Program Information Documents (PID)

Appraisal Stage | Date Prepared/Updated: 06-Apr-2023 | Report No: PIDA280101

BASIC INFORMATION

A. Basic Program Data

Country	Project ID	Program Name	Parent Project ID (if any)
Indonesia	P180491	INVESTING IN NUTRITION & EARLY YEARS PHASE 2 PROGRAM	
Region	**Estimated Appraisal Date**	**Estimated Board Date**	**Practice Area (Lead)**
EAST ASIA AND PACIFIC	01-May-2023	22-Jun-2023	Health, Nutrition & Population
Financing Instrument	**Borrower(s)**	**Implementing Agency**	
Program-for-Results Financing	Republic of Indonesia	Ministry of Finance, Secretariat of the Vice President	

Proposed Program Development Objective(s)

To enhance the delivery of services to accelerate the reduction of stunting in Indonesia.

COST & FINANCING

SUMMARY (USD Millions)

Government program Cost	14,638.00
Total Operation Cost	994.00
Total Program Cost	970.00
IPF Component	24.00
Total Financing	994.00
Financing Gap	0.00

FINANCING (USD Millions)

Total World Bank Group Financing	600.00
World Bank Lending	600.00
Total Government Contribution	370.00

Total Non-World Bank Group and Non-Client Government Financing	24.00
Trust Funds	24.00

Decision

The review did authorize the team to appraise and negotiate

B. Introduction and Context

Country Context

1. Indonesia – a diverse archipelago nation of more than 300 ethnic groups – has charted impressive economic growth since overcoming the Asian financial crisis of the late 1990s. Indonesia has a population of over 273 million people, of which approximately 10% are children under the age of five[1]. Today, the country is the tenth largest economy in terms of purchasing power parity. The country has made enormous gains in poverty reduction, cutting the poverty rate by more than half since 1999, to under 10 percent in 2019 before the COVID-19 pandemic hit.

2. Despite global slowdown, Indonesia has experienced strong growth in 2022 thanks to robust commodity prices and a reopening of the economy. Real GDP growth has accelerated from 3.7 percent in 2021 to 5.4 percent year-over-year (YOY) in the first three quarters of 2022. A drop in COVID-19 infection rates and a successful vaccination program has prompted the lifting of mobility restrictions. This has released pent-up demand and led to a sharp acceleration in private consumption. The unemployment rate has fallen below 6 percent and average wages rose by 12 percent YOY[2]. Indonesia briefly graduated to upper middle-income country status in 2019, though the economic impacts of the COVID-19 pandemic returned the country to low middle-income country status in 2020. Nevertheless, the country aspires to become a high-income country by 2045[3].

3. Economic conditions in Indonesia have remained stable amidst global shocks, but it has not been insulated from price pressures. Inflation has picked up, reaching 5.7 percent (YOY) in October 2022. Price pressures have been driven by rising international commodity prices, increased domestic energy tariffs, and higher producer prices. Indonesia's external vulnerability has been low to moderate as strong exports have supported the external balance although tighter global finances have put some pressure on the capital account. The fiscal consolidation plans in 2022 have been aided by higher taxes from the

[1] Total Population by Age Group and Gender, 2022. Badan Pusat Statistik.
https://www.bps.go.id/indikator/indikator/view_data_pub/0000/api_pub/YW40a21pdTU1cnJxOGt6dm43ZEdoZz09/da_03/1
[2] World Bank. (Dec 2022). Indonesia Economic Prospects December 2022.
[3] Indonesia broke the upper middle-income threshold in 2020 but reverted back to low middle-income the following year because

recovery and commodity windfalls, and lower spending on COVID-19 related measures. Bank Indonesia is hiking its policy rate to curb inflation and contain capital outflows though current economic conditions provide space to ease the pace of tightening and safeguard economic growth. Indonesia is projected to have a robust growth over the next three years though with significant downside risks emanating from the global economic environment[4].

4. Investing in human capital is central to the Government of Indonesia (GoI) 2045 Vision[5] and, accordingly, the country has advanced this agenda over the past decade. In Indonesia, human capital has been estimated to account for more than half of the national wealth[6]. The period 2010 to 2019 saw robust economic growth, job growth and poverty reduction. In parallel, Indonesia was able to reduce stunting, progress toward universal health coverage, and expand student enrollment in education (Table 1). Indonesia has also been an early and strong champion of the Human Capital Project (HCP)[7], launched at the 2018 Annual Meetings in Bali, and is committed to further accelerating multisectoral efforts to enhance human capital outcomes. The country's National Medium-Term Development Plan (*Rencana Pembangunan Jangka Menengah Nasional*, RPJMN) 2020–2024 recognizes that human capital needs to be the main driver to achieve inclusive and equitable development. Accordingly, its fourth chapter focuses on improving the quality and competitiveness of Indonesia's human resources – with the objective to mold a healthy, intelligent, adaptive, innovative, and skilled population.

Table 1. Key Human Capital Indicators

Indicator	Indonesia 2020 or latest	Indonesia 2010	East Asia and Pacific 2020 or latest
Human Capital Index (HCI)	0.54	0.50	0.59
Probability of Survival to Age 5	0.975	0.966	0.978
Expected Years of School	12.4	11.4	11.9
Harmonized Test Scores	395	398	432
Survival Rate from Age 15-60	0.850	0.828	0.864
Fraction of Children Under 5 Not Stunted	0.723	0.608	0.759

Source: World Bank. 2020.

