

INDONESIA

INVESTING IN NUTRITION AND EARLY YEARS (INEY)

PROGRAM-FOR-RESULTS (PforR)

Technical Assessment (Summary)

DRAFT VERSION 9

16 April 2018

Table of Contents

1. INTRODUCTION	3
THE GOVERNMENT PROGRAM	3
THE PFORR PROGRAM	7
2. INTERVENTION REVIEW.....	9
3. EXPENDITURE FRAMEWORK.....	15
GOVERNMENT PROGRAM EXPENDITURE BOUNDARIES.....	16
GOVERNMENT PROGRAM: BUDGET ESTIMATE	17
PFORR PROGRAM EXPENDITURE BOUNDARIES.....	19
4. RESULTS AREA 1: STRENGTHEN NATIONAL LEADERSHIP AND CONVERGENCE PERFORMANCE	22
TNP2K AND STUNTING SUMMITS	23
SYNCHRONIZED NATIONAL DEVELOPMENT PLANNING AND BUDGETING.....	26
ANTHROPOMETRIC MEASUREMENT	30
5. RESULTS AREA 2: STRENGTHEN COORDINATION OF DISTRICT PROGRAMS AND ACTIVITIES	51
6. RESULTS AREA 3: STRENGTHEN DELIVERY OF SECTOR PROGRAMS.....	35
NUTRITION-SPECIFIC AND -SENSITIVE HEALTH INTERVENTIONS	35
NUTRITION-SENSITIVE ECED INTERVENTIONS	40
NUTRITION-SENSITIVE WASH INTERVENTIONS	44
NUTRITION-SENSITIVE FOOD ASSISTANCE INTERVENTIONS.....	47
7. RESULTS AREA 4: PRIORITIZE CONVERGENCE OF VILLAGE SERVICE DELIVERY.....	51
8. MONITORING & EVALUATION	73
9. ANNEX A: DETAILED EXPENDITURE FRAMEWORK	77
EXPENDITURE FRAMEWORK (CENTRAL GOVERNMENT LEVEL).....	77
ATTACHMENT 1: POSSIBLE SOLUTIONS FOR STUNTING CONVERGENCE PROGRAM.....	94
ATTACHMENT 2: THE COMPLEMENTARY ROLES OF MOF AND BAPPENAS	99
ATTACHMENT 3: MONITORING AND EVALUATION OF INEY.....	101
ATTACHMENT 4: A PROPOSED CYCLE OF EXPENDITURE AND PERFORMANCE REPORTING, REINFORCED WITH REPORTING ON HOW THOSE REPORTS HAVE INFLUENCED THE ANNUAL BUDGET.....	102

1. Introduction

1.1 The Government Program

1. **The Vice-President launched a National Strategy to Accelerate Stunting Prevention (NatStrat Stunting) to consolidate “top-to-bottom” political leadership, strengthen the execution of existing multi-sectoral policy frameworks, and drive consolidation and convergence of national, regional and community programs.** The Stunting Reduction Acceleration Strategy was approved in a ministerial cabinet meeting chaired by the Vice President on August 11, 2017. It 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 performance systems.
2. **The NatStrat Stunting consists of five pillars:**
 - 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

Priority Target Groups

3. **The NatStrat Stunting prioritizes the first 1,000 days (pregnant mothers and children aged 0-24 months).** It distinguishes three categories within this group for the purposes of targeting nutrition-specific interventions: pregnant women, lactating women and children 06-months-old, and children 6-23-months-old.

Priority Interventions

4. The Government Program also prioritizes the convergence of 21 nutrition-specific and 12 nutrition-sensitive interventions as detailed in the table below (see Table 1).

Table 1: Priority Nutrition-specific and Nutrition-sensitive Interventions

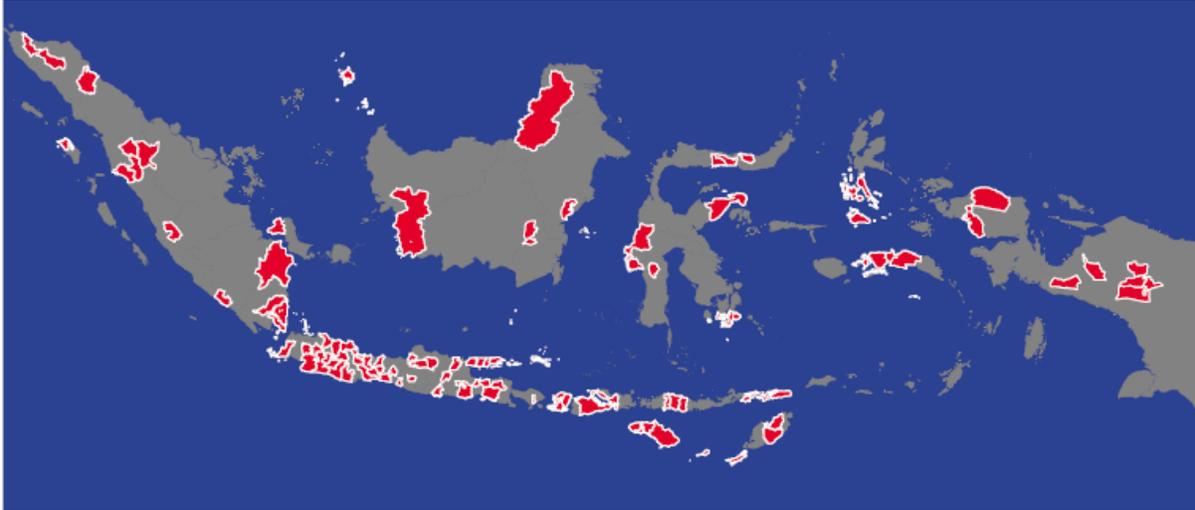
Nutrition-specific Interventions	Nutrition-sensitive Interventions
1. Pregnant women	1. Access to JKN (Social Health Insurance)

<ul style="list-style-type: none"> a) Supplementary feeding b) Iron folic acid supplementation c) Iodized salt d) Deworming e) Protection from malaria 	<ul style="list-style-type: none"> 2. Access to Jampersal (Pregnancy Insurance)
<ul style="list-style-type: none"> 2. Lactating women and children 0-6 months <ul style="list-style-type: none"> a) Promotion of early initiation of BF b) Promotion of exclusive breastfeeding c) Assisted delivery d) Iron folic acid e) Basic immunization f) Monthly growth monitoring and promotion 	<ul style="list-style-type: none"> 3. Provision of youth sexual and reproductive counselling 4. Provision of community nutrition counselling 5. Access to family planning services 6. Access to clean water 7. Access to sanitation 8. Provision of universal ECED services 9. Provision of parent counselling
<ul style="list-style-type: none"> 3. Lactating women and children 6-23 months <ul style="list-style-type: none"> a) Continued breastfeeding and complementary feeding b) Deworming c) Zinc supplementation d) Iron fortification e) Complete immunization f) Protection from malaria g) Diarrhea prevention h) Integrated Management of Child Illness i) Provision of nutrition counselling 	<ul style="list-style-type: none"> 10. Provision of social assistance to poor households (PKH and Rastra/BPNT) 11. Access to fortified food 12. Access to nutritious food security program

Priority Locations and Scale Up Strategy

5. **The NatStrat Stunting 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 NatStrat Stunting also lays out an ambitious plan to scale up 160 districts in 2019 and to reach full coverage in all 514 districts by 2021.

Figure 1: Priority Locations (2018-2019)



Source: NatStrat Stunting, TNP2K, 2017.

6. **The NatStrat Stunting will scale up to full coverage by 2021.** Table 2 below summarizes the planned scale up. The specific districts are yet to be selected, but will use the same criteria used to select the initial 100 priority districts.

