffs with practical tools and equipment on safe-handling of pharmaceutical waste in general and particularly waste disposal system are needed.

Table 6: Environmental Measures to Strengthen Institutional Capacity

Institutions	Identified Capacity Building
National Level	
Ministry of Health (MOH), including: - Directorate of Primary Care - Directorate General of Community Health - Directorate General of Public Pharmaceutical and Health Supplies	MOH to ensure adequate budget allocation and resource planning for the implementation of the following policy and regulations that relate to the delivery of the nutrition-specific interventions: - The MOH Guidelines (2016) regarding: The Integrated Management for Vitamin A Supplement. - MOH Regulation No. 12 Year 2017 on The Implementation of Immunizations. - MOH Regulation No. 27 Year 2017 on the Guidelines for Prevention and Control of Infection in Health Care Facility.
Ministry of Public Works (MPWH) & MOH, MOV	Although INEY does not directly include MPWH activities in the program boundaries, the Program, in its focus on appropriate use of water and sanitation facilities, MPWH in cooperation with MOH and MOV should pay attention to water resource management so as to ensure INEY's target beneficiaries have sustainable access to safe drinking water and sanitation facilities.
Province/District/Sub-district and Village Levels:	
DHOs, Pharmaceutical Facility at the provincial and district levels. Sub-district: *Puskesmas* staff Village: *Posyandu*	Training on waste reduction and handling of pharmaceutical waste, special attention on procedures, techniques and mechanism in emergency situations. Emergency situations range from the lack of disposal facility to inadequate provision of the available transporter company. In specific circumstances, burial technique is allowed for *Puskesmas* that are very remote and has no access to a proper transportation system

102. Measures to strengthen system performance for environmental management are aimed to generate the desired environmental effects such as: (i) providing technical guidelines for effective implementation of environmental mitigation measures such as promoting water resource management; and (ii) applying standard good practices. These measures aim to strengthen institutional capacity as well as to generate the desired environmental effects

Table 7: Environmental Measures to Generate the Desired Environmental Effects

Objectives	Measures
Strengthen institutional capacity and compliance regarding safe handling and disposal of medical/pharmaceutical waste.	Ensuring adequate capacity of safe handling and disposal of medical/ pharmaceutical waste in PHC is the focus of other relevant GOI program, e.g., I-SPHERE, DAK Penugasan Kesehatan Non Fisik (Coordination Forum and BOK). It is therefore recommended that INEY work with I-SPHERE in improving management of medical/pharmaceutical waste, including through facilitate coordination among relevant agencies at the district level (involving HDW facilitarors, mid wives etc.). Monitoring system for waste disposal by appropriate authority should be made available at the district level to ensure compliance.
Strengthen institutional capacity and compliance regarding provision of safe water supply and sanitation	As per standard practice, hand washing facilities should be available at all latrines and in proper working conditions. Ensuring that new sanitation installations have the minimum safe distance between latrines and water sources should be maintained as per standard practice. For existing facilities where the standards have not been made, the water sources should be continuously screened for bacterial contamination and adequate water treatment (filtering, chlorination) should be adopted where water have been found to be bacteriologically contaminated. Budgetary provisions for water quality monitoring should be made available at the district level.

G.2 Social Measures

103. Village systems and participation: Potential for inequality and conflict may stem from real or perceived differences in how the program's benefits are distributed. There is also a potential for elite capture. The use of HDW and social mapping exercise, if well trained, should ensure the participation of all groups within the village.

104. Access and Inclusion: The INEY PforR is expected to build on lessons learnt to mainstream gender into its planned interventions and these are addressed as part of the technical assessment. It is expected that the program will through the social mapping and use of HDW program ensure that interventions take into account local context, culture, belief and value systems of Indigenous Peoples as well as of those groups identified as vulnerable. A Social Inclusion Specialist will form part of the Delivery Unit under TNP2K and will have specific experience on Indigenous Peoples, gender and adolescent girls.

a. **Behaviour Change:** To affect the behaviour change needed to address stunting, strategies will require contextualising knowledge, skills and attitudes of men and women, which in turn are shaped by societal and gender norms based on customary, indigenous, personal and formal laws, customs and practices.
b. **Gender, Nutrition and Stunting:** To effectively address child stunting and malnutrition, the review of literature, including evidence from Indonesia, suggests the need to combine nutrition-specific interventions with measures for empowerment of women and men's participation. Improvement in nutrition of and uptake of health services by women and access to water and sanitation will not be sufficient. Prevention of early age marriage and conception, education, increasing women's decision-making power over resources, creating a supporting environment, reduction of women's workloads, and addressing gender based violence are a few areas that deserve attention. It will be important to ensure that appropriate foods are provided as part of the nutritional package and that take into account nutritional value, cultural preferences, and time and resources to prepare. Indigenous Peoples and indigenous women will have very specific needs and matriarchal communities may present differing

gendered perspectives which all will need to be understood. A range of measures to increase men's participation and for effectively reaching adolescent girls and women prior to as well as during and after pregnancy should be used to accelerate reduction in stunting.

105. Complaint and Feedback Handling: There is no one system and the systems that exist are not equipped to capture feedback and complaints across the planned interventions. The Village Convergence Scorecard is proposed as the system though which feedback and complaints could be identified, handled and monitored.

106. Informed Decision Making and Consent: While systems exist to secure consent for vaccination, blood testing and surveillance, there is insufficient awareness over rights and the practice of consent is varied dependent on the capacity of the frontline health workers. Capacity could be strengthened through training and ensuring that the information, education and communication activities associates with vaccination campaigns inform people of their rights.

Table 8: Proposed Environmental and Social Actions.

Action Description	DLI	Responsibility	Recurrent	Frequency	Due date	Completion Measurement
SoVP prepares Program Operations Manual (POM) in collaboration with Bappenas, MoF and all implementing agencies covering program planning, budgeting, monitoring, reporting and evaluation. It will also include procedures for coordinating with other programs (e.g., PAMSIMAS, I-SPHERE) on environmental issues.	N/A	SoVP	No		31 Jul-2018	Program Steering Committee approves POM for dissemination and operational reference
MOV to establish a mechanism to capture feedback, concerns and complaints as part of the Village Convergence Scorecard.	DLI 9 & 10	MOV	Yes	Continuous	31-Jul-2018	Completed scorecards and system operationalised for addressing feedback and grievances.
SoVP establishes a Program Support Unit that a social inclusion specialist with experience with Indigenous Peoples, gender and adolescent girls. TORs of all staff will include requirements to pay appropriate attention to environment and social issues in their tasks.	Program Management	SOVP	Yes	Continuous	31-Jul-2018	Specialist recruited and retained during the life of the Program.
MOH conducts a review of knowledge, behaviours and specific requirements of Indigenous Peoples as part of preparing *Gerakan Masyarakat* (*Germas)* or Community Action Guidelines and modules with training materials for local BCC/IPC programming.	6	MOH	No		31-Jul-2018	Review conducted and consulted with key stakeholders as part of preparation of *Germas* Guidelines. Modules with training modules prepared and records of training undertaken.
MOHA to include environment specialist in provincial TA pool structure to advise districts on environment issues (e.g., medical waste, watersheds/water resource management).	N/A	MOHA	No		31 Dec 2018	Specialist in place

H ENVIRONMENTAL AND SOCIAL RISK RATING

107. Based on the assessment findings and draft mitigation and improvement measures the overall environmental and social risk is considered to be moderate.

108. Overall, the risk assessment and screening suggests that the environmental impact of the program is likely to be positive; delivering a number of environmental benefits, such as access to improved drinking water supply, access to better sanitation facilities and improved sanitation conditions. Main environmental issues and risks are expected to be moderate and relate to safe handling of pharmaceutical waste and disposal systems managed by *Posyandu* and *Puskesmas,* quality and quantity (continuity) aspects of water supply provision and unsafe construction practices for sanitation facilities. Measures to strengthen system performance for environmental management include: (i) strengthening relevant institutions through the provision of practical knowledge and resources that ranges from providing relevant training to implement policies and technical guidelines to equipping related staffs with practical tools and equipment on safe-handling and disposal system of pharmaceutical waste; and (ii) generating the desired environmental effects such as promoting water resource management, applying standard good practices, allocating more experienced facilitators and consultants in providing technical support and supervision for the provision of basic water and sanitary services, providing technical guidelines for effective implementation of environmental mitigation measures, and closely collaborating between local governments and other relevant stakeholders such as private sector, university, association and NGOs.

109. The INEY PforR with its focus on a 100 priority districts to address high levels of and the rising inequality in stunting in Indonesia has overall beneficial social outcomes. There are currently no infrastructure related investments planned. Adverse impacts are not anticipated in relation to natural resources, or to assets or livelihoods of people based on the activities supported by the INEY PforR. Social effects will mainly arise from activities associated with RA 4 on prioritising convergence of village service delivery. There will be some effects also associated with RA 2 (strengthen delivery of sector programs and RA 3 (strengthen convergence of district activities). The effects considered as part of the ESSA focus on households' and groups' need to obtain services in an accessible, safe and inclusive manner. The ESSA also considers whether the delivery of educational, behavioural change communication, information on nutrition specific interventions, particularly health services consider local context (literacy, language, and cultural aspects of the beneficiaries). Potential inequality and conflict may stem from real or perceived differences in how the program's benefits are distributed. To address these risks, it is important to make available an accessible process for raising complaints and concerns and ensuring they are addressed appropriately. If village level systems are inclusive and participatory and managed well the most vulnerable stand to benefit. In light of this, it is expected that Indigenous Peoples, if present in the targeted communities, should benefit from the program and vulnerable groups should not be adversely impacted. Poorer families, lesser educated mothers, young mothers, older mothers, unmarried mothers, single parent families or child headed households, and parents with HIV status are likely to be the most vulnerable. Based on the above assessment, the program is expected to contribute to addressing equity issues the risk has been rated as low.

I INPUTS TO THE PROGRAM IMPLEMENTATION SUPPORT PLAN

I.1 Environment

110. A workshop with key stakeholders has been conducted to discuss input for required action plans. During implementation support stage, the program will work together with MOH to develop a waste reduction work plan which will include the provision of capacity building, with a particular emphasis on issues related to transportation of medical waste and specific training on medical waste treatment including burial technique for *Posyandu* in remote locations. At the Mid Term Review stage, the program will review the applicability of the proposed action items and the work plan; identify the challenges and opportunities; and make necessary corrective actions and adjustment for the next term of project implementation.

I.2 Social

111. A consultation workshop on the draft ESSA was undertaken on April 09, 2018 with representatives from with representatives from central ministries, including MOHA, MOEF, MOH as well as representatives from Central Maluku District, Gorontalo District of Gorontalo Province, Cianjur District of West-Java, Central Lombok District of NTB and Ketapang District of West Kalimantan. The findings from the workshop suggested the social effects and actions considered as part of the social systems assessment wereappropriate. Amont other points the following issues were raised at the workshop:

a. Strengthening of capacity of cadres, revisiting incentives, extra resouces, increased collaboration of PAUD, integrated guidelines for education, insufficient infrastructure, sustainability of services;
b. Accessibility remains an issue particularly for remote communities, frontline health worker distribution,
c. Interventions specifically designed for men and outreach to men to enable their participation;
d. Outreach to adolescent girls requires a tailored approach, need for parenting education for youth,
e. PAUD services cater for the age 2 and above children but the Program is aimed households with 0-2 years;
f. District government's ability to adjust fiscal transfer from central government to address localised and changing needs, national planning not synchronised with district planning;
g. Socio-cultural factors prevent access to services including vaccinations;
h. Smoking habits are an issue;
i. Correct targeting of beneficiaries and inclusive engagement by facilitators; and
j. Further understanding is needed of quality of services and perceptions of those services from end beneficiaries.

112. To address the challenges of the numerous systems for managing feedback and complaints, it is recommended as part of the action plan to institutionalise the feedback and complaints handling through the Village Scorecard. This will require the following:

a. Engaging with beneficiaries on the feedback and complaints mechanism;
b. Capacity building of frontline service providers particularly HDW and Cadres including on informed consultation and use of the scorecard; and
c. Supporting district and village governments to operationalise the mechanism in the scorecard to better inform planning and monitoring of service delivery at the village and district levels.

113. To ensure interventions take into account local context and address social inclusion (gender, vulnerability, early marriage, child pregnancy and Indigenous Peoples), it has been recommended that a specialist is recruited and retained as part of the Program Support Unit at the SOVP.

a. To support the recruitment of an appropriate specialist, a TOR will need to be developed and support may need to be provided to SOVP on the development of the TOR and the recruitment and selections process;

b. To support the specialist and based on the reviews of district capacity to deliver required interventions that take in local context including barriers to social inclusion, develop a training plan to support on capacity building and technical assistance needs; and
c. Undertake periodic review with the specialist as part of the capacity building.

114. The program action plan as part of the Program Appraisal Document has addressed specific inequalities with regards to gender and that have been informed by the analysis undertaken as part of social systems assessment of the ESSA. These actions include:

a. a review of knowledge and behaviours of men's caregiving is undertaken as part of preparing Germas Guidelines and modules with training materials for local BCC/IPC programming;
b. women's empowerment and men's parenting roles are integrated in parent modules in ECED Professional Development Program;
c. module is developed and included in HDW training and socialization materials on women's empowerment and role of men in childcaring, and on use of quarterly stunting forums to communicate on the benefits of delaying early marriage and pregnancy; and
d. module is developed and included on early marriage and pregnancy in training materials for implementing the Germas Guidelines for local BCC/IPC programming.

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ANNEXES

Annex 1: Program Results Framework

PDO Indicators by Objectives / Outcomes	DLI	Unit of Measure	Baseline	Intermediate Targets (IT)			End Target
				Y1	Y2	Y3	
Results Area 1: Strengthen national leadership							
Increased public commitment of Priority District leaders to accelerate stunting reduction	DLI 1	Number	0.00	60.00	96.00	234.00	308.00
Results Area 2: Strengthen delivery of sector programs							
Priority Districts implement locally-adapted interpersonal communication (IPC) activities	DLI 6	Number	0.00	80.00	128.00	312.00	380.00
Results Area 3: Strengthen convergence of district activities							
Increased performance of districts in delivery of priority nutrition interventions to 1,000-day households	DLI 8	Percentage	55.00			69.00	77.00
Consumption of IFA supplements during pregnancy			32.70		40.00	50.00	60.00
Results Area 4: Converge village service delivery							
Village-level convergence of nutrition interventions on 1,000-day households.	DLI 10	Percentage	5.00			25.00	45.00

Intermediate Results Indicators by Results Areas	DLI	Unit of Measure	Baseline	Intermediate Targets (IT)			End Target
				Y1	Y2	Y3	
Results Area 1: Strengthen national leadership							
Improved tracking and performance evaluation of national spending on priority nutrition interventions	DLI 2	Text	Ad hoc performance reports and budget reviews	Tagging and tracking systems developed	Six monthly performance report issued	Performance report issued and budget reviewed	Performance report issued and budget reviewed
Increased transparency and timely publication of annual district stunting rates	DLI 3	Text	Low data transparency and 4-5 year gap between surveys		Publication district stunting rates by July	Publication of district stunting rates by July	Publication of district stunting rates by July
Results Area 2: Strengthen delivery of sector programs							
Priority Districts have delivered nutrition-sensitive professional development program for ECED Teachers	DLI 4	Number	0.00	0.00	100.00	200.00	300.00
Beneficiaries receiving food assistance program (BNPT) in Priority Districts	DLI 5	Percentage	0.00	60.00	90.00		90.00
E-warungs in Priority Districts disbursing BPNT benefits have all eligible food items available including additional nutritional items.	DLI 5	Percentage	0.00	0.00	0.00	50.00	80.00
Incorporation of women's empowerment programs in NatStrat Stunting list of priority nutrition-sensitive internventions		Text	Women's empowerment programs not included				Women's empowerment programs included
Results Area 3: Strengthen convergence of district activities							

Increased predictability and results-orientation of fiscal transfers that support convergence	DLI 8	Text	Fragmented guidelines and performance assessment	Convergence program guidelines published	Performance assessment conducted and published	Performance assessment conducted and published	Performance assessment conducted and published
Results Area 4: Converge village service delivery							
Villages empowered to identify 1,000-day households and converge intervention delivery	DLI 9	Number	0.00		96.00	234.00	308.00
Men's participation in community nutrition counselling		Percentage	20.00		30.00	30.00	40.00