5. Nevertheless, low absolute levels of human capital represent a key structural bottleneck to achieving Indonesia's inclusive growth and poverty reduction agenda [8]. According to the latest Human Capital Index (HCI), Indonesia's next generation will only be 54 percent as productive as it could have been with full health, nutrition, and complete education. Indonesia's HCI score is below the average of countries in East Asia and the Pacific (EAP) and upper-middle income countries. Significant differences in HCI scores across provinces and districts mean that some parts of Indonesia have HCI scores almost at

[4] World Bank. (Dec 2022). Indonesia Economic Prospects December 2022.
[5] Vision for Indonesia 2045 *Bappenas.*
[6] Lange, G.-M., Q. Wodon, and K. Carey. 2018. *The Changing Wealth of Nations 2018: Building a Sustainable Future*. Washington, DC: World Bank.
[7] https://www.worldbank.org/en/publication/human-capital
[8] World Bank. (2021).

par with Vietnam and China while HCI scores in others are like those in Niger and Sierra Leone. The correlation between government spending and HCI performance at the district level is weak. A child born into a family with in the first quintile of the consumption distribution is expected to achieve an HCI that is 10 percentage points lower than a child born into the fifth quintile [9]. Child (under-5) mortality currently stands at 22 deaths per 1000 births, one of the highest in the region,[10] and almost 14.5% of deaths in infants and 5% of deaths in children under the age of five are caused by vaccine preventable diseases[11].

6. Stunting reduction is a priority issue for economic development and poverty reduction in Indonesia. A study by the World Bank estimated that stunting costs the Indonesian economy approximately US$3.7 billion per year, equivalent to 2.3% of Indonesia's GDP. The costs are attributed to the long-term consequences associated with stunting. Childhood stunting can predict poor human capital outcomes. This condition is a marker of a deficient environment in which children grow up and the result of multiple deprivations, including poverty, where diets are nutritionally inadequate and children are exposed to frequent infection, and where families lack access to quality essential health services which can support healthy pregnancy, safe delivery, and decrease risk of childhood illness. Children who experience stunting are more likely to have impaired child development outcomes, lower educational achievement, decreased earning and increased risk of chronic disease. Women who were stunted in childhood are more likely to have difficult birth, and their children to have poorer birth outcomes. As a result, improving the conditions which lead to stunting can yield positive impacts on child health and development and adult productivity and wellbeing, contributing to long-term economic growth.

7. A public expenditure review of the stunting reduction program found the spending to be adequate[12]. At US$8.4 per capita in 2017, the GOI spending on the program was deemed to be adequate (against a package of nutrition interventions costed at US$ 7 per capita). Increasing the efficiency of expenditure was recommended, including through: (a) improved reliability of data across ministries, agencies, and levels of government to enable the tracking and performance review of spending at all levels and demonstrate a clear link between inputs and outcomes; (b) use incentives and performance-based measures to increase accountability; (c) harmonize timelines, roles, and responsibilities for central, district, and village governments to enable effective financing and service delivery in the decentralized context.

8. Climate change is predicted to impact water availability, health and nutrition, disaster risk management, and urban development in Indonesia–particularly in coastal zones—with dire impacts

[9] Sari and Tiwari (2021). Girls show a higher average human capital potential than boys (HCI score of 0.56 vs. 0.52). World Bank (2020b).
[10] Geographical Indicators, Indonesia. UNICEF. https://data.unicef.org/country/idn/#/
[11] "The government guarantees PCV immunization for all Indonesian children to protect them from the dangers of pulmonary inflammation (pneumonia)". WHO, 2022. https://www.who.int/indonesia/news/detail/12-09-2022-the-government-guarantees-pcv-immunization-for-all-indonesian-children-to-protect-them-from-the-dangers-of-pulmonary-inflammation-(pneumonia)
[12] World Bank. 2020. Spending Better to Reduce Stunting in Indonesia; Spending Better to Reduce Stunting in Indonesia : Findings from a Public Expenditure Review. © World Bank, Washington, DC. https://openknowledge.worldbank.org/entities/publication/3a1f21cd-550f-58e4-9639-1d142265177c

on human capital, poverty, and inequality. Indonesia represents the third largest tropical rainforest in the world (94.1 million hectares) and is home to the world's largest tropical peatlands (14.9 million hectares) and mangrove forests (3.31 million hectares). These natural resources store vast amounts of carbon that mitigate climate change impacts, crucial to sustain the livelihood of Indonesians and support the country's long-term development. However, as an archipelagic country, Indonesia experiences increased exposure and vulnerability to the impacts of climate change, including sea level rise, flooding, strong winds and drought[13]. Conservative projections estimate that potential economic losses from climate change impacts in Indonesia will reach 115 trillion IDR in 2024 (7.6 million USD), across the marine & costal sector, water, agriculture and health10. The climate disaster risk index is considered "high" in 221 out of the 514 districts of Indonesia (43 percent)[14]. Eighty percent of the disasters that occurred in Indonesia between 1998 and 2018 were attributable to climate change, among which 39% were flooding 39%, 26% heavy wind/storm, 22% landslides and 8% drought[15]. In 2017 alone, extreme weather events caused by climate change affected over 300, 000 people and caused around 200 direct deaths[16]. Indonesia is particularly vulnerable to sea-level rise. Without adaptation, the total population likely to be exposed to permanent flooding by the period 2070–2100 could reach over could reach over 4.2 million people[17]. Climate change is also predicted to negatively impact the agricultural production, food safety and nutrition in Indonesia. Food supplies of subsistence-farming households are disrupted by climate-related effects such as flooding, extreme heat, or pestilence[18].

Sectoral and Institutional Context

9. Indonesia has made great strides to bend the curve on stubbornly high childhood stunting over the past five years; however, 1 in five children under age five are stunted, signaling a key barrier to human capital outcomes. Between 2013 and 2018, the National Health Survey (*Riset Kesehatan Dasar* or RISKESDAS) showed a decline in stunting among children under age five from 37.2 to 30.8 percent (or about 1.3 percentage points each year). With the 2018 launch of the high-profile, multisectoral National Strategy to Accelerate Stunting Prevention (*Stranas Stunting*) the country has accelerated its reduction in childhood stunting. From 2018 to 2022, the stunting prevalence fell from 30.8 to 21.6 percent, and the total number of stunted children dropped from approximately nine million to five million in the same period. This pace nearly doubled the annual rate of decline over the previous five-year period. Despite significant progress the country will need further attention to reach the target of 14 percent stunting by 2024.