Table 2: NatStrat Stunting – Scale Up Plan (2018-2021)

Year	Number of Districts
2018	100
2019	160
2020	390
2021	514

7. **The NatStrat Stunting’s Implementation Framework specifies six instruments (“convergence instruments”) that the Government will use to converge priority interventions across sectors and levels of government in the priority districts.** They are:
- a. **Stunting Leadership Summits**—the purpose of the stunting leadership summits is to ensure political leaders of all levels (i.e. Ministers, Governors, District Heads and Mayors, and Village Heads) commit to accelerate stunting reduction; and that leaders of sector agencies (e.g. relevant DGs, district sector department heads) commit to contribute to this outcome in accordance with their responsibilities. The annual stunting summits will also recognize districts that successfully reduce stunting and showcase best practices.
 - b. **Results-based Convergence Planning and Budgeting**—the purpose of results-based convergence planning and budgeting is to enable Bappenas and MoF to ensure the

- annual development plans and budgets of sector line agencies align with NatStrat Stunting priorities, and enable SoVP to track sub-program budget execution and implementation in the priority locations. Bappenas and MoF will use their existing planning and budgeting information systems (KRISNA and SPAN) to “tag” relevant expenditure, and generate semi-annual implementation and annual performance reports.
- c. **Programmatic Special Allocation Transfer (P-DAK) for Stunting Reduction**—Bappenas and the MoF will incentivize districts through a “programmatic fiscal transfer” to align district development plans and budgets with NatStrat Stunting objectives, and to help overcome the fragmentation of district financing for nutrition interventions. It will also help plug gaps in the existing sector-based DAK allocations, both in terms of eligible activities critical to stunting reduction as well as financing gaps. The P-DAK is also a mechanism through which the national government will consolidate support for villages and incentivize districts to put in place enabling regulations and capacity support for villages.
 - d. **Multi-Sectoral Technical Support**—building on the multi-sectoral stunting “boot camps” for district governments that TNP2K, Bappenas and Menko PMK held in 2017, MoHA will establish provincial multi-sectoral technical support pools to strengthen capacity of districts to collect local data on stunting and nutrition interventions, diagnose local drivers of stunting including local social and cultural norms that constrain to stunting reduction, and develop local action plans including local behavior change communication strategies.
 - e. **Multi-Sectoral Human Development Workers (HDW)**—building on MoV’s Generasi Project (P132585), the NatStrat Stunting will deploy HDWs to support village governments to identify, implement and monitor priority nutrition interventions to “first 1,000-day households”. HDWs will work multi-sectorally to increase information about stunting and its drivers, identify priority target groups, and support villages to increase Dana Desa spending on nutrition interventions from around 6 to 20 percent over the life of the program. It will also use HDWs to support posyandu (village level health posts) to expand from weight-based to height-based growth monitoring and promotion.
 - f. **Data for Evidence-based Program Management**—the NatStrat Stunting will improve the collection and use of budget execution data, intervention delivery data and stunting outcome data to improve intervention convergence and quality. It proposes two specific innovations: annual collection and publication of district-level stunting rates via integration of a mini-anthropometric module in the government’s semi-annual socio-economic survey (SUSENAS) and the nation-wide roll-out of a Village Convergence Scorecard to track frontline delivery of the priority interventions.

1.2 The PforR Program

8. **The PforR Program is anchored to the Government’s National Strategy to Accelerate Stunting Prevention (NatStrat Stunting).**

Program Development Objective

9. **The Program Development Objective (PDO) is to increase simultaneous utilization of nutrition interventions by 1,000-day households in priority districts.** The PforR Program will achieve this objective by supporting the government to converge national, district and community programs and activities that deliver priority nutrition interventions relating to maternal and child health and nutrition services, water and sanitation, ECED, and social protection. The term “1,000-day households” refers to households with pregnant women and/or children aged 0-24 months. The term “priority districts” refers to those with highest prevalence and incidence of stunting as identified in the government’s strategy.

Program Scope: Priority Interventions and Convergence Instruments

10. **The PforR Program will support a subset of interventions of the NatStrat Stunting’s priority interventions as well as the convergence instruments that are critical to coordinating the delivery of all priority nutrition-specific and nutrition-sensitive interventions in the priority locations.** Building on the experience of Peru and other multi-sectoral efforts to reduce stunting, the government’s NatStrat Stunting acknowledges both the need to improve the delivery of individual priority sector interventions as well as the planning, budgeting, monitoring, evaluation and citizen engagement systems that can drive coordination, public participation, accountability and performance across all interventions. The government has requested that the PforR Program support both aspects of the Government Program.
11. **The INEY PforR Program’s scope includes delivery of those NatStrat Stunting nutrition-specific and nutrition-sensitive interventions that are high-impact and not currently supported by existing operations and development partners.** In relation to nutrition-specific interventions, this includes the primary health care system’s delivery of nutrition services as well as frontline delivery of maternal and child health services at the village level. It also includes the delivery of sanitation interventions by MoH, but not WASH infrastructure delivered by the Ministry of Public Works (MoPW). The PforR Program scope also includes the delivery of nutrition counselling, parent counselling as well as nutrition-sensitive ECED services and food assistance for the poor (BPNT).
12. **The red shading in Table 6 below summarizes the scope of the INEY PforR Program.** It includes the delivery of all nutrition-specific and nutrition-sensitive interventions at the

village-level posyandu.¹ It also shows that three existing operations support delivery of NatStrat Stunting’s nutrition-specific and nutrition-sensitive interventions: the Indonesia–Supporting Primary Healthcare Reform Program (I-SPHERE, P164277) support for maternal and child health as well as health insurance (blue shading), the National Rural Water Supply and Sanitation Project (PAMSIMAS, P154780) support for clean water and sanitation infrastructure (yellow shading), and the Family Hope Program (PKH, P160665) conditional cash transfer support for the poor (green shading). In addition, United Nations Children’s Fund (UNICEF) supports the family planning and adolescent health interventions and the World Food Program (WFP) the food security programs (shaded grey).

Table 6: PforR Program Scope – Priority Interventions

Sector	Intervention	Implementing Agencies		
		National	District	Village
<i>Nutrition-specific</i>				
Primary Health: Maternal & Child Health	1. Iron folic acid supplementation	DG-P&MD (MoH)	DINAS Health Puskesmas ²	Posyandu ³
	2. Iodized salt	DG-P&MD (MoH)		
	3. Complete immunization	DG-P&MD (MoH)		
	4. Deworming	DG-P&MD (MoH)		
	5. Vitamin A supplementation	DG-P&MD (MoH)		
	6. Protection from malaria	DG-PH (MoH)		
	7. Inte. Man. of Child Illness (ICMI)	DG-PH (MoH)		
Primary Health: Nutrition	8. Supplementary feeding	DG-PH (MoH)	DINAS Health Puskesmas	Posyandu
	9. Antenatal care/post-natal care ⁴	DG-PH (MoH)		
	10. Growth monitoring & promotion	DG-PH (MoH)		
	11. Infant Young Child Feeding (IYCF)	DG-PH (MoH)		
<i>Nutrition-sensitive</i>				
Health	1. Access to JKN	BPJS	BPJS	-
	2. Access to Jampersal	BPJS	BPJS	-
	3. Provision of youth sexual and reproductive counselling	DG-PH (MoH)	DINAS Health Puskesmas	Posyandu
	4. Provision of community nutrition counselling	DG-PH (MoH)	DINAS Health Puskesmas	Posyandu
	5. Access to family planning services	BKKBN	BKKBN Puskesmas	PKK
WASH	6. Access to clean water facilities	DG CK (MoPWH)	DINAS PW	BP SPAM or equiv
	7. Access to sanitation facilities	DG CK (MoPWH)	DINAS PW	BP SPAM or equiv
Education	8. Provision of parent counselling	DG-ECED (MoEC)	DINAS Edu	PAUD

¹ More details on program expenditure boundaries, including breakdowns by interventions and levels of government, are included in the Expenditure Framework in the Technical Assessment.

² Community health centers at the sub-district level.

³ Integrated service post at the village and hamlet level.

⁴ The ANC/PNC package include consolidates following priority interventions in the NatStrat Stunting: 1e. Protection from malaria (as part of counselling on danger signs in ANC/PNC; 2a. Promotion of early initiation of breastfeeding; 2b. Promotion of exclusive breastfeeding; 2c assisted delivery; and 3j. Provision of nutrition counselling.

