

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

Report No.:PIDC0133468

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<b>Program Name</b>	Investing in Nutrition and Early Years
<b>Region</b>	EAP
<b>Country</b>	Indonesia
<b>Sector</b>	Health (34%); Primary Education (33%); Other Social Services (33%)
<b>Financing Instrument</b>	Program-for-Results
<b>Program ID</b>	P164686
<b>Parent Program ID</b>	N/A
<b>Borrower(s)</b>	Ministry of Finance
<b>Responsible Agency</b>	Secretariat of the Vice President of Indonesia
<b>Date PID Prepared</b>	November 10, 2017
<b>Estimated Date of Appraisal Completion</b>	April 20, 2018
<b>Estimated Date of Board Approval</b>	June 8, 2018
<b>Concept Review Decision</b>	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**

1. **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.**<sup>1</sup> 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.

2. **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

<sup>1</sup> World Bank (2015), “Indonesia Systematic Country Diagnosis: Connecting the Bottom 40 percent to the Prosperity Generation.”

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 in 2014, by far the fastest widening seen in East Asia.

**3. Despite overall progress on poverty reduction, Indonesia's rates of stunting and malnutrition are at crisis levels.** Per the 2013 National Health Survey (RISKESDAS), 37.2 percent of Indonesian children under 5 years of age (almost 9 million children) were stunted, 19.6 percent were underweight, 12.1 percent were wasted (low weight-for-height), and 11.9 percent were either overweight or obese.<sup>2</sup> The prevalence of stunting remained virtually unchanged between 2007 and 2013. While more recent data (not comparable to RISKESDAS) indicate some improvements, the stunting and malnutrition rates remain unacceptably high.

**4. Early childhood development outcomes are also lagging and demonstrate variability across socioeconomic class.** Average scores for language and cognitive development amongst children aged four to five differ considerably between rich and poor households.<sup>3</sup> A four-year-old child from the richest 20 percent of households in Indonesia has a 40 percent probability of enrolling in Early Childhood Education and Development (ECED) services, while this probability is only 16 percent for a four-year-old child from the poorest 20 percent of households. This is a significant disadvantage; children who are enrolled in preschool typically score better on tests of social competence, and language and cognitive development than children who are not, with disadvantaged children benefiting the most.<sup>4</sup>

**5. Improving nutrition and early learning outcomes are critical to reducing inequality, and are also widely recognized to be among the most cost-effective investments however, the window of opportunity is narrow.**<sup>5</sup> Inequalities of opportunity at birth and in early childhood have been identified as a key driver of rising inequality in Indonesia.<sup>6</sup> And globally, every dollar invested in high-quality early childhood education programs can yield between USD 6-17 in return,<sup>7</sup> while every dollar invested in proven maternal and child nutrition interventions can deliver returns of USD 16. For nutrition, interventions have the highest returns during the first 1,000 days of life, from conception through to two years of age. The critical window for early child development—including physical, cognitive, linguistic and socioemotional development—extends to five years of age.

## ***B. Sectoral and Institutional Context of the Program***

**6. There are still large nation-wide gaps in the provision of basic nutrition and early learning services that are critical to addressing the stunting crisis.** Table 1 summarizes key

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<sup>2</sup> Note that different data sources are being used when referencing Indonesia's nutrition status. We are using the 2013 RISKESDAS, as it is considered the most reliable and methodologically sound source. Government may refer to the 2016 Surveillance data which shows stunting rates at 27.5 percent, however there are concerns about the methodology of this data, and it is not comparable to the RISKESDAS.

<sup>3</sup> There is also evidence that this gap begins to widen from around the age of four and a half years, when the language and cognitive development of children in poor households starts to plateau.<sup>3</sup>

<sup>4</sup> Jung and Hasan (2015).

<sup>5</sup> Black et al. (2016), Heckman (2008), Campbell et al. (2014), Walker et al. (2011).

<sup>6</sup> World Bank (2015a).