Annex 2: Environmental and Social Risks and Impacts Screening

Five Priority Service Packages	E&S Issues and Risks	Significance (Low, Moderate, High)	Capacity to be Assessed	Systems to Manage the Risks	Assessment of Gaps	Stakeholders to be consulted incl. Affected Parties
1.b. Taking iron tablets during pregnancy	**Environment:** Public health issues related to handling, distribution and storage of oversupplied tablets.	Low (social) to Moderate	Trained/qualified staff to implement the national guidelines, government regulations and procedures for handling and distribution of supplements	National guidelines on handling, distribution and storage of supplements (roles and responsibilities and oversight) *Posyandu* management system overall (including manuals for midwives and cadres with regards to community engagement, consent, and grievance handling, or the lack thereof)	Level of capacity to implement provision of the legal, policy and regulatory framework Availability of budget provision for training and supervision Level of monitoring and supervision on the implementation of the national guidelines.	National: MOH-DepKes (Directorate of Primary Care) District and Village: District Health Offices (DHOs), *Puskesmas* staffs, and frontline health workers (midwives and *Posyandu* cadres), community members
1.a. Four prenatal care visits for pregnant women 1.b. Taking iron tablets during pregnancy 1.c. Growth monitoring 1.d. Three postnatal care visits	**Social:** Access to services (be framed within the overall access to healthcare), information, and consent needs to be sensitive to social, religious, cultural and other beliefs and values.					
1.e. Complete childhood immunizations	**Environment:** Manifest management: the supply, distribution and storage of vaccines, including the availability of Safety Box, Cold Chain, vaccine refrigerator, cold box (for vaccine transportation), etc. Handling and disposal of used syringes Handling and disposal of pharmaceutical waste (expired/damaged/unused vaccines). Handling and disposal of vaccine vial (empty vial)	Low (social) to Moderate	Trained/qualified staff to implement the national guidelines, government regulations and procedures for handling and distribution of supplements, community engagement (consultation, provision of information, as well as exercise of consent), access to grievance redress mechanisms	1. Government regulation (PMK No. 12/2017) Regarding the implementation of immunizations which include provisions for the supply, distribution and storage of vaccines. 2. Procedures for handling and disposal of medical waste including: used syringes, expired/damaged/unused vaccines, and empty vaccine vial. (reference: 1. Minister (MOEF) Regulation no 56 year 2015 on procedure and technical requirement for management of hazardous waste from health service facility) ; 2. Minister of Health regulation no 27 year 2017 on Guidelines for	Level of capacity to implement provision of the legal, policy and regulatory framework Availability of budget provision for training and supervision Equipment/ infrastructure needed for safe-handling of medical waste and storage of vaccines - Level of monitoring and supervision on the implementation of the national guidelines. -Community engagement and consent practices, as well as	National: MOH/DepKes (Directorate of Primary Care) District and Village: DHOs, *Puskesmas* staffs, frontline healthworkers (midwives and *Posyandu* cadres), community members
	Social: Access to immunization services (to be framed within the					

Five Priority Service Packages	E&S Issues and Risks	Significance (Low, Moderate, High)	Capacity to be Assessed	Systems to Manage the Risks	Assessment of Gaps	Stakeholders to be consulted incl. Affected Parties
	overall access to health services), consent and access to information need to be sensitive to social, religious, cultural and other beliefs and values.			prevention and control infection in health service facility) 3. *Posyandu* management system overall (including manuals for midwives and cadres with regards to community engagement, consent, and grievance handling, or the lack thereof)	handling of complaints/grievances	
2. Nutrition, Hygiene and Parent Counselling (including 2.a and 2.b)	**Social:** Access to counselling, cultural appropriateness of counselling delivery and social acceptability, community engagement.	Low	*Puskesmas'* capacity building and oversight systems to frontline healthcare providers who deliver counselling services (midwives, cadres, and Kesling staff)	Communication and community engagement systems	Community engagement, behavioural change communication, and consent practices	MOH (Directorate Kesmas), District and Village: District Health Offices (DHOs), *Puskesmas* staffs, and frontline health workers (midwives and *Posyandu* cadres), community members
3.a. Access to improved drinking water (this may be delinked with *PAMSIMAS*)	**Environment:** - Water quality: water testing/sampling before using a new water source. Need to apply parameters prescribed by MOH. - Apply safe distance (minimum of 10m) from toilets and septic tanks. - Water collection and distribution. **Social:** Access to water for all and includes participation of	Low (social) to Moderate	Implementation of the technical guidelines. Can be assessed through lessons learned from *PAMSIMAS* and PNPM Rural. Capacity of BPSAM staff or facilitators in understanding basic water treatment technology such as filtration, Fe and Mn, treatment, peat water etc.	Existing technical guidelines/code of practice for the construction of community level water supply facility (developed through *PAMSIMAS* and PNPM Rural) MOH guidelines for water quality for drinking water Village law guidelines (including village deliberation)	Gaps between the technical guidelines and the quality of construction, land donation practices, as well as selection of beneficiaries (at the village level through village deliberation). This can be assessed through lessons learned from *PAMSIMAS* and PNPM Rural as well as village law implementation Gaps between the initial coverage of the system vs the	National: MPWH and MOH District/Village: Staff at relevant Dinas, village governments and BPPSPAM, and community members BPSAM of visited village or BUMdes who

Five Priority Service Packages	E&S Issues and Risks	Significance (Low, Moderate, High)	Capacity to be Assessed	Systems to Manage the Risks	Assessment of Gaps	Stakeholders to be consulted incl. Affected Parties
	girls, women and vulnerable groups in provisioning.			Continuity of monthly fee from the water users (*PAMSIMAS* participants). Adequate funds/money for purchasing spare parts if break down System to maintain the watershed or the water recharge area intact to ensure the sustainability and continuity of the water source	current application (decreased). Gaps between the cost for operations vs the "*iuran*" or fee from beneficiaries.	manage the *PAMSIMAS*
3.b. Access to improved sanitation facility (STBM – Community total led sanitation)	**Environment:** - Location/site selection of sanitation facilities: apply safe distance (minimum of 10m, downstream) from water sources. - Quality of sanitation facilities: construction and provisions of water supply to toilets. **Social:** Needs to take into account the needs of girls and women. Since the model adopted is Community Led Total Sanitation (CLTS) risks are low. Facilitation skills could be an important determinant for social outcomes.	Low (social) to Moderate	Implementation of the technical guidelines. Can be assessed through lessons learned from *PAMSIMAS* and PNPM Rural as improvement recommendations for their program.	Existing technical guidelines/code of practice for the construction of community level sanitation facilities (developed through *PAMSIMAS* and PNPM Rural), facilitation skills and community engagement	Gaps between the technical guidelines and the quality of construction. This can be assessed through lessons learned from *PAMSIMAS* and PNPM Rural, level of participation and inclusion for community mobilization and facilitation	National: MPWHMPWH and MOH District/Village: DHO, DPMD, Staff at relevant Dinas, village governments, CLTS facilitators, community members
5. a. Participation in *PAUD* for early learning/stimulation	**Environment:** Hand-washing program will benefit the early years learning towards improved personal hygiene for the school children **Social:** Access to *PAUD* services for all, including poor and vulnerable families	Low (social) to Moderate	Provision of the staff who are trained to deliver the curriculum and capacity building and incentive mechanisms available Transition mechanisms (participation in *musdes*	Provisions of the program/subject within the existing *PAUD* curriculum, *PAUD* manuals Budget allocation in RKPDes and APBDes	National curriculum and budget to implement, implementation practices with regards to social inclusion and appropriateness of services	National: MOEC District: District Education Agencies, *GSC* facilitators

Five Priority Service Packages	E&S Issues and Risks	Significance (Low, Moderate, High)	Capacity to be Assessed	Systems to Manage the Risks	Assessment of Gaps	Stakeholders to be consulted incl. Affected Parties
	previously supported by *GSC*, appropriateness of service delivery.		and *musdun* to vocalise these) implemented to ensure vulnerable and poor families continue to be supported			*PAUD* cadres, community members
5.b. Introducing Parenting Education through *PAUD* teachers	**Social:** Access to marginalized and vulnerable groups that do not reside in a village/and mothers and fathers that do not place their children in TK/*PAUD*. Men should also be involved. Potential for reaching out to adolescent girls and boys should be explored.	Low	Capacity of *PAUD* staff to provide these extra services re incentives and willingness	Provisions of the program/subject within the existing *PAUD* curriculum, *PAUD* manuals Effective socialization and appropriate compensation for *PAUD* teachers to do extra outreach Identifying how many villages have included this module into their RKPDes (Village Development Plan)	This program is targeted towards mothers of TK/non-*PAUD* children therefore it will be extra outreach for them to engage them, incentives may need to compensate for this Gaps: - Incentives - Monitoring systems - Budgeting It won't be launched until 2019 because the Village Development Planning session for 2018 has already taken place	National:, MOEC, Directorate ECED Teacher Training District: District Education Agencies Kepala desa, *PAUD* cadres, community members

Annex 3: Stakeholder Engagement

Table 9: Stakeholders consulted in the preparation of the INEY Program.

Administrative Level	Stakeholders
National	
Bappenas	- Deputy for Human Development - Directorate for Health and Community Nutrition - Deputy for Developing Financing - Deputy for Regional Development
Coordinating Ministry for Human Development and Culture	- Directorate for Health
Ministry of Education and Culture	- Directorate General for Early Childhood Education Development (ECED/*PAUD*) - Directorate of Parenting - Directorate for Teachers
Ministry of Finance	- Directorate General of Budget - Information Systems and Technology Treasury Division - Directorate General of Budget Financing and Risk Management - Directorate General of Fiscal Balance - Fiscal Policy Division - Directorate for *APBN* Preparation
Ministry of Health	- Health promotion and Community Empowerment Division - Primary Healthcare Division - Community Nutrition Division - Planning and Budgeting Division - Directorate of Family Health - Human Resources Development and Empowerment Division - Directorate of Community Nutrition - Environmental Health Division - Bureau of Planning - *RISKESDAS*
Ministry of Public Works and Housing	- Environmental Health Development Division - Water Supply Development Division - Integrated Settlements Infrastructure Division
Ministry of Social Affairs	- Directorate General of Handling the Underprivileged - Working Group Monitoring and Evaluation, *TNP2K*
Ministry of Villages	- Directorate General of Village Development and Community Empowerment - Directorate for Basic Social Services
Ministry of Environment and Forestry	- Directorate for Performance Assessment of Management of Waste (Hazardous and Non-hazardous)
Secretariat of Vice President	- Deputy for Human Development and Equality - *TN2PK* Secretariat
Development Partners	- DFAT - UNICEF - MCA-I
Private Sector	- Indofood - SUN Business Network
North Sulawesi Province	
Provincial Government	- Secretary of Department of Community and Village Empowerment *GSC* Provincial Coordinator

Administrative Level	Stakeholders
District Government of Talaud	- *BAPPEDA* - Head of Village Community Empowerment and Development Agency - Health Agency - Education Agency - *GSC* facilitators - *GSC* treasurer
Village Government, civil society, service providers, and affected communities: Melonguane, Kabaruan, Desa Bowone Damau, Desa Damau Karakelong, Desa Bantik Karakelong, Desa Ensem Rainis, Desa Rainis	- Mothers - Pregnant women - *Puskesmas* doctor - Head of *Puskesmas* - *Puskesmas/Posyandu* cadres - *PAUD* operators - *PAUD* staff - *PAUD* cadres
Gorontalo Province	
Provincial Government	- Provincial *GSC* Coordinator - Provincial *PAMSIMAS* Coordinator
District Government of Gorontalo	- Secretary of Department of Community and Village Empowerment Agency - *BAPPEDA* - Village Community Empowerment and Development Agency - District Health Office - Health Agency - Head of Community Health Division - *GSC* District Secretary Office - *GSC* District - Public Works Agency - *PAMSIMAS* Team, Local Government Specialist, Water and Sanitation Specialist, District Coordinator - Head of Environmental Health - Head of Disease Control and Environmental Health Division - District Housing/Human Settlement Office - Agency for Implementation of Water Supply System
Village Government, civil society, service providers, and affected communities: Pulubala; Desa Bakti Kec Pulubala, Desa Kayu Merah and Desa Liyodu Kec Bongomeme, Desa Tabumela Kec Tilago	- Head of village - Village committee - Mothers - Fathers - Village midwives - Nutritionist - Cadres
West Nusa Tenggara Province	
Provincial Government	- Procurement Unit - State Treasury Regional Office - Head of Bank Section
District Government of Lombok Tengah	- *BAPPEDA* - Head of Social and Cultural Affairs - Head of Education - Head of Health - Head of Monitoring and Evaluation - Head of Planning

Administrative Level	Stakeholders
	- District Finance and Asset Management Office – Head of Budget Division, Staff of Treasure Division, Head of Treasury Division - Health Agency - Head of Community Health Division - Head of Environmental Health - Head of Disease Control and Environmental Health Division - Agency for Implementing Water Supply Systems - *PAMSIMAS* District Team - *PAMSIMAS* facilitators - *GSC* District Team - HDW facilitators - *GSC* facilitators
Village Government, civil society, service providers, and affected communities: Praya Barat; Desa Mekar Sari	- Village Head - Village Committee - Head of *Dusun* - Community Members - Head of *Puskesmas* - Nutritionist - *Puskesmas* Treasurer
West Java Province	
Provincial Government	
District Government of Cianjur	- *BAPPEDA* - Agency for Cultural and Social Affairs - Planning Agency - Health Agency - Head of Public Health Division - *Bupati* - Health Agency - Health Promotion - Head of Family Health and Nutrition - Head of Pharmacy Agency - Staff of Family Health and Nutrition - Head of Human Resources - Head of Field and Disease Control - Head of Environmental Health - Head of Human Resources - Head of Environmental Sanitation - Environmental Agency - Education Agency - *PAUD* Division - Population Control, Family Planning, Female Empowerment and Child Protection Agency - Head of Family Resilience - Education Implementing Agency
Village Government, civil society, service providers, and affected communities: Cikalong Kulon; Desa Cikancana**,** Desa Ciwalen**,** Desa Kamuran**g**	- Village Committees - Village Heads - Community members - Health Coordinator - Head of *Puskesmas* - Environmental Health staff - *PAUD* operators

Administrative Level	Stakeholders
	- *PAUD* staff - *PAUD* teachers - Midwife - Nutrition staff
Maluku Province	
Provincial Government	
District Government of Maluku Tengah	- *BAPPEDA* - District Planning Officer - District Finance and Asset Management Agency - *GSC* District Office - *GSC* Team - Social Agency - Housing and Settlements Agency - Village Empowerment and Development Agency - MCA-I Team - Health Agency – Data Collection Officers, Finance and Planning Officers, - Head of Pharmacy Division - Staff of District Health ((Maternal and Child Health, Nutrition, and Family Planning, Health Promotion) - Public Works Agency - Water and Sanitation Division staff - *PAMSIMAS* District Coordination - Implementing Water Supply Systems Division - *PAMSIMAS* staff - Education Agency - Head of Planning Division - Staff of Planning Division - Staff of *PAUD* Division
Village Government, civil society, service providers, and affected communities: Tehoru; Mosso Village	- Village Head - Village Committee - Community members - Head of *Puskesmas* - *BOK* Treasurer - Midwives coordinator - Nutritionist - Cadres - Mothers - Fathers

Consultations undertaken for supporting preparation of the INEY Program.

