PROGRAM-FOR-RESULTS INFORMATION DOCUMENT (PID)
CONCEPT STAGE

Report No.:PIDC0090998
(The report # is automatically generated by IDU and should not be changed)

Program Name	*Social Assistance Reform Program*
Region	*East Asia and the Pacific*
Country	*Indonesia*
Sector	*Social Protection and Labor*
Lending Instrument	*Program for Results*
Program ID	*P160665*
Borrower(s)	*Republic of Indonesia*
Implementing Agency	*Ministry of Social Affairs*
Date PID Prepared	*November 6, 2016*
Estimated Date of Appraisal Completion	*February 28, 2017*
Estimated Date of Board Approval	*April 28, 2017*
Concept Review Decision	Following the review of the concept, the decision was taken to proceed with the preparation of the operation.

I. Introduction and Context

A. Country Context

Indonesia is the world's largest archipelagic state, its fourth most populous nation, and the 10th largest economy in terms of purchasing power parity. It is a member of the ASEAN group of countries that have a combined population of 608.4 million and is also a member of the G-20.With more than 17,500 islands, of which 6,000 are inhabited, Indonesia has a population of over 250 million, with 300 distinct ethnic groups and over 700 languages and dialects. With a GDP per capita of about US$3,500 (2014), Indonesia is currently classified as a lower middle-income country and will transition to an upper middle income country with continued economic growth.

Over the past decade, Indonesia has seen strong growth and job creation, supporting poverty reduction, but the end of the commodity boom has exposed structural weaknesses. Following the recovery from the Asian financial crisis, annual growth averaged 5.6 percent over 2001-12. As the external tailwinds of commodity prices and demand and global financing conditions have turned to headwinds, growth has slowed, down to 4.8 percent in 2015 and projected at 5.1 percent in 2016. The slowdown in growth and weakening of commodity prices has increased fiscal pressures significantly in 2015 and 2016.

Indonesia's progress on poverty reduction contrasts sharply with its performance in sharing prosperity. From 1999 to 2016, the national poverty rate more than halved to 10.8 percent, largely through sustained growth and job creation. Recently, however, the rate of poverty reduction has begun to stagnate, with a near zero decline in 2015. Lifting the "hard core" poor permanently out of poverty will require greater focus and new programs. The number of

vulnerable in 2016 (i.e., those between the poverty line and 1.5 times the line) remains high, at 24 percent of the population, mainly due to a lack of productive employment and vulnerability to shocks. Together, the poor and vulnerable are 35 percent of the population. Inequality, as measured by the Gini coefficient, increased from 30 points in 2000 to 41 points by 2014, by far the fastest widening seen in East Asia.

In terms of human development indicators, despite progress, several challenges remain. In education, adult literacy is at almost 95%; gross enrollment has reached 100%, 83%, and 32% in primary, secondary and tertiary education, respectively; and the share of female enrollment exceeding that of males at each level. But disparities in access amongst socio-economic groups have persisted. About 23 percent of villages do not have any pre-primary education services. There are also severe disparities in education service provision between urban and rural areas and across provinces.

Health outcomes and outputs in Indonesia have also improved in recent years. Life expectancy at birth has steadily increased to 69 years in 2014, up from 63 years in 1990. The under-five mortality rate has declined from 85 per 1,000 live births in 1990 to 27 in 2015, while infant mortality has declined six-fold since 1960, down to 23 per 1,000 live births in 2015, meeting the child-health related Millennium Development Goal (MDG). Pregnant women receiving four or more antenatal care visits have also increased from 81% in 2002 to 88% in 2012. However, key challenges remain, including slow progress on maternal health and chronic malnutrition. Maternal mortality has fallen from 340 to 220 deaths per 100,000 live births (between 2000 and 2010) but remains far above the 2010 average rate of 83 per 100,000 in the East Asia and Pacific (EAP) region. Births attended by skilled health staff, rates of immunization, and rates of access to improved sanitation facilities also remain behind the region's developing country average. Moreover, last data in 2013 showed that 37 percent of under-five children were stunted (9 million children), while 12 percent were wasted, rated that worsened between 2007 and 2013. Stunting affected all income groups but worsened amongst the poorest, it increased from 41% in 2007 to 48% in 2013.