<sup>7</sup> Engle et al. (2011).

service and behavior indicators for 5 priority service packages critical to addressing stunting: maternal and child health, nutrition, hygiene and stimulation counselling, water and sanitation, ECED, and social protection. As the table below indicates, there is variation across the key nutrition-specific and nutrition-sensitive interventions. It is also important to note that these national averages mask significant regional and income differences. Eastern Indonesia lags the rest of the country for almost all health and development indicators. And, in 2013, 49 percent of children under five years of age in the poorest 40 percent of households were stunted, which represents even an increase from 43 percent in 2007, worsening the income gap.<sup>8</sup>

**Table 1: Nutrition and Early Years – Key Service and Behavior Indicators**

Priority Service Packages / Intervention Indicators	%	Data source (most recent available)
<i>Maternal and child health indicators:</i>		
Antenatal care visit K1 (at least one, any trimester)	95.2	RISKESDAS 2013
Antenatal care visit K1 (at least one, first trimester)	81.3	RISKESDAS 2013
Antenatal care visit K4 (at least four)	70.0	RISKESDAS 2013
Took 90+ iron tablets during pregnancy	32.7	RISKESDAS 2013
Children who were weighted in Posyandu at least 4 time in the last 6 month	77.0	RISKESDAS 2013
Children Receipt of Vitamin A supplements in previous 6 months	75.5	RISKESDAS 2013
Vaccination - complete immunization (up to one year)	65.7	IDHS 2012
Children 12-59 who received deworming tablet in the last 12 months	26.0	IDHS 2012
<i>Nutrition, hygiene and stimulation counselling</i>		
Early initiation of breastfeeding within 1hr after birth	34.5	RISKESDAS 2013
Exclusive breastfeeding (under 6 months)	41.5	RISKESDAS 2013
% infants aged 6-23 months who fed a minimum acceptable diet (adequate diversity, adequate frequency, and milk)	33.0	IDHS 2012
<i>Water and sanitation</i>		
% of household with access to improved drinking water	70.14	SUSENAS 2015
% of households with access to improved sanitation ODF (Open Defecation Free)	62.14	SUSENAS 2015
	70.9	Kemendes 2013
% household members aged at least 10 years who practice hand washing	47.0	RISKESDAS 2013
<i>Early learning and development</i>		
ECED Enrollment 0-2 years old children	6.0	KEMENDIKBUD, 2015
ECED Enrollment 3-6 years old children	70.1	KEMENDIKBUD, 2015
<i>Social protection</i>		
% of PKH mother groups that received FDS from certified facilitator	6.9	KEMENSOS, 2017
% of PKH beneficiaries whose NIK numbers have been verified	73.5	KEMENSOS/PKH PMIS, 2017
% of children aged 0-6 years of PKH beneficiaries who received health and nutrition services	79.7	KEMENSOS/PKH PMIS, 2017

<sup>8</sup> World Bank (2017a).

7. **Recent research highlights that majority of mothers and children lack simultaneous access to these priority services.** The study, which the Bank conducted with the Ministry of Health (MoH), found that only 1 percent of 0-36 month old children had adequate access to basic nutrition-sensitive and nutrition-specific interventions. The research also demonstrated that children are 5 percent less likely to be stunted if they have access to 1 of 4 priority packages (quality caregiving practices, health and early learning services, nutritious food, water & sanitation), 9 percent less likely if have access to 2 packages, and 13 percent less likely if they have access to 3 packages. These findings confirm global evidence on the need to tackle the multi-sectoral drivers of stunting holistically.

8. **Over the past decade, Indonesia has launched several national programs to expand access to basic services underpinning stunting, however, these programs are not integrated or implemented at sufficient scale.** GoI has a suite of programs focused on maternal and child health, parent counselling, water and sanitation, early learning and development as well as social protection, many of which the Bank has supported. However, these programs are present in only 160 sub-districts or 2.3 percent of Indonesia’s 7,044 sub-districts. As shown in Table 2 below, five programs are present in only 24 districts or 4.7 percent of districts in Indonesia. Geographic convergence is even lower at the sub-district level. Annex 5 provides more details on these programs.

**Table 2: Geographic Convergence of National Programs – District and Sub-district (2016)**

Program Coverage	District Coverage		Sub-district coverage	
	Frequency	Percentage	Frequency	Percentage
0 programs	8	1.6%	546	7.8%
1 program	48	9.3%	1,249	17.7%
2 programs	117	22.7%	2,070	29.4%
3 programs	280	54.4%	2,809	39.9%
4 programs	38	7.4%	210	2.9%
5 programs	24	4.7%	160	2.3%
<b>Total</b>	<b>515</b>	<b>100</b>	<b>7,044</b>	<b>100</b>