1. National Consultations

Date	Location	Stakeholders consulted	Topics discussed
08/12/2017	Bappenas	Basah Hernowo Direktur Sistem & Prosedur Pendanaan Pembangunan, Bappenas	KRISNA (Kolaborasi Perencanaan dan Informasi Kinerja Anggaran, or collaborated planning and budgeting performance information) which is an application built by Bappenas and currently used by the line ministries to develop their annual work plans (Renja-KL); The process of planning a program as National Priority PP 17/2017 that will require a data sharing and synchronizing of both KRISNA and RKA-KL (DG Budget's application for work and budget plan)
11/12/2017	MOF	Sudarto Direktur Sistem Informasi dan Teknologi Perbendaharaan; Ditjen Perbendaharaaan MOF	Indonesia FMIS (SPAN) to capture each of individual Central Government payment transactions and to generate financial reports OM-SPAN (on-line monitoring) SPAN to produce budget realization data in detail by unit organization, economic classification, and output Budget execution process
13/12/2017	Ashley Hotel Stunting Measurement Survey Workshop	TNP2K BPS (Central Statistics Bureau) MOH Riskesdas Survey Meter	Discuss and asses local experience and global regarding Stunting measurement including experience from Riskesdas
13/12/2017	TNP2K Office	Bambang Widianto, Deputy to the VP, Human Development and Equitable Development Policy Support/Executive Secretary TNP2K Lucky Alfirman, Director General of Budget Financing and Risk Management - MOF Suahasil Nazara, Head of Fiscal Policy – MOF Askolani, Director General of Budget Subandi, Deputy Minister for Human Development, Community and Culture – Bappenas Kennedy Simanjuntak, Deputy Minister for Development Financing	Kick off Meeting
14/12/2017	TNP2K Office Workshop on Delivery Units		The current practices and approaches of TNP2K Office in dealing and managing its key stakeholders, in particular line ministries and agencies that are involved in poverty reduction efforts in carrying out its duties and responsibilities; The challenges TNP2K Office in carrying out its duties and responsibilities; The current scope of works, duties, responsibilities and accountabilities of TNP2K Office as well as the current capacities and capabilities of the Office in running its tasks and duties The background, scope of works, mandates, challenges, success story and lessons learn from PEMANDU Malaysia that TNP2K might benefit from

Date	Location	Stakeholders consulted	Topics discussed
			Discussions around key national priorities as the targets for PEMANDU, the former UKP4 and TNP2K Office A brief comparison between the former UKP4, PEMANDU and TNP2K in terms of structures and hierarchies, mandate, scope of works, managerial approaches, accountabilities and results
20/12/2017	Aston Rasuna, Kuningan	dr. Riskiyana Sukandhi Putra, M.Kes, Director of Health Promotion and Community Empowerment	Healthy Indonesia Program with Family-Based Approach (Program Indonesia Sehat dengan Pendekatan Keluarga, PIS-PK) Community Movement for a Healthy Life (Gerakan Masyarakat Sehat, Germas) Stunting Campaign
20/12/2017	MOH	drg. Saraswati, MPH, Director of Primary Healthcare	Puskesmas revitalization Puskesmas planning cycle Puskesmas accreditation Puskesmas Berprestasi Award Puskesmas Information System
11/01/2018	Hotel Ashley	Kementerian Koordinator PMK Kementerian Kesehatan Kementerian Keuangan TNP2K Bappenas	Discussion on Development of DAK Health for 2018 & 2019 (thematic Stunting)
11/01/2018	MOSA	Andi ZA Dulung, DG PFM	
15/01/2018	MOH	Doddy Izwardy, Director of Community Nutrition – MOH	Introduction of length-mat as a stunting awareness tool
16/01/2018	Hotel Borobudur	Askolani, Director General of Budget Elan Satriawan, Head of Working Groupu Monitoring and Evaluation – TNP2K Pungkas Ali, Director of Health and Community Nutrition – Bappenas Kunta Nugraha, Director of APBN Budgeting – MOF Eka Hendra Permana, Climate Change Fiscal Policy – BKF Purwanto, Director of Budget for Human Development and Culture	Understanding the government's system on the program planning, budgeting, execution and reporting of central government budget Learning the example of Budget Tagging on Climate Change Program that is done by Fiscal Policy Office Getting inputs from line ministry on their current practices in planning and budgeting the stunting reduction as a government national priority program
16/01/2018	MOSA	Dillon Zufri, Dewie Ratnasari, Citra Utami BPNT technical team / Assistant to DG PFM	Information sharing about Government plan to address stunting and how BPNT could help address it. Explanation about the workings of modalities of World Bank Support. Agreement to share data and information about current and planned BPNT operation
16/01/2018	MOEC	Ella Yulaelawati, Director for ECED	Confirming that Directorate's priority is 3-6 and that 0-2 is within Directorate for Parenting
17/01/2018	TNP2K Included BPNT/Rastra in INEY	Elan Satriawan, Head Working Group M&E TNP2K	Included BPNT/Rastra in INEY
17/01/2018	MOH	Susiyo Luchito, Okta Iskandaria, Bureau of Planning and Budgeting, MOH	Discussed MOH's Holistik Integrative Stunting Intervention Approach, and coordination efforts within and across sectors Formulation/preparation of Annual Plan and allocation of funds under various schemes/programs
18/01/2018	TNP2K Office		

Date	Location	Stakeholders consulted	Topics discussed
	Produksi dan Penempatan Materi Kampanye Stunting 2018		
18/01/2018	MOH	Dr. Eni Gustina, MPH, Directorate of Family Health	Healthy Indonesia Program with Family-Based Approach (Program Indonesia Sehat dengan Pendekatan Keluarga, PIS-PK) Kelas Ibu Hamil and Ibu Balita MNCH Book (the pink book) SDIDTK, MTBS
19/01/2018	MOH	Dr. Mawari Edy, Kepala Bidang Pendayahgunaan SDM, RR. Endah Khristanti Wahyu, Kepala SubBidang Pendayahgunaan SDM Daerah Khusus, BPPSDM	Human resource for health planning and distribution Nusantara Sehat: recruitment, deployment, training, complaint handling Zero growth policy (PNS moratorium) Task Shifting
19/01/2018	MOEC	Sukiman, Director of Parenting	Introducing PforR, Fiduciary and Safeguard Assessment
19/01/2018	MPWHH	Dodi Krispatmadi, Director of Environmental Health Development M Sundoro, Director of Water Supply Development Dwityo Akoro Soeranto, Director of Integrated Settlements Infrastructure	Program and activities on water supply development Strategy to increase convergent delivery for stunting reduction
20/01/2018	MOEC	Nurzaman, Secretary to DG for Teacher	Introducing PforR, Fiduciary and Safeguard Assessment
22/01/2018	Bappenas discuss stunting PER & expenditure framework	Pungkas Ali, Director of Health and Community Nutrition – Bappenas	Socialized the PER stunting activities and the connection with P4R INEY project Get input and comment from Bappenas to enrich PER stunting analysis MoF perspective in looking at PER stunting : more on fiscal space Bappenas perspective in looking at PER stunting : more on the efficiency issues especially on specific intervention Discussed stunting intervention definition that can be used for PER stunting
22/01/2018	The Falatehan Hotel HDW Training	Provincial Coordinators, Subdistrict Facilitators, KPMDs and Generasi Cadres of: NTB West Java West Kalimantan Gorontalo Maluku	
22/01/2018	MOH	Giri Wurjandaru and Dakhlan, Directorate of Community Nutrition	Key nutrition interventions delivery arrangement and budget PSG e-PPGBM
22/01/2018	MOH	Dr Imran Agus Nurali, Director of Environmental Health, Sonny, Kasubit PASD, Kristin, Elly, Kasubit TU, Director of Environmental Health	Community Led Total Sanitation/STBM program and activities by central and district government Mechanism to monitor result and areas for improvement Strategy to increase convergent delivery for stunting reduction
23/01/2018	Bappenas		Development in the preparation of GOI annual work plan (RKP)

Date	Location	Stakeholders consulted	Topics discussed
	DAK Stunting Discussion with Pak Firman		Bappenas thinking on policy direction for DAK 2019
23/01/2018	TNP2K Meeting with TNP2K to discuss stunting PER and expenditure framework	Elan Satriawan, Head of Working Group M&E – TNP2K	Discussed the stunting intervention definition and method used to collect 100 local government relate stunting expenditure Discussed the role of TNP2K in the local government spending data collection and monitoring Discussed underlying data and method to select 100 priority district
24/01/2018	MOH	Directorate of Health Promotion and Community Empowerment	Program and activities by central and district government Linkage with other program and ministries for content development Mechanism to monitor result and areas for improvement Strategy to increase convergent delivery for stunting reduction
31/01/2018	MOH	Dr. Embry Netty, M.Kes, Head of BBPK Cilandak	Cascade training for Mindwives and Nurses
07/02/2018	Borobudur Breakfast meeting on DAK Stunting Design	Putut Hari Satyaka (MOF) Irianto Nainggolan (MOF)	Consultation on DAK Stunting Design and DAK pilot
08/02/2018	MOEC	Haris Iskandar, Director General of ECED	Confirming that Parenting Education is MoEC's program for Stunting Reduction. Discussion on longer-term possibility of DAK BoP *PAUD* to support Parenting Education.
13/02/2018	MOEF	Ms. Sinta Saptarina- Director and staff (Ms. Euis and Ms. Mitha)	Medical waste management and safe handling; relevant policy and regulation
14/02/2018	MOH	Windu, Bureau of Planning – MOH	Socialized the PER stunting activities and seek possible collaboration with MOH as there is assignment to this unit to analyse expenditure relate to stunting Discussed stunting intervention definition that has been used by MOH
19/02/2018	MOH	Susiyo Luchito, Bureau of Planning	MOH monitoring and evaluation mechanism
19/02/2018	MOEC-Directorate for Parenting education)	Dr. Sukiman – Director of Parenting and staff	Understanding vision for Parenting Program in 1000 days and its contribution to reduce stunting; identifying entry points for improvement regarding environmental and social systems; looked at 1000 HPK learning materials and delivery of parenting sessions through *PAUD.*
21/02/2018	MOH-BPPSDM	Dr. Mawari Edy - Head of Human Resources RR. Endah Khristanti Wahyu - Head of Special Utilization of Human Resources	Mobilization of staff for *Fasyankes/Puskesmas* in districts, including preparation and training
05/03/2018	Bappenas	Dr. Kennedy Simandjuntak, Deputy Minister for Development Financing Ir. Ade Kuswoyo, Deputy Director for Multilateral Cooperation	Discussed GFF implementation arrangement for the IPF component

Date	Location	Stakeholders consulted	Topics discussed
26/02/2018	Bappenas, TNP2K	Dr. Elan Satriawan, Head of Working Group, M&E, TNP2K Dr. Pungkas Bajhuri Ali, Director of Health and Community Nutrition, Bappenas Ir. Ade Kuswoyo, Deputy Director, Multilateral Cooperation	Discussed about IPF component that includes GFF process and implementation arrangement in Indonesia and activities that will be financed under IPF component
08/03/2018	MoH-Directorate of Community Health	Ir. Doddy Izwardy, Director of Nutrition Dr. Rizky, Director of Health Promotion Dr. Eni Gustina, Director of Family Health	Discussed behavioural change communication, particularly interpersonal communication through home visits as one of the DLIs that MoH will be responsible for.
09/04/2018	Mandarin Oriental Hotel, Jakarta	central ministries, including MOHA, MOEF, MOH as well as representatives from Central Maluku District, Gorontalo Province, Cianjur District of West-Java, Central Lombok District of NTB and Ketapang District of West Kalimantan	INEY PforR; ESSA Process and Findings. Minutes of meeting can be found in Section 7 of this Annex.

2. Generasi ISM/ INEY Social, Talaud District, November 2017

Date	Location	Stakeholders consulted	Topics discussed
12/11/2017	DPMD Secretary Office	DPMD Secretary	Mission objective Villages to be visited
13/11/2017	Health Agency		Understanding annual planning and budgeting re programs around health, nutrition and *GSC*, monitoring systems
14/11/2017	Education Agency	Head of *PAUD* section	Understanding role of education agency re programs around early childhood education, annual planning and budgeting, incentives, capacity building
15/11/2017	Provincial *GSC*	*GSC* Provincial Coordinator	Understanding role re *GSC*
14/11/2017	Puskesmas Damau	Head of Puskesmas Damau	Understanding incentives, accreditation, planning, budgeting, coordination with health agency, challenges and limitations
14/11/2017	Desa Bantik Desa Ensem Desa Rainis Desa Damau Desa Pangeran	Posyandu cadres Posyandu operators *GSC* Facilitators *GSC* Treasurer *PAUD* cadres *PAUD* operators Beneficiaries	Understanding *GSC* activities, incentives, coordination, planning and budgeting, capacity building Benefits and limitations of *GSC* Impressions of *GSC*

3. INEY Mission, Gorontalo District, February 2018

Date	Location	Stakeholders consulted	Topics discussed
06/02/2018	BPMD Gorontalo Office	BPMD/Community and Village Empowerment Office Bappeda/District Planning Office (Bu Rola) Dinas PUPR/District Public Work Office (Pak Firman, Pak Mukhlisan)	Mission objective Villages to be visited Schedule re-arrangement for technical meeting

Date	Location	Stakeholders consulted	Topics discussed
		Dinas Kesehatan/District Health Office (Bu Sukarni) Provincial Coordinator-*GSC* Team District Coordinator-*GSC* Team	
07/02/2018	Bappeda Gorontalo Office	Bappeda (Pak Ichsan, Bu Rola) Dinas Kesehatan (Bu Sukarni, Bu Sita) Dinas Pendidikan Dinas PUPR (Pak Firman, Pak Mukhlisan) Dinas Perumahan & Permukiman (District Housing/Human Settlement Office) Provincial Coordinator *GSC* Team District Coordinator *GSC* Team *PAMSIMAS* Team (Provincial Coordinator, Local Government Specialist, Water and Sanitation Specialist, District Coordinator)	District systems and possibility to support convergence program for Stunting Reduction: priority setting coordination forum monitoring and evaluation process incentive mechanism policies support Locus of DAK 2018 and possibility for re-allocation to 10 priority villages Program and budget (various financing)
07/02/2018	Puskesmas Kec. Pulubala-Gorontalo	Staff of Puskesmas Pulubala, Pulubala district	To assess the health and nutrition services at Puskesmas and villages (the planning, budgeting, forecasting, implementation, M&E, reporting/MIS, supportive supervision, in service training, convergence with other sectors) To conduct FGD among mothers, health workers to pre-test the length mat.
7-8 Feb 2018	Desa Bakti Kec Pulubala, Desa Kayu Merah and Desa Liyodu Kec Bongomeme, Desa Tabumela Kec Tilago	Head of Village, village committee, village midwives, nutritionist, cadres, mothers, and fathers, BPPSPAMs (Desa Liyodu)	To review the village planning, budgeting, implementation, M&E, reporting/MIS, supportive supervision, in service training, convergence with other sectors (esp with water and sanitation) To review HDW, the posyandu implementation To conduct FGD among mothers, health workers to pre-test the length mat.
09/02/2018	Bappeda Office	Bappeda (Pak Ichsan, and Bappeda Secretary) Dinas Kesehatan (Bu Sita) Dinas PUPR (Pak Firman, Pak Mukhlisan)	Data collection: DPA and RKA (FY 2017 and 2018) related to sensitive intervention Clarify availability program in 10 priority villages
09/02/2018	District Health Office	District Health Officer (Bu Sukarni)	To review the district health office planning, budgeting, implementation, M&E, reporting/MIS, supportive supervision, in service training, convergence with other sectors

3. INEY Mission, Lombok Tengah District, February 2018

Date	Location	Stakeholders consulted	Topics discussed
06/02/2018	Bappenda Lombok Tengah	Zainal Mustakim, Kabid Sosial Budaya, Bappeda, Annusapati, Kasubbid Pendidikan, Bappeda	Introduction to mission's objective and stunting convergence program;

Date	Location	Stakeholders consulted	Topics discussed
		Arief Djoko, Kasubbid Kesehatan, Bappeda	District's understanding, policy, budget, regulation, strategy, target and updated achievement to address stunting; District monitoring system; District budget; and Request access to other dinas. One data pilot: Sistem Layanan Rujukan Terpadu Ps. Earlier, in the morning, we were invited to join the TKPKD's coordination meeting to discuss about stunting. Hence, we basically have met with all dinas' representatives and heard stunting issues in their perspectives.
07/02/2018	Bappeda Lombok Tengah	Yusuf Anshori, Kabid Litbang Ekpol, Bappeda Drh. Taufik, kasubdit Monev, Ekpol, Zamzami, Kasubdit perencanaan, Ekpol	DAK, e-planning, decision making process for DAK at district level Elaborate about possibility of piloting DAK-Programmatic.
07/02/2018	District Health Office	H. Omrah, Head of Health Dinas Kusriadi, Kabid Gizi, Head of Community Health Division Lalu Malik, Kasubdit Kesling dan Kesgaor, Head of Subdivision Environmental Health H. Hasyim, Kabid Kesmas, Head of Disease Control and Environmental Health Division *PAMSIMAS* district team. *GSC* district team	District health office policy, target, budget and issues with regards to stunting. Elaborate on nutrition specific intervention and nutrition sensitive intervention, in particular Water and Sanitation. Elaborate possibility to piloting DAK Programmatic.
07/02/2018	Public Works office	Suraji, Kasi Air Minum dan Sanitasi, Syam, Kabid Infrastruktur	Access to rural water and sanitation, demarcation of roles and responsibility between Public Works office, Settlement office, and Environment Office and issues with regards to Padat Karya and stunting program. Elaborate possibility to piloting DAK programmatic and how to do it. Some concerns about changing approach, from community-based such as *PAMSIMAS* and STBM to Padat Karya.
07/02/2018	Unit Layanan Pengadaan/ ULP (Procurement Unit)	Helmi Qazwaini – Head of ULP	Procurement process in Lombok Tengah
07/02/2018	LPSE (Electronic Procurement Service)	Sunarno – Head of Subdivision of Electronic Procurement	E-procurement process in Lombok Tengah, including the electronic system and server
08/02/2018	Desa Mekar Sari, Praya Barat	Kepala Desa and team, Nutritionist Puskesmas, Bidan desa and posyandu cadres, Kepala dusun and some community members, HDW, *GSC*, *PAMSIMAS* consultants	Their understanding about stunting prevention program, their follow up plan, demarcation of roles and responsibility to address stunting. Access to water and sanitation and other behavior (marriage, family planning, changing names, food intake, education, ect.) Adjustment of APBDes to address stunting.
08/02/2018	Puskesmas Mangkung	Head of Puskesmas, Nutritionist, sanitarian, treasury	Puskesmas plan, activity, and budget to address stunting. Access to wash, nutrition, stunting case, health service.