	9. Provision of universal ECED	DG-T (MoEC)		
Social Assistance	10a. Nutrition-sensitive CCT program (PKH)	DG-Linjamsos (MoSA)	DINAS Social	-
	10b. Nutrition-sensitive food assistance program (BPNT)	DG-PFM (MoSA)	DINAS Social	-
Food	11. Increase in food fortification	MoT/BPOM	-	-
	12. Nutritious food security programs	MoAg	DINAS Ag	-

13. The PforR Program’s scope includes the six convergence instruments of the government program mentioned above. This includes support for those activities 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 7 below summarizes the convergence instruments in relation to the PforR program scope. The multi-sectoral technical support pools are a new initiative, and will be financed from the IPF Component in 2019.

Table 7: PforR Program Scope – Convergence Instruments

Instrument	Enabling and Implementing Agencies (IAs)		
	National	District	Village
1. Stunting Leadership Summits	SoVP/TNP2K	Sekda/Bappeda ⁵	-
2. Results-based Convergence Planning and Budgeting	DG-B (MoF) Deputy-HD (Bappenas)	-	-
3. Programmatic Approach to DAK for Stunting Reduction	Deputy-HD (Bappenas) DH-PK (MoF)	Bappeda	-
4. Multi-sectoral Technical Support Pools	DG-Bangda (MoHA)	Bappeda (Prov.)	-
5. Multi-sectoral Human Development Workers (HDW)	DG-PPMD (MoV)	BPMD	Villages
6. Annual Stunting Survey	BPS	-	-

Exclusions

14. There are no proposed exclusions of activities within the PforR Program expenditure boundaries.

2. Intervention Review

15. Scope. At the request of SoVP, a review of current evidence and of the status of the interventions was undertaken to answer the following questions: (a) Is the proposed causal

⁵ Secretary to the District Head (Sekretaris Daerah, or SekDa).

framework appropriate for the stunting situations in the high priority areas and do the proposed interventions in the NatStrat Stunting and PforR align appropriately to address the identified immediate causes of stunting? (b) Are the proposed interventions the right ones? (c) Are the interventions classified appropriately? (d) Are the interventions defined in an appropriate, operational manner? (e) Do the interventions have clear indicators?

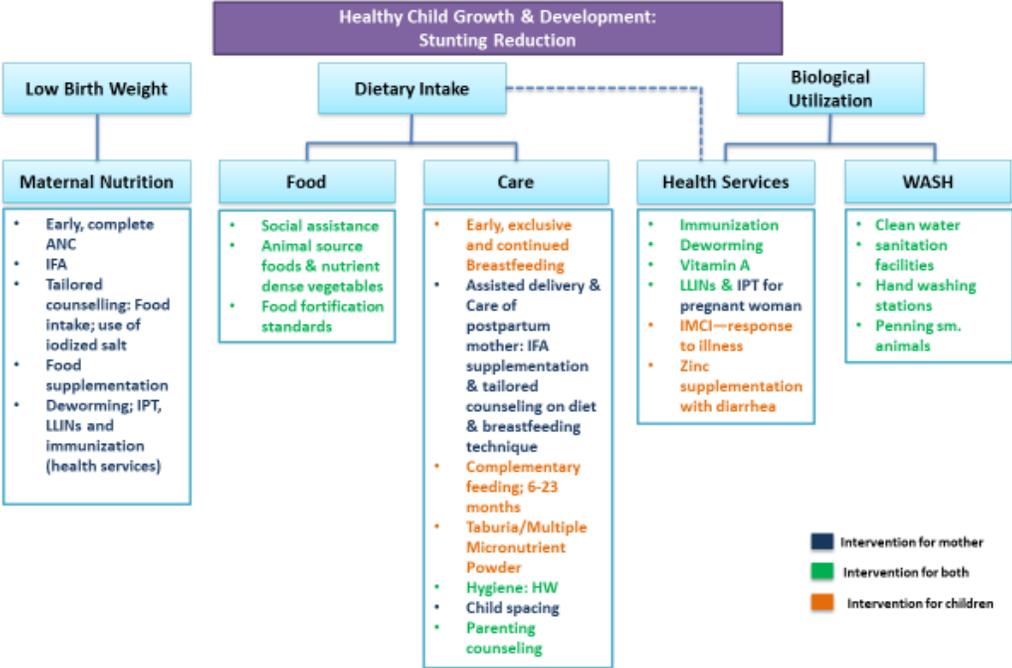
Table 3: Selected Nutrition Service and Behavior Uptake indicators

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)	96.9	SIRKESNAS 2016
Antenatal care visit K1(at least one, first trimester)	81.4	SIRKESNAS 2016
Antenatal care visit K4(at least four)	77.4	SIRKESNAS 2016
Took 90+ iron tablets during pregnancy	32.7	SIRKESNAS 2016
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 - basic immunization (0-1 years old)	65.2	IDHS 2017
Vaccination - basic immunization (0-2 years old)	35.6	SUSENAS 2017
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	11.2	SIRKESNAS 2016
Exclusive breastfeeding (under 6 months)	60.2	SUSENAS 2017
% infants aged 6-23 months who fed a minimum acceptable diet (adequate diversity, adequate frequency, and milk)	32.5	SUSENAS 2017
<i>Water and sanitation</i>		
% of household (w 0-2 year olds) with access to improved drinking water	74.2	SUSENAS 2017
% of households (w 0-2 year olds) with access to improved sanitation	68.0	SUSENAS 2017
ODF (Open Defecation Free)	70.9	KEMENKES 2013
% household members aged at least 10 years who practice hand washing	47.0	RISKESDAS 2013
<i>Early learning and development</i>		
Access to ECED (0-2 years old children)	8.4	SUSENAS 2017
Access to ECED (3-6 years old children)	70.1	KEMENDIKBUD, 2015
<i>Social protection</i>		
Birth certificate (0-2 year old children)	83.1	SUSENAS 2017
% 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

16. **Causal Framework.** The NatStrat Stunting uses a causal framework based on UNICEF model that recognizes that the root causes of stunting are complex and multi-sectoral to guide program design. It covers diet, behavior, and health determinants of optimum nutrition, growth and development, and how they are affected by underlying food security, caregiving resources, and environmental conditions. The framework recognizes that these factors are shaped by economic and social conditions, national and global contexts, capacity, resources, and governance. An adjusted framework (see Figure 2 below) is offered for consideration. This framework calls out the high rates of low birth weight seen in Indonesia to highlight the importance of maternal care and nutrition to preventing stunting; it emphasizes environmental health (WASH) to highlight actions that address environmental enteric dysfunction thought to be a key determinant in stunting and, it draws attention to child development actions, proving critical to both physical as well as mental development.

Figure 2: Proposed Causal Framework



17. Description of causal elements of the framework:

- a. **Low birthweight.** Indonesia has high rate of LBW (11%). Children born with LBW are typically stunted or at risk and likely due to poor maternal stature and poor weight

- gain during pregnancy due to sub-optimal diets. Maternal health and nutrition is often a neglected piece of the stunting puzzle since many maternal health initiatives are focused on preventing mortality, not necessarily on healthy weight gain during pregnancy and other factors such as WASH that will support a healthier pregnancy, but not necessarily influence mortality. LBW is called out here to focus efforts such as early ANC to get women on IFA and into counselling on healthy diets—ex. managing nausea and understanding that healthy weight gain will not mean a difficult delivery.
- b. **Food.** The causal pathway of access to nutrient-rich foods in the case of this project focused on actions already underway that might be better targeted or enforced:
 - a) ensure that if eligible families get food assistance; that families are supported either at home or in the village to access locally available sources of animal source foods (egg/fish) and nutrient-rich vegetables and fruit (micro / kitchen gardens); and that food fortification standards are enforced ensuring adequately fortified salt, wheat and oil and that those products are used in food assistance and early childhood development programs.
 - c. **Care.** This pathway is central to stunting reduction because it is most directly related with consumption. Interventions include the usual young child feeding and diet/care for postpartum women, with more emphasis placed on tailored counselling and potentially the use of nudges to improve young child feeding. Important new behavioral foci are: recuperative feeding following illness (diet intake); hygiene—both handwashing and improved food hygiene (biological utilization—reducing EED) and early stimulation, referred to here as parent counselling offered by the early childhood development center (PAUD) teacher.
 - d. **Health Services.** These are the classic interventions. The added angle is that they are tied not only to mortality reduction but to improved child growth. This means that resolving child illness goes beyond saving lives, but to help children thrive—early care seeking and diet counselling, for example, need to be viewed a crucial piece’s health care.
 - e. **Water & Sanitation.** Recent studies indicate that contamination of the gut begins early and as inflammation worsens with exposure to more contamination it becomes harder to reverse, and poor nutrient absorption becomes a permanent condition effecting not only nutrient, but also vaccine and drug absorption. Community-wide actions such as Community Led Total Sanitation (CLTS) as well as actions in the microcosm of the home are required to reduce human and animal fecal contamination. That means latrine construction & sweeping and keeping animals from homes and yards; clean water supply & treatment of water for young children; handwashing stations & keeping flies and small animals away from food.