B. Sectoral (or multisectoral) and Institutional Context of the Program

The year 2005 marked Indonesia's shift to begin investing comprehensively in social assistance (SA) programs as a result of the creation of fiscal space through the phasing out of a regressive fuel subsidy. In 2010, a main development priority of the re-elected Government was poverty reduction, implying a redesign of Indonesian SA programs to achieve broad-based economic growth and fiscal sustainability with the aim to improve access to and quality of basic social services.

Between 2010 and 2015, the Government executed several SA reforms, with the aid of development partners such as the Bank. For example, standardized procedures for targeting and identifying potential beneficiaries, drawing on a new national registry of nearly 26 million poor and vulnerable households (the Unified Database, UDB), were put in place. Several reductions in poorly targeted energy subsidies were achieved while the fiscal savings were reallocated to more effective purposes, including: (i) a temporary, emergency, unconditional cash transfer targeted to poor and vulnerable households (BLSM); (ii) a social protection card (KPS/KKS) giving beneficiaries access to multiple programs; and (iii) benefit and coverage increases for

Indonesia's scholarships (PIP) and the conditional cash transfer (CCT) program (Program Keluarga Harapan, PKH). Over this period, the national health insurance for the poor scheme (Jamkesmas/PBI) was also expanded to reach 92.4 million people in 2016, while the rice subsidy scheme for the poor (Rastra) reached 15.5 million households in the same year.

Since then, spending on SA has kept its upward trend to reach 0.7% of GDP in 2015. But spending still remains too low to contribute to poverty reduction (world average is 1.6% of GDP) and there is scope to improve the poverty reduction impact of current spending. In 2012, less than one quarter of total expenditures in the four permanent SA programs went to poor households while SA benefits eliminated only 16 percent of the poverty gap.

The administration that took office in 2015 added a focus on reducing inequality and it also has identified social assistance as a means of reducing inequality in income and in opportunity. One of the first steps that the new administration took was to review the design, process and systems of the PKH CCT program, implemented by the Ministry of Social Affairs (MoSA). It has decided a most needed scale-up in coverage, from the coverage of 3.5 million families in 2015 (5 percent of the population) to the Government's target of 6 million households nationally (10 percent of the population) by the end of 2016. With the expansion, all provinces in Indonesia, including Papua, with the highest poverty rates in the country but previously not covered by PKH, would be covered. The ultimate goal is, budget permitting, to expand the program to reduce exclusion errors (poor families with children not covered; highly marginalized and remote regions with high presence of indigenous populations excluded) to levels in line with other countries with large CCT programs (Mexico, Brazil, and the Philippines CCTs cover between 20 and 30 percent of the population). The program would have come a long way from when first introduced in 2007 in seven Indonesian provinces and to just under half a million families.

PKH eligibility depends on both family resources and demographic composition. To be eligible, a family must be in the bottom 25 percent of families as defined by the UDB. Then, they must meet at least one of the following conditions: a family member is pregnant or lactating; the family has one or more children below 5 years of age; the family has children from 6 to 15 years of age attending primary or middle school; or the family has children aged from age 16 to 18 that have not yet completed basic education. Furthermore, PKH beneficiary families must be in compliance with the relevant health and education conditions, and disbursement of the cash transfers is made only after verification of the compliance of the conditions. Mothers are in the majority of cases the main recipient. Starting in November 2016, eligible families that have a severely disabled or an elderly person living with them will also be receiving additional transfers.

Robust impact evaluations (using the gold-standard technique of randomized-control trial) has already shown positive impacts of PKH on food expenditure, health-seeking behavior (access to prenatal services, immunization) and education (elementary and secondary school) for poor families and the communities in which they live. Participation in elementary and secondary schools, birth delivery by medical staff, and complete immunization for children have shown increases attributed to the CCT not only among PKH beneficiaries, but also among non-beneficiaries. It has also shown a reduction in child severe stunting. Equally important, a recent study showed that both worldwide and in Indonesia, CCTs do not increase recipients purchasing

of alcohol or cigarettes. Furthermore, another presumption was disproven, the notion that cash transfers discourage work.