Date	Location	Stakeholders consulted	Topics discussed
			Possibility to conduct DAK programmatic pilot M&E system and capacity building strategy
08/02/2018	BPPSPAMs Mertak Jumat, Bangket Parak, Pujut	Disahari, Ketua Asosiasi BPPSPAMs Lombok Tengah	Awareness of stunting program, relation between wash and stunting, Role of BPPSPAMS to support stunting prevention program, Issues and support needed by BPPSPAMs to accelerate wash access and support stunting
08/02/2018	District Health Office	Putrawangsa, MPH (Sub Bagian Perencanaan) Ikromudin Idris, Ns (Seksi Gizi Masyarakat) Sudarman S.Kep (Seksi Promosi dan Pemberdayaan Masyarakat) H. Hasyim, SKM, MM (Bidang P3KL)	District health office planning, budgeting, supportive supervision, convergence with other sectors Delivery arrangement for key interventions MIS for key interventions DAK Fisik and Non Fisik planning and proposal process BOK Puskesmas planning and utilization Budgeting process for Dinas and Puskesmas
08/02/2018	Lombok Tengah, BPKAD (District Finance and Asset Management Office)	Bowo Susatyo, Secretary of BPKAD Ida Ayu Wayan Maret – Head of Budget Division, BPKAD Zuryati – staff of Treasury Division, BPKAD Kusna Hariyadi – Head of Treasury Division, BPKAD	Reporting mechanism for DAK Fisik, Non Fisik, and Dana Desa Budget planning process Disbursement realization of DAK 2017 Implementation of DAK Fisik/Non Fisik and possibility to adjust locus/focus Role of KPPN on DAK reporting
09/02/2018	Health Office, Lombok Tengah	H. Hasyim, kabid Kesmas, Darlan, Fasilitator STBM Kabupaten/staf PNS Kesmas	Issues related to sustainability of wash (quantity, quality, continuity, affordability), STBM strategy and target, Plan for integration with nutrition to address stunting, Clarify data.
09/02/2018	Health Office, Lombok Tengah	M. Ali, S.Kep (Seksi Sistem Info Litbangkes) Baiq Atmawati (Seksi Kesehatan Keluarga) Dwinta (Sengkol Midwive)	SIKDA Generik e-Puskesmas MIS for MNCH, including OpenSRP pilot project In service training for midwives and refresher training for cadres Provision of Kelas Ibu
09/02/2018	KPPN (State Treasury Regional Office)	Henry Rosamirandha, Head of Section of Bank	Process of DAK reporting by district

4. INEY Mission, Cianjur District, February 2018

Date	Location	Stakeholders consulted	Topics discussed
07/02/2018	Bappeda Office	Ali Mahmudin, Kepala SubDit Sosial Budaya Pak Cupit, Fungsional Perencanaan Dinas Kesehatan Staff (Trisna Gumilar, Kepala Dinas Kesehatan, Dr Irvan, Kepala Bidang KesMas, Kepala Puskesmas, Aisyah Foundation staff (In a Bappeda side event)	Meeting to discuss the objective of the mission and to prepare for technical meetings with the different departments in the district. Briefly discussed district convergence planning for stunting reduction. Received inputs on challenges in the puskesmas, and challenges in implementing nutrition-specific and –sensitive interventions in the sub-district and village.
07/02/2018	Bupati Office	H Herman, Wakil Bupati Trisna Gumilar, Kepala Dinas Kesehatan	Meeting to discuss the objective of the mission and to prepare for technical meetings with the different departments in the district.

Date	Location	Stakeholders consulted	Topics discussed
			Briefly discussed district convergence planning for stunting reduction.
07/02/2018	Dinas Kesehatan	Ibu Liste, Kepala Seksi PromKes Ibu Teni Hernawati, Kepala Seksi Kesehatan Keluarga Gizi Ibu Aning Yuningsih, Kepala Instalasi Farmasi Dinas Kesehatan Ibu Rita Surtini, Staff Seksi Kesehatan Keluarga Gizi	To assess the health and nutrition services at Puskesmas and villages (the planning, budgeting, forecasting, implementation, M&E, reporting/MIS, supportive supervision, in service training, convergence with other sectors
08/02/2018	Dinas Pendidikan Kab. Cianjur	Ruhli Solehudin, Kasi *PAUD*	Assessment of *PAUD* activities and opportunities to focus on stunting-relevant ages (0-3) and parental counseling
08/02/2018	Dinas Pengendalian Penduduk, Keluarga Berencana, Pemberdayaan Perempuan dan Perlindungan Anak (DPPKBP3A)	Drs Ade Suherilan Sofyan, Head of Family Resilience	Discussion on Dinas activities at the district, subdistrict and village level related to stunting interventions, particularly counseling for parents on stunting health and education.
08/02/2018	Dinas Kesehatan	Dr Sanny Sanjaya, Ketua Bidang SDK Ibu Kiki Yunita, Ketua Seksi Alkes)	To assess the health and nutrition services at Puskesmas and villages (the planning, budgeting, forecasting, implementation, M&E, reporting/MIS, supportive supervision, in service training, staffing, convergence with other sectors
08/02/2018	Puskesmas Cikalong Kulon	Pak Alfian, Staff Seksi Kesehatan Lingkungan Dr Budi Bakhtiar, Kepala Puskesmas Ibu Imas, Koordinator Bidan Ibu Ela, Bidan Pak Kang Hidaya, Staff Gizi	To review the puskesmas planning, budgeting, implementation, M&E, reporting/MIS, supportive supervision, in service training, convergence with other sectors.
08/02/2018	Kecamatan Sukaresmi UPT Dinas Pendidikan Kec. Sukaresmi	Heri, Penilik *PAUD*	Assessment of *PAUD* activities and opportunities to focus on stunting-relevant ages (0-3) and parental counselling
08/02/2018	Desa Cikancana Kantor Desa Cikancana Pos *PAUD* Anggur (Terintegrasi Posyandu) Pos *PAUD* AL Hasanah Desa Cikancana	Suryadi, Village Sekretariat Ibu Cucu Sumiyati, Kepala/ Pengelola Pos *PAUD* Anggur Ibu Yuli, Guru *PAUD* Ibu Imas, Guru *PAUD* merangkap Kader Posyandu Ahmad Badri, Pengelola Pos *PAUD* AL Hasanah	Assessment of village planning, monitoring and evaluation processes and education activities related to stunting, particularly timing of activities, staffing, and capacity. Discussion on stunting rates in village and possible interventions. *PAUD* activities related to stunting. Discussion on emphasizing ages 0-3 and possibility of adding parent counselling

Date	Location	Stakeholders consulted	Topics discussed
	Kec. Sukaresmi		
08/02/2018	Desa Ciwalen	Budiyanto, Head of Village	Assessment of village planning, monitoring and evaluation processes and education activities related to stunting, particularly timing of activities, staffing, and capacity.
08/02/2018	Desa Kamurang	Kepala Desa Pak Kang Hidaya, Staff Gizi Ibu Imas, Koordinator Bidan Village Midwife Villagers	To review the village planning, budgeting, implementation, supportive supervision, posyandu facilities, convergence with other sectors Focus group discussion with selected villagers on IYCF practices, and household diet.
08/02/2018	Dr Eva Fatimah, Kepala Bidang P2P	Dr Eva Fatimah, Kepala Bidang P2P Ibu Rita Surtini, Staff Seksi Kesehatan Keluarga Gizi Ibu Sri, Kepala Seksi Kesehatan Lingkungan Ibu Meita, Ketua Seksi Farmasi Ibu Sanny, Ketua Seksi SDM	To assess the health and nutrition services at Puskesmas and villages (the planning, budgeting, forecasting, implementation, M&E, reporting/MIS, supportive supervision, in service training, staffing, convergence with other sectors
08/02/2018	Dinkes Kabupaten Cianjur	Head Section Environmental Sanitation- Ibu Sri-082218250499	Medical Waste Management at Fasyankes
08/02/2018	Puskesmas CIKALONG Kab. Cianjur	Head of Puskesmas and Env.Health officer	Medical waste handling, storage, permitting
08/02/2018	Dinas Lingkungan Hidup (Environmental Agency) Kab. Cianjur	Secretary of Dinas-Bapak Deden (08122311743 and Pak Iden, Ibu Evi (Waste)-085797119710	Law enforcement of regulation related to medical waste handling from Fasyankes
08/02/2018	Kamurang Village	Head of Village	Water supply and sanitation priority

5. INEY Mission, Ketapang District, February 2018

Date	Location	Stakeholders consulted	Topics discussed
12/02/2018	District Secretary Office	Sekretaris Dinas PU dan Tata Ruang Kasie Perencanaan Sekretaris Dinas Kimrum Kabid Kesmas Kadis Kesehatan	Mission kick off meeting Discussion on WASH
	Desa SukaMaju	Posyandu cadres Posyandu operators Beneficiaries	Socializing length-mat to posyandu operators and cadres Discussion on informed consent, access to information, early pregnancies and marriages, FGM, traditional practices
	Desa SukaBangun	Posyandu cadres Posyandu operators Beneficiaries	Socializing length-mat to posyandu operators and cadres Discussion on informed consent, access to information, early pregnancies and marriages, FGM, traditional practices
	Desa Ulak Medang	Posyandu cadres Posyandu operators Beneficiaries	Socializing length-mat to posyandu operators and cadres Discussion on informed consent, access to information, early pregnancies and marriages, FGM, traditional practices

6. INEY Mission, Maluku Tengah District, February 2018

Date	Location	Stakeholders consulted	Topics discussed
12/02/2018	District Secretary Office	Asisten II Setda Dinas Kesehatan Dinas Pendidikan Dinas Sosial Dinas Pekerjaan Umum Dinas Perumahan & Permukiman Dinas Pemberdayaan Masy & Desa *GSC* team *PAMSIMAS* Team MCA-I Team	Mission objective District systems and possibility to support convergence program for Stunting Reduction Schedule arrangement for technical meetings with different district offices
13/02/2018	District Health Office	District Health Officers, including Data Collection Officers and a Planning Officer	Data collection, reporting and M&E systems in the health sector, including data quality assurance mechanisms, design of the M&E system and the use and dissemination of the collected results information.
13/02/2018	District Health Office	Division of Environmental Health Officer (Bu Sukma)	FY 2017 and 2018 Program and budget (target output, locus, financing source) CLTS/STBM implementation and monitoring challenges Sanitarian performance and incentive Coordination with other programs/sectors
13/02/2018	District Health Office	Kusranggi L – Staff of Planning and Finance Ismail – Staff of Planning and Finance	Planning and timeline of DAK Fisik preparation Planning, implementation and reporting of BOK
13/02/2018	District Planning Office	District Planning Officer (Pak Joko)	Review of monitoring and evaluation arrangements for the District Development Plan, including the collection of routine monitoring information and the use and dissemination of data.
13/02/2018	BPKAD (District Finance and Asset Management Office)	Wisen Titaley – Staff of Treasury Division, BPKAD	DAK Reporting mechanism through OM-SPAN Reporting mechanism from Dinas to BPKAD
13/02/2018	District Public Work Office	Rikonusa Waelerony (Officer-PPK *PAMSIMAS*) M Nur (Officer-Division of Water and Sanitation) Lusan Marini Putri Siregar (*PAMSIMAS* District Coordination)	FY 2017 and 2018 Program and budget (target output, locus, financing source) Challenges in provision of access to clean water in rural areas Monitoring system to subdistrict and village level BPPSPAMs performance and incentive Coordination with other programs/sectors
13/02/2018	District Education Office	Katarina Latarissa – head of Planning Division Sani Tehuwayo – Staff of Planning Division Dewi Tuasikal – Staff of Planning Fivision Sitra Silawane – Staff of ECED Division Education Officer	Review of District monitoring and evaluation arrangements for the Ministry of Education, including the collection of routine education data and monitoring information and the use and dissemination of data. Utilization and reporting of BOP *PAUD*
13/02/2018	District Social Office	Head of department/Kepala Dinas Secretary of department /Sekretaris Dinas	FY 2017 and 2018 Program and budget (target output, locus, financing source) Human resources and challenges to increase health insurance coverage for poor/vulnerable group

Date	Location	Stakeholders consulted	Topics discussed
			Coordination of PKH program with other programs/sectors
13/02/2018	Puskesmas Kecamatan Tehoru	Nutritionist and midwives at Puskesmas Tehoru	To assess the health and nutrition services at Puskesmas and villages (the planning, budgeting, forecasting, implementation, M&E, reporting/MIS, supportive supervision, in service training, convergence with other sectors
13/02/2018	Mosso Village	Head of Village, village committee, village midwives, nutritionist, cadres, mothers, and fathers	To review the village planning, budgeting, implementation, M&E, reporting/MIS, supportive supervision, in service training, convergence with other sectors To review HDW, the posyandu implementation To conduct FGD among mothers, health workers to pre-test the length mat.
14/02/2018	District Health Office	Staff of District Health Office (Maternal and Child Health, Nutrition, and Family Planning, Health Promotion)	To review the district health office planning, budgeting, implementation, M&E, reporting/MIS, supportive supervision, in service training, convergence with other sectors To review District Pharmacy and medicine supply division and DAK Pharmacy
14/02/2018	District Health Office	Hendry Novrial – Head of Section for Pharmacy	Review of district Pharmacy and medicine supply division Understanding the usage of DAK Fisik Pharmacy and BOK Pharmacy Distribution
14/02/2018	Puskesmas Layeni	Dr. Claartje Leunufna – Head of Puskesmas Midwives coordinator Josemina – BOK Treasurer	To assess the health and nutrition services at Puskesmas and villages (the planning, budgeting, forecasting, implementation, M&E, reporting/MIS, supportive supervision, in service training, convergence with other sectors To review BOK
14/02/2018	Desa Trana	Head of Village Planning and Health Officers BPPSPAMs	Review of Village planning and M&E arrangements, including performance review mechanisms and citizen feedback on service delivery. Review of data collection mechanisms, including reporting templates and quality assurance mechanisms. Inclusion of stunting target group as priority target in expansion plan of water and sanitation services

7. ESSA Validation Workshop, April 2018

Participant List of the ESSA Validation Workshop

No	NAMA	INSTANSI
1	Hj TENI H. [illegible]	Dinkes Cianjur
2	dr. Budi Bakhtiar	Puskesmas Rawat Inap Cikalong kulon
3	Drs. Jawari	DPMD Kab. Cianjur
4.	Winangsih Kadir	Dinas LH & SDA
5	Asmin Muslulu	puskesmas Lembar
6	[illegible]	DPMD Kab-Sitio
7	[illegible]	[illegible]
8	DENNY	DPMN - PPPA
9.	TITI mutia	PUSKESMAS TUMBANG TIT KETAPANG, KAL-BAR
10	YUAN AGAN-	DINAS PERKIM LH Ktp.
11	A. Rudi Hartono	Dinas Pemberdayaan Masyarakat dan Pemerintahan Desa.
12	NUHDI ARFARISY	DINKES KOTA PANG
13	Asriningtias A	Dit. PPLP, DJCK Kementerian PUPR
14	ALFREDUS RATU	BANK DUNIA
15	Annaliza Robertson	Bank Dunia
16	Faza Bahi	WB
17	Meida Octarina	KMKO PMK
18	SULAMI	PUSKESMAS PASAHARI
19	Ir. C.M. Noija	Dinas Lingkungan Hidup Melawi Timur
20	Mahyuddin Talaohu	Dinas Kesehatan
21	H. KUSRIADI	Dinkes Lombok Tengah NTB
22	Nurdin	PKM Mantang
23	L. MAKSUM SUPARDI	DLH.
24	IDEN ARINGGA	DLH
25	[illegible]	[illegible]

No	NAMA	INSTANSI
26	ZAMZAM ISLAMIE	[illegible]
27	Taufiqqurrahman	Ditjen Bangda
28	Herlinta	PKPLB3 - KLHK
29	Kurnia Nur W.U.	Dit. PKPLB3 - KLHK

Minutes of the ESSA Validation Workshop

Date : April 9, 2018
Venue : Mandarin Oriental Hotel, Jakarta
Participants : See the list of attendance