18. **Review of Table of Interventions.** The table of nutrition-specific and nutrition-sensitive interventions in the NatStrat Stunting covers most of the recommended actions that the causal framework dictates. There are, however, suggested modifications that would better define the beneficiary of the intervention, and add or subtract an intervention or add more specificity. Below are recommendations for the table.

- a. **Beneficiaries.** The suggested revision is to categorize those direct beneficiaries of the nutrition sensitive interventions as follows—pregnant women; intra-partum and post-partum women; infants and children under 2 years of age; universal interventions. Using this beneficiary segmentation will ensure that activities such as growth monitoring and promotion, immunization and Integrated Management Childhood Illness (IMCI) are applied to all infants and children, that post-partum women receive iron supplements and that other interventions such as malaria prevention are included for all groups in areas where malaria is endemic.

19. Suggested revision for nutrition specific interventions:

a. Pregnant women:

- i. **Add early and complete antenatal care.** Although use of antenatal care (ANC) is quite high, early use can be improved. ANC service delivery can be strengthened in its focus of maternal diet, weight gain monitoring and preparation for breastfeeding. ANC is an important platform to reach this group and the full package of services, including infection control, impacts prevalence of low birthweight. Other services such as IFA supplementation should be singled out since they can be delivered within or outside of ANC and coverage in Indonesia is 32.7%.
- ii. **Move iodized salt.** Although iodized salt is critical for pregnant women it is a universal product in Indonesia and certainly should not be restricted to pregnancy. Ensuring the quality of the iodized salt program should be mentioned with fortification.
- iii. **Move assisted delivery to pregnant women since these arrangements should be made as one nears the time for birth.** This has little to do with preventing stunting although as a maternal life saver and it should be a good opportunity to ensure immediate breastfeeding and maternal support.

b. Intra-partum & Post-partum women:

- i. **Immediate, exclusive breastfeeding.** add exclusive to discourage the use of pre-lacteals and the continuation with these substances in the first few days.
- ii. **Add iron supplementation for women until 6 months post-partum.**

- iii. **Add pre-natal care.** Like ANC, the pre-natal care (PNC) visits serve as a platform for reaching these women and the quality of support for a healthy maternal diet and full breastfeeding can be improved. Vitamin A supplementation is part of this service.

c. Infants and young children (0-23 months):

- i. Basic interventions are listed but can be groups and redundancies omitted.
- ii. If the age group is extended to 6 years old, then an intervention on healthy diets should be added for the child 24- 60 months since this is no longer referred to as complementary feeding.
- iii. Add vitamin A supplementation
- iv. Omit diarrhea prevention since these interventions are covered under nutrition-sensitive hygiene promotion.

20. Interventions for all beneficiary categories:

- a. **Move increase in food fortification from nutrition-sensitive to the nutrition-specific interventions and group together all food fortification actions.** Fortified foods should reach every beneficiary category. Specifying an emphasis on iron fortification and adding a nutritional supplement, such as Taburia micronutrient powder, is important given the high rates of anemia and the importance of anemia prevention to preventing low birth weight and to promoting infant and child growth and development.

21. Suggested revision of nutrition-sensitive interventions:

- a. **Change access to clean water and sanitation to promote improved access and use of clean water and sanitation.** This change is critical since many studies show that access is not enough to make a difference.
- b. **Add promotion of improved hygiene as sub-component of access and use to sanitation.** These actions are critical to breaking the fecal contamination pathways that lead to environmental enteric dysfunction thought to inhibit the absorption of nutrients in the gut. These actions include handwashing, construction of handwashing stations and the separation of children from animals.
- c. **Add the word “use” to the family planning intervention so it is worded “access to and appropriate use of modern family planning”.**
- d. **Add specificity to food security measures, clarifying that these actions will focus on food security of nutrient rich foods.**
- e. **Clarify provision of social assistance to the poor (PKH).**

f. Clarify Provision of food assistance to the poor (BPNT).

22. Below is the suggested revision of the Intervention Table (see PAD, Section II, A, Table 1).

Table 4: Suggested Revision of Intervention Table

Nutrition-specific Interventions	Nutrition-sensitive Interventions
<ol style="list-style-type: none"> 1. Pregnant women <ol style="list-style-type: none"> a. Early and complete ANC b. Supplementary feeding c. Iron folic acid supplementation d. Deworming e. Promotion of assisted delivery 2. Intra-partum and Post-partum women <ol style="list-style-type: none"> a. Early and exclusive initiation of BF b. PNC—including IFA 3. Infants and young children birth-24 months <ol style="list-style-type: none"> a. Complete immunization b. Monthly growth monitoring and promotion c. Integrated Management of Child Illness (IMCI) d. Exclusive breastfeeding for the first 6 months e. Complementary feeding with continued breastfeeding to age 2 f. Deworming g. Vitamin A h. Zinc supplementation 4. Interventions for all groups <ol style="list-style-type: none"> 1. Protection from malaria 2. Provision of nutrition counselling 3. Increase and improve the quality of food fortification, special attention to iron—including Taburia (multiple micronutrient powders). 	<ol style="list-style-type: none"> 1. Access and use to improved drinking water facilities 2. Access and use to improved sanitation facilities <ol style="list-style-type: none"> a) Access to improved human waste facilities (i.e. latrines) b) Access to improved animal waste facilities c) Provision of individual hygiene counselling d) Provision of community ODF trigger events 3. Access and appropriate use of modern family planning 4. Delivery of JKN (Social Health Insurance) 5. Delivery of Jampersal (Pregnancy Insurance) 6. Provision of parent counselling (early child stimulation) 7. Provision of universal ECED services 8. Provision of youth sexual and reproductive counselling 9. Provision of social assistance to poor households 10. Increase food security, specifically for nutrient-rich foods

3. Expenditure Framework

3.1 Introduction

23. The Expenditure Framework for the PforR focused on two elements: central, district and village government budgeting processes, and expenditure estimates of relevant spending across these three levels of government. This section presents a summary of the expenditure estimates. The analysis of process is integrated at various points in the document. The analysis of central government budgeting processes is found in Section 4.2 below; the analysis of district government budgeting processes is in Section 6; and the analysis of village

budgeting processes is in Section 7 below. There is also a detailed assessment of the government budgeting processes for convergence programming (see Annex A).

3.2 Government Program Expenditure Boundaries

24. Projected expenditure on the government program has been estimated based on current spending on nutrition interventions and convergence instruments. Financing from four sources is included, as shown in Table 5. Specific purpose transfers to local governments and villages finance the majority of subnational expenditures.

