Program Information Documents (PID)

Appraisal Stage | Date Prepared/Updated: 27-Apr-2018 | Report No: PIDA151198

BASIC INFORMATION

A. Basic Program Data

Country	Project ID	Program Name	Parent Project ID (if any)
Indonesia	P164686	Investing in Nutrition and Early Years	
Region	**Estimated Appraisal Date**	**Estimated Board Date**	**Practice Area (Lead)**
EAST ASIA AND PACIFIC	02-Apr-2018	19-Jun-2018	Social, Urban, Rural and Resilience Global Practice
Financing Instrument	**Borrower(s)**	**Implementing Agency**	
Program-for-Results Financing	Republic of Indonesia	Secretariat of the Vice President, Ministry of Finance, Ministry of Home Affairs, Ministry of Health, Ministry of Education and Culture, Ministry of Social Affairs, National Statistical Agency, National Planning Agency (Bappenas), Ministry of Villages, Disadvantaged Areas and Transmigration, Coordinating Ministry for Human Development and Cultural Affairs (Menko PMK)	

Proposed Program Development Objective(s)

To increase simultaneous utilization of nutrition interventions by 1,000-day households in priority districts.

COST & FINANCING

SUMMARY (USD Millions)

Government program Cost	14,638.00
Total Operation Cost	9,662.00
Total Program Cost	9,642.00
IPF Component	20.00
Total Financing	9,662.00
Financing Gap	0.00

FINANCING (USD Millions)

Total World Bank Group Financing	400.00
World Bank Lending	400.00

Total Government Contribution	9,242.00

B. Introduction and Context

Country Context

1. **Indonesia is the world's largest archipelagic state, fourth most populous nation, and tenth-largest economy in purchasing power parity terms.** It is a member of the Association of Southeast Asian Nations group of countries as well as the G-20. Indonesia has a population of more than 261 million, with 300 distinct ethnic groups and over 700 languages and dialects. With a gross national income per capita of about $3,440 (2015), Indonesia is classified as a lower-middle-income country.

2. **Indonesia has made significant gains in economic growth and poverty reduction in the past decade.** Relatively strong economic growth (5.5 percent per year since 2000) has been accompanied by a sustained decline in poverty rates: about 31 percent and 6.8 percent of the population lived on $3.1 a day and $1.9 a day, respectively, in 2016, down from 82 percent and 48 percent, respectively, in 1998.[1] However, Indonesia's progress on poverty reduction contrasts sharply with its performance in sharing prosperity. Inequality, as measured by the Gini coefficient, increased from 30 points in 2000 to 41 points by 2014, by far the fastest widening in the East Asia and Pacific Region.

3. **The county's strong growth and sustained investments in human capital—allocating 25 percent of the national budget to health and education—have translated into significant progress in service delivery and human development.** In education, gross enrollment has reached 100 percent, 83 percent, and 32 percent in primary, secondary, and tertiary education, respectively; life expectancy at birth has steadily increased to 69 years in 2015, up from 63 years in 1990; and the under-five mortality rate has declined from 85 per 1,000 live births in 1990 to 26 in 2016.

4. **However, despite this progress, Indonesia's rates of stunting and malnutrition are at crisis levels, and its child development outcomes are poor.** According to the 2013 National Health Survey (RISKESDAS), 37.2 percent of Indonesian children under 5 years of age were stunted (almost 9 million children), 19.6 percent were underweight, 12.1 percent were wasted (low weight-for-height), and 11.9 percent were either overweight or obese.[2] The national prevalence of stunting remained virtually unchanged between 2007 and 2013.[3] Average scores for language and cognitive development among

[1] World Development Indicators, 2017.

[2] Note that different data sources are being used when referencing Indonesia's nutrition status. The Bank uses the 2013 RISKESDAS, as it is considered the most reliable and methodologically sound source despite some data quality issues. Government may refer to the 2016 Nutrition Status Surveillance data, which show stunting rates at 27.5 percent in 2017. There are, however, concerns about the methodology this surveillance systems uses, particularly its use of non-probability sampling.