While the government has in place a collection of SA programs (PKH, Rastra, PBI, PIP, BLSM, etc.) that could potentially achieve its poverty reduction goals, these programs reach only portions of all intended beneficiaries and are highly fragmented both internally and vis-a-vis the rest of the social safety net system. In recognition of the great potential of better coordination between its suite of social assistance programs and implementation units, the MoSA leadership is also undertaking a review of its organizational structure, management models, and human resource base, starting with a ministry-wide information management and IT strategic plan. It has also started to pilot a payment integration model between PKH and the subsidized rice scheme Rastra (given current coverage gaps of Rastra among PKH families). And, fulfilling its legal mandate, MoSA is undertaking technology and human resource upgrading to be able to manage the UDB (currently hosted under the Vice President's Office for Poverty Reduction, TNP2K, until MoSA's capacity is strengthened), and eventually transform it into a dynamic social registry information system for SA interventions.

C. Relationship to CAS/CPF

The proposed Program-for-Results (PforR) operation responds to a request by MoSA, and its proposed development objective aligns with improving the effectiveness of fiscal spending in poverty and inequality reduction in Indonesia, as stated in the country's national development plan (RPJMN, 2015-2019). The RPJMN recognizes the need to perfect the social protection system comprehensively for all citizens, and to support special programs for the poor by improving targeting accuracy. Its policy direction also discusses the need to: (i) integrate several family based social assistance schemes for poor and vulnerable families that have children, disabled and elderly in the form of conditional cash transfers and/or through in-kind assistance to support nutrition; (ii) transform the rice subsidy for the poor in a phased way so that it becomes a more nutrition focused program; and (iii) structure temporary social assistance at the central and local level by raising the coordination and sharing of authority between ministries / institutions that implement temporary social assistance.

The Program is also well aligned with the World Bank's twin goals of eliminating extreme poverty and increasing shared prosperity. It supports the Country Partnership Strategy (CPF) for Indonesia FY16-FY20, in particular under the Engagement Area (EA) 4: Delivery of Social Services and Infrastructure; EA 6: Collecting More and Spending Better; and the Supporting Beam (SB) II: Shared Prosperity, Equality, and Inclusion. The task is also contributing to the achievement of CPF objective indicators on: (i) Percentage of mothers and children receiving maternal and child health and nutrition services in community health center and its network in targeted areas (EA4); (ii) Central government spending on health, capital expenditure and social assistance (EA6); (iii) Number of households benefiting from PKH, disaggregated by gender (SB II); and (iv) Increase in the number of social assistance beneficiaries receiving payments digitally (SB II).

Finally, with a strategic focus on delivery systems strengthening, promoting human capital, and increasing coordination across social assistance interventions, the Program is aligned with the Bank's Social Protection and Labor Strategy 2012-2022.

D. Rationale for Bank Engagement and Choice of Financing Instrument

The Bank is well positioned to support the Government of Indonesia (GoI) in establishing the Social Assistance Reform Program. Through the last several years of engagement in the SA sector, the Bank has established itself as a knowledge organization that is uniquely positioned to bring international good practice to bear. The Bank has supported a range of analytical work that has strengthened the overall SA sector (through the Social Assistance Reform TA, P117975, operating during FY09-FY16; and now to continue with the Social Assistance Strengthening TA, P160590, during FY17-FY18), while increasing the efficiency and effectiveness of individual programs. Additionally, the Bank's convening authority in the sector is well recognized, as is its commitment to supporting government-led, multi-donor processes.

In particular, the Bank has an extensive track record in leveraging substantial expertise in expanding/reforming CCTs (e.g. from many LAC region countries; Philippines, Kenya, Pakistan, etc.), and in fostering coordination between CCTs and other social assistance interventions, bringing the best available global knowledge to the project. Moreover, the Bank is among MoSA's major external partners, and MoSA sees value in having the Bank's credibility and backing in reforming its social assistance program. In particular, the Bank brings expertise to develop the instruments and tools required to operationalize the scale-up of large CCTs and monitor them adequately. The Bank financing support can also allow deep engagement and dialogue with other central ministries (Ministry of Finance, Ministry of Planning/Bappenas) on the importance of continuing supporting the social assistance agenda and its key flagship interventions, and in helping protect the budget to fulfill this mandate.