Table 5: Assumptions used to calculate government program expenditure

<i>Category of financing</i>	<i>Assumptions used in calculation</i>
National Government (APBN)	Expenditures on nutrition interventions and convergence instruments, not including staff salaries or capital spending except where directly related to household water or sanitation investments.
Sectoral specific purpose transfers to local governments (DAK)	Specific purpose transfers are specified to be either for capital (fisik) or recurrent (non-fisik). The technical assessment showed that the most important inputs to nutrition interventions are non-capital in nature, except in three areas: DAK fisik transfers related to capital investment in the water and sanitation sector, family planning and the pharmacy sub-sector of the Health DAK. DAK non-fisik transfers related to nutrition interventions include the BOK for health centers (Puskesmas) and the DAK BOP PAUD for early child development centers (PAUD).
Local Government budget (APBD) sourced from unconditional transfers and other revenues	Estimated net spending by local governments on nutrition sensitive and nutrition specific expenditures are based on the following assumptions and data sources: <ul style="list-style-type: none"> • Data on budget for 429 districts for the year 2016 is used to estimate the net local government expenditure on direct costs of service delivery for the sub-sector of health, sub-sector of family planning, sub-sector of water and sanitation, sub-sector of agriculture and sub-sector of ECED. • Capital investments are not included except in relation to household water and sanitation. • All direct operational spending on the <i>family planning sub-sector</i> is assumed to contribute to delivery of nutrition specific and nutrition sensitive interventions. • The proportion of direct operational spending on the <i>health sub-sector</i> attributable to nutrition interventions has been estimated based on detailed examination of District DPA (detailed spending document) obtained from the district Financial Management Bureaus. • Since DAK is spent by districts without being separately identified as a source of funds, DAK is subtracted from total local government estimated spending to derive estimated net spending.
Village budgets (APBDes) financed from central government transfers to villages (Dana Desa)	<ul style="list-style-type: none"> • Expenditure from village budgets on the operational costs of health services (posyandu), early childhood education (PAUD) and water and sanitation. • Percentage of total village spending on these items have been estimated using the Village Public Expenditure Review (ViPER) study of 1,868 village budgets and village realization reports, and applied to the value of village transfers from the center (Dana Desa) plus estimated district transfers to

	villages (Alokasi Dana Desa). ⁶
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3.3 Government Program: Budget Estimate

25. The government spent approximately Rp. 51.9 trillion (\$3.9 billion) in 2017 on nutrition-specific and nutrition-sensitive interventions. See Table 6 below.

Table 6: Existing Spending – Central, District and Village Spending (2017)

Spending category	Level of Government			Total	Total (\$ m)
	Central	District	Village		
Nutrition-specific	4,007	3,624	3,120	10,751	808
Nutrition-sensitive	20,095	13,792	7,280	41,167	3,095
Total	24,102	17,416	10,400	51,918	3,904

26. Central Government spending is the largest component; however, this mostly consists of two large social assistance programs: the PKH conditional cash transfer (CCT) program and the Rastra/BPNT food assistance program. The proportion of these programs directed to 1,000-day households (approx. 21%) are included in the estimates. Table 7 details the central government spending on the nutrition-specific and nutrition-sensitive interventions for the period between 2015 and 2017.

Table 7: NatStrat Stunting – Central Government Spending (2015-2017)

Sector	Intervention	Year			
		2015 (actual)	2016 (actual)	2017 (revised)	2017 (\$ m)
<i>Nutrition-specific</i>					
Health	1. Supplementary feeding	257.7	609.6	1,086.8	81.2
	2. Iron folic acid supplementation	0.0	0.0	15.1	1.1
	3. Iodized salt				
	4. Deworming	32.3	33.5	54.9	4.1
	5. Protection from malaria	129.3	10.4	31.0	2.3
	6. IYCF	0.0	0.0	11.0	0.8
	7. Antenatal care/post-natal care				
	8. Immunization	1,675.6	2,475.9	2,734.2	204.3
	9. Growth monitoring & promotion				
	10. Zinc supplementation				
	11. Diarrhea prevention	1.2	1.5	0.0	0.0
	12. Integrated Mgt Childhood Illnesses	99.1	0.0	74.5	5.6
	13. Community nutrition counselling ⁷	202.3	591.0	8.1	3.3
	Sub-total	2,195.0	3,130.9	4,007.6	299.5
<i>Nutrition-sensitive</i>					
WASH	1. Access to clean water	7,086.5	3,434.7	4,443.0	332.0
	2. Access to sanitation	2,593.7	2,646.8	2,674.0	199.8

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

⁷ Community nutrition counselling is classified as nutrition-sensitive in the intervention matrix but ease of calculation. The recent sums are small.

Health	3. Access to family planning services	11.0	5.5	5.0	0.4
	4. Delivery of JKN	198.8	248.1	255.0	19.1
	5. Delivery of Jampersal	0.0	0.0	0.0	0.0
	7. Youth sexual and reproductive counselling	108.8	0.0	0.0	0.0
Education	8. Provision of parent counselling	43.8	43.3	36.2	2.7
	9. Provision of ECED services	265.8	476.3	526.7	39.4
Social Assistance	10. Nutrition-sensitive CCT (PKH)	1,337.2	1,793.9	2,695.9	201.5
	11. Nutrition-sensitive food assistance (BPNT)	4,587.5	4,181.7	4,441.3	331.9
Food	12. Increase in food fortification				
	13. Nutritious food security programs	651.3	862.6	1,010.4	75.5
Sub-total (Rp.)		16,884.5	13,692.9	16,087.5	1,202.3
TOTAL		19,079.5	16,823.9	20,095.1	1,501.8

27. The next largest component is from several DAK transfers to local governments. Table 8 shows DAK contributions to nutrition interventions for the period 2015-2017 (and budget for 2018). This needs to be read together with the table relating to central government financing, because some sources of central government financing in 2015 were converted to DAK non-fisik financing in 2016.

Table 8: DAK financing contributing to NatStrat Stunting financing (IDR)⁸

CAPITAL DAK (FISIK)	2,015	2,016	2,017	2,018
Water (Regular, Penugusan, Afirmasi)	1,067,737,000	741,068,770	1,200,300,000	2,070,747,000
Sanitasi (Regular, Penugusan, Afirmasi)	873,603,000	606,327,710	1,250,200,000	2,160,993,000
	1,941,340,000	1,347,396,480	2,450,500,000	4,231,740,000
OPERATIONAL DAK (NON-FISIK)				
BOK Health Center		2,426,370,885	4,826,654,272	6,189,644,740
BOK Childbirth Assistance (Jampersal)		1,625,853,850	1,266,053,848	1,563,433,900
BOK Family Planning (KB)		212,318,185	292,800,000	1,808,787,200
BOP Paud		2,281,900,000	3,581,700,000	4,070,194,800
		6,546,442,920	9,967,208,120	13,632,060,640

28. The total government budget to scale up the NatStrat Stunting from 100 districts in 2018 to all 514 districts in 2021 is estimated at Rp. 122 trillion (\$ 9.2 billion). Table 9 details the estimated budget allocations at the central, district and village level using 2017 as baseline.

Table 9: NatStrat Stunting– Estimated Scale Up Budget (2018-21)

Level	2018	2019	2020	2021	Total
# districts	100	160	390	514	514
# villages	21,453	31,064	67,095	74,954	74,954
NatStrat Stunting (Rp. billion)	15,077	25,171	64,617	89,821	194,686
Central	4,572	7,572	19,102	26,308	57,554
District	6,285	9,086	19,586	26,127	61,085
Village	4,219	8,513	25,929	37,385	76,047

⁸ Note this table shows total DAK allocations to all districts, not just those covered by the program.

NatStrat Stunting (\$ million)	1,134	1,893	4,858	6,753	14,638
Central	344	569	1,436	1,978	4,327
District	473	683	1,473	1,964	4,593
Village	317	640	1,950	2,811	5,718

3.4 PforR Program Expenditure Boundaries

29. The total budget for the PforR Program for the four-year period 2018-2021 is estimated at **Rp. 87.6 trillion (\$6.6 billion)**. Table 10 below summarizes the budget estimates by year and level of government.