[3] While more recent data (not comparable to RISKESDAS) indicate some improvements, the national stunting and malnutrition rates remain high, declining slowly at best. The Indonesia Family Life Survey, which is one of the longest-running surveys that includes anthropometric data and is representative of about 83 percent of the population, indicates the following long-term stunting trend: 43 percent in 1993, 46 percent in 1997, 40 percent in 2000, 36 percent in 2007, and 35 percent in 2014. Some recent impact evaluation surveys have shown more significant declines for certain incomes groups and regions (e.g., the PKH impact evaluation and the Generasi IE long-term impact evaluation). MoH, in collaboration with BPS, will conduct the RISKESDAS in April

children aged four to five are low, and significantly lower than those for regional peers.

5. **Addressing the stunting crisis is a key investment in human capital and critical to achieving the country's ambitious twin development goals of accelerating economic growth and reducing poverty.** Childhood stunting and poor early childhood development outcomes have life-long consequences not just for health, but also for human capital and economic growth.[4] The Government of Indonesia has great ambition to accelerate its impressive economic growth and development. To achieve this will require significant investments in human capital investments, particularly in today's children who are the labor force of tomorrow.[5]

Sectoral and Institutional Context

6. **Since 2001 there has been a significant increase in the transfer of fiscal resources from Indonesia's central Government to districts.** Indonesia's "big bang" decentralization reforms in 2001 shifted responsibility for providing most public services, including health and nutrition services, to districts. The proportion of government spending that takes place at the subnational level increased from 26 percent in 2001 to 43 percent in 2015. Spending through line ministries (i.e., net of subsidies and interest) is roughly equivalent to that of subnational governments. Districts mostly finance relevant nutrition-specific and nutrition-sensitive interventions from sector-based conditional transfers (DAK). As Table 1 shows, there are 12 capital (*fisik*) and operational (*non-fisik*) sector DAKs that help finance nutrition interventions in the health, water, sanitation, education, and civil registration sectors. These transfers are not wholly focused on nutrition intervention; indeed, they are further divided into around 50 subsectors, and only a relatively modest proportion of these funds is directed toward nutrition interventions.

7. **Over the past decade the central government launched a suite of national sector programs focused on maternal and child health, water and sanitation, early learning and development, and social protection.** On the supply side, the main programs include the National Health Insurance (JKN) scheme, the National Insurance for Maternal and Delivery Services (Jampersal) Program, and the Community-based Health and Nutrition Program in the health sector; the National Rural Water and Sanitation Project (PAMSIMAS), the Community-based Total Sanitation Program, and the Water and Sanitation Hibah Program in the WASH sector; and the National Early Childhood Education and Development Program in the education sector. On the demand side, the Government's conditional cash transfer program, the Program Keluarga Harapan (PKH), has been scaled up to support 10 million households, with consumption support conditioned on their utilization of health and education services, and the Generasi program has used a community-based conditional cash transfer to increase access to basic health and education services.

2018, with the results expected in August 2018.

[4] Studies have shown that children who were stunted in 1993 were shorter and demonstrated lower cognitive function as young adults in 2014-15, spent fewer years enrolled in formal education, and had lower adult earnings (Cesar Victoria et al. (2008), "Maternal and Child Undernutrition: Consequences for Adult Health and Human Capital," *Lancet* 371(9609): 340-57) and that Stunting is strongly associated with the probability that young men are not in employment or education/training (World Bank 2015a).

[5] Indonesia has one of the highest benefit-cost ratios for investments in stunting reduction; it is estimated that every dollar spent generates $48 in economic return. See Hoddinott, J., Alderman, H., Behrman, J. R., Haddad, L. and Horton, S. (2013), The Economic Rationale for Investing in Stunting Reduction. *Maternal Child Nutrition* 9: 69–82.