9. **The decentralization framework, particularly the lack of a strong results-orientation to the intergovernmental planning and fiscal transfer systems, poses challenges to coordinating the convergence of nutrition-specific and nutrition-sensitive interventions.** Indonesia is highly decentralized. Approximately 50% of government spending is done locally; the majority financed from unconditional fiscal transfers from the national government. Districts are responsible for primary health care, early childhood education, water and sanitation as well as population services critical to accessing services including many social protection programs. Villages also retain important responsibilities for basic service delivery. The national government retains a capacity development and oversight role of service delivery, and it has some mechanisms to direct districts to priority interventions and results (e.g., DAK, DID and Dana Desa prioritization) but these activities and systems are not optimally used to improve delivery nutrition and early learning services. Annex 6 summarizes the institutional arrangements for the delivery of for nutrition-specific interventions and ECED.<sup>9</sup>

<sup>9</sup> Summaries of the institutional arrangements for water and sanitation as well as the district and village planning systems are in preparation.

10. **Each national program relies on multiple facilitation consultants and community workers to strengthen frontline delivery of these services.** The national programs such as Generasi and Pamsimas place technical consultants at the district and sub-district level to support program delivery. They also provide capacity building and incentives for volunteer community workers. An initial review of current arrangements and consultations with district officials suggests there is significant scope to better coordinate the activities of these consultants and volunteers, and to improve their targeting of pregnant women and children at the village level.

11. **The existing frameworks to guide policy and drive multi-sectoral coordination and implementation are not yet effective.** The government included stunting reduction targets in its Medium-Term Development Plan (RPJMN) for 2015-2019 and signed up to the global Scaling Up Nutrition (SUN) movement in 2011. The previous government issued multiple presidential decrees to establish the “National Movement to Accelerate the Reduction in Undernutrition in Indonesia during the First 1000 Days of Life” (*Gerakan 1000 HPK*), which articulates the broad roles of key sectors and stakeholders in supporting the nationwide effort to improve nutrition. The Coordinating Ministry of Human Development (Menko PMK) is responsible for coordinating ministries to monitor the implementation of the Presidential Decree, while the National Planning Agency (Bappenas) is responsible for cross-ministry coordination on planning and budgeting. However, these coordinating bodies are not yet functional. In the absence of the functional coordinating bodies, there are currently few requirements or incentives for ministries to work together, which explains the lack of synergy across programs.

12. **In 2017 the current government launched a Presidential National Action Plan to consolidate “top-to-bottom” political leadership, strengthen execution of existing multi-sectoral policy frameworks, and drive consolidation and convergence of national, regional and community programs (“the National Action Plan”).** The National Action Plan, which was approved in a ministerial cabinet meeting chaired by the Vice President in August 2017, acknowledges that stunting is at crisis levels and recognizes the need for an ambitious multi-sectoral response. It emphasizes the need to better use the inter-governmental planning and transfer system to better monitor and allocate financing across programs and levels of government, strengthen coordination across sectors as well levels of government, to improve the quality of existing programs and activities, better utilize community-based programs and financing, and strengthen the performance systems. The National Action Plan consists of five pillars to address these weaknesses:

- a) Pillar 1: National Leadership and Commitment
- b) Pillar 2: National Public Awareness Campaign
- c) Pillar 3: National, Regional and Community Program Convergence, Coordination and Consolidation
- d) Pillar 4: Nutritional Food Security
- e) Pillar 5: Monitoring and Evaluation

13. **The National Action Plan also directs national ministries to focus their programs and activities on 100 districts with high stunting prevalence and incidence in 2018.** There is at least one district per province including Jakarta. These districts cover 1,891 sub-districts,

21,888 villages and an estimated 3.1 million stunted children. The National Action Plan also lays out an ambitious plan to scale up 160 districts in 2019 and to reach full coverage in all 514 districts by 2021.

### *C. Relationship to CAS/CPF*

14. **The proposed Program-for-Results (PforR) operation will support the government’s current Medium-Term Development Plan (RPJMN) 2015-2019.** Indonesia’s commitment to reducing stunting is evidenced by the inclusion of ambitious targets in the current RPJMN. By 2019, the Government of Indonesia is targeting reduction of stunting nationwide by 7 percentage points. RPJMN recognizes that the acceleration of the progress towards reducing stunting in Indonesia require enlisting more sectors, in addition to the health sector, such as agriculture, education, social protection, and water, sanitation, and hygiene in the effort to improve nutrition. Large scale “nutrition-sensitive” interventions in these sectors must not only address the key underlying determinants of nutrition effectively, but also intensify the impact of “nutrition-specific” interventions (Lancet 2013). The focus on stunting reduction is expected to remain in the next RPJMN.