[13] National Adaptation Plan for Indonesia (2019). Ministry of National Development Plannning/ National Development Planning Agency (Bappenas)
[14] Disaster Risk Index by Districts in Indonesia (2021)
[15] Haryanto, Budi & Lestari, Fatma & Nurlambang, Triarko. (2020). Extreme Events, Disasters, and Health Impacts in Indonesia. 10.1007/978-3-030-23773-8_16.
[16] Haryanto, Budi & Lestari, Fatma & Nurlambang, Triarko. (2020). Extreme Events, Disasters, and Health Impacts in Indonesia. 10.1007/978-3-030-23773-8_16.
[17] Le Bars, D., Drijhout, S., de Vries, H. (2017). A high-end sea level rise probabilistic projection including rapid Antarctic ice sheet mass
[18] Le Bars, D., Drijhout, S., de Vries, H. (2017). A high-end sea level rise probabilistic projection including rapid Antarctic ice sheet mass

10. Attention is needed in the "first 1000 days," the period from conception to the child's second birthday, to prevent linear growth faltering which leads to stunting. Stunting is the result of immediate causes—namely nutrient intake and disease—as well as underlying causes. A package of nutrition-specific interventions—which address the immediate causes of undernutrition—and nutrition sensitive interventions—which address the underlying causes is necessary. Convergence, or delivery of the package of interventions to the individuals and households that require them, can help ensure that the multiple deprivations are addressed.

11. Scale up of the high impact, evidence-based services delivered through the health sector is necessary to address the immediate drivers of stunting (Table 2). Comprehensive, high quality antenatal care (ANC) is necessary to address maternal diet during pregnancy and minimize the risk of low birth weight/small for gestational age deliveries, representing the in-utero origins of growth faltering. However, only one in four women are receiving six visits, as the new Ministry of Health (MOH) guideline. Iron-folic acid (IFA) supplementation is delivered during ANC to reduce iron-deficiency anemia and minimize the risk of poor birth outcomes for women and children, yet only 39.5 percent of pregnant women who receive at least 90 IFA tablets consume this minimum amount. Infant and young child feeding practices, including breastfeeding according to recommendations and the consumption of a nutritionally adequate diet is necessary to ensure sufficient nutrient intake. The adequacy of feeding is highest among children breastfed within one hour (58.3 percent) and for children below six months of age (52.2 percent) because of the extent of exclusive breastfeeding. However, as children begin to transition to complementary foods, feeding adequacy reduces to 41.7 percent between the ages of 0 and 11 months and 40.3 percent of children between the ages of 6-23 months fed a minimally acceptable diet. Immunization is one of the most effective interventions to limit the incidence and severity of childhood illness, yet less than 60 percent of children receive the full package of basic immunization. Indonesia has, however, done remarkably well on achieving near universal coverage of the availability of improved water and sanitation.

Table 2. Coverage of Nutrition Specific and Sensitive Interventions, Indonesia, Most Recent Available

Nutrition specific and Sensitive Intervention	Coverage (%)	Data Source
Maternal, child, and adolescent health indicators		
Antenatal Care (at least six visits)	26.1	SSGI 2022
Antenatal care (at least four visits)	70.0	SSGI 2022
IFAS consumption in pregnant women (at least 90 tablets)	39.5	SSGI 2022
Pregnant women with anemia	48.9	RISKESDAS 2018
Low Birth Weight (under 6 months)	6.2	SSGI 2022
Low Birth Length (< 48cm, under 6 months)	16.4	SSGI 2022
Wasting (children under five)	7.7	SSGI 2022

Underweight (children under five)	17.1	SSGI 2022
Stunting (children under five)	21.6	SSGI 2022
Overweight (children under five)	3.5	SSGI 2022
Children receiving vitamin A (6-11 months)	62.1	SSGI 2022
Nutrition, hygiene, and stimulation counselling		
Breastfeeding initiation within 1 hour after birth (under 6 months)	58.3	SSGI 2022
Exclusive breastfeeding (under 6 months)	52.2	SSGI 2022
Children aged 6-11 months received complementary food	47.7	SSGI 2022
Children aged 6-23 months fed a minimum acceptable diet	40.3	IDHS 2017
Water and sanitation		
Access to improved drinking water	91.05	BPS 2022
Access to improved sanitation	80.92	BPS 2022
Open Defecation Free (ODF)	5.69	BPS 2021

Note: IFAS=Iron-folic acid supplementation. *Full immunization includes 12 antigens: Hepatitis B, Bacillus Calmette–Guérin (BCG), Diphtheria, Pertussis, and Tetanus - Haemophilus influenzae type B vaccine – Hepatitis B (DPT-Hib-HepB), Oral Poliovirus Vaccine (OPV), and Measles and Rubella (MR).