8. **More recently, the Government massively expanded fiscal transfers directly to Indonesia's 74,954 villages.** Under Law 6/2014 on Villages, fiscal transfers to villages are substantially increased compared with previous years. Transfers to villages are financed partly from the Central Government budget through an envelope equivalent to 10 percent of transfers to regions (*Dana Desa*) and partly by districts, which are required to pass on 10 percent of their untied revenue sources (*Alokasi Dana Desa*). On average, villages now receive about Rp. 1.4 billion ($110,000) each per year, 70 percent of which they are required to spend on village development and community empowerment. Many nutrition interventions are village-scale in nature (e.g., village health posts or *posyandu*, water, sanitation, early childhood education or ECED), so there is significant scope for villages to use these resources to overcome "last mile" supply-side challenges as well as to address demand-side constraints.

9. **Indonesia's spending on nutrition-specific and nutrition-sensitive interventions across the three levels of government is significant: in 2017, for example, the government spent approximately Rp. 51.9 trillion ($3.9 billion).** This is broadly comparable, on a per capita basis, to the expenditure of other low-middle-income countries. As Table 1 shows, Indonesia spends approximately Rp. 24 billion ($1.8 billion) at the central level, mainly for two large nutrition-sensitive interventions at the Ministry of Social Affairs (MoSA): the PKH conditional cash transfer program and the BPNT food assistance program. The Expenditure Framework estimated that districts spend about Rp. 17 billion ($1.3 billion) on nutrition interventions in total. Village spending on nutrition interventions is low: the Village Expenditure Review concluded that villages spend about 5 percent of their budget on relevant health and education interventions, and about another 5 percent on relevant WASH sector interventions.[6]

Table 1: Central, District, and Village Nutrition-related Spending (2017, Rp trillion)

Spending category	*Level of government*			*Total*	*Total ($ b)*
	Central	*District*	*Village*		
Nutrition-specific	4.007	3.624	3.120	10.751	808
Nutrition-sensitive	20.095	13.792	7.280	41.167	3.095
Total	**24.102**	**17.416**	**10.400**	**51.918**	**3.903**

10. **Although these reforms and resources have helped increase access to basic services, there are still large nationwide gaps in the provision of the basic nutrition and early learning services that are critical to addressing the stunting crisis.** For example, access to water among households with children aged 0-2 years has increased from 58 percent in 2008 to 74 percent in 2016, access to sanitation from 57 percent to 68 percent, and enrollment in JKN from 20 percent to 40 percent. Access to birth certificates, which facilitates access to other basic nutrition services, has increased significantly and now stands at 83 percent for children under two (2017). There are, however, critical interventions for which access remains low. Only 65 of children complete the basic package of immunizations in their first year, and only 36 percent complete those due in their first and second year. Iron supplementation and deworming are also low at 33 and 26 percent, respectively. Participation in community growth promotion activities is high in the first six months (77 percent); however, exclusive breastfeeding remains low at 60 percent and only 33 percent of children aged 6-24 months are fed a minimum acceptable diet. Access to ECED services is also low, at around 8 and 21 percent for children aged 0-2- and 3-6-years, respectively.

[6] World Bank (2017), Village Expenditure Review (ViPER).

11. **Furthermore, the convergence of priority nutrition-specific and nutrition-sensitive interventions on households with pregnant mothers and children under two is low.** There is growing global and local evidence that a "convergence" approach—in which multisectoral interventions are coordinated to jointly target priority geographic areas and beneficiaries—is critical to accelerating improvements in health and child development outcomes and can help address stunting.[7] Such an approach has been applied in Peru, Brazil, and Bangladesh.[8] In Peru, for example, child stunting rates fell by almost half in less than a decade (2008-2016), partly because of major multisectoral nutrition efforts focused on convergence.[9] A recent World Bank study done jointly with Indonesia's Ministry of Health also concluded that the multisectoral convergence approach is critical to addressing stunting and malnutrition in Indonesia.[10] The study found an upward shift in the growth faltering curve in the first 24 months of age depending on children's access to none, one, two, and three or four drivers of nutrition.[11] However, most mothers and children lack simultaneous access to priority nutrition interventions in Indonesia. Table 2 shows the access of children under two to eight individual indicators associated with nutrition-specific and nutrition-sensitive interventions from six sectors—health, nutrition, WASH, education, social protection and food—as well as simultaneous access to these services. Access to any four services—which mostly includes those with birth certificates, access to drinking water and sanitation, and exclusive breastfeeding—is only 28 percent. Meanwhile, those who have access to all eight services is extremely low at less than 0.1 percent.