15. **The proposed PforR operation supports the Country Partnership Strategy (CPF) for Indonesia FY16-FY20.** Specifically, it supports Engagement Areas 4 & 6 on Delivery of Social Services and Infrastructure and Collecting More and Spending Better.<sup>10</sup> It also supports Supporting Beam II on Shared Prosperity, Equality, and Inclusion. The operation will contribute to achievement of CPF objective indicators on: (i) Improvements to DAK reporting and verification systems (EA4); (ii) Percentage of mothers and children receiving maternal and child health and nutrition services in community health center and its network in targeted areas (EA4); and (iii) Central government spending on health, capital expenditure and social assistance (EA6).

16. **Indonesia is a priority country under the World Bank’s “Investing in Early Years” agenda and the proposed operation is also a key contribution to this initiative.** This Agenda, to which Indonesia’s Minister of Finance committed during the 2016 Annual Meetings, is focused on significantly increasing investments that support interventions from pregnancy to six years of age, given the importance of good early child development outcomes on longer term development and productivity of the workforce. The Bank has committed to contributing to a measurable increase in funding by 2020 in this key area.

## **II. Program Development Objective(s)**

### **A. Program Development Objective(s)**

17. The Program Development Objective (PDO) is to increase simultaneous utilization of

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<sup>10</sup> It will support the pillars on strengthening the decentralization framework for local service delivery and quality delivery of health, education and water and sanitation in rural areas (EA 4) as well as improving the poverty and inequality focus of government programs and policies (EA 6).

priority nutrition and early learning services in priority districts.

18. The Program will achieve this objective by supporting the government to focus on expanding and converging national, district and community programs and activities that deliver five priority service packages: (i) maternal and child health services; (ii) nutrition, hygiene and parenting counselling; (iii) water and sanitation; (iv) ECED; and (v) social protection. The priority districts refer to those with highest prevalence and incidence of stunting.

**B. Key Program Results**

19. Progress towards achieving the PDO is proposed to be measured through 19 key results indicators provided below:

<p>PDO-level indicators</p>	<ul style="list-style-type: none"> <li>a) % of 0-5 year old children that simultaneously utilize the five age-appropriate priority service packages<sup>11</sup></li> <li>b) % of districts demonstrate progress towards achieving targets in District Action Plan for Nutrition and Early Learning</li> <li>c) % of technical ministries (Ministry of Health, Ministry of Education and Ministry of Village) reported progress towards achieving targets on nutrition and early learning in ministerial action</li> <li>d) Annual report demonstrates progress in the implementation of convergence and expansion of national programs and ministerial budgets in high stunting prevalence districts</li> </ul>
<p>Intermediate results indicators</p>	<ul style="list-style-type: none"> <li>a) % of villages with greater budget (APBDes) allocations for the 5 priority service packages</li> <li>b) % of villages that issue a Village Action Plan for nutrition and early learning</li> <li>c) % of villages that establish community monitoring for the 5 priority service packages</li> <li>d) % of mothers of children 0-5 years old who receive integrated nutrition, hygiene, early learning and parenting education</li> <li>e) % of service providers (Puskesmas, Posyandu, PAUD) implementing integrated nutrition, hygiene and early learning counselling services</li> <li>f) % of districts that issue enabling regulations for village spending on the 5 priority service packages</li> <li>g) % of DAK (Special Budget Allocation fiscal transfer) allocated to the 5 priority service packages</li> <li>h) % of districts that conduct annual sub-district nutrition and early</li> </ul>

<sup>11</sup> The age-appropriate refers particularly to nutrition and ECED services, while the water and sanitation and social protection intervention spans across 0-5 years old. For children 0-2 years-old the focus is on Infant and Young Child Feeding (IYCF) practices (including responsive feeding), micronutrient supplementation, early stimulation and parenting, while for children 3-5 years-old the focus is on integrated services that promote cognitive and socioemotional development

	<p>learning performance and innovation forum</p> <p>i) % of budget increase of selected technical ministries for the delivery of training and implementation support to priority districts</p> <p>j) % of district officials that receive technical TOT on delivery of technical support to villages</p> <p>k) % of district health officials that receive technical ToT on nutrition service standards</p> <p>l) % of district ECED Trainers that receive ToT on professional development for ECED teachers</p> <p>m) Annual national stunting and early learning summit of provincial and districts leaders</p> <p>n) Annual anthropometric and early child development modules implemented in Susenas</p> <p>o) Annual subnational delivery audit on 5 priority service packages</p>
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20. These indicators reflect the four Results Areas (RAs) that the proposed PforR lending operation is expected to support:

- Results Area 1:** Converge village service delivery
- Results Area 2:** Prioritize district programs and activities
- Results Area 3:** Strengthen delivery of ministerial programs and activities
- Results Area 4:** Strengthen national leadership and coordination

21. The first PDO indicator reflects the enhanced service delivery convergence and improved simultaneous utilization of priority services package among the target population (Results Area 1). The second indicator ensures district and service providers capacity and incentives to implement multi-sectoral responses to improve nutrition and early learning outcomes (Results Area 2). The third indicator ensures concrete technical ministries commitment to support sub-national government in delivering quality services (Results Area 3). Finally, the fourth indicator reflects the strengthen leadership and performance to create the necessary enabling environment to ensure the vertical, horizontal and delivery convergence (Results Area 4).

**III. Program Description**

22. **The PforR Program will be anchored in the Government’s national strategy to accelerate stunting reduction efforts (“the National Action Plan”).** Building on the experience of Peru and global evidence, Pillar 3 adopts a program convergence strategy to maximize the impact of national programs and local government activities to reduce stunting and improve early learning outcomes. As summarized in Table 3 below, it prioritizes 13 nutrition-specific and 12 nutrition-sensitive interventions and programs that 6 national ministries and agencies implement. Pillar 3 also emphasizes the opportunity to leverage the inter-governmental fiscal transfer system, explicitly DAK and Dana Desa, to incentivize district and village governments to prioritize these nutrition-specific and sensitive interventions.

**Table 3: National Action Plan Priority Nutrition-Specific and -Sensitive Interventions**



Nutrition-specific Interventions	Nutrition-sensitive Interventions
<ol style="list-style-type: none"> <li>1. Pregnant women               <ol style="list-style-type: none"> <li>a) Supplementary feeding</li> <li>b) Iron folic acid supplementation</li> <li>c) Iodized salt</li> <li>d) Deworming</li> <li>e) Protection from malaria</li> </ol> </li> <li>2. Lactating women and children 0-6 months               <ol style="list-style-type: none"> <li>a) Promotion of early initiation of BF</li> <li>b) Promotion of exclusive breastfeeding</li> <li>c) Assisted delivery</li> <li>d) Basic immunization</li> <li>e) Monthly growth monitoring and promotion</li> <li>f) Integrated Management of Child Illness (IMCI)</li> </ol> </li> <li>3. Lactating women and children 6-23 months               <ol style="list-style-type: none"> <li>a) Continued breastfeeding and complementary feeding</li> <li>b) Deworming</li> <li>c) Zinc supplementation</li> <li>d) Iron fortification</li> <li>e) Complete immunization</li> <li>f) Protection from malaria</li> <li>g) Diarrhea prevention</li> </ol> </li> </ol>	<ol style="list-style-type: none"> <li>1. Clean water (Pamsimas) - MoPW</li> <li>2. Sanitation (STBM) – MoH</li> <li>3. Food Fortification – MoA</li> <li>4. Family Planning – BKKBN</li> <li>5. JKN – MoH</li> <li>6. Jampersal – MoH</li> <li>7. Parent Counselling – MoH</li> <li>8. Nutrition counselling - MoH</li> <li>9. Universal ECED - MoEC</li> <li>10. Youth Reproduction Counselling – MoH</li> <li>11. Rastra/BPNT &amp; PKH – MoSA</li> <li>12. Nutritious Food Program - MoA</li> </ol>

23. It is proposed that the geographic scope of the PforR Program follow the scale up plan of the National Action Plan, although this will be reviewed during the technical assessment.

24. **The Program supported by the PforR (“the PforR Program”) will mostly support activities under Pillar 3 of the National Action Plan as well as select activities from Pillars 1, 2 and 5.** the PforR Program will support nutrition-specific and nutrition-sensitive interventions under Pillar based on three criteria: (i) evidence of impact on stunting and early child development outcomes; (ii) existing operational and/or technical engagement on government executed activities; and (iii) opportunity leverage subnational transfers and Dana Desa to deliver frontline delivery platforms. It will also support activities under Pillars 1, 2 and 5 that are critical to improving coordination and convergence including securing political commitments across sectors and levels of government and annual performance assessments. It will also support districts and planning processes. Table 4 below summarizes the National Action Plan and the PforR Program.