Themes	Feedback/inputs
Program-related design	**Central Maluku Representatives** - Further clarity with regards to institutional arrangements, particularly roles and responsibilities at the district level is needed to enable interventions to be synchronized. At this stage, the program's arrangements are not fully understood and/or communicated to the district governments. Therefore guidance for institutional arrangements within districts is required. - Stunting issues tend to affect in-land, remote communities, who are hard to reach and hence, underserved. There are issues with regards to the availability of basic services as well as accessibility to say the least. Some of the key roles for the delivery of basic services are assumed by non-government stakeholders, e.g. church and therefore, their participation needs to be considered. **Gorontalo Representatives** - While the national medium-term plan (RPJMN) has incorporated stunting interventions, the district medium-term plan (RPJMD) is yet to follow suit. The program would imply the need for revisions to the current RPJMD, which could not be done quickly. - Proposed nutrition-specific interventions under the program may only partly address the issues, but the major root-causes may stem from environmental health and social/behavioral factors. Human Development Workers (HDW) supported as a convergence instrument under the Program, while strategic, would require concerted efforts to ensure sustainability e.g. skills development, incentives, distribution, etc. - The delivery of basic services that are in need under the Program would fall under the purview of village governments, and therefore there is a need to align this with the implementation of the Village Law to enable proper use of village funds (*Dana Desa* and *Alokasi Dana Desa*); - The new presidential regulation PP 2/2018 on basic minimum standards for basic services would require inter-agency collaboration for the regulation to be operational, which still remains a challenge. **Central Lombok Representatives** - Village-led initiatives to support basic services exist and could be strengthened by improving village-level facilitation as well as governing regulatory frameworks with regards to the use of village funds; - The data on stunting was only recently made available despite the earlier programs supported by the World Bank, including PNPM and GSC, which now represent a missed opportunity to address the issues.
Posyandu and overall delivery of basic health services, including reproductive health	**Central Lombok Representatives** - The provision of food supplements (Program Makanan Tambahan-PMT), as envisioned by the GoI, still favors factory-made products. Encouraging use of locally sourced food items is important to ensure sustainability; - Facilitation at the village level, by strengthening Posyandu cadres' capacity as well as revisiting their incentives, is critical to ensure optimal delivery of needed services and interventions to address stunting; - Posyandu are still dominated by women/mothers and there have been efforts to promote involvement of fathers through a tailored session (at least once a month). **Gorontalo Representatives** - Accessibility remains an issue with remote communities being excluded;

Themes	Feedback/inputs
	- Some existing interventions are limited in scope, such as the piloting of the anthropometric survey funded by the MCI, and scaling up this intervention into villages with pockets of stunting issues would require extra resources and capacity. - Existing interventions at the village level tend to operate independently and if convergence is considered as an approach to address stunting, there is a need to ensure that PAUD services can be integrated into other interventions such as family planning, parenting, youth education, etc. This would need strengthening facilitation roles of cadres, collaboration with other sectoral agencies as well as integrated guidelines. **Cianjur Representatives** - Outreach to men or fathers is generally constrained by socio-cultural and economic factors where men usually act as breadwinners and are therefore perceived to have less time with children. This would require an intervention that is specifically designed for men, including seeking their participation in parenting sessions during sessions at Posyandu. - Reaching out to adolescent girls would require a tailored approach, including education on reproductive health, equally, the program could capitalize on the role of mothers to access this population group. **Maluku Representatives** - Distribution of health workers or the lack thereof especially in remote districts needs to be addressed, particularly with Ministry of Health (MoH) due to district limited fiscal capacity to cover remote areas. **Ketapang Representatives** - Frontline health services are mostly delivered through Puskesmas, located in sub-district capitals and with an extension service in some villages. In this case, not all villages with pockets of stunted children have the needed facilities to reach them and therefore, distribution of these facilities and accessibility still remain an issue.
Early Childhood Education Services (ECED/PAUD)	**Cianjur Representatives** - Current ECED services only cater to children aged two years old and above. This suggests that children or parents under two, who are the targets of stunting interventions could potentially get excluded; - There is the need for parenting education for youth, including education on reproduction health; - There is the need to encourage involvement of fathers e.g. perhaps creating Father's day once a month could achieve this. **Maluku Tengah Representatives**: - Challenges of access still concern communities found in sub-districts in-land, however coastal communities do not have this problem; - There is a lack of human resources, therefore services are provided by religious leader. **Central Lombok Representatives** - The district government, in collaboration with Education and Health Agencies are currently developing an integrated PAUD and POSYANDU service which is expected to enable more systematic interventions and sustained service delivery through strengthened partnership with village stakeholders. **Gorontalo Representatives** - Various education programs have been introduced including through PAUD, Posyandu and Bina Keluarga Balita (BKB); - GSC is funded by PNPM, whilst PAUD teachers are still working on a voluntary basis. **Ketapang representatives** - For PAUD, there are constraints in the field due to geographical location of communities. Focus activities in Puskesmas, important role of sanitarian. **Min of Health/Kesling Representative** - What are concrete suggestions for involvement of father? Father's day?

Themes	Feedback/inputs
	- Various existing programs relevant to parenting education, including STBM/CLTS-Community Lead Total Sanitation. There is a special fund (Dana Dekon) that can be tapped into.
Environmental hygiene, water and sanitation	**Gorontalo Representatives** - Empowering village actors, notably cadres and PKK (Family Welfare Movement) teams to provide outreach to youth and children on hygiene and sanitation. - Handover of water and sanitation facilities to village governments remains problematic since existing regulations pertaining to the establishment of facility management teams and their roles are out of sync with village regulations, causing disconnect and lack of integration with village planning. Sustainability of operations is also an issue. - Fiscal regulatory frameworks, particularly with regards to fiscal transfers from the central government to the district government have certain restrictions that prevent adjustment of allocation to address context-specific and changing issues. - In Gorontalo, there are 53 PAMSIMAS project locations, but 14 of them are no longer functioning. **Central Lombok Representatives** - Solid waste issues remain problematic, especially in remote areas. The district environmental agency, through their waste pick-up services, could only serve urban areas, not rural. - Access to water and sanitation has improved overtime and some communities now have access to communal waste water treatment facilities (IPAL). Smoking habits remain prevalent. **Cianjur Representatives** - The GoI has invested a lot in the "hardware" of basic water and sanitation infrastructure at the village level, yet the "software" including facilitation aspects would still need strengthening to ensure complimentary services, systematic interventions and local ownership. - Additional training, guidelines for development of HDW, midwives and sanitarian with regards to the benefit of access to water, sanitation and strict adherence of hazardous waste handling such as sharps, expired products etc. - It is highly recommended that we use the existing accreditation system of Puskesmas to tackle the issues with medical waste handling in Puskemas and environmental sanitation (standard 8.5.2) of Permenkes 46//2015. **Ketapang Representatives** - Third party services to handle medical waste are not available due to lack of economies of scale to attract private investments. Such waste is managed at the facility level; - It is important to look beyond the existing central government programs, including PAMSIMAS, due to their limited coverage and there is a need to capitalize on village funds to expand access to water and sanitation. - There is still a lack of waste water treatment facilities in many Puskesmas. **Central Maluku Representatives** - Facilitation is key to enhance accessibility and correct targeting of beneficiaries; - The handling of household/solid waste needs to be regulated, including supervision of their enforcement; - Access to water and sanitation at remote locations is still a huge challenge in Maluku. **Ministry of Home Affairs (MoHA) Representatives** - A new presidential regulation No.2/2018 on basic minimum standards for basic services is expected to leverage districts' investments in water and sanitation, as well as other basic services. The guiding regulations and manuals are currently still being formulated, and these will provide further clarity with regards to specific incentives, funding mechanisms, as well as sanctions for failures to meet the standards. - In RPJMN, the national target for the 100-0-100 program needs to be fulfilled in 2019.

Themes	Feedback/inputs
	- The PAMSIMAS program does not cover all of the villages therefore there should not be full dependence on PAMSIMAS to ensure availability of clean water
Medical waste management	**Ministry of the Environment and Forestry (MoEF) Representatives** - The MoEF Regulation No.56/2015 on the guidelines for the handling of medical waste from health facilities acknowledges that some facilities cannot access third-party services. Alternative mechanisms, such as burial of such waste, is allowed provided that they meet certain standards stipulated in the regulation. The District Health Offices are responsible for oversight and facilitation to ensure compliance of the SOPs. - There is still a lack of medical waste treatment service companies in Indonesia. So far there are only 6 companies for the whole of Indonesia. MoEF has established a pilot project for a medical waste treatment facility in South Sulawesi that is meant to support eastern Indonesia, however the facility appears to be limited in capacity, so far it is only able to cover areas around Makassar. **Central Maluku Representatives** - While basic medical waste handling is available at the district hospital, availability of such services is non-existent in *Puskesmas* where such waste is usually buried; - Private health facilities/clinics are usually not equipped with building permits and this has prevented issuance of permits for temporary waste handling facilities/storage. **Central Lombok Representatives** - A third-party medical waste handling service is available (e.g. PT Artha Santoso) and every Puskesmas in the district has been served. **Cianjur Representatives** - While safety boxes have been provided, lack of compliance to the SOPs remains an issue and this would require strengthened oversight by the district health agency - for midwives and Puskemas staff. **Gorontalo Representatives** - Puskesmas are not equipped with medical waste handling facilities due to permitting and infrastructure constraints, and therefore, burial of such waste becomes a usual practice.
Vaccination and supplements, including ANC/PNC	**Cianjur Representatives** - Socio-cultural factors, including belief systems, still prevent people from accessing vaccinations. This has been associated with the recent Diphtheria outbreaks in the region; - Compliance for ANC and PNC (minimum 10 visits) is also problematic among mothers. Similarly, lack of intake of FE pills amongst pregnant mothers is also observed. Addressing such issues would require strengthened facilitation and persuasion by midwives and cadres; - Issue of compliance by health workers in terms of safe handling of "used needles" - which may impact environment. **Gorontalo Representatives** - Issue of cold chains. Recurrent power outages risks vaccine quality/safety; - Since vaccinations are currently administered through injection, only licensed health workers, including midwives, are able to deliver such a service. This has implications to communities and villages with no access to health workers, or with heavy reliance on cadres (where in the past there were other options e.g. drips which did not involve injection and therefore could be performed by cadres). • Challenges regarding 'fake' or faulty vaccines place community at risk. **Cianjur Representatives** - *Puskesmas* accreditation schemes can be considered as an instrument to hold facilities accountable (e.g. compliance to SOPs), however the pressures for delivery of health services now mostly fall under Puskesmas and there is no mechanism to hold District Health Agency (Dinas Kesehatan) accountable for their performance.

Themes	Feedback/inputs
	Central Lombok Representatives - While coverage for vaccination and ANC/PNC has improved greatly over time, there is a lack of understanding with regards to the quality of such services including quality of immunization due to the problem of cold-chains which affect the quality of vaccines. Further assessments would be needed to understand health staff and frontline service workers' performance as well as people's perceptions of such services.
Behaviour change & social mapping	**Gorontalo Representatives** - There was no clear opinion, suggestion or experience over how to create behaviour change. He projected a view that it is household manager's responsibility to ensure children are not stunted, given that women are largely responsible for household – it is their responsibility to ensure children are not stunted – perhaps it was not understood that behaviour change is targeted towards parents and adolescents and not children. **Ketapang Representatives** - Existing need to increase general knowledge about causes of stunting and methods of reducing risk of stunting amongst communities; once this is achieved behaviour change will follow. This can be done through more intensive knowledge delivery and intervention from HDW and other cadres. **Cianjur Representatives** - There must be stronger synergy from central, province, district to village level with regard to integration of 3 (sectoral) areas; education levels, environmental health, and economy amongst communities. **Central Lombok Representatives** - Cadres are essential in creating behaviour change; - Kartu Indonesia Sehat (Healthy Indonesia Card) should be provided for cadres in the village as incentives. **Central Maluku Representatives** - Approach towards behaviour change is increasing capacity of cadres and empowering community through socialization activities to communities, particularly parents. - Behaviour change discussion was very short, perhaps further assessment could have been made. - No comments made on social mapping. **Ministry of Health/ Kesling-Environmental Health Representatives;** - Efforts to introduce behavior change in STBM/CLTS programs. Example of implementation in Asmat - within 2 weeks there were successful behaviour changes towards ODF.

Ringkasan

Kajian Sistem Lingkungan dan Sosial

(*Environmental and Social System Assessment -ESSA)*

INVESTING IN NUTRITION AND EARLY YEARS (INEY)
PROGRAM-FOR-RESULTS (PforR)
INDONESIA

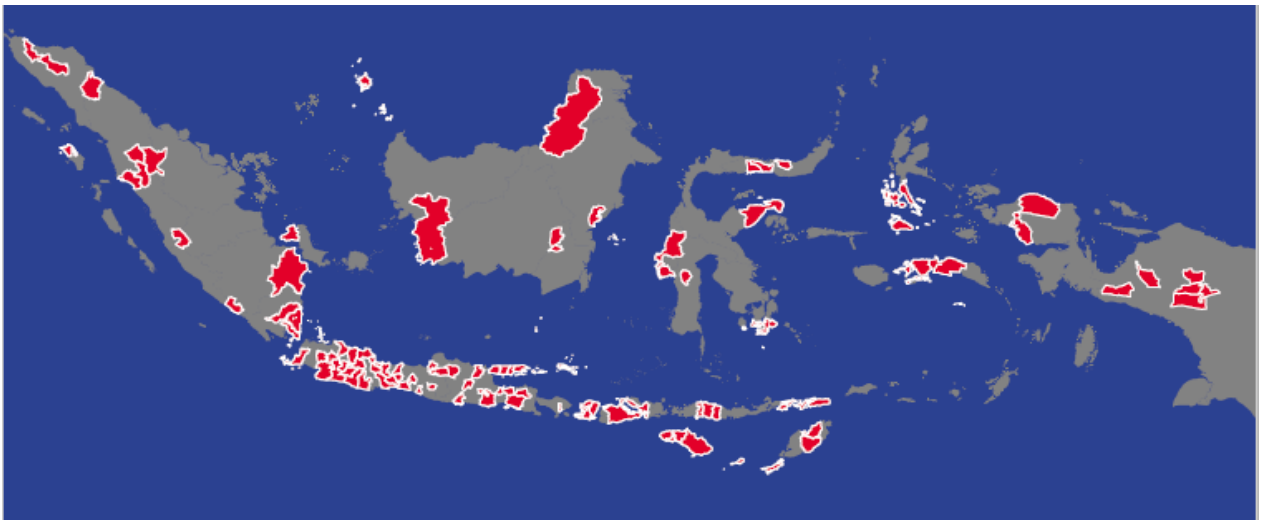
A. *PforR INEY* dan *ESSA*

1. **Proses *ESSA* menguji sistem pengelolaan lingkungan dan sosial yang berlaku pada program PforR INEY dalam rangka mengkaji sejauh mana sistem memenuhi persyaratan sesuai Kebijakan Bank Dunia tentang pembiayaan *PforR*.** Proses ini bertujuan untuk memastikan bahwa risiko lingkungan dan sosial program akan dikelola secara memadai dan mematuhi prinsip-prinsip dasar pembangunan berkelanjutan**.** Ruang lingkup proses *ESSA* termasuk mengkaji:

   a. potensi risiko dan manfaat dari sudut lingkungan dan sosial;
   b. sistem lingkungan dan sosial yang berlaku untuk program;
   c. pengalaman dan kapasitas implementasi;
   d. apakah sistem dan kinerja konsisten dengan prinsip-prinsip utama dari Kebijakan Bank Dunia; dan
   e. langkah-langkah yang harus diambil untuk meningkatkan ruang lingkup sistem atau kaupasitas.

2. ***Program Development Objective (PDO)* atau tujuan dari program *INEY* yang diusulkan adalah untuk: *"Meningkatkan pemanfaatan intervensi gizi secara simultan oleh "rumah tangga 1.000 hari" di kabupaten prioritas".*** "Rumah tangga 1.000 hari" di artikan sebagai rumah tangga dengan perempuan hamil dan/atau anak-anak berusia 0-24 bulan.