Table 2: Individual and Simultaneous Access to Nutrition Services (children under two, 2017)

Sector	*Indicator*	*% Access*	*Convergence*	*% Access*
Health	Basic immunization	35.6	Access to any one	4.3
Nutrition	Exclusive breastfeeding	60.2	Access to any two	12.4
	Dietary diversity	32.5	Access to any three	25.4
WASH	Drinking water	74.2	Access to any four	28.7
	Sanitation	68.0	Access to any five	18.8
Education	Early childhood education	8.4	Access to any six	8.5
Agriculture	Food insecurity access score	11.9	Access to any seven	1.2
Social Protection	Birth certificate	83.1	Access to all eight	<0.1

Source: World Bank staff calculations based on SUSENAS 2017.

12. **The convergence of nutrition interventions on 24 million households with pregnant mothers and children under two dispersed across 6,000 islands requires actions at the central, district, and village levels.** The primary responsibility for the delivery of most nutrition interventions lies with Indonesia's mayors and its 514 districts, each with a population ranging from 200,000 to over 1 million. The central Government retains an important role, however, including in the provision of select inputs (e.g., vaccines) as well as capacity development and oversight. Indonesia's 74,914 villages, the average population of which is 2,500, also play an important role in frontline service delivery. Convergence in this context therefore requires that the central Government prioritize select geographic regions, particularly for

[7] Levinson and Y. Balarajan (2013).
[8] Levinson and Y. Balarajan, 2013; Gillespie, Stuart, ed.; Hodge, Judith, ed.; Yosef, Sivan, ed.; and Pandya-Lorch, Rajul, ed., 2016; Huicho et al., 2016.
[9] Huicho et al. (2016).
[10] World Bank / Ministry of Health (2017) *Operationalizing a Multisectoral Approach for the Reduction of Stunting in Indonesia*.
[11] According to the UNICEF Conceptual Framework on Malnutrition developed in 1990, the four underlying determinants of malnutrition or drivers of nutrition in developing countries are food security, environment, health, and childcare practices.

additional capacity-building support; that districts identify and prioritize subdistricts and subregions with low levels of public service delivery; and that villages and citizens themselves identify and converge priority interventions at the front line in coordination with subdistrict service providers.

13. **The implementation of a convergence approach in Indonesia requires fixing management and accountability problems that have plagued service delivery for the past two decades to ensure better value for money from spending on stunting reduction.** At all levels, management problems relate to diagnostic and planning capacity, fragmented financing arrangements, lack of cross-sector coordination arrangements, fragmented or ineffective data systems, and weak accountability and transparency. The combined impact of these challenges constrains the improved delivery of nutrition interventions. The Government has underinvested in public awareness campaigns and behavioral change campaigns. The Government has opportunities to use national programs in the education and social protection sectors to address important drivers of stunting. Finally, there is also significant scope to use well-designed citizen engagement and community empowerment tools to raise awareness of stunting at the village level and significantly increase the amount that villages spend on stunting reduction efforts.

14. **In August 2017, the Vice-President of Indonesia launched the Government's ambitious national strategy to accelerate stunting reduction in the next four years (2018-2021).** The development of the National Strategy to Accelerate Stunting Reduction (NatStrat Stunting) was based on intensive technical assistance and advisory services from the World Bank and built on Indonesian and global lessons, particularly Peru's success at sustained stunting reduction. The strategy was designed to accelerate Indonesia's stunting reduction by addressing key constraints comprehensively and multisectorally. It aims to strengthen the execution and quality of programs across five sectors, and to drive the convergence of national, regional, and community programs. It represents the Government's determination to operationalize the commitment it made when it joined the global Scaling Up Nutrition (SUN) movement in 2011.[12] The NatStrat Stunting commits 20 ministers and an estimated $3.9 billion per year to converge priority nutrition interventions across health, water and sanitation, early childhood education, social protection, and food security.