In fact, the Bank has been engaged through Bank-executed technical assistance (with funding from the Australia Department of Foreign Affairs and Trade, DFAT), through the Social Assistance Reform TA (P117975, closed in June 2016), and the ongoing Social Assistance Strengthening TA (P160590, started in October 2016), which provides advice to PKH in the areas of identification/enrolment of beneficiaries, compliance verification, business processes and MIS, payments, grievance redress system, Family Development Sessions (FDS), graduation, communications/social marketing, monitoring and evaluation, and institutional reform and human resources management, as well as to improve coordination with other SA programs. As such, the Bank-executed TA package is closely aligned to this proposed P4R and its results areas, and is critical to help MoSA achieve the intended results.

Adopting the Bank's new PforR instrument will ensure that the proposed operation effectively supports this government-led agenda. The PforR instrument seems appropriate for the proposed operation due to its focus on results for a mature program operating since 2007. More specifically, by linking disbursements to achievement of results that are tangible and verifiable, PforR can be an effective instrument to shift focus towards policies and sector results and generate cross-sectoral consensus towards the reform, and away from the financing of inputs as in Investment Project Financing (IPF). The PforR instrument would enable the Bank's efforts to focus on technical inputs to key elements of the well-defined SA reform agenda and to help build capacity within MoSA by complementing it with the existing Bank-executed TA task. This is particularly useful in areas such as IT modernization where Bank involvement through IPF lending has typically involved complex procurement challenges and lags in disbursement,

lessening the time available for engagement on strategic issues such as overall system architecture and links between business needs and systems strengthening. As in other countries undertaking similar SA reforms, the PforR can also help leverage additional development partners' support to the Government program through a common programmatic framework.

II. Program Development Objective(s)

The Program Development Objective (PDO) is to enhance the results of the PKH CCT program by supporting coverage expansion, strengthening delivery system, and improving coordination with other complementary social programs.

The progress towards achieving the PDO will be measured through six key results indicators provided below:

a. Total number of PKH beneficiary families;
b. Percentage of 7-12 year-old monitored children in CCT beneficiary families attending school at least 85% of the time;
c. Percentage of 0-6 year-old monitored children in CCT beneficiary families undergoing growth monitoring and check-ups in accordance with protocol;
d. Percentage of PKH beneficiary families receiving PKH payments via cashless methods;
e. Percentage of complaints redressed in a timely manner;
f. Percentage of PKH beneficiary families receiving at least one other complementary program;

These indicators reflect the three Results Areas that the proposed Bank lending operation is expected to support:

Results Area 1: Expanding coverage and improving equity of the CCT program.
Results Area 2: Strengthening the program delivery system to improve efficiency, transparency, and accountability.
Results Area 3: Improving access to complementary services by the CCT beneficiaries.

The first to third indicators reflect the progressive expansion of the PKH program among the poor and vulnerable population (Results Area 1). The fourth and fifth indicators reflect the enhanced operational efficiency and transparency of the PKH delivery system (Results Area 2) with regard to payments made to the program beneficiaries being accurate, timely and flexible through modern electronic payment modalities, and complaints redressed in a timely manner. Finally, the sixth indicator reflects the improved coordination between PKH and other complementary social programs such as Rastra that the PKH beneficiary families are eligible and should take benefit from (Results Area 3).