Table 10: PforR Program– Estimated Scale Up Budget (2018-21)

Level	2018	2019	2020	2021	Total
# districts	100	160	390	514	514
# villages	21,453	31,064	67,095	74,954	74,954
PforR Program (Rp. billion)	5,497	10,181	29,229	42,680	87,587
Central	2,227	3,689	9,306	12,816	28,038
District	1,239	1,763	3,717	4,940	11,658
Village	2,032	4,729	16,206	24,924	47,890
PforR Program (\$ million)	9,642	27,252	41,405	83,645	9,642
Central	413	765	2,198	3,209	6,585
District	167	277	700	964	2,108
Village	93	133	279	371	877

30. The expenditure boundaries of the PforR Program cover operational spending on delivery of **nutrition-specific interventions, select nutrition-sensitive interventions, and the convergence instruments within the priority districts**. Table 11 shows the inclusions and exclusions in respect of each type of intervention.

Table 11: Types of expenditure included in the program boundaries

Intervention area	National	District	Village
Health nutrition specific	All relevant operational spending associated with delivery of health nutrition-specific interventions but not including salaries and capital investments.	In relation to priority districts, spending of relevant DAK non-fisik for health, but not including district expenditure financed by district funds other than DAK non-fisik (DAK BOK,). DAK BOK transfers are split between the INEY Program for Results and	In relation to priority districts, spending of Dana Desa transfers on sub-sector of community empowerment.
Health nutrition sensitive	All relevant associated with delivery of nutrition counselling interventions but not spending not including salaries and capital investments.		

WASH	All operational spending associated with behavior change programs for sanitation but not including salaries and capital investments.	the I-sphere Program for Results. ⁹	
Education	All operational spending associated with delivery of parent counselling and stimulation program home visits but not including salaries and capital investments.	In relation to priority districts, spending of DAK non-fisik for early childhood education (DAK BOP-PAUD)	
Social Assistance	All operational spending associated with delivery of nutrition-sensitive food assistance program but not including salaries and capital investments.		

31. **To facilitate tracking of program spending at the national level, Ministry of Finance will implement a “tag” which can be applied to selected expenditure lines related to the Government Program.** Tagging will apply to program expenditures both inside and outside the PforR expenditure boundaries (i.e. to the entire NatStrat Stunting), but PforR expenditures will be readily identifiable by virtue of the Ministry that undertakes the expenditure and the type of intervention they support.

32. **Only operational spending financed by the DAK non-fisik at the district level is included within the expenditure boundaries of the PforR Program.** Analysis by Bank staff shows that the net amount spent from unconditional district sources of funding, on operational costs of nutrition interventions, is relatively low. Furthermore, there is limited availability of reliable data on spending by local governments at the sub-sector level. In view of the potential challenges in obtaining reliable data to complete the program financial statements, the large number of local governments involved and the relatively small amount contributed to program costs from this source, it was decided to omit district level spending from sources other than DAK from the expenditure boundaries of the Program for Results.

33. **Data on spending of DAK non-fisik is readily available from national reports that local governments are required to supply to the Ministry of Finance.** Reporting arrangements are set out in a Ministry of Finance regulation and expanded on in Ministerial regulations. DAK Fisik reporting arrangements are set out in an annual Presidential regulation. Eligible expenditures for each type of DAK are set out in technical guidelines issued as regulations by

⁹ Both the INEY and I-SPHERE PforR operations include distinct components of the special transfer for district health operational costs (DAK BOK Non-Fisik) in their program expenditure boundaries. The INEY and I-SPHERE teams have agreed a division of national and subnational spending that avoid overlap between the two program boundaries whereby INEY includes nutrition activities and I-SPHERE includes maternal and child health activities.

each ministry responsible for the relevant sector. There are no excludable items. Expenditure reports on utilization and absorption are provided as each tranche of DAK is released, and annually. The DAK types which are included in the program expenditure boundaries are set out in Table 12.

Table 12: Allowable expenditures of DAK included in the program expenditure boundaries

Intervention Area	DAK types	Allowable expenditure items
Health	DAK BOK Puskesmas (Health center)	<ol style="list-style-type: none"> 1. Antenatal & Postnatal Services, including provision of additional food (PMT) to pregnant women, classes for mothers 2. Infant health services; 3. Child and pre-school services, including monitoring of children health, provision of additional food; 4. Environmental health services, including orientation for community leader, community empowerment through Community Based Total Sanitation program (STBM), and follow up.
Education	DAK BOP-PAUD	<ol style="list-style-type: none"> 1. Meeting activities with parents/student Guardians (parenting); 2. Purchase of Early Detection Growth Tools (DDTK), light medications, and First Aid Box content; 3. Cost of teachers meeting in PAUD cluster activities, attending educator capacity building activities, and transport of health workers visit; 4. Adding educators' transport; and 5. Provision of nutritious food

34. Data on use of Dana Desa for village development activities is readily available from reports provided to the Ministry of Finance. Villages are required to report on Dana Desa expenditure to the district level, which then provides a consolidated report to the Ministry of Finance. Financial reports are provided against four categories of village expenditure. One category, community empowerment, captures non-infrastructure related expenditures which are predominantly concerned with health services (posyandu and postu), education services (PAUD) and delivery of related social programs including behavior change programs for sanitation.

Predictability

35. The expenditure framework shows that resources have increased significantly for nutrition interventions, and it is expected that this trend will continue, particularly once relevant budget lines are identified through tagging. Indonesia has a medium-term expenditure framework in theory, but in practice this is yet to give any real security of forward funding to program managers. Conversely, Indonesia's budgeting system is mainly incremental, meaning that spending units are routinely allocated what they were in the previous year. The upside of this practice is that existing programs are less likely to have their funding disturbed. The downside is that the pressure to demonstrate performance (value for money) is greatly

reduced, even when program managers are asking for an increased budget beyond the baseline funding.

36. **Allocations to the relevant DAK non-fisik have been increasing consistently over the last three years, as shown in Table 13.** DAK fisik was introduced in 2016. Prior to this, these four types of inputs were financed through the budgets of line ministries.

Table 13: Total allocation to selected DAK non-fisik 2016-2018

	2016	2017	2018
BOK child birth assistance (Jam)	1,625,853,850.22	1,266,053,848	1,563,433,900
BOK Health	2,426,370,885.00	4,826,654,272	6,189,644,740
BOK Family Planning (KB)	212,318,185.00	292,800,000	1,808,787,200
BOP Early Childhood (PAUD)	2,281,900,000	3,581,700,000	4,070,194,800

Adequacy

37. **Expenditure on nutrition interventions is substantial, and the more significant issues are with efficiency and effectiveness of spending, rather than overall amount.** A core objective of the center of government monitoring arrangements led by Bappenas and Ministry of Finance is to incrementally develop a sounder basis for assessing the adequacy of program spending, and the relative efficiency of different intervention sub-programs in achieving their targets. This assessment should feed into subsequent year decisions on allocation across different interventions. Similarly, at the district level a key convergence instrument is the diagnostic (see Results Area 2 for details on district Convergence Actions), which aims to help districts identify geographical locations within the district where vulnerability to stunting is highest, and where service gaps are greatest. The diagnostic will inform district plans and budgets, and annual retrospective reviews will identify whether investments in interventions during the previous budget cycle delivered reductions in service gaps.

4. Results Area 1: Strengthen national leadership and convergence performance

38. **Center of government systems are critical to ensure that stunting remains politically salient, resources are managed to ensure program delivery, and there remains a consistent focus on outcomes.** There are three core elements of an effective center of government approach: (a) cascading political commitment at all levels of government to implement the NatStrat Stunting within their area of responsibility, (b) planning and budgeting systems that link resources for NatStrat Stunting components to planned targets, evaluation of program performance across different ministries, and monitoring of implementation progress that

identifies bottlenecks so that they can be followed up and resolved, and (c) robust monitoring of stunting reduction performance, disseminated publicly, to ensure high level accountability for program achievement.