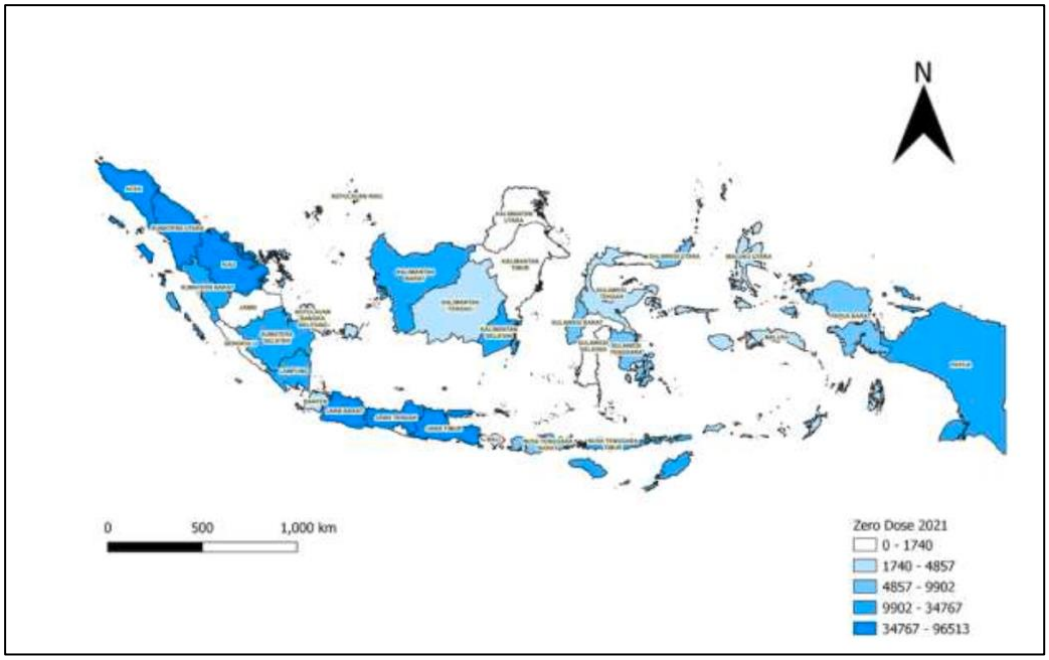
12. Indonesia experienced major COVID-19 related disruptions across essential health and nutrition services. At the peak of disruptions, the number of third dose Diphtheria, Tetanus toxoid and Pertussis (DTP3) immunizations in May 2020 were 60% lower than in May 2019. Despite some recovery, in 2021 Indonesia's DTP3 coverage rate was 80 percent - a decline from 83 percent in 2020. Moreover, drop-outs between the first and third dose of DTP-containing vaccines increased almost six-fold between 2019 and 2021. As of January 2021, there were approximately 300,000 toddlers that had not been vaccinated at all which makes them vulnerable to vaccine-preventable diseases and to preventable mortality and morbidity. Furthermore, National Population and Family Planning Board (*Badan Kependudukan dan Keluarga Berencana Nasional* or BKKBN) predicted that Indonesia will experience a baby boom due to unplanned pregnancies; it is estimated that 300,000 - 500,000 unplanned pregnancies have occurred in 2020 alone, due to reduced access to family planning facilities such as *Puskesmas*[19] and independent midwives. It is estimated that due to COVID-19, there has been a reduction in birth control measures; total new users to family planning in February 2020 were 427,133, which had shrunk to 267,132 by April 2020.

13. This backsliding in immunization coverage—exacerbated by the COVID-19 pandemic—poses a threat to continued downward trends in reduction of child mortality and stunting reduction. Studies

[19] *Pusat Kesehatan Masyarakat*, or primary health center at sub-district level

have shown a negative correlation between immunization and malnutrition, where children with incomplete immunizations are more likely to be stunted and wasted. Despite significant improvements in immunization coverage in the last two decades, Indonesia is still among the top ten countries with the greatest number of unimmunized children in the world[20]**.** This has resulted in a drastic increase in zero dose children[21] – where in 2021 the reported combined zero dose and under immunized children was at 1,525,936 children, increasing 65% from the previous year[22]. These zero-dose children are concentrated in 10 priority provinces across Indonesia (Figure 1). Improving the coverage of primary health care (PHC) services the district and village level, and ensuring the integration of immunization and nutrition services at health system contacts, is critical to improving child health, nutrition, and wellbeing in the first 1000 days of life.

Figure 1. Distribution of Zero-Dose Immunization Children in Indonesia, by Province, 2022



Source: MOH.

14. Climate change poses a serious threat to food security, nutrition, and stunting in Indonesia. The country is exposed to climate shocks through by both El Niño events - where drier conditions are experienced – and La Niña events – associated with wetter conditions[23]. In the last 25 years, a strong correlation is observed between El Niño occurrence of manmade fire events in Indonesia, which is

[20] World Health Organization. Immunization coverage. 2016. http://www.who.int/mediacentre/factsheets/fs378/en/
[21] **Zero-dose children** are those that have not received any routine vaccine. For operational purposes, Gavi defines zero-dose children as those who lack the first dose of diphtheria-tetanus-pertussis containing vaccine (DTP1). https://www.gavi.org/our-alliance/strategy/phase-5-2021-2025/equity-goal/zero-dose-children-missed-communities
[22] MOH-MIC GAVI Proposal, 2021.
[23] Polade, S. D., Pierce, D. W., Cayan, D. R., Gershunov, A., & Dettinger, M. D. (2014). The key role of dry days in changing regional climate and precipitation regimes. Scientific Reports, 4(1), 4364. https://doi.org/10.1038/srep04364

detrimental to agricultural land[24]. In 2015 and 2016, extreme El Niño and La Niña events have also affected the production performance of major agricultural crops[25]. In addition while fisheries represent a key component of national food security in Indonesia, they are considered to be among the most climate vulnerable in the world[26]. Rice, a central element of Indonesian diets, is particularly sensitive to temperature changes, with some estimates suggesting that an increase of 1°C could reduce national production by 10%–25%[27]. Under the most extreme projected scenario, it is projected that approximately 35.1 climate-related deaths per million population could occur because of scarce food availability in Indonesia by 2050[28].