III. Program Description

The PforR is anchored in the Government of Indonesia's overall program for social assistance spending. The objectives of the Government of Indonesia's are anchored in the aforementioned RPJMN 2015-2019. In it, under the section on "Policy Directions and Development Strategies"

(page 1-71), in the "Organization of Comprehensive Social Protection" subsection, and "Structuring of regular and temporary social assistance based on families and the life cycle through productive and prosperous families" theme, priorities highlighted are:

a. *Integrate several family based social assistance schemes for poor and vulnerable families that have children, disabled and elderly in the form of conditional cash transfers and/or through in-kind assistance to support nutrition.*
b. Provide community based social rehabilitation for PMKS that are outside of the family as well as provide such services in institutions/homes as a last resort.
c. Raise the integration of empowerment programs for poor and vulnerable via increasing the welfare of families their financial inclusion, as well as raising access to financial services so as to provide greater opportunities for economic development.
d. Transform the rice subsidy for the poor in a phased way so that it becomes a more nutrition focused program.
e. Implement temporary social assistance for individual victims of violence, drug abuse and trafficking as well as groups (victims of natural and economic disasters)
f. Structuring of temporary social assistance at the central and local level.

The proposed PforR supports thus only selected elements within the Government's program areas, namely point i) above. It focuses on three results areas, and a complete results chain illustration is provided below.

Results Area 1: Expanding coverage and improving equity of the CCT program. The expansion of the PKH program has taken advantage of both the updated Unified Database (BDT) and a vetting process involving verification and validation with local governments. The program would expand to 42 new districts, with which the program would achieve the coverage of all districts for the first time. More importantly, the majority of the new districts are in Papua and West Papua provinces, which suffer high poverty but have been underserved by the PKH program and other public services. This results area aims to support the coverage expansion, particularly to the underserved areas in the Papua region.

Results Area 2: Strengthening the program delivery system to improve efficiency, transparency, and accountability. This results area aims to address a number of gaps and weakness in the building blocks of the PKH delivery system in order to ensure smooth expansion and enhance the program results. Program activities cover business process simplification, information management system upgrading, electronic payment modalities roll-out, grievance redressal system (GRS) implementation, monitoring and evaluation (M&E) system strengthening, communication strategy development, human resources management, and error, fraud, and corruption (EFC) detection and control mechanisms development.

Results Area 3: Improving access to complementary services for the CCT beneficiaries. The PKH beneficiary families need to have better access to other social services that are complementary to the cash benefit provided with regard to achieving human development potential. This results area would facilitate the enrollment of the PKH families into the Rastra, PBI, and KIP programs. Furthermore, it would strengthen both the content and delivery modality of FDS to be more effective in reducing malnutrition, particularly through knowledge and

behavior change related to good feeding and hygiene practices.

These results areas aim are consistent with Government strategy to improve PKH performance and coordination with other complementary interventions. Several reforms lie ahead to improve PKH implementation that this PforR would support, in conjunction with the parallel Bank-executed TA package (P160590). For instance, in the short term, MoSA will require assistance in the establishment of a clear roadmap for identification and progressive inclusion of PKH beneficiaries, including in remote underserved areas (e.g., Papua) and to new beneficiary groups (elderly, disabled). A rapid scale-up of PKH would also require a review of the MIS to verify how it can effectively cope with expansion, including a potential review of its business processes, to ensure its capability and reliability to support expanded operational needs. MoSA also intends to pursue a rapid roll-out of card payment options (including savings accounts) for more diversified financial inclusion strategy, and increase frequency to bimonthly payments, which will also require support. Changes in program rules and scale-up will require an overhaul of the GRS, starting with an assessment and recommendations on how to improve it. In terms of M&E, a process evaluation to gauge the effectiveness and efficiency of the program's scale-up, as well as rigorously evaluating additional impacts of the new components and changes to its design. Similarly, MoSA has decided to expand implementation of the landmark FDS, but before scaling up it is needed to take stock and evaluate the implementation aspects of it. A massive scale-up and other potential program changes will require a thorough strategy on how to effectively communicate such innovations to the beneficiaries and the general public (including media). Finally, PKH expansion will demand a thorough strengthening of the institutional architecture of the program, which will be much harder to administer from the central level, and revise the current HR strategy in particular with relation to the role and functions of the program facilitators.