4.1 TNP2K and Stunting Summits

Strategic Relevance

- 39. The importance of driving results from the center through “top to bottom” political leadership is a key lesson from countries that have successfully tackled nutrition.** The NatStrat Stunting proposes to achieve this through a “cascade” of political commitment from the President and Vice President through to local mayors (*Bupati* and *Walikota*) and village heads (*Kepala Desa*), as well as establishing commitment by relevant ministers at the national level. At the national level, the key convergence instrument that stimulates this commitment is an Annual National Stunting Summit hosted by the President or Vice President, which will bring together district and national leaders to (i) jointly commit to achieve annual stunting reduction targets, and to align district plans and budgets to the priority nutrition interventions and priority geographic locations; (ii) publicize performance information and reward high-performing districts and (iii) disseminate good practices. Ministerial Leadership Summits will bring together ministers of relevant ministries and agencies to agree on intervention targets, reward good performance, and share good practices. Districts will be responsible to hold similar leadership summits at the district level, convening district and sub-district officials and village leaders to agree stunting targets, commit to align village budgets, reward good performance, and share lessons on good practices. To reinforce commitment by districts, central government will monitor their performance and reflect performance in the allocation of the programmatic DAK that support nutrition interventions and convergence actions.
- 40. National leadership will be critical to ensure that political leadership, program monitoring and follow up of performance challenges occurs.** The Secretariat of the Vice President (SoVP) is well placed to provide this national leadership and delivery oversight because of its ability to work across relevant ministries and tap the political authority of the Vice President and President. As well as being the executing agency for the PforR Program, the SoVP will execute four key functions: (i) convene leadership summits, (ii) work with Bappenas and MoF to align the development plans of implementing agencies with the NatStrat Stunting targets and prior year performance, and monitor national and sub-national progress by implementing agencies and implement a tiered approach to problem-solving (debottlenecking) where performance is not satisfactory (a key source of data for which will be the performance reviews in DLI 2—section on Synchronized Planning and Budgeting Systems below), (iii) review and report on the NatStrat Stunting annual achievements including progress in achieving DLIs, and (iv) liaise with the independent verification agent.

41. **SoVP will be supported to carry out its role by the Secretariat to the National Team to Accelerate Poverty Reduction, TNP2K.** TNP2K is established under a Presidential Regulation with a mandate to (i) improve household and regional targeting of poverty reduction programs, and (ii) improve program delivery mechanisms. Reporting to the President, TNP2K is chaired by the Vice President and includes representatives of all ministries responsible for sub-programs that implement nutrition interventions covered by the NatStrat Stunting. TNP2K is supported in its role by the TNP2K Secretary, a senior Echelon 1 civil servant, and three other senior officials. The Secretariat has a staff of externally financed advisers organized into eight thematic and functional units, of which four are relevant to the implementation of the NatStrat Stunting: (i) the Communications team; (ii) the Subnational Advocacy team; (iii) the Monitoring and Evaluation team; and (iv) the Ad hoc Pilot teams. The staff of the TNP2K Secretariat is almost entirely financed by the Australian-funded program Makhota.

Technical Soundness

42. **There is already considerable political commitment to strengthen national leadership and establish convergence instruments, and the key issue will be to buttress this commitment with robust institutional arrangements.** The NatStrat Stunting provides high level political authorization for the core center of government components envisaged in the program.

43. **TNP2K's mandate and capacity are well aligned with the program needs but would benefit from strengthening in some areas.** TNP2K is a high powered, high capacity unit of about 60 staff which coordinates and provides analytical inputs to a range of poverty programs. Its corporate identity is more akin to that of a think tank but it does have some of the attributes needed to convene agencies and hold them accountable for performance. TNP2K's institutional capacity for coordination and monitoring will need to be strengthened in the following areas so that it can effectively perform the functions required by the program for results:

- a. **Systematic centralized monitoring.** TNP2K's current role focuses mainly on rigorous evaluations while monitoring is delegated to implementing ministries. For the program for results, TNP2K will need to develop a strong monitoring function with a centralized dashboard and reporting routines. This function will be much more operational and process-oriented than intellectual and academic, which will necessitate some adjustment in the corporate identity of the unit.
- b. **Ability to de-bottleneck.** The whole purpose of central monitoring is to inform action from the center to unblock areas where the program is not achieving its targets. TNP2K will assume some delivery unit functions to play this role. This is an area where staff have limited experience as this function was previously played by another unit, UKP4. At the technical level, TNP2K staff will work directly with ministry staff to solve

problems. If solutions are not technical but rather relate to higher level decisions, a process will need to be established whereby decisions that cannot be solved at a lower level are progressively escalated until they are resolved.

- c. **Capacity to secure political commitment through annual national stunting summits.** TNP2K has a well-developed communications and advocacy function that includes outreach to subnational level, which bodes well for its capacity to convene national stunting summits. However, securing credible commitments in different ways may prove challenging. TNP2K would benefit from assistance in conducting the summits and designing the process for capturing commitments that are both credible and binding.

Recommendations

44. Effective functioning of TNP2K will be critical to the success of the program. In order for TNP2K to play the role required for the PforR Program (and the NatStrat Stunting more generally), it will need assistance in the following areas:

- a. **Facilitating annual national stunting summits.** Ensure technical assistance is provided for the design and facilitation of summits to ensure they are successful in capturing credible and binding commitments by leaders. There may be an opportunity to draw on the experience of delivery units such as PEMANDU in performing a similar role in relation to nationally-led reform programs in other countries.
- b. **Establishing a robust monitoring function.** TNP2K will need support to develop capacity for monitoring, create a centralized dashboard for DLI monitoring, and monthly/quarterly reporting routines from implementing agencies to TNP2K. TNP2K will also need to establish capacity and routines to assemble program expenditure statements in auditable format for all expenditures within the program expenditure boundaries.
- c. **Strengthen capacity to debottleneck program implementation.** At the technical level, TNP2K's structure will need to be aligned with the key results areas for the program, so that particular staff/units are responsible for engaging with particularly implementing agencies on particular result areas. At the policy level, the mechanism to escalate problems that cannot be solved at the technical level through a cascade or periodic high-level meetings will have to be designed and implemented.

45. Financing of TNP2K will need to be placed on a more sustainable footing. TNP2K is currently financed almost entirely from external sources (DFAT). Alternative external financing is available from the GFF, but this should be seen as temporary solution. Government should introduce domestic financing for TNP2K in the near future. Changes to TNP2K's financing

provide an opportunity to adjust its role and better align incentives. Shifting focus to delivery functions will require some adjustment to TNP2K form and functions, possibly at the expense of some of its think tank functions. This provides an opportunity to reorient towards a more prominent role in supporting leading the NatStrat Stunting.

4.2 Synchronized National Development Planning and Budgeting

Strategic relevance

- 46. Effective management of medium-term and annual planning and budgeting processes is the second core element of strengthened national leadership for convergence.** Indonesia has a highly engineered and orderly planning and budgeting system, but it does not function as effectively as it could to drive the achievement of national priorities. Key areas of weakness are: (i) weak links between planning and budgeting, and siloed view of line ministry budgets even where they to the same national priority, (ii) limited exercise of function to “challenge” line ministries to demonstrate that their programs achieve the value for money in a policy sense, (iii) information on previous years’ performance is not taken into account in evaluating future years’ budget submissions and, (iv) limited opportunity for a joined-up view of program financing across levels of government. Institutional arrangements for the NatStrat Stunting will need to address these challenges to achieve convergence and increase the impact of Indonesia’s annual \$5.3 billion of spending on nutrition interventions.
- 47. The primary budgetary unit in Indonesia is the program, usually executed at the level of Director-General (DG).** Most DGs have a single program, meaning that their organization and budget allotment are an identity. Each program is divided into activities, designed to give effect to a program. Each activity has measurable outputs; services or products that the action produces, and the outputs have indicators (measures of success). They may also have components and sub-components (inputs to the level above). The new financial management information system, SPAN, and the planning applications (KRISNA and RKA-KL) help to synchronize between planning, budgeting and execution of the government’s program. SPAN is a robust system with 12 segments and 62 digits of chart of accounts, covering all the information needed to make a direct comparison between original budget and realization. A single accounting classification is consistently applied across the budget formulation, execution and reporting cycle. Each level of each program has a unique, traceable code. These codes enable MoF to control allocations and track expenditure by type at a granular level.
- 48. Below the level of program, budget is allocated to spending units, or satkers.** Satkers consist of four office-holders, at least three of which must be different people. There is no overriding strategic pattern to this arrangement, and there are around 24,000 satkers at the level of the central government. The result is a high degree of fragmentation in the purposes to which funding is allocated. Shifting funds between these different purposes is challenging, even at

the lowest levels. Shifting funding between satkers in different programs requires parliamentary approval.