**Table 4: Government Program and PforR Program – Overview**

	The Government Program – the programs and activities that	The PforR Program – the programs and activities that the PforR operation will

	<b>constitute the National Action Plan</b>	<b>support</b>
Objective	To reduce stunting in priority districts of high stunting prevalence and incidence	To increase simultaneous utilization of priority nutrition and early learning services in priority districts.
Activities (by Pillar)	<ol style="list-style-type: none"> <li>1. National leadership forums</li> <li>2. National campaign activities (awareness raising, political commitments and accountability)</li> <li>3. Program Convergence: <ol style="list-style-type: none"> <li>a. 18 Nutrition-specific interventions</li> <li>b. 12 Nutrition-sensitive interventions</li> </ol> </li> <li>4. Nutritional Food Security</li> <li>5. Monitoring &amp; Evaluation</li> </ol>	<ol style="list-style-type: none"> <li>1. National leadership forums</li> <li>2. National campaign activities (focus on regional political commitments and accountability only)</li> <li>3. Program Convergence: <ol style="list-style-type: none"> <li>a. 7 Nutrition-specific interventions</li> <li>b. 6 Nutrition-sensitive interventions</li> </ol> </li> <li>4. –</li> <li>5. Monitoring &amp; Evaluation<sup>12</sup></li> </ol>
Geographic Scope	100 districts in 2018, scaling up to national coverage by 2021	160 districts in 2019, scaling up to national coverage by 2021
Implementation Period	2018-2021 (and beyond)	2019-2022
Cost (estimate)	\$12 billion	\$7.3 billion

25. **The PforR Program will focus on four Results Areas (RAs):**

- a) **Results Area 1: Converge village service delivery.** This RA will focus on village-level leadership, planning and budgeting for 5 priority service packages, the delivery of 3 priority services packages (maternal and child health, behavior change communication and ECED), and community monitoring of the 5 priority service packages. This RA will incorporate a Village Convergence Scorecard to incentivize simultaneous utilization of nutrition and early learning services.<sup>13</sup>
- b) **Results Area 2: Prioritize district programs and activities.** This RA will focus on district leadership and multi-sectoral planning and delivery of technical inputs to village-level delivery platforms, as well as strengthening district-wide monitoring and performance systems.
- c) **Results Area 3: Strengthen delivery of ministerial programs and activities.** This RA will focus on key sector ministries on providing technical, capacity and logistical support to districts as well as villages. It will also support multi-sectoral

<sup>12</sup> Specific activities including annual stunting program reviews at Bappenas, village district planning and budgeting capacity support at MoHA, village planning and technical support at MoV as well as incorporation of an anthropometric module into BPS's semi-annual Susenas Survey. See Program Results Chain for more details.

<sup>13</sup> Preliminary findings of the Generasi Long-Term Impact Evaluation (June 2017) found that 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.

capacity building and financing mechanisms.

- d) **Results Area 4: Strengthen national leadership and coordination.** This RA will focus on strengthening activities that facilitate cross-ministerial coordination as well as strengthening political commitments to reduce stunting through annual assessment of district stunting reduction outcomes.

26. **The PforR Program will use DLIs across the results chain to tackle the institutional and management weaknesses identified in the National Action Plan.** Although DLIs have yet to be identified, it is anticipated that they will be used to strengthen political commitments at all levels, incentivize coordination across sectors and levels of government, focus ministries, districts and villages on a core set of service packages and interventions, incentivize results-based budgeting, ensure timely action across levels, encourage vertical and horizontal information flows as well as help identify bottlenecks and implementation quality issues.

#### IV. Initial Environmental and Social Screening

27. The initial environmental and social systems screening concluded that the proposed PforR Program will not likely to generate significant social and environmental effects (see Annex 4 for the Environmental and Social Initial Screening). An Environmental and Social System Assessment (ESSA) will be developed as part of Program preparation. The ESSA will review the existing environmental and social systems within key ministries and agencies relevant to the delivery of the activities for the implementation of the result areas. The assessment will also require a consideration of capacity at subnational and village level. The results of the ESSA will inform the Program design, including the program boundaries, expenditure framework, disbursement-linked indicators as well as the Program Action Plan. The ESSA will be disclosed in draft, public consultations will be held, and the final version of the ESSA will be made public before appraisal.

#### V. Tentative financing

Source:	(\$m.)
Borrower/Recipient	
IBRD	400 million
IDA	
Others (specify)	
	Total 400 million

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