Gambar 1: Distrik Prioritas (2018-2019)



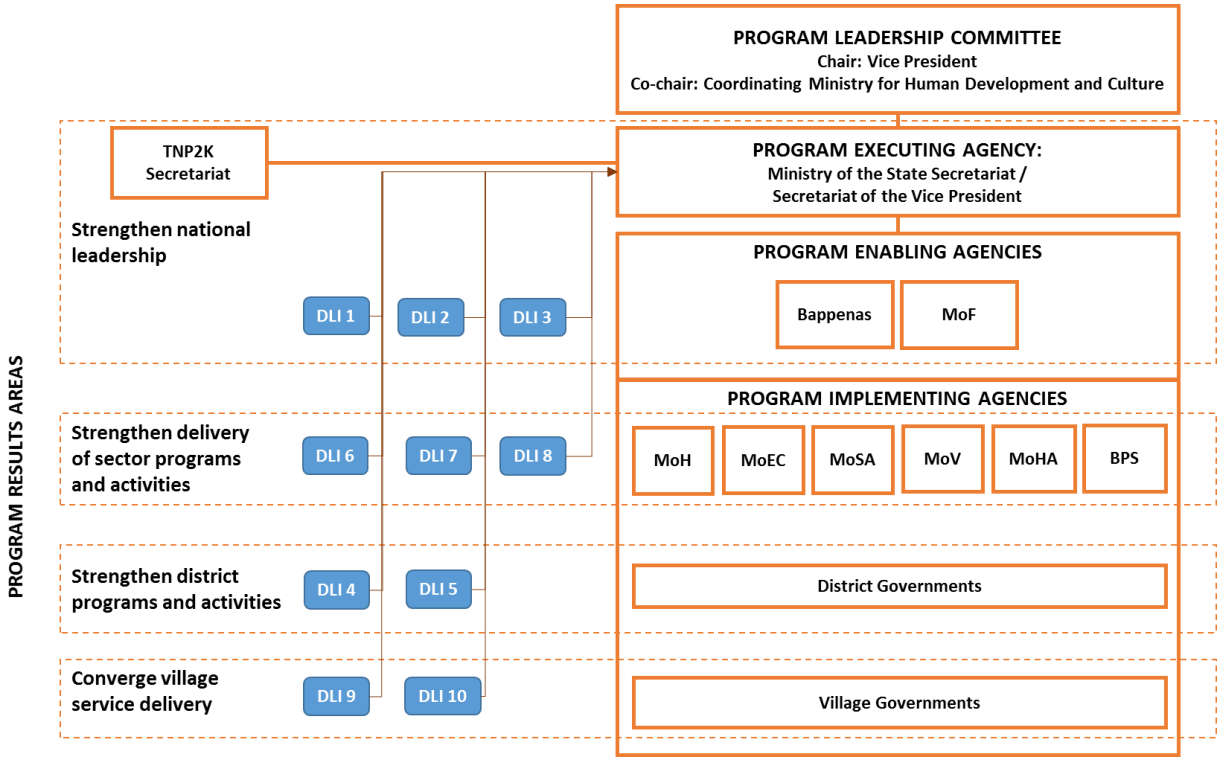
3. **Program *INEY* akan mendukung sebagian intervensi dari program konvergensi pemerintah untuk mempercepat pengurangan stunting (*Convergence Program to Accelerate Stunting Reduction-CPASR*) serta konvergensi instrumen-instrumen yang sifatnya sangat penting dalam mengkoordinasikan penyampaian semua intervensi prioritas spesifik-gizi dan peka-gizi di lokasi prioritas.** Tujuan keseluruhan dari Program Konvergensi adalah untuk mempercepat pengurangan stunting dalam kerangka peraturan dan kelembagaan yang ada. Program Konvergensi akan mendukung pencapaian target Rencana Pembangunan Jangka Menengah Nasional (RPJMN) untuk mengurangi "tingkat kejadian"(prevalensi) stunting dari sebesar 37,2% menjadi 28% pada tahun 2019. Program Konvergensi juga akan mendukung pencapaian target Peningkatan Gerakan Nutrisi (Scaling Up Nutrition; SUN) 2025.

4. ***PforR* INEY mencakup empat result/hasil koordinasi dan konvergen, termasuk:**

   Result Area 1: Memperkuat kepemimpinan nasional.
   Result Area 2: Memperkuat pelaksanaan program dan kegiatan sektor.
   Result Area 3: Memperkuat program dan kegiatan kabupaten.
   Result Area 4: Konvergensi Penyampaian di tingkat desa.

5. **Sekretariat Wakil Presiden (SWP) di Kementerian Sekretariat Negara merupakan institusi yang memimpin (*Executing agency)* untuk program *PforR*.** Program ini akan melibatkan dua lembaga pendukung (Enabling Agencies; EA) dan tujuh Lembaga Pelaksana termasuk pemerintah kabupaten dan pemerintah desa. Diagram di bawah ini merangkum pengaturan kelembagaan, termasuk bagaimana Sekretariat TNP2K akan mendukung SWP untuk menggunakan indikator (DLI) untuk memantau pelaksanaan di berbagai tingkat pemerintahan.

Gambar 2: Pengaturan Kelembagaan



B. SISTEM LINGKUNGAN DAN SOSIAL YANG RELEVAN

6. **Program *INEY PforR* tidak memiliki sistem tunggal yang terkait dengan kinerja lingkungan dan sosial.** Dengan demikian, pengkajian difokuskan pada sistem kunci yang berdampak pada kesehatan, terutama kesehatan seksual dan reproduksi perempuan dan anak perempuan, WASH, dan pemberian layanan pendidikan di tingkat rumah tangga dan desa, termasuk ketentuan dan sistem yang relevan yang memperkuat UU Desa. Demikian pula, pengkajian lingkungan berfokus pada peninjauan kecukupan dan implementasi kebijakan, peraturan dan pedoman nasional yang terkait dengan penanganan, distribusi dan penyimpanan suplemen dan vaksin serta penanganan limbah medis yang aman (di Puskesmas).

C. PERTIMBANGAN DAN RISKO LINGKUNGAN DAN SOSIAL

7. **Secara keseluruhan, hasil pengkajian resiko dan penyaringan menunjukkan bahwa dampak lingkungan dari program ini cenderung positif; memberikan beberapa manfaat lingkungan seperti akses ke pasokan air minum yang lebih baik, akses ke fasilitas sanitasi yang lebih baik dan peningkatan kondisi sanitasi.** Masalah lingkungan utama terkaitan dengan penanganan yang aman atas limbah farmasi dan sistem pembuangan yang dikelola oleh Posyandu dan Puskesmas; aspek kualitas dan kuantitas (kontinuitas) penyediaan air minum dan sanitasi. Risiko lingkungan diharapkan pada tingkat “moderate”. Potensi risiko lingkungan diidentifikasi sebagai berikut: (I) pembuangan vitamin kedaluwarsa dan penyimpanan kelebihan pasokan vitamin; (ii) penyediaan, distribusi dan penyimpanan vaksin serta pembuangan limbah farmasi (vaksin kadaluwarsa/rusak/tidak digunakan, botol vaksin dan jarum suntik bekas); (iii) aspek kualitas dan kuantitas (kontinuitas) penyediaan air minum dan sanitasi.

8. ***PforR* saat ini tidak berencana untuk mendukung investasi infrastruktur.** Kegiatan infrastruktur yang terkait dengan Air, Sanitasi Kebersihan (WASH) didanai melalui proyek PAMSIMAS (P154780). Tidak ada antisipasi dampak buruk terhadap habitat alam, properti budaya fisik, sumber daya alam, atau aset atau mata pencaharian masyarakat berdasarkan kegiatan yang didukung oleh *PforR*. Pengkajian sistem berkenaan dengan resiko lingkungan dan sosial dan pengelolaan dampak yang muncul dari kegiatan pembebasan lahan, konversi lahan dan kegiatan infrastruktur, tidak termasuk dalam lingkup *ESSA* ini.

9. **Efek sosial cenderung muncul dari kegiatan yang terkait dengan RA 4, (Konvergensi pemberian layanan desa), RA 2 (Memperkuat program dan kegiatan sektor) dan RA 3 (Memperkuat program dan kegiatan kabupaten).** *ESSA* mempertimbangkan efek sosial yang berkaitan dengan kemampuan individu, rumah tangga dan kelompok untuk mendapatkan layanan dengan cara yang mudah diakses, aman, dan inklusif. *ESSA* juga mempertimbangkan apakah komunikasi edukatif, perubahan perilaku, informasi tentang intervensi khusus gizi, khususnya layanan kesehatan, disampaikan dengan cara yang mempertimbangkan konteks lokal termasuk aspek literasi, bahasa, dan budaya dari penerima manfaat. Hal ini termasuk dalam memastikan penjelasan dan persetujuan serta penyediaan proses pengajuan keluhan dan kekhawatiran. Potensi ketidaksetaraan dan konflik akan berasal dari perbedaan nyata atau persepsi tentang bagaimana manfaat dari program didistribusikan yang membuat pentingnya kebutuhan akan sistem pengaduan yang efektif. Jika sistem tingkat desa inklusif dan partisipatif serta dikelola dengan baik, pihak yang paling rentan akan memperoleh manfaat. Dalam hal ini, diharapkan Masyarakat Adat, jika ada dalam masyarakat yang ditargetkan, harus mendapatkan manfaat dari program dan kelompok rentan dan Masyarakat Adat tidak boleh mendapat dampak buruk. Keluarga miskin, ibu yang berpendidikan rendah, ibu muda, ibu yang lebih tua, ibu yang tidak menikah, keluarga dengan orang tua tunggal atau rumah tangga yang dikepalai oleh anak, dan orang tua dengan

status HIV cenderung menjadi kelompok yang paling rentan. Berdasarkan penilaian di atas, Program ini diharapkan berkontribusi dalan mengatasi masalah kesetaraan dan oleh karena itu tingkat risikonya dinilai rendah.

10. Masyarakat Adat tidak terkena dampak buruk dari kegiatan yang didukung oleh INEY *PforR*. Informasi yang berkaitan dengan stunting dan nutrisi dan Masyarakat Adat di Indonesia tampaknya terbatas. Untuk setiap layanan dan intervensi yang direncanakan akan ada kebutuhan untuk memahami konteks, aksesibilitas, sistem kepercayaan dan pilihan untuk menginformasikan kesesuaian dan penyerapan layanan atau intervensi yang direncanakan. Idealnya pekerja garis depan harus berasal dari komunitas mereka sendiri dan akan diperlengkapi untuk memastikan partisipasi laki-laki, perempuan dan remaja yang sesuai.

D. PENGKAJIAN SISTEM DAN TINDAKAN YANG DIREKOMENDASIKAN

11. Beberapa usulan kegiatan awal untuk lingkungan dan sosial telah dikembangkan sebagai bagian dari Rencana Aksi/Tindakan Program INEY *PforR*. Usulan rencana aksi ini perlu didiskusikan dan disetujui secara internal dan dengan pemangku kepentingan eksternal yang berkaitan. Aksi utama meliputi:

a. Upaya Lingkungan
   - **memperkuat kapasitas kelembagaan:** mulai dari memberikan pelatihan yang relevan untuk melaksanakan kebijakan dan panduan teknis hingga melengkapi staf terkait dengan alat dan perlengkapan praktis tentang penanganan limbah farmasi yang aman secara umum dan khususnya sistem pembuangan limbah
   - **memperkuat kinerja sistem untuk pengelolaan lingkungan yang bertujuan untuk menghasilkan efek lingkungan yang diinginkan:** (i) memberikan pedoman teknis untuk pelaksanaan langkah-langkah mitigasi lingkungan yang efektif seperti mendorong pengelolaan daerah aliran sungai (DAS); (ii) menerapkan standar praktik-praktik baik; dan (iii) mempromosikan program cuci tangan yang bermanfaat bagi pembelajaran tahun-tahun awal menuju praktik kebersihan pribadi yang lebih baik untuk anak-anak sekolah.

b. Upaya Sosial:
   - **Penanganan Pengaduan dan Umpan Balik:** Tidak ada satu sistem, dan sistem yang adapun tidak dilengkapi untuk menangkap umpan balik dan keluhan di seluruh intervensi yang direncanakan. Kartu Nilai Konvergensi Desa (Convengence scorecard) diusulkan sebagai sistem yang dipakai sebagai sarana penyampaian umpan balik. Sehingga keluhan dapat diidentifikasi dan ditangani serta dipantau.
   - **Partisipasi, Akses dan Inklusi:** Ada potensi ketidaksetaraan dan ketegangan muncul dari perbedaan yang nyata atau secara persepsi tentang bagaimana manfaat program didistribusikan. Penggunaan h*uman development workers* (HDW) dan latihan pemetaan sosial harus memastikan partisipasi yang inklusif yang memperhitungkan gender, konteks lokal, budaya, kepercayaan dan sistem nilai Masyarakat Adat serta kelompok-kelompok yang diidentifikasi sebagai kelompok rentan. Seorang Spesialis Inklusi Sosial sebagai bagian dari Unit Koordinasi di bawah TNP2K sedang diusulkan. Spesialis ini harus memiliki pengalaman khusus tentang Masyarakat Adat, gender dan remaja putri.

E. TINGKAT RISIKO LINGKUNGAN DAN SOSIAL

12. Berdasarkan temuan penilaian dan rancangan mitigasi serta tindakan perbaikan, risiko lingkungan dan sosial dianggap pada <u>tingkat "moderate"/sedang</u>.

F. KETERLIBATAN PEMANGKU KEPENTINGAN DAN "DISCLOSURE" *ESSA*

13. **Dalam penyusunan draft ESSA, tim Bank Dunia berkonsultasi dan melibatkan berbagai pihak dan pemangku kepentingan termasuk pemerintah (pusat, kabupaten dan desa); mitra pembangunan; penyedia jasa; organisasi masyarakat sipil; sektor swasta; dan masyarakat yang terkena dampak dan penerima manfaat serta perwakilan mereka.** Setelah melalui diskusi dan mendapatkan kesepakatan tentang tindakan/aksi lingkungan dan sosial serta masukan bagi rencana dukungan pelaksanaan program, tim Bank Dunia akan menyelesaikan draft dokumen *ESSA* dan selanjutnya di unggah ke situs web Bank sebagai bagian dari prosedur "disclosure" . Draft *ESSA* yang dibagikan sebelum lokakarya,, akan menjadi bahan diskusi pada lokakarya,, yang akan dihadiri oleh berbagai pemangku kepentingan baik tingkat pusat dan daerah.

G. MEKANISME PENGADUAN

14. **Masyarakat dan individu yang menganggap bahwa mereka terkena dampak negatif akibat operasi *PforR* yang didukung oleh Bank Dunia, sebagaimana didefinisikan oleh kebijakan dan prosedur yang berlaku, dapat mengajukan pengaduan ke mekanisme pergaduanv yang ada atau Layanan Penanganan Keluhan WB (Grievance Redress Service; GRS).** GRS memastikan bahwa keluhan yang diterima segera ditinjau untuk mengatasi masalah yang terkait. Masyarakat dan individu yang terkena dampak dapat mengajukan keluhan mereka ke Panel Inspeksi independen WB yang menentukan apakah kerusakan telah terjadi, atau dapat terjadi, sebagai akibat dari ketidakpatuhan WB terhadap kebijakan dan prosedurnya. Keluhan dapat diajukan kapan saja setelah kekhawatiran telah dikemukakan langsung ke Bank Dunia, dan Manajemen Bank telah diberi kesempatan menanggapi. Untuk informasi tentang cara mengajukan keluhan ke Layanan Penanganan Keluhan korporat (GRS), silakan kunjungi http://www.worldbank.org/GRS. Untuk informasi tentang cara mengajukan keluhan ke Panel Inspeksi Bank Dunia, silakan kunjungi www.inspectionpanel.org.

***

Annex 4: Analysis Against Key Policy Elements of Bank Policy Program-for-Results Financing

Policy Element a) Program systems promote environmental and social sustainability in the PforR Program design; avoid, minimize, or mitigate adverse impacts, and promote informed decision-making relating to the PforR Program's environmental and social impacts.			
Key Attributes related to Core Principles	**Relevance to Program**	**Provisions in System**	**Practice**
Operate within an adequate legal and regulatory framework to guide environmental and social impact assessments at the Program level.	Relevant	A complete set of regulatory and legal framework related to handling, distribution and storage of supplement, vaccines, vitamins are available. Also, the regulation on how to implement immunization activities. Moreover, regulations on Primary Health Care facilities is quite comprehensive including its accreditation system. Also, a clear distinction between national, provincial and district level jurisdiction for permitting system of Medical waste management handling at primary care level is available (MOEF Decree 56/2014) with regulation on permitting system for wastewater effluent and emission. A complete assessment of regulatory framework related to INEY program is presented in section D1. I Sphere Program.	Permit documents are found at HFCs in the field also all necessary equipment for waste handling such as dedicated bins for expired medicines, sharps, infectious waste. However, the main challenge is to maintain the same level of performance 2-3 year after the permit granted for keeping the practice/equipment running well and when handling abnormal situation (the disposal company's licence is revoked). A management system for periodic evaluation, training, annual refresher and work instructions development for task with high environmental and social risk is needed. The capacity of Local Environmental Agency is still low in regulation implementation, monitoring and advice provision.
Incorporate recognized elements of environmental and social assessment good practices	Relevant. See below.		
(a) early screening of potential effects;		National regulatory system on AMDAL regulates this in more detail. PermenLH no 5/2012 about Environmental Assessment.	Manageable. Ministry of Public Works or Local contractors has adequate information related to screen out the potential natural hazard in the area in

Policy Element a) Program systems promote environmental and social sustainability in the PforR Program design; avoid, minimize, or mitigate adverse impacts, and promote informed decision-making relating to the PforR Program's environmental and social impacts.			
Key Attributes related to Core Principles	**Relevance to Program**	**Provisions in System**	**Practice**
		Permenkes 75/2015- Appendix 1- regulates the requirement of the location of the *Puskesmas* that must be free from natural hazards such as hurricanes, floods, earthquake (faults), steep slope, tsunami, at riverbank area (erosion potential) etc. Element Criteria 2.1.1 of *Permenkes* 46/2014 about accreditation. *Puskesmas* have the necessary valid building permits and in accordance with the spatial layout of the district/cities.	addition to information from local communities.
(b) consideration of strategic, technical, and site alternatives (including the "no action" alternative);	Relevant	*Permenkes* 75/2014 about *Puskesmas* location and building permit system.	Manageable. See above.
(c) explicit assessment of potential induced, cumulative, and trans- boundary impacts;	Relevant	National regulatory system on AMDAL regulates this in more detail. PermenLH no 5/2012. Also, accreditation system for waste management storage and transport. And also, the permitting system for wastewater effluent and emission and the manifest system from MOEF	Manageable, in term of the comprehension that the potential induced impacts must be taken care of in the regulation. It has been explicitly assessed and regulated.
(d) identification of measures to mitigate adverse environmental or social impacts that cannot be otherwise avoided or minimized;	Relevant	National regulatory system on AMDAL regulates this in more detail. PermenLH no 5/2012.	No significant gap, the measures for mitigation has been regulated.
(e) clear articulation of institutional responsibilities and resources to support implementation of plans	Relevant	A clear distinction between national, provincial and district level jurisdiction for permitting system of Medical waste management handling at HCF level is available (MOEF Decree 56/2014). *Permenkes* 1204/2004 also regulates the	Cleary articulated.