With respect to other social assistance programs beyond PKH, in the past 6 years, TNP2K has developed and manage the UDB. In 2016, the Government has decided that the responsibility to manage the UDB will be moving to MoSA, but in the process the capacity of MoSA needs to be fully strengthened (IT, HR, etc.). More importantly, while the UDB has up to now provided an important basis for determining eligibility of programs such as PKH, PIP, Rastra and JKN, it is a static system as it is based on a semi-census that is conducted infrequently and thus results in 'fixed' lists that cannot be altered until the next data collection is conducted. Therefore, over the long term, UDB will shift from "direct data collection" as the sole means of determining eligibility, to a hybrid mix of "self-reported" information and "administrative" information from other information systems and an open, continuous, integrated, on-demand system. An additional challenge is how central and local governments can coordinate and control implementation and monitoring of social assistance programs. This is not currently happening: in 2014, less than 30 percent of CCT families in the poorest decile received PIP, JKN and Rastra even though they are eligible for all three programs. Efforts at integration have been made, however, very little progress has been made regarding common standards and processes among programs. More recently, MoSA, in coordination with Ministry of Planning/Bappenas is piloting "single window services" (SLRT) in 50 districts to promote better coordination, referral and update beneficiary information. Similarly, MoSA is piloting and aiming to scale up coverage for a new concept (called "e-Warong") to integrate digital payments of benefits at local level, including PKH, Rastra, and KUBE-PKH (livelihood projects for PKH beneficiaries) in several localities.

Activities	Outputs	Intermediate Outcomes	Outcomes
Results Area 1: Expanding coverage and improving equity of the CCT program			
Prepare the potential new beneficiaries list using the most recent data	New eligible beneficiaries informed, validated, and registered	***First PKH cash transfer to the new PKH beneficiaries disbursed****	Progressive expansion of coverage until 2020 based on policy targets, including previously excluded geographical areas (**PDO Indicator i**)
Assess and adapt the PKH parameters and procedures for areas with implementation challenges	% of PKH beneficiaries in previously underserved provinces		
Identify existing PKH beneficiaries eligible for Disabled/Elderly benefits	Adjusting identified PKH beneficiaries to add Disabled/Elderly benefits	Eligible PKH beneficiaries receive Disabled/Elderly benefits	Increased consumption among PKH beneficiaries
Results Area 2: Strengthening the program delivery system to improve efficiency, transparency, and accountability			
Assess, design and develop a new PKH information system architecture	***New information system developed***	New integrated information system deployed to support operation	Improved efficiency of program implementation
Review and re-engineer PKH business processes	PKH Operation Manuals revamped	***Increased % payment to PKH recipients via cashless methods**** (**PDO Indicator iv**)	
Develop a roll-out strategy to transition towards cashless payments	Decisions on cashless modalities made and implemented		
Assess, design and develop a M&E system	Improved operational M&E system implemented	Improved evidence-based management decisions	Improved transparency of program implementation
Assess, design and pilot a GRS system	***Roll out of a standardized GRS after evaluating pilot experience***	Complaints recorded and redressed in a timely manner (**PDO Indicator v**)	
Develop a communication strategy for the central and local government levels	Improved communication strategy implemented	Increase awareness amongst stakeholders	
Assess and revamp HR development and management plan, including redefinition roles and responsibilities of internal units	HR competency and performance monitoring system developed, and roles for internal units defined	HR competency enhanced, and coordination among units improved	Improved accountability of program implementation
Develop systems for error, fraud, and corruption (EFC) detection and control	EFC systems implemented	EFC managed properly	
Results Area 3: Improving access to complementary services for the CCT beneficiaries			
Identify PKH beneficiaries eligible but excluded for other basic social services (Rastra, PBI, KUBE, and PIP)	Enrollment of PKH beneficiaries in other basic social services	***PKH beneficiaries receive completmentary basic social services package through E-Warong KUBE-PKH**** (**PDO**	Improved access for PKH beneficiary families to social protection programs

		Indicator vi)	
Development of an FDS implementation strategy and training of PKH facilitators to implement FDS	***Total PKH recipients attending FDS increase****	Positive behavioral change in terms of use of basic social services (health, nutrition, education) and proper nutrition and hygiene practices for PKH families (**PDO Indicators ii, iii**)	Increased knowledge of household financial planning
Review and revise Health Module of FDS and delivery modality			Improved nutrition status of PKH beneficiaries, particularly children

Note: Proposed DLIs are bold and in italic. * indicates scalable DLI.