PforR Program Scope

15. **The PforR Program will complement the Bank's existing portfolio of operations and advisory services.** Specifically, the INEY PforR will focus on the following:

(a) Addressing the management and system problems that undermine program convergence at each level of intervention delivery (central, district, and village);
(b) Plugging critical gaps in the Government's mix of sector programming; and
(c) Strengthening citizen engagement in the frontline delivery and oversight of nutrition interventions.

16. **An Investment Project Financing (IPF) component will support the implementation of the PforR Program.** The IPF component will finance catalytic investments to accelerate improvements in

[12] The movement in Indonesia, known as the "National Movement to Accelerate the Reduction in Undernutrition in Indonesia during the First 1000 Days of Life" (1000 *HPK*), was launched by the President in 2013 following the release of Presidential Decree 42/2013.

implementation capacity and strengthen intervention delivery systems that lay the foundation for long-term and sustainable reform. Particularly, it will (a) strengthen multisectoral coordination by the Secretariat of the Vice President (SoVP); (b) strengthen the capacity of Bappenas (National Planning Development Agency) and the Ministry of Finance (MoF) to implement their planning and budgeting functions and enhance the use of results-based approaches; (c) provide technical support to sector line agencies and subnational governments that are responsible for nutrition intervention delivery; and (d) strengthen the systems for monitoring, evaluation, and continuous learning at the Secretariat of the National Tim to Accelerate Poverty Reduction (TNP2K) and Bappenas, including promoting innovations and implementation research. The IPF component is financed by the Global Financing Facility multidonor trust fund.

C. Proposed Program Development Objective(s)

Program Development Objective(s)

17. **The Program Development Objective (PDO) is to increase the simultaneous utilization of nutrition interventions by 1,000-day households in priority districts.** The PforR Program will achieve this objective by supporting the Government in converging national, district, and village programs and activities that deliver priority nutrition interventions for maternal and child health and nutrition services, water and sanitation, ECED, and social protection.[13]

18. **Progress toward achieving the PDO will be measured through five key results indicators:**

PDO-level indicators	(a) Public commitment of subnational leaders to accelerate stunting reduction (b) Priority Districts implement locally-adapted interpersonal communication (IPC) activities (c) Performance of districts in targeting priority nutrition interventions (d) Consumption of IFA supplements during pregnancy (e) Village convergence of nutrition interventions on 1,000-day households

19. **The proposed PforR will support the Government's program by providing incentives for key actions required to drive convergence across the five core sectors that are responsible for delivering the Government's priority nutrition interventions.** The PforR Program will focus on four Results Areas (RAs):

(a) **Results Area 1: Strengthen national leadership.** This RA will strengthen national leadership and ensure the effective national coordination and accountability mechanisms that are critical for the sustained and high-quality implementation of the NatStrat Stunting. This includes national actions to secure the annual commitments of subnational leaders (district heads and mayors) to deliver and converge priority district programs and activities, improved expenditure systems for monitoring, performance assessments of national spending on nutrition interventions, and accelerated learning on what works and what doesn't through improved data systems. Key

[13] "Simultaneous utilization" means that households have access to all these services at the same time. The term "1,000-day households" refers to households with pregnant women and/or children aged 0-24 months. "Priority districts" refers to those selected for the annual scale-up within the NatStrat Stunting based on assessments of the prevalence and incidence of stunting.

activities include Annual Stunting Summits (SoVP/TNP2K), National Expenditure Tagging and Performance Reviews (Bappenas and MoF), and implementation of an annual anthropometric module in the government's annual socio-economic survey (SUSENAS) (National Statistical Agency/BPS).

(b) **Results Area 2: Strengthen delivery of national sector programs.** This RA will support the improved design and delivery of national sector programs that have been identified as key to reducing stunting. There are currently significant gaps in the delivery of ECED programs, food assistance, and IPC. Results will include improved delivery of nutrition-sensitive services by ECED teachers to parents and children aged 0-2 years; enhanced nutrition-sensitivity and implementation quality of the BPNT food assistance program; and increased capacity of districts to design, and of subdistrict-level health centers (Puskesmas) to deliver, locally adapted IPC activities. Key activities include strengthened implementation of the ECED teacher professional development program with nutrition-sensitive modules (Ministry of Education and Culture/MoEC and Ministry of Villages, Disadvantaged Areas and Transmigration/MoV), the nutrition-sensitive BPNT program (MoSA) and IPC capacity development for districts (MoH).