Policy Element a) Program systems promote environmental and social sustainability in the PforR Program design; avoid, minimize, or mitigate adverse impacts, and promote informed decision-making relating to the PforR Program's environmental and social impacts.			
Key Attributes related to Core Principles	**Relevance to Program**	**Provisions in System**	**Practice**
		required competency for environment sanitation staff of the HCF.	
(f) responsiveness and accountability through stakeholder consultation, timely dissemination of Program information, and responsive grievance redress measures.		MoEF Decree no 17/2012 regulates the community participation in environmental assessment for AMDAL and UKL UPL. Village level systems Systems associated with health interventions	No one system.

Policy Element b) Program systems avoid, minimize, or mitigate adverse impacts on natural habitats and physical cultural resources resulting from the PforR Program.			
Key Attributes related to Core Principles	**Relevance to Program**	**Provisions in System**	**Practice**
Includes appropriate measures for early identification and screening of potentially important biodiversity and cultural resource areas.	No adverse impacts to important biodiversity of physical cultural heritage.	National regulatory system on AMDAL regulates this in more detail. PermenLH no 5/2012. *Permenkes* 75/2014 about *Puskesmas* location and Permit Requirement for HCF establishment by respective jurisdiction.	The location of *Puskesmas* is always designed to be close/nearby human settlement area for easy access and is not located at protected or sensitive area (Appendix I.1.b of *Permenkes* 75/2014).
Supports and promotes the conservation, maintenance, and rehabilitation of natural habitats; avoids the significant conversion or degradation of critical natural habitats, and if avoiding the significant conversion of natural habitats is not technically feasible, includes measures to mitigate or offset impacts or program activities.	Not relevant.	Not relevant.	Same as above.
Takes into account potential adverse impacts on physical cultural property and, as warranted, provides adequate measures to avoid, minimize, or mitigate such effects.	Not relevant.	*Permenkes* 75/2014 Appendix 1 - about *Puskesmas* location.	The construction of *Puskesmas* facility often involved local community leaders and "*gotong royong*" system (in-kind, or working together) so that necessary information related to physical cultural resources is always taken into account.

Policy Element c) Program systems protect public and worker safety against the potential risks associated with: (i) construction and/or operations of facilities or other operational practices under the PforR Program; (ii) exposure to toxic chemicals, hazardous waste, and other dangerous materials under the PforR Program; and (iii) reconstruction or rehabilitation of infrastructure located in areas prone to natural hazards.			
Key Attributes Related to Policy Element	**Relevance to Program**	**Provisions in System**	**Practice**
Promotes community, individual, and worker safety through the safe design, construction, operation, and maintenance of physical infrastructure, or in carrying out activities that may be dependent on such infrastructure with safety measures, inspections, or remedial works incorporated as needed.	Relevant.	Accreditation system for *Puskesmas* and private clinics under I-Sphere program (including standards related to worker and patient safety and public health during the operations of the HCF and its waste management handling).	In general, the promotion of health and safety in HCF operations is meeting the standard for some areas in western part of Indonesia (Sumatera, Bali, Jawa) but need attention for eastern part of Indonesia.
Promotes the use of recognized good practice in the production, management, storage, transport, and disposal of hazardous materials generated through Program construction or operations; and promotes the use of integrated pest management practices to manage or reduce pests or disease vectors; and provides training for workers involved in the production, procurement, storage, transport, use, and disposal of hazardous biological waste in accordance with GIIP.	Relevant	Law No. 32/2009 on The Protection and Environmental Management, requires management of materials and waste that are classified as dangerous and/or poisonous or B3 (*Bahan Berbahaya dan Beracun*) Government Regulation No. 74/2001 on Management of Hazardous Materials), Government Regulation No. 101/2014 on Management of Toxic and Hazardous Waste, Government Regulation No.27/2012 on Environmental Permit). MOEF Decree no 56/2015 on Procedures and Technical Requirement of Hazardous Waste Management from Health Care Facilities or *FASYANKES* and *Kepbappedal* No 03/*Bapedal*/09/1995 on Emission standards from Incinerators.	For the national laws and regulations: No significant gaps with regards to policy and law and regulations. As part of *Puskesmas* Accreditation requirements, HCFs are required to develop Standard Operating Procedures (SOPs) or Work Instructions in the handling of both medical solid and liquid waste and also expired chemicals/reagents/medicines and radioactive waste. The requirements in MOEF Decree no 56/2015 are equivalent to the WBG EHS Guidelines for Healthcare Facilities as they cover GIIP such as labelling and symbols for hazardous materials and waste, waste reduction, segregation, storage, transportation (manifest), treatment and handling (with autoclave, incineration), health workers' occupational health and safety and public health and safety. From the field visit to Riau, Java, Bali from

Policy Element c) Program systems protect public and worker safety against the potential risks associated with: (i) construction and/or operations of facilities or other operational practices under the PforR Program; (ii) exposure to toxic chemicals, hazardous waste, and other dangerous materials under the PforR Program; and (iii) reconstruction or rehabilitation of infrastructure located in areas prone to natural hazards.			
Key Attributes Related to Policy Element	**Relevance to Program**	**Provisions in System**	**Practice**
		Medical Solid Wastes: As regulated in the MOEF Decree No 56/2015 above and MOH Decree No 1204/*Menkes*/SK/X/2004 on Provision of Hospital Environmental Sanitation. PP 101/2014 and MOH Decree no 1204/*Menkes*/SK/X/2004 on Provision of Hospital Environmental Sanitation specifies incinerator requirements and outlines requirements for safe-handling of hazardous waste materials. MOH Decree no 1204/*Menkes*/SK/X/2004 provides specific treatment for each type of medical wastes. **Medical Liquid Wastes** The MOH Decree no 1204/Menkes/SK/X/2004 (aligned with WHO's guidelines) require HCFs to apply the following measures in the handling of medical liquid wastes. MoE Decree No 58/1995 on Hospital Effluent Discharge Standard includes pH, BOD, COD, Temperature, NH3, PO4, Microbiology (e-Coli) and Radioactive (11 elements, 12 isotopes).	other projects related to health care system (*DAK*, *RIDF*), permit documents are found in the field also all necessary equipment for waste handling such as dedicated bins for sharps, infectious waste and all personnel wear PPEs. However, this is not be the case for Eastern part of Indonesia as the capacity and the comprehension of the staff at HCF and government agencies are still low. A specific intervention might be needed for this region under the I-Sphere program. Management System (HWMS). No significant gaps between the policy and procedures for handling the wastewater. The GOI system has also the effluent standard that specifically regulate hospital's effluent similar and to the WBG EHS Guidelines for Health Care Facilities (Performance Monitoring), even for specific parameter it is stricter, for example 100 mg/L for COD (Indonesia) and 250 mg/L (WBG Guidelines). The main challenge now is to strengthen the accreditation system by developing a standardized work instruction or SOP on how to evaluate

Policy Element c) Program systems protect public and worker safety against the potential risks associated with: (i) construction and/or operations of facilities or other operational practices under the PforR Program; (ii) exposure to toxic chemicals, hazardous waste, and other dangerous materials under the PforR Program; and (iii) reconstruction or rehabilitation of infrastructure located in areas prone to natural hazards.			
Key Attributes Related to Policy Element	**Relevance to Program**	**Provisions in System**	**Practice**
		MOH Regulation No 37/2012 about Laboratory Management for *PUSKESMAS* covers provisions about liquid and hazardous waste from hospital laboratory. I Sphere program.	the performance of the treatment system for wastewater and understanding the mechanism for identification and troubleshooting of the abnormal condition (excedance, equipment malfunction etc.).
Includes measures to avoid, minimize, or mitigate community, individual, and worker risks when Program activities are located within areas prone to natural hazards such as floods, hurricanes, earthquakes, or other severe weather or climate events.	Relevant	*Permenkes* 75/2015- Appendix 1- regulates the requirement of the location of the *Puskesmas* that must be free from natural hazards such as hurricanes, floods, earthquake (faults), steep slope, tsunami, at river bank area (erosion potential) etc. Also the provision of the community participation approach as required in the *Puskesmas* accreditation system (under I-Sphere program).	No significant gaps between regulation and implementation as the construction of *Puskesmas* facility often involved local community leaders and "g*otong royong*" system (in-kind, or working together) so that necessary information related to natural hazards is always taken into account.

Policy Element d) Program systems manage land acquisition and loss of access to natural resources in a way that avoids or minimizes displacement, and assist the affected people in improving, or at the minimum restoring, their livelihoods and living standards.			
Key Attributes Related to Policy Element	**Relevance to Program**	**Provisions in System**	**Practice**
Avoids or minimizes land acquisition and related adverse impacts;	Not relevant.	Not relevant.	Not relevant.
Identifies and addresses economic and social impacts caused by land acquisition or loss of access to natural resources, including those affecting people who may lack full legal rights to assets or resources they use or occupy;	Not relevant.	Not relevant.	Not relevant.
Provides compensation sufficient to purchase replacement assets of equivalent value and to meet any necessary transitional expenses, paid prior to taking of land or restricting access;	Not relevant.	Not relevant.	Not relevant.
Provides supplemental livelihood improvement or restoration measures if taking of land causes loss of income-generating opportunity (e.g., loss of crop production or employment);	Not relevant.	Not relevant.	Not relevant.
Restores or replaces public infrastructure and community services that may be adversely affected.	Not relevant.	Not relevant.	Not relevant.

Policy Element e) Program systems give due consideration to the cultural appropriateness of, and equitable access to, PforR Program benefits, giving special attention to the rights and interests of the Indigenous Peoples and to the needs or concerns of vulnerable groups.			
Key Attributes Related to Policy Element	**Relevance to Program**	**Provisions in System**	**Practice**
Undertakes free, prior, and informed consultations if Indigenous Peoples are potentially affected (positively or negatively) to determine whether there is broad community support for the program.	Interventions to be undertaken in priority districts that will potentially benefit Indigenous Peoples.	Community level systems exist to enable participation. HDW and Social Mapping.	HDW is new and social mapping has been tested and the practice is varied.
Ensures that Indigenous Peoples can participate in devising opportunities to benefit from exploitation of customary resources or indigenous knowledge, the latter (indigenous knowledge) to include the consent of the Indigenous Peoples.	Not relevant.	Not relevant.	Not relevant.
Gives attention to groups vulnerable to hardship or disadvantage, including as relevant the poor, the disabled, women and children, the elderly, or marginalized ethnic groups. If necessary, special measures are taken to promote equitable access to program benefits.	The program is focused on the 100 priority districts of high stunting prevalence and incidence.	So specific systems exist except for village level systems.	Vulnerable groups identified based on literature review and fieldwork. Practice on inclusive approaches still under assessment.

Policy Element f) Program systems avoid exacerbating social conflict, especially in fragile states, post-conflict areas, or areas subject to territorial disputes.			
Key Attributes Related to Policy Element	**Relevance to Program**	**Provisions in System**	**Practice**
Considers conflict risks, including distributional equity and cultural sensitivities.	Program involves distribution of supplements including nutritional supplements. Potential for elite capture. Real or perceived differences in how benefits of program are distributed may lead to potential conflict.	Human Development Workers Social Mapping.	HDW is new and social mapping has been tested and the practice is varied.

Annex 5: Capacity Assessment in Managing Environmental Related Issues and Risks for INEY-PforR

Environmental Issues and Risks	Capacity Assessment in Managing Environmental Issues and Risks			
	Policies, Regulations, Guidelines	Institutional Arrangement	Budget for Improved Capacities	Monitoring & Supervision (Support Needed for the Implementation)
	(1)	(2)	(3)	(4)
Priority Service #1: Maternal and Child Health Services				
Supply, distribution, and storage of vitamins/supplements. Particular issues on disposal of expired vitamins, and storage of oversupplied vitamins.	The Ministry of Health Guidelines (2016) regarding: The Integrated Management for Vitamin A Supplement. **Provisions:** Planning, supply, storage and distribution of Vitamin A. **(a). Planning:** Number of supplies is calculated and prepared based on data derived from the district health offices of the MOH. This process aims to avoid either under-supply or over-supply of vitamins. Data for targeted beneficiaries were taken from the Health Development Program (*Program Pembangunan Kesehatan*) (**b) Supply:** Vitamins are supplied by Directorate General of Public Pharmaceutical and Health Supplies *(Direktorat Tata Kelola Obat Publik dan Perbekalan Kesehatan)* through pharmaceutical facility at the district level. At the same time, buffer stocks are kept at the	National: Ministry of Health, including: - Directorate of Primary Care - Directorate General of Community Health - Directorate General of Public Pharmaceutical and Health Supplies Province/District: District Health Offices, Pharmaceutical Facility at the provincial and district levels. Sub-district: *Puskesmas* staffs Village: *Posyandu* cadres	**Questions to ask:** ***National level:*** - To implement the provisions stated in the column (1), are the systems/operational/running cost etc funded from APBN or APBD or other sources? - How much or what is the percentage of the overall health funding: national (if it is funded by APBN) and/or district level (if APBD) is used to implement the provisions stated in column (1)? ***Provincial/District levels:*** - How they feel/think about the quality of supervision/monitoring from the central government? - What would be the best approach to improve/build capacities (i.e. their	**Questions to ask:** ***National Level:*** - What are their experience(s) in implementing these provisions? - What are the main constraints in getting the system working in accordance to the Guidelines? - Who monitor/supervise the implementation? - Since the Guidelines does not provide tools to manage the rare case of over-supply, what is the government provision on such a cases? Is this regulated? ***Provincial/District levels:*** Are they aware of this Guidelines? - If so, what are the main constraints in getting the

	provincial level of the pharmaceutical facility. **(c) Storage and Distribution:** Vitamins are kept safely at the pharmaceutical facility according to procedure regulated by the MOH. Distribution is handled by pharmaceutical facility at the district level to *Posyandu through Puskesmas*.		suggestions on improved capacities) ***Village level (Posyandu):*** Have they been trained regarding the implementation of the Guidelines? Particularly on procedure to apply when vitamins are oversupplied?	system working in accordance to the Guidelines. - If not, what mechanism (of planning, supply, storage and distribution) that they currently use? ***Village level (Posyandu):*** - Have they been trained regarding the implementation of the Guidelines? - What procedures to apply when vitamins are oversupplied? - Who came to visit their health post/center (*Posyandu)*? How many times a year? - What are the main messages they got during the visit? - How they feel/think about the quality of supervision/monitoring? - What would be the best approach to improve/build capacities (i.e. their suggestions on improved capacities)

Supply, distribution, and storage of vaccines, and disposal of Pharmaceutical waste (expired/damaged/unused vaccines, vaccine vials, used syringes)	Ministry of Health Regulation No. 12 Year 2017 on The Implementation of Immunizations. **<u>Provisions:</u>** Planning, supply and distribution, storage and maintenance, waste disposal, and monitoring & evaluation. (**a) Planning:** The central government in collaboration with the local governments conduct regular planning on the implementation of immunizations. Local governments are responsible for the operational of the immunization including the maintenance of cold chain equipment. Number of supplies is calculated and prepared based on local government's annual proposal (to the central government) on target beneficiaries. **(b) Supply:** The central government is responsible for the supplies; include Vaccines, ADS (Auto Disable Syringe), Safety Box, Anaphylactic equipment, Cold Chain equipment, and Record-keeping of immunization services. In regards to Cold Chain equipment, it includes storage (cold room, freezer room, vaccine refrigerator, freezer), vaccine transportation (cold box, vaccine carrier, cool pack), and supporting equipment (thermometer, alarm,	National: Ministry of Health, including: - Directorate of Primary Care - Directorate General of Community Health - Directorate General of Public Pharmaceutical and Health Supplies Province/District: District Health Offices, Pharmaceutical Facility at the provincial and district levels. Sub-district: *Puskesmas* staffs Village: *Posyandu* cadres	**Questions to ask:** ***National level:*** - Since the immunization program is conducted regularly by qualified/trained staffs, what is the percentage of training budget from the overall total budget of national immunization program? - What is the source of funding: APBN/APBD/Others? ***District and village level:*** Have they been trained on this particular provision? How many times? When is the last time?	**Questions to ask:** ***National Level:*** - What are their experience(s) in implementing this provision? - Who (or which directorate) is responsible to monitor/supervise the overall quality of the implementation? - Who (which institution exactly) is responsible to provide storage and transportation for vaccines at provincial and district level? And who monitors the safety of equipment for vaccine storage and transportation) - The Regulation suggests that disposal of pharmaceutical waste are the responsibility of *Puskesmas.* In this case, which Directorate at MOH monitors and supervises the quality control? ***District and village level:*** - How they feel/think about the quality of safety in handling, distribution, storage and transportation of the vaccines?