The Bank will disburse funds for $200 million over four years through six preliminar disbursement-linked indicators (DLIs) for the Program. These are identified in Annex 3, along with the Program's results monitoring framework (RMF). The three main criteria for selecting these DLIs are that: (a) the desired results are within the control of the implementing agency MoSA; (b) the DLIs are achievable in the program period; and (c) the DLIs are verifiable. It is expected that the chosen DLIs will allow predictability in financing and guarantee MoSA with needed resources to achieve these intended results. The DLIs will be designed combining both scalability (financing proportional to the progress towards achievement) and floating (disbursements made when they are met) features.

IV. Initial Environmental and Social Screening

In conjunction with the OP/BP 9.00, the Environmental and Social Systems Assessment (ESSA) should take into account applicable and relevant environmental and social issues. The initial environmental and social systems assessments indicated that the proposed PforR operation will not likely to generate significant environmental effects. The proposed operation aims to support the PKH program in expanding its coverage, enhancing the program's delivery system as well as coordination and complementarity with other social programs. PKH will directly provide cash transfers to poor and vulnerable households and no infrastructure and other activities that could result in the potential loss, degradation or conversion of natural habitats, pollution, and/or changes in land or resource use. Depending on the size of household members, each member receives IDR 2,150,000 – 6,250,000 (approx. USD 165 – 480) annually, which represents 4 – 14 percent of the current GDP per-capita (USD 3,346.5). Earlier impact evaluations indicate that recipient households used this additional income to increase their spending on food items and associated health costs. The program also showed positive impacts on increased usage of primary healthcare and education services. Under these considerations above, it has been proposed that the ESSA to focus on mainly social aspects, as detailed in the paragraphs below.

Potential challenges are mostly related to the process by which the poor and vulnerable are included in and have access to the program and complementary social assistance programming. The interventions introduced through this operation are intended to improve social inclusion measures in the identification, targeting and delivery cash transfer and therefore, is expected to generate positive impacts. The expansion of the PKH CCT also aims to cover people with disabilities and the elderly and also reach underserved areas such as Papua and West-Papua Provinces and outer islands in East Indonesia where concentration of Indigenous Peoples (*Masyarakat Hukum Adat*) and vulnerable community groups is highest in the country. Expanded implementation is likely constrained by the current capacity of district social agencies to deliver

the program effectively and target potential beneficiaries accurately, and therefore there might be exclusion issues especially in new areas.

The ESSA will assess the beneficiary identification, targeting practices, delivery of cash transfer, consultative and participatory processes, grievance redress practices, incentives and disincentives as well as potential social impacts and perceptions of impacts both at the beneficiary and program implementation levels. The ESSA aims to serve as a diagnostic assessment of how the current systems operate and what measures are needed to improve social inclusion and reduce exclusion issues. Action plans will be presented and consulted to relevant stakeholders both at the national and sub-national levels during appraisal to ensure that inputs are widely captured and reflected in the final ESSA.

V. Tentative financing

Source:	($m.)
Borrower/Recipient	200
IBRD	
IDA	
Others (specify)	
Total	200

Contact point
World Bank

Contact: Pablo A. Acosta
Title: Senior Economist
Tel: 5776-2634
Email: pacosta@worldbank.org

Borrower/Client/Recipient

Contact: Robert Pakpahan
Title: Director General of Budget Financing and Risk Management, Ministry of Finance
Tel: +62 21 3500841
Email: rpakpah@yahoo.com

Implementing Agencies

Contact: Mr. Harry Hikmat
Title: Director General, Directorate General for Social Assurance for Families
Tel: +62 812 10798374
Email: h_hikmat@kemsos.go.id

For more information contact:

The InfoShop
The World Bank
1818 H Street, NW
Washington, D.C. 20433
Telephone: (202) 458-4500
Fax: (202) 522-1500
Web: http://www.worldbank.org/infoshop