15. The broad-based climate change risks, associated natural disasters, and impacts on food security constitute a 'threat multiplier' for hungry and undernourished people, especially young children[29]. Climate change puts a strain on food availability and prices, hinder the consumption of calories and micronutrients of low-income households[30]. A modelling study showed that a 100% increase in food prices would result in at least a 25% increase in the number of Indonesians living in extreme poverty[31]. It is estimated that without substantial investment in climate change adaptation, 2.33 million children will be malnourished in Indonesia in 2045[32]. A study conducted on data from the Indonesian Family Life Survey between 1993 and 2015 showed that delays in the monsoon onset are associated with stunting among children aged 2-4 years[33]. This will particularly affect the provinces of Bali and Java where

[24] Nurdiati, S., Bukhari, F., Julianto, M. T., Sopaheluwakan, A., Aprilia, M., Fajar, I., Septiawan, P., & Najib, M. K. (2022). The impact of El Niño southern oscillation and Indian Ocean Dipole on the burned area in Indonesia. Terrestrial, Atmospheric and Oceanic Sciences, 33(1), 16. https://doi.org/10.1007/s44195-022-00016-0

[25] Asian Development Bank. (2019). Policies to Support Investment Requirements of Indonesia's Food and Agriculture Development during 2020-2045 (0 éd.). Asian Development Bank. https://doi.org/10.22617/TCS190447-2

[26] Blasiak, R., Spijkers, J., Tokunaga, K., Pittman, J., Yagi, N., & Österblom, H. (2017). Climate change and marine fisheries : Least developed countries top global index of vulnerability. PLOS ONE, 12(6), e0179632. https://doi.org/10.1371/journal.pone.0179632

[27] USAID (2015). Climate Risk Profile: Indonesia Fact Sheet.

[28] Springmann, M., Mason-D'Croz, D., Robinson, S., Garnett, T., Godfray, H. C. J., Gollin, D.,Scarborough, P. (2016). Global and regional health effects of future food production under climate change: a modelling study. The Lancet: 387: 1937–1946. URL: https://www.sciencedirect.com/science/article/pii/S0140673615011563?via%3Dihub

[29] How climate change increases hunger—And why we're all at risk. (s. d.). Concern Worldwide. Consulté 3 février 2023, à l'adresse https://www.concernusa.org/story/climate-change-and-hunger/

[30] Fanzo, J., Davis, C., McLaren, R., & Choufani, J. (2018). The effect of climate change across food systems : Implications for nutrition outcomes. Global Food Security, 18, 12-19. https://doi.org/10.1016/j.gfs.2018.06.001

[31] Ivanic, M. and Martin, W. (2014). Short- and Long-Run Impacts of Food Price Changes on Poverty. The World Bank Group. URL: http://documents.worldbank.org/curated/en/106581468325435880/pdf/WPS7011.pdf [accessed 14/01/2019].

[32] Asian Development Bank. (2019). Policies to Support Investment Requirements of Indonesia's Food and Agriculture Development during 2020-2045. Asian Development Bank. Table 3.10b: Projected Impact of Baseline R&D Investment Scenarios on Food Security in Indonesia under No CC and Climate Change Scenarios, 2030 and 2045. https://doi.org/10.22617/TCS190447-2

[33] Thiede, B. C., & Gray, C. (2020). Climate exposures and child undernutrition : Evidence from Indonesia. Social Science & Medicine, 265, 113298. https://doi.org/10.1016/j.socscimed.2020.113298

estimates project an increase in the probability of 30-day delay in the wet season from 9%–18% today to 30%–40% by mid-century[34,35].

Indonesia's Initiatives to Accelerate Stunting Reduction

16. Under the leadership of Indonesia's Vice President, the National Strategy to Accelerate Stunting Prevention (*Stranas Stunting*) was endorsed in 2018, drawing on World Bank technical advice. The *Stranas Stunting* adopts a multi-sectoral convergence approach that commits 23 ministries to increase the impact of almost US$4 billion of government spending each year on nutrition-specific and nutrition-sensitive interventions and services. More recently, the President has added stunting reduction as one of 16 National Priority Projects and incorporated the *Stranas Stunting* targets and multi-sectoral convergence approach in the National Medium-Term Development Plan (RPJMN) for 2020-24. The GOI rolled out the *Stranas Stunting* in 100 priority districts in 2018, expanded to an additional 60 districts in 2019, and added an additional 100 districts each year in 2020 and 2021, bringing the total to 360 districts in 2021 and achieved nationwide coverage of all 514 districts in 2022.

17. The *Stranas Stunting* is based around five pillars of action (Table 3), which reflect the global experience on accelerating stunting reduction, adapted to Indonesia's decentralized context. Indonesia drew upon the experience of Peru, Brazil, and Bangladesh in improving child development outcomes and accelerating stunting reduction and: (a) securing high level political commitment along with broad social participation; (b) leveraging results based financing mechanisms to drive progress; (c) targeting areas of greatest need and low-income populations; (d) addressing both supply and demand issues in the delivery of nutrition-specific and -sensitive services; and (e) introducing a convergence approach to coordinate and geographically target interventions across sectors to the same districts, villages, and households.

Table 3. Overview of the Pillars of the National Strategy for Acceleration of Stunting Reduction

Pillar	Scope and Rationale
Pillar 1: Improving leadership commitments and visions in ministries/agencies, provincial governments, district/city governments, and village governments;	Under this pillar, the President and Vice President will hold limited cabinet meetings; convene national Stunting Summits and encourage subnational leaders to hold local stunting summits to build top-to-bottom leadership; and hold ministers, governors, district heads, and mayors to account for meeting service delivery and stunting reduction targets. The annual Stunting Summits will also recognize districts that successfully reduce stunting, share and promote innovation, and showcase best practices.
Pillar 2: Improving behavior change	The President and Vice President will lead a sustained public awareness campaign targeting policymakers, regional governments, community leaders, parents,

[34] Naylor, R., Battisti, D., Vimont, D., Falcon, W., Burke, M. (2007). Assessing Risks of Climate Variability and Climate Change for Indonesian Rice Agriculture. Proceedings of the National Academy of Sciences of the United States of America. 104. 7752–7. 10.1073/pnas.0701825104.