	etc.). Supplies of vaccines are managed by BUMN, appointed by the Health Minister. (**c) Distribution:** Central Government distributes Vaccine, ADS and Safety Box to *Puskesmas* through the provincial and district governments, whereas Cold Chain is delivered directly to the targeted locations. Other logistics distributed directly by the Provincial and District Governments. **(c) Storage and Maintenance:** Governments at the provincial and district levels are responsible for the storage and maintenance of the equipment and logistic of immunization program, as well as provisions for trained/qualified human resources to manage and implement the program. **(d) Waste Disposal:** For immunization conducted in *Posyandu*, staffs who conduct the immunization are responsible to collect the ADS waste (vial and/or vaccine vial) into the Safety Box. The Safety Box is then delivered to *Puskesmas* to handle and dispose the waste. *[Note: Puskesmas will be the key actor in pharmaceutical waste*			- With their experiences in this provision, what would be the best approach to improve the implementation of safety measures for the equipment. - Were they involved in the safe-handling procedure? If so, did they get any training for that?

	disposal. Assessment on their capacity is crucial] **(e) Monitoring and Evaluation:** Central government, provincial and district governments are responsible for M&E. [*Note: Although the instruments are well-planned, M&E on the implementation of waste management and disposal at Puskesmas is not included]*.			
	Ministry of Environment and Forestry (MoEF) Decree No. 56 Year 2015 on Procedures and Technical Requirements of Hazardous Waste Management from Health Care Facility. **Provision:** As part of *Puskesmas* Accreditation requirements, Health Care Facilities (HCFs) are required to develop Standard Operating Procedures (SOPs) in the handling of medical waste (solid and liquid) and pharmaceutical waste. Permitting System. District environmental agency issues a permit for solid hazardous waste handling (burial technique). For transportation, handling and disposal is from MoEF Jakarta.	National: MoEF Province/District: District Health Offices, Pharmaceutical Facility at the provincial and district levels. Sub-district: *Puskesmas* staffs	**Questions to ask:** ***National Level***: - The standard is regulated by MoEF and implemented by MOH. In this case, has MOH provided budget to support the provision of handling and disposal of medical and pharmaceutical waste? - Assuming that the national level does not provide funding for the implementation of MoEF's standard, how does the central government ensure the waste disposal is properly handled?	**Questions to ask:** ***National Level***: Since the provision is regulated by the MoEF, what is the level of coordination between MOH and MoEFF (i.e. do they meet regularly discussing the quality control and compliance?) ***District/Village Level:*** *Puskesmas'* SOPs for handling medical and pharmaceutical waste: - Can we have a copy of it? - Do they have the facility/equipment to implement the SOP? - Any SOP related to patient safety, public health safety and worker's health and safety.

	Bupati can only issue permit for temporary hazardous waste storage at district level (if Puskemas has one)			- Within the boundary of *Puskesmas* institution, who is responsible for the handling and disposal of these waste? Trained/qualified? - What are the struggles in the implementation? - What is the suggestion for improved implementation? -Any permit required for storage, handling, transporting or disposal of hazardous waste?
	Ministry of Health Regulation No. 2 Year 2017 on the Guidelines for Prevention and Control of Infection in Health Care Facility. **<u>Provisions:</u>** Safe handling and disposal of used syringes, including the method of waste disposal (use of incinerator)	National: MOH District/Village: *Puskesmas*		**Questions to ask:** ***District/Village (Puskesmas):*** - What is their experience in handling the used syringes? Did they get training for this purpose? - Do they know the location of the incinerator where they send the used syringes?
Priority Service #3: Water and Sanitation				
Access to improved drinking water: water testing/sampling, safe distance from water pollution sources, water collection and distribution	Technical guidelines for the construction of community level water supply facility (developed through *PAMSIMAS* and PNPM Rural) MOH guidelines on parameters for water quality	National: MPWH and MOH District: District level SKPD Village: village governments, BUMDes, BPSAM, community members	**Questions to ask:** ***National Level:*** - Availability and access to budget for training on the installation of water supply? ***District/Village Level:***	**Questions to ask:** ***National Level:*** - Which institution conducts regular monitoring and supervision for the quality of drinking water installation? - Which institution is responsible for watershed protection?

			Operational/running costs for monthly fee (*iuran)* and spare parts	Village Level/KSM/BPPSPAM: Water quality testing, number of membership, sustainability of the sources
Access to improved sanitation facility: safe distance, construction quality (engineering design), provisions of water supply to toilets.	Technical guidelines for the construction of community level water supply facility (developed through *PAMSIMAS* and PNPM Rural)	National: MPWH and MOH District: District level SKPD Village: village governments, BUMDes, BPSAM, community members	**Questions to ask:** ***National Level:*** - Availability and access to budget for training on construction of sanitation facility?	**Questions to ask:** ***National Level:*** - Which institution conducts regular monitoring and supervision for the quality of sanitation facility? Village Level/KSM/BPPSPAM: ODF Free, distance of septic tanks from water source (> 10 m).
Priority Service #5: ECED				
Hand washing program	National curriculum on the provision of hand-washing program	National: MOEC District: District education agencies, *GSC* facilitators, *PAUD* cadres, community member	N/A	**Questions to ask:** ***National Level:*** Does the ministry have the provision of such a curriculum?

Annex 6: Social considerations of nutrition-specific and nutrition-sensitive interventions.

Interventions	Activities	Activities with Social Risk Potential	Level of Concern	Systems and Capacity to be Reviewed
Nutrition Specific	-			
Iron folic acid supplementation	- IFA Data Verification & Forecasting - IFA Procurement, Storage (buffer stock only) and Distribution (buffer stock only) - IFA Verification, Collection, Storage and Distribution - Anemia hemoglobin test - Dispensing of IFA supplements - *Posyandu* outreach	- Anemia hemoglobin test - Dispensing of IFA supplements - *Posyandu* outreach	Low	Delivery to understand approach to different beneficiary groups. Inclusiveness, Consent, Complaints, Accessibility, Context Specific.
Vitamin A Supplementation	- Vitamin A Procurement, Storage and Distribution - Vitamin A Forecasting - Vitamin A campaigns (including integrated campaigns with immunization, deworming) - Dispensing of Vitamin A supplements - School coordination activities - Outreach/Sweeping activities - *Posyandu*, *PAUD* coordination activities	- Vitamin A campaigns (including integrated campaigns with immunization, deworming) - Dispensing of Vitamin A supplements - Outreach/Sweeping activities	Low	Delivery to understand approach to different beneficiary groups. Inclusiveness, Consent, Complaints, Accessibility, Context Specific.
Basic Immunization	- Data Verification and Forecasting - Vaccines Forecasting, Procurement and Distribution - Auto Disable Syringe (ADS) Procurement and Distribution - Safety Box Procurement and Distribution - Cold Chain Storage Procurement and Distribution - Temperature Monitoring Device Procurement and Distribution - Vaccine Transportation Equipment and Temperature Monitoring Device Procurement and Maintenance - Auxiliary Cold Chain Equipment Procurement and Maintenance - Vaccine and Equipment Storage	- Vaccine Administration - Outreach Activities - Coverage Improvement Activities - Outbreak Response Immunization	Low	Delivery to understand approach to different beneficiary groups. Inclusiveness, Consent, Complaints, Accessibility, Context Specific.

Interventions	Activities	Activities with Social Risk Potential	Level of Concern	Systems and Capacity to be Reviewed
	- Vaccine, ADS, Safety Box, Anaphylatic Devices Distribution - Medical Waste Management - Vaccine Collection and Distribution - Immunization Operational Costs at Facilities (*Puskesmas*, *Posyandu*, School) - Vaccine Collection and Distribution - Vaccine Administration - Outreach Activities - Coverage Improvement Activities - Outbreak Response Immunization			
Micronutrient Powder Supplementation (Taburia) (Pilot ONLY)	- Taburia Forecasting - Taburia Procurement, Storage and Distribution - Taburia Storage - Taburia Distribution - Outreach Activities	- Taburia Distribution - Outreach Activities	Low	Delivery to understand approach to different beneficiary groups. Inclusiveness, Consent, Complaints, Accessibility, Context Specific.
Deworming	- Deworming Medicine Forecasting, Procurement, Storage and Distribution - Laboratory Test Supplies and Equipment Procurement - Laboratory Testing for Worms - Mass Deworming Medicine Administration - Mass Deworming Campaign at Schools - Mass Deworming Campaign at *Posyandu*	- Mass Deworming Campaigns	Low	Delivery to understand approach to different beneficiary groups. Inclusiveness, Consent, Complaints, Accessibility, Context Specific.
Growth Monitoring and Promotion	- Production of Buku KIA, KMS - Procurement for Dacin - Ensuring adequate GMP content in the national pre- and in-service training for healthcare providers - Conduct GM surveillance - Procurement of PWS Gizi Form, *Posyandu* Kit and Balok SKDN - Conduct supervision for POKJANAL *Posyandu* team - GMP TOT training for midwifes/nutritionist and cadres	- Growth Monitoring and Promotion - Home Visit - Outreach and sweeping	Low	Delivery to understand approach to different beneficiary groups. Inclusiveness, Consent, Complaints, Accessibility, Context Specific.

Interventions	Activities	Activities with Social Risk Potential	Level of Concern	Systems and Capacity to be Reviewed
	- Conduct supportive supervision for *Puskesmas* to implement GMP practice - Create *Puskesmas* POA for GMP - Refresh the cadre in GMP practice - Production of IEC materials - Recording and reporting - Cross-program coordination for GMP at *Puskesmas* level - Multisectorial coordination for GMP at sub-district level - Consult *Puskesmas* GMP practice to district level - Conduct supportive supervision for *Posyandu* to implement GMP practice - Growth Monitoring and Promotion - Home Visit - Outreach and sweeping			
Infant and Young Child Feeding:	- Multisectorial coordination for nutrition intervention and 1000 HPK at national level - IYCF counselling course for master trainers - Ensuring adequate IYCF content in the national pre- and in-service training for healthcare providers - Institutionalization of Baby Friendly Hospital Initiative and Hospital's baby Friendly accreditation - Improve complementary feeding and diets for children aged 6-23 months - Procurement of supplementary feeding (Makanan Tambahan Penyuluhan dan Pemulihan) for pregnant women (MT Ibu Hamil), children under five (MT Balita) Provinces and elementary school students (MT Anak Sekolah) - Procurement of supplementary feeding for elementary school students (MT Anak Sekolah) – buffer stock only - Conduct nutrition surveillance - Production of pedoman Gizi	- Dispensing MT to the district/*Puskesmas* level - Distribute pedoman gizi to district level - Behaviour change communication training for *Puskesmas* and cadres - Dispensing MT Anak Sekolah to *Puskesmas* level - Production of IEC materials Dispense MT to *Posyandu*/other	Low	Delivery to understand approach to different beneficiary groups. Inclusiveness, Consent, Complaints, Accessibility, Context Specific.

Interventions	Activities	Activities with Social Risk Potential	Level of Concern	Systems and Capacity to be Reviewed
	- Conduct supportive supervision for Provincial and District to implement IYCF practice - Dispensing MT to the district/*Puskesmas* level - Distribute pedoman gizi to district level - Behaviour change communication training for *Puskesmas* and cadres - Procurement of supplementary feeding for elementary school students (MT Anak Sekolah) - Dispensing MT Anak Sekolah to *Puskesmas* level - IYCF TOT training for midwifes/nutritionist and cadres - Conduct supportive supervision for *Puskesmas* to implement IYCF practice - Create *Puskesmas* POA for IYCF - Cross-program coordination for IYCF at *Puskesmas* level - Multisectorial coordination for IYCF at sub-district level - Procurement of MP-ASI Lokal - Refresh the cadre in IYCF practice - Production of IEC materials - Recording and reporting - Dispense MT to *Posyandu*/other *Puskesmas* networks, e.g. *PAUD*, school - Appointment of health promotion contract workers at *Puskesmas* for IYCF - Conduct supportive supervision for *Posyandu* to implement IYCF practice - Dispense MT Pemulihan for target beneficiaries - Produce local source MT Penyuluhan - Provision of local commodities and sustainable foodstuffs	*Puskesmas* networks, e.g. *PAUD*, school - Dispense MT Pemulihan for target beneficiaries - Produce local source MT Penyuluhan - Provision of local commodities and sustainable foodstuffs		
Antenatal and Postnatal Care	- IFA Data Verification & Forecasting - IFA Procurement, Storage (buffer stock only) and Distribution (buffer stock only)	- Dispensing of IFA, Vitamin A supplements	Low	Village and Household Level Delivery to understand approach to different beneficiary groups.

Interventions	Activities	Activities with Social Risk Potential	Level of Concern	Systems and Capacity to be Reviewed
	- Vitamin A Procurement, Storage and Distribution - Integrated Family Health Services Training - Ensuring adequate Integrated Health Services for Mother and Child content in the national pre- and in-service training for healthcare providers - Procurement for KB logistics - Procurement for IEC materials (KIE Kit Kependudukan KB dan Pembangunan Keluarga/KKBPK) - Orientation for Kelas Ibu Facilitators - Create *Puskesmas* POA for integrated family health services - Cross-program coordination for integrated family health services at *Puskesmas* level - Multisectorial coordination for integrated family health services at sub-district level - Refresh the cadre on integrated family health services - Anemia hemoglobin test - Dispensing of IFA, Vitamin A supplements - Vitamin A campaigns (including integrated campaigns with immunization, deworming) - School coordination activities - Outreach/Sweeping activities - ANC/PNC visits - Establish Midwife-Traditional Birth Attendance Partnership Program - Conduct supportive supervision for *Polindes* - *Posyandu* outreach - *Posyandu*, *PAUD* coordination activities - Outreach/Sweeping activities - Conduct Kelas Ibu	- Vitamin A campaigns (including integrated campaigns with immunization, deworming) - ANC/PNC visits - Establish Midwife-Traditional Birth Attendance Partnership Program - *Posyandu* outreach - Outreach/Sweeping activities - Conduct Kelas Ibu		Inclusiveness, Consent, Complaints, Accessibility, Context Specific.
Nutrition Sensitive	-	-		
Access to Clean Water	- Program dissemination and advocacy workshop to district leaders	- *PAMSIMAS* Grant for Facilities	Low	The construction aspects will be undertaken under *PAMSIMAS* so

Interventions	Activities	Activities with Social Risk Potential	Level of Concern	Systems and Capacity to be Reviewed
	- Support to local gov't on WASH strategy development and evaluation - Provision and capacity building of community facilitators - Capacity building of village-leaders - Capacity Building for BPPSPAMs and its Association - Capacity building of BPMD for mentoring BPPSPAMs - *PAMSIMAS* Grant for Facilities Construction and community empowerment activities - Technical and Management Consultants Recruitment - Village selection and updating target beneficiaries - WSS Facilities construction to expand service, including school sanitation and public facilities - Capacity building of CBOs/BPPSPAMs - Matching fund (10% of project budget) - Grant to BPPSPAMs to expand service	Construction and community empowerment activities - WSS Facilities construction to expand service, including school sanitation and public facilities		represents no risk for the INEY Program.
Access to Sanitation	- Knowledge management and benchmarking among districts & provinces on STBM progress - STBM network and partnership development - Capacity building for DHO through workshops and coordination meeting - Capacity Building on STBM-Stunting and multisectoral intervention context - Provincial Coordinators Recruitment - Capacity building and coordination meeting with sanitarian - STBM activities for community level - Upgrading infrastructure support to sustain ODF villages - District Facilitator Recruitment - Acceleration access in targeted beneficiaries	- Upgrading infrastructure support to sustain ODF villages - Acceleration access in targeted beneficiaries	Low	The Upgrading infrastructure support to sustain ODF villages will be done under *PAMSIMAS* so represents no risk for the INEY Program.
Provision of universal, high-	- ToT and Capacity Building (for District Trainers and NGO Training Organizers)	- Education activities	Low	Delivery to understand approach to different beneficiary groups.

Interventions	Activities	Activities with Social Risk Potential	Level of Concern	Systems and Capacity to be Reviewed
quality ECED services (for children ages 3-6)	- ToT and Capacity Building (for district ECED Supervisors) - Accreditation of ECED facilities - Training of ECED teachers & personnel - Supervision of ECED teachers and facilities - Education activities			Inclusiveness, Accessibility, Context Specific.
Parenting education on early stimulation and nutrition (for children ages 0-2)	- ToT and Capacity Building (for district government officials) - Training of village cadres (and other village stakeholders) - Education activities	- Education activities	Low	Delivery to understand approach to different beneficiary groups. Inclusiveness, Accessibility, Context Specific.