(c) **Results Area 3: Strengthen convergence of district activities.** This RA will strengthen the management and implementation of nutrition activities implemented at the district level and reduce financial fragmentation. It will help to strengthen evidence- and results-based budgeting at the district level, providing incentives to districts to spend more and better on nutrition interventions and monitoring systems (including behavioral change programming), and to improve the prioritization of district and village plans and budgets to address stunting. The main activity is implementation of an annual performance assessment to measure districts' implementation of the convergence program, incentivized by a performance assessment of stunting convergence actions (Ministry of Home Affairs/MoHA), which together will support districts in implementing district-level convergence actions, including local stunting surveillance, district diagnostics, and HDW mobilization.

(d) **Results Area 4: Converge village service delivery.** This RA will support activities that will converge delivery of priority interventions on all 1,000-day households in villages, incentivize villages to allocate additional budget from the *Dana Desa* to priority nutrition-specific and nutrition-sensitive interventions, and increase the quality of and participation in community-based growth promotion activities. Key activities will include village-level social mapping of 1,000-day households, Village Convergence Scorecards, and Height-based Community Growth Promotion (MoV, MoH, and MoF).[14]

D. Environmental and Social Effects

20. **The Bank has undertaken a screening of activities to be supported by the IPF in light of potential environmental and social risks and assigned a low risk category.** The IPF component triggered OP/BP 4.01 on the Environmental Assessment as an umbrella safeguards policy and OP/BP 4.10 on Indigenous

[14] Preliminary findings of the Generasi Long-Term Impact Evaluation (June 2017) found that the project's 12 performance targets for health and education, which includes nutrition-specific and nutrition-sensitive interventions, motivated community workers and village leadership to prioritize health and education.

Peoples due to the likelihood that the PforR activities supported by the IPF TA component will be implemented in districts with presence of Indigenous Peoples. The nature of the investments under this component will be limited to TA type of activities, and will not support any physical works or other activities that generate downstream adverse environmental and social impacts. The ISDS was confirmed and revised during appraisal.

21. **The TA activities aim to strengthen environmental and social measures proposed as part of the Environmental and Social System Assessment (ESSA) for the PforR preparation.** The ESSA identifies the overall environmental and social effects are expected to be positive since the PforR seeks to support convergence of nutrition specific and sensitive interventions to reduce stunting. Key environmental concerns are associated with pharmaceutical waste disposal systems managed by *Posyandu* and *Puskesmas*. Whereas, social concerns are mostly related to people's ability to obtain basic services in an accessible, safe and inclusive manner.

22. **The ESSA also considered whether the interventions supported by the PforR are delivered in a way that takes into consideration local contexts including literacy, language, and cultural aspects of the beneficiaries.** Potential risks for inequality stemming from perceived or real differences in how benefits are distributed makes the need for an effective grievance redress system at the village level. The IPF Component will support the PforR Program to strengthen relevant measures to enhance environmental and social outcomes, including recruitment of social and environmental specialists, various capacity building programs to key stakeholders, Behavior Change Communication (BCC), Inter-Personal Communication (IPC) and awareness raising activities, development of a feedback and grievance redress strategy through the use of village scorecards and development of a strategy and instrument to monitor water quality by the district governments. No infrastructure investments will be supported by either the PforR or the IPF Component.

23. **An Environmental and Social Systems Assessment (ESSA) of the PforR program was prepared.** A workshop to finalize the ESSA was conducted on April 9, 2018 to ensure that PforR program's environmental and social risks, including follow-up actions, are agreed by key agencies.

E. Financing

Program Financing (Template)

Sources	Amount (USD Million)	% of Total
Counterpart Funding	**9,242.00**	**95.65**
Borrower	9,242.00	95.65
International Bank for Reconstruction and Development (IBRD)	**400.00**	**4.14**
Trust Funds	**20.00**	**0.21**

Global Financing Facility	20.00	0.21
Total Program Financing	**9,662.00**	

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