[35] ADB (2019). Policies to Support Investment Requirements of Indonesia's Food and Agriculture Development during 2020-2045.

communication and community empowerment;	Prospective brides and grooms, and the general public. The campaign will use a variety of outreach strategies, from mass media to home visits, and will also scale up and strengthen BCC programming.
Pillar 3: Improving the convergence of specific and sensitive interventions in ministries/agencies, provincial governments, district/city regional governments and village governments;	Indonesia has a highly decentralized system of government under which most service delivery is the responsibility of sub-national governments. Most nutrition-specific and nutrition-sensitive interventions are the responsibility of local governments. National government has the authority to set priorities which local governments should follow, and programs which they should implement, but there are limited mechanisms to enforce compliance with national priorities. The role of districts is even more important since the introduction of the Village Law in 2014. Substantial resources are now channeled from the central government and to the district and on to the village, but the quality of village expenditure is highly dependent on the quality of support and supervision which districts provide to villages. This is particularly important for nutrition interventions, many of which are delivered at the village level.
Pillar 4: Improving food and nutrition security at individual, family and community levels	This pillar focuses on food policy reforms and investments to enable improved access to good-quality and affordable nutritious food. It identifies the following four areas: food policy reforms, food fortification reforms, food contamination reforms, and food market investment policies.
Pillar 5: Strengthening and developing systems, data, information, research and innovations.	The President and Vice President will use a dashboard to monitor progress and identify, reward, and sanction the performance of line ministries, provinces, districts, and villages in accelerating stunting prevention. *Perpres* 72 calls for strengthening national, district, and village data systems on service delivery, intervention targeting, and stunting. These improvements will also allow for faster and more robust learning and feedback loops and will facilitate course corrections during implementation.

18. The convergence of nutrition-specific and nutrition-sensitive interventions under Pillar 3 is a core element of Indonesia's approach to enhance the delivery, quality, and utilization of services for stunting reduction in the country's decentralized context. The *Stranas Stunting* introduced convergence instruments at the national, district, and village levels in order to drive progress. At the central level, stunting leadership summit convened political leaders of all levels to commit to stunting reduction and engaged district leaders (*Bupatis*) to sign commitments to (a) hold district stunting summits with relevant stakeholders; (b) implement convergence actions for nutrition interventions; (c) collect and publish data on stunting and intervention delivery, and to utilize data to improve intervention delivery; (d) formulate a communications and behavior change communication (BCC) policy to accelerate stunting reduction; and (e) support village-level nutrition intervention convergence.

19. The delivery and convergence of services at the village level for Indonesia's nearly 75,000 rural villages remain a priority. Village-level institutions are involved in the frontline delivery of key nutrition-speicific and nutrition sensitive interventions and have substantial financial revenues (including the village fund, or *Dana Desa*) for financing these services. The government have now instructed villages to prioritize resources for human development including for the acceleration of stunting prevention and reduction. Building on the experience of the *Generasi* project for increasing access to basic health and education services in the villages, Indonesia introduced a human development worker (HDW) cadre in

each village. HDWs work across sectors to carry out social mapping to identify target 1,000 day households and to report on a village convergence scorecard to monitor the implementation of specific and sensitive interventions in priority districts.

20. The Investing in Nutrition and Early Years (INEY) Program[36], a flagship initiative financed by World Bank and the Global Financing Facility for Women, Children and Adolescents (GFF) has supported the implementation of the *Stranas Stunting* since 2018 (Box 1). INEY was designed to complement the existing World Bank portfolio at the time of approval and aimed to: (i) address the multisectoral management and system challenges that undermine convergence at each level of intervention delivery (central, district, and village); (ii) plug critical gaps in the Government's mix of sector programming; and (iii) strengthen citizen engagement in the frontline delivery and oversight of nutrition interventions. Based on the existing World Bank portfolio and GoI priorities, INEY's support for nutrition-specific interventions was limited to improving the enabling environment for and delivery of BCC at the district level and below.

21. The onset of the COVID-19 pandemic created headwinds for the stunting reduction program in its nascent stages. Although national level allocations to nutrition were protected, the COVID-19 pandemic adversely affected subnational attention to the delivery and convergence of essential health and nutrition interventions and utilization plummeted, threatening to reverse past gains. Financial and human resources for nutrition convergence were diverted to pandemic response, and frontline services have been disrupted for a prolonged period.

22. Despite these challenges, GoI has made unprecedented progress in reducing stunting from 30.1 percent to 21.6 percent in the first four years implementing its national program, including through support of INEY. The center of government coordination mechanism under the Secretariat of the Vice President (SoVP, or Setwapres) has worked very well, particularly for debottlenecking and advocacy and securing subnational commitments. With broad-based commitment and publication of stunting rates on an annual basis, stunting reduction has evolved from an invisible ambition to a community priority and a mainstay across political agendas. The program reached nationwide coverage of all 514 districts in 2022, two years ahead of schedule. Subnational governments have created an enabling environment to coordinate across sectors and converge nutrition interventions by having consistently implemented annual convergence actions at each level respectively. Coordination across sectors has improved, with greater involvement of district offices (Dinas). Capacity building for districts has enhanced coordination in targeting and prioritizing the required nutrition interventions. The annual performance assessment organized by provinces and close monitoring of convergence actions progress by MoHA have maintained districts' motivation to improve the implementation of their convergence actions.

23. Additional implementation achievements include:

(a) Nutrition-sensitive early childhood education in at least 10% of villages in over 50 districts;

[36] *Indonesia - Investing in Nutrition and Early Years Project (English).* Washington, D.C. : World Bank (PAD2796) Group. http://documents.worldbank.org/curated/en/303221529811053670/Indonesia-Investing-in-Nutrition-and-Early-Years-Project

(b) Over 150 districts that formulated regulations on behavioral change communication for stunting reduction and over 75 districts that implemented interpersonal communication at the village-level;
(c) Provision of a food basket of improved nutritional value through a non-cash social assistance transfers to over 12 million vulnerable families across 360 districts;
(d) Nearly 75,000 HDW cadres were introduced into the village apparatus and financed through the *Dana Desa;*
(e) Over 50 percent of villages in over 150 districts were empowered to diagnose and converge key nutrition interventions by leveraging the village fund to finance stunting reduction interventions.

24. The *Perpres 72* includes a holistic approach to children development known as "Holistic and Integrative Early Childhood Education (*PAUD HI*)". It aims to deliver integrated services on education, health, nutrition, care, parenting, protection and welfare. It calls for a National Action Plan to deliver these services under a holistic and integrated manner in *PAUD* centers nationwide, with a goal of achieving 70 percent of *PAUD* centers by 2024. Such approach is coherent with a large body of evidence that shows that integrated services in areas such as education, health and nutrition are effective in fostering both the cognitive and socioemotional development of children[37].

[37] For example, the Head Start program in the United States, which integrates health, nutrition, education and parenting. Similarly, India's Integrated Child Development Services program, which started in 1974, bundles services addressing education, health, nutrition and support to mothers through a focus on the most disadvantaged.

Box 1. Overview of the Investing in Nutrition and Early Years Program

The World Bank's flagship instrument to support Indonesia in reducing stunting is the Investing in Nutrition and Early Years (INEY) PforR (P164686). INEY is a hybrid US$400 million PforR loan + US$24 million investment project financing (IPF) component financed through GFF grants. The development objective is to increase simultaneous utilization of priority nutrition-specific and nutrition-sensitive interventions by 1,000-day households in priority districts. INEY acts as the platform for a multi-sectoral, cross-government, community-based approach to tackle stunting, as well as to improve the quality of government spending by incentivizing ten ministries to implement *StraNas Stunting*. It aims to incentivize ten implementing agencies, hundreds of local governments, and tens of thousands of villages to collaborate to converge a multi-sectoral package of priority nutrition-specific and -sensitive interventions on priority households at the village level.

INEY fosters leadership, coordination/convergence, and community-based interventions for grassroots integrated solutions. The DLIs support achievement of results not only by sectoral line ministries, but by engaging leaders at the national, district, and village levels to plan for, implement, and monitor a package of multisectoral, evidence-based interventions targeting the same geographies and households (the convergence approach). It empowers families to use services and change behaviors and mobilizes Human Development Workers (HDWs) in all villages to coordinate and monitor the use of services across sectors, using digital technology (eHDW application) to enable real-time monitoring of nutrition interventions.

Table B1.1 Design of the Investing in Nutrition and Early Years PforR

Results Area	Disbursement-linked Indicators (DLI)	Lead agency(ies)
1. Strengthening national leadership	DLI 1: Public commitment of priority district leaders to accelerate stunting prevention	SoVP
	DLI 2: Tracking and performance evaluation of national spending on priority nutrition interventions	MoF & Bappenas
	DLI 3: Timely publication of annual national and district stunting rates	BPS
2. Strengthening delivery of national sector programs	DLI 4: Priority districts delivery of nutrition-sensitive professional development program for ECED teachers	MoECRT & MoV
	DLI 5: Nutrition-sensitivity of the food assistance program (BPNT)	MoSA
	DLI 6: Priority districts implementation of locally adapted IPC activities	MoH
3. Strengthening convergence of district activities	DLI 7: Predictability and results orientation of fiscal transfers that support convergence	Bappenas, MoF & MoHA
	DLI 8: Performance of districts in targeting priority nutrition interventions to 1,000-day households	SoVP & BPS
4. Converging village service delivery	DLI 9: Villages empowered to identify 1,000-day households and converge intervention delivery	MoV & MoF
	DLI 10: Village convergence of nutrition interventions on 1,000-day households	SoVP & MoF

25. A Presidential Regulation number 72 of 2021 (*Peraturan Presiden,* or *Perpres 72*) updated the *Stranas Stunting* and elevated its legal status. The *Perpres 72* enacted into law Indonesia's whole-of-government approach to improve nutritional outcomes, reduce stunting, and accelerate human capital development. Furthermore, the issuance of *Perpres 72* contributed to sustained commitment from high-level leadership. The President of Indonesia, for example, led a high-level meeting on stunting reduction in January 2022, and the Program maintains continued support and endorsement from the Vice President and other senior leaders.

26. The flagship transformation agenda of the Ministry of Health (MoH) offers complementary opportunities to strengthen the quality and delivery of PHC and tackle the unfinished agenda for the delivery of nutrition specific services for stunting reduction. The country's PHC network includes *Puskemas*[38] and *Posyandu*[39] in each district and village. The public primary care system also includes *Pustus* - auxiliary health centers for outreach activities in remote regions, *Polindes* - village-level delivery posts (often the home of the village midwife) and *Poskesdes* - village health posts. Frontline service delivery in the villages is also undertaken through *Posyandu* and by mostly female village cadres (*Posyandu kader)* who are not part of the formal health system and work on a voluntary basis[40]. However, MoH has identified key gaps in the PHC system: (i) lack of standardization and integration of health services across the primary care facilities; (ii) unavailability of critical infrastructure, medical equipment and consumables; (iii) lack of suitably qualified and trained staff at the *Puskesmas* and *Posyandu kaders* capable of providing a broader set of essential health services in each of Indonesia's 85,000 villages with higher frequency than typically associated with *Posyandus*; and (iv) limited health surveillance capacity at *Puskesmas*-level of national health laboratory system (*Labkesmas*). These gaps were laid bare throughout the COVID-19 pandemic. The health transformation objective is to strengthen the health system's capacity to deliver high-quality, affordable and accessible PHC services to all Indonesians, particularly those in remote and disadvantaged areas. As one of four key reform areas, the PHC is recognized as the foundation of a strong and effective healthcare system. One of the key components of the PHC transformation agenda is the development and scaling up of a service delivery model that utilizes the Integrated Health Posts (*Posyandu*) as the frontline modality of care for patients across the life cycle. *Posyandus* will the entry point for primary healthcare services, providing essential health services and nutrition interventions.

27. **Stunting reduction and immunization remain a thematic focus of the PHC pillar.** The MoH has identified eleven specific nutrition interventions for scale up, including: screening for anemia for adolescent, IFA consumption for adolescent, at least six ANC, IFA consumption for pregnant women, complementary food with high animal protein for malnourished pregnant women, exclusive breastfeeding for at least 6 months, complementary foods rich in animal protein for age of 6-23 months, monitoring children under five growth and development through *Posyandu* activities, proper treatment for wasting and undernourished children under five, improving immunization coverage and expansion, and health and nutrition education/promotion. Through the delivery of these nutrition interventions at

[38] Puskesmas - primary health centers that cover a population of about 25,000-30,000, with almost a third having inpatient beds.
[39] 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 ANC as part of outreach services of primary health care centers (puskesmas).
[40] *Posyandu*, or integrated village-level service facilities are supported by a health worker and run by (volunteer) community health workers, or *kader*, that deliver essential health services, particularly related to child and maternal health. *Puskesmas* are sub-district level community health centers that provide primary care and population health management.

the sub-national level, Indonesia aims to strengthen primary health care and combat childhood stunting. The recruitment of approximately 75,000 human development workers has provided frontline support in identifying gaps in services while simultaneously drawing household members to obtain better health and nutrition services at the *Posyandu* and *Puskesmas* level.

28. **The MoH has embarked on program of PHC service delivery redesign aimed to increase service utilization and enhance health outcomes**. In December 2021, the MoH introduced the Integrated Primary Care (*Integrasi Layanan Primer* or ILP) concept. By integrating primary care services, patients can access a range of health services that are tailored to their specific needs in the life-cycle (rather than by vertical program), including prevention, diagnosis, treatment, and rehabilitation. ILP involves the coordination of various healthcare providers and stakeholders, including doctors, nurses, midwives, pharmacists, and other health professionals. It also involves the integration of different health programs and services, such as maternal and child health, immunization, family planning, and nutrition. A pilot of the ILP model included: (i) shifting to life-cycle cluster-based services at *Puskesmas;* (ii) introducing a new service delivery unit, the upgraded and daily staffed and functional *Posyandu Prima* at the village level; (iii) monthly preventive and promotive activities at *Posyandu*; and (iv) adding home visits by the community health workers (*Posyandu kader*). Implemented across eight districts representing Indonesia's diversity, the pilot demonstrated great promise in increasing service utilization in *Puskesmas*, improving screening for chronic diseases, increasing health promotion contacts at home, among others. With these positive findings, MoH has ambitious targets for scaling up PHC standardization, supported by the ILP, by 2024.

PforR Program Scope

32. **The proposed second phase PforR comprises an IBRD loan in the amount of US$600 million accompanied by grants from GFF and Gavi that will finance IPF component.** The second phase Program aligns with the national program for acceleration of stunting reduction and the primary health care transformation agenda.

33. **INEY's second phase deepens the engagement on high impact essential health and nutrition services and village level implementation while sustaining select central and district level actions targeting leadership and accountability.** With many of the multisectoral governance, coordination, and management bottlenecks at central and district levels addressed in INEY's first phase, the opportunity is apt to fill gaps in support for sectoral interventions, namely the essential health, nutrition, and immunization services. This focus aligns with the lagging coverage of these high impact interventions and the PHC systems strengthening initiatives under the Health Transformation Agenda. Village level implementation is prioritized in the second phase due to: (a) the centrality of village service delivery platforms for specific and sensitive interventions; and (b) the need to remediate the capacity gaps and coordination challenges that have emerged in the transition to *Perpres 72* implementation arrangements.

C. Proposed Program Development Objective(s)

Program Development Objective(s)

36. The Program Development Objective is to enhance the delivery of services to accelerate the reduction of stunting in Indonesia.

37. The PDO will be measured by the indicators in Table XX.

Table7. Investing in Nutrition and Early Years 2 Program Development Objective Indicators

PDO Dimension	Indicators
To enhance delivery of services	- Share of community health posts delivering essential health and nutrition services according to agreed standards - Share of fully immunized children (age 11-24 months) in identified, low performing districts
To accelerate the reduction of stunting	- Share of village governments achieving good performance in convergence for the acceleration of stunting reduction -Prevalence of child (<5 years) stunting

D. Environmental and Social Effects

Legal Operational Policies

	Triggered?
Projects on International Waterways OP 7.50	No
Projects in Disputed Areas OP 7.60	No

Summary of Assessment of Environmental and Social Risks and Impacts (With IPF Component for PforR)

38. An Environmental and Social Systems Assessment (ESSA) of the PforR Program was conducted as part of the preparation process. The ESSA examined the environmental and social management systems that are applicable to the Program to assess their compliance with the World Bank Policy Program-for-Results Financing. It aimed to ensure that the PforR 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 includes the 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) System and performance consistency with key principles.
(e) Steps to improve the scope of the system or capacity.

39. The assessment of the environmental and social (E&S) aspects of this INEY Phase 2 was conducted based on review of the E&S performance to-date of the related multisectoral agencies and the existing system currently implemented for the ongoing program in managing the potential E&S risks; sites visit to representative/selective regions (including to Surabaya city and District of Manggarai Timur); and consultations undertaken at the central and sub-national level.

40. The E&S risks/impacts are likely to be similar with the Phase 1 of the Program considering the nature and type of the proposed activities will be generally the same, with some additional intervention activities.

41. With regards to the IPF component, given the nature of the program is institutional development and capacity building, which is not envisaged to involve any civil works nor purchase of equipment with environmental and social implications, the environmental and social risk rating is low with no adverse environmental and social risks and impacts are expected from the program activities. Further risk and capacity assessment for the IPF component of the INEY Phase 2 is being prepared through an Appraisal ESRS.

E. Financing

Program Financing (Template)

Sources	Amount (USD Million)	% of Total
Counterpart Funding	**370.00**	**37.22**
Borrower/Recipient	370.00	37.22
International Bank for Reconstruction and Development (IBRD)	**600.00**	**60.36**
Trust Funds	**24.00**	**2.41**
Global Alliance for Vaccine and Immunization	10.00	1.01
Global Financing Facility	14.00	1.41
Total Program Financing	**994.00**	

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