49. **The high degree of correspondence between programs and organizational structure limits the strategic perspective of the performance budgeting system.** Because most DGs manage a single program, the focus tends to be on inputs, and there is less flexibility during the year for funds to be moved between programs depending on their performance. The NatStrat Stunting will be funded from multiple sources and so this single program approach is not a practical way to manage it. Instead, a ‘super program’ which bridges DG and ministerial boundaries is needed. Such an approach offers a number of benefits: (i) providing a holistic view of resources allocated to all interventions, (ii) facilitating strategic links across different interventions that benefit achievement of individual objectives in the different interventions; and (iii) creating a forum for evaluating performance in the presence of other peer managers, to increase the pressure for performance.
50. **Recent adoption of Government Regulation 17 of 2017 have laid a stronger foundation for alignment of planning and budgeting.** Indonesia has an extensive and highly consultative development planning process managed by the planning agency Bappenas, which at the whole of government level incorporates a 20-year development plan, five-year development plan (RPJMN) and an annual work plan (RKP). Development of the RKP begins more than a year before the annual budget is adopted. Line ministries are required to prepare five-year plans (Renstra) and annual work plans (Renja-KL). Prior to 2017, Bappenas’ role in the annual budget cycle ended once line ministries had finished their annual work plan, with the result that consistency between plans and budgets was reduced. Regulation 17 aims to correct this by improving coordination between Bappenas and MoF in the development of the annual budget.

Technical soundness

51. **Adopting a joined-up view of resource allocation and performance achievement across a super program like the NatStrat Stunting poses some challenges in the context of the current Indonesian planning and budgeting system.** A number of features of the Indonesian system mean it is more challenging to manage the planning and budgeting for the NatStrat Stunting in a joined-up way:
- a. **Rigid and granular budget allocations.** The budget is allocated to the level of 24,000 spending units. This makes it challenging to move funds from programs which are low performing to those which are high performing, without Parliamentary intervention. Results-based decisions on budget reallocation during the budget year are for practical purposes not possible.

- b. **Incremental budgeting.** Since spending units are routinely allocated what they were last year, the pressure to demonstrate performance (value for money) is greatly reduced. This reduces the incentive for program managers to use innovative approaches to achieve better performance. There is no routine requirement to analyze program achievements or unit performance. The pressure to demonstrate results is weak even when a unit is seeking increased budget beyond its established baseline. Conversely, this does mean that existing programs are likely to continue to be adequately funded and less likely to be disturbed.
- c. **Budgeting all available resources.** Indonesia has a strict fiscal rule limiting the combined deficit to 3% of forecast GDP. The normal procedure is to budget this amount in full, leaving no fiscal room to introduce new programs.
- d. **Poor output specification.** Outputs are not necessarily linked to outcomes. Some have a very high level of specificity and measurability, but little relevance to program outcomes. A recent exercise to tag outputs that contribute to mitigating climate change showed that reform is possible, with extra outputs added to existing activities which better target the objectives.
- e. **Trilateral (not multilateral) consultations over budgets.** Line ministries are required to meet with Bappenas and MoF in a trilateral meeting, which improves the scope for linking planning and budgeting, but will not be sufficient for management of national convergent programs. Simultaneous consultation of all relevant line ministries will be required to ensure that needs and performance can be assessed and balanced across the NatStrat Stunting.
- f. **Poor internal communications (“siloeing”).** It is normal for siloeing to happen between and within organizations, partly for reasons of individual interest, but also because communications impose a transaction burden on busy people. The high degree of specificity in the Indonesian budget vastly exaggerates this tendency. It impedes the flow of information and de-emphasizes the importance of cooperation.
- g. **Extended budget timeline.** Line ministries begin work on the budget for year T in the year T-2, using baseline information from the Supreme Audit Office (BPK) which relates to the operations of government in year T-3. By the time the BPK information on T-2 becomes available in June of T-1, it is too late in the budget process to have a meaningful impact on the budget proposals. The result is that budgets are based for the most part on information which is three years old.

52. **Coordination, communication, flexibility and responsiveness are the hallmarks of a budget management for a program which covers multiple interventions.** The NatStrat Stunting needs strong coordinated action, robust information flows, and budget flexibility so that priorities for action can be determined dynamically, investments can be focused in areas of higher priority, and those responsible for central coordination have access to the strongest

and most recent data available. These over-arching objectives are undermined in the Indonesian context by: (i) detailed budget allocations, which weaken stakeholder incentives for cooperation in pursuit of a common goal; (ii) low incentives to perform, and perverse incentives to choose irrelevant, easily measured outputs and indicators which fail to measure performance reliably, with the result that spending cannot be evaluated properly; and (iii) strong incentives against knowledge sharing, lack of formal data exchange, and (iv) use of out-of-date data in formulating the initial budget mean that decision-making is based on incomplete and outdated information.

Recommendations

53. Overcoming the rigidities, and unhelpful incentives inherent in the Indonesian budgeting process will be challenging, but not impossible. The following recommendations are proposed:

- a. **Anchor the NatStrat Stunting program in the annual plan.** Ensure that stunting is formally adopted as a priority in the RKP 2019. This will provide a basis for relevant ministries to identify stunting interventions and Bappenas and MoF to review the allocations and performance across the whole NatStrat Stunting rather than individually.
- b. **Locate and structure the relevant activities.** Line ministries will need to identify the relevant budget lines that contribute to nutrition interventions and are therefore part of the NatStrat Stunting. Tagging in SPAN and Krisna will ensure that these can be tracked. Bappenas should take the lead to help line ministries identify the relevant activities, and MoF should lead the issue of a program budget tagging guideline, and ensure that tagging is captured in SPAN. Outputs will need to be revised to ensure that they are meaningful.
- c. **Ensure that data is available (where relevant) on district level outputs.** National systems do not routinely specify the district or province where outputs are delivered. Line ministries should be assisted to identify data collection arrangements to ensure that they can identify location for location-sensitive contributions (for example, provision of training to district level staff).
- d. **Establish a performance baseline.** The performance baseline will provide the data on which subsequent year budgets can be negotiated. Establishing the first-year baseline may require some retrospective reconstruction, especially if outputs for some activities are poorly structured.
- e. **Undertake analytical work to evaluate budget performance.** Annually, Bappenas and MoF should undertake analytical work to ascertain which interventions are delivering and which are not. Evaluation should draw on the most recent data

available on program performance. Since the fiscal year is not complete when the budget preparation process starts, performance reports will need to combine partial data from the most recent year with partial data from the previous year.

- f. **Incorporate performance information into allocation decisions on the subsequent year budget.** A review of spending and performance is of limited value unless it informs the subsequent year's spending decisions.
- g. **Establish positive incentives for cooperation across DGs and ministries.** Implementation of the NatStrat Stunting will require engagement of multiple sectors and DGs across government.

4.3 Anthropometric Measurement

Strategic Relevance

- 54. **Anthropometric measures such as the proportion of children under age of 5 years that are excessively short for their age provide ideal indicators of outcomes of the PforR supporting the NatStrat Stunting.** Reduction of the stunting rate in each of the 100 priority districts is the objective of the PforR supporting the NatStrat Stunting of the GoI. The strategic relevance of anthropometric measures is very high for the variety of reasons discussed below.
- 55. **Anthropometric measures, such as stunting offer numerous advantages as outcome indicators:** they are clearly defined (i.e., precise and unambiguous), can be available at a reasonable cost, can provide a sufficient basis for assessing performance, and can be monitorable (i.e. amenable to independent validation). In addition, estimates of stunting at the district level can also serve the critical role of a disbursement linked indicator (DLI) in the PforR supporting the GoI since funds can be released based on the achievement of the outcome.
- 56. **Performance.** A DLI based on the extent to which district stunting rates decline from year to year can increase performance by ensuring that targets are being met in the 100 districts as specified in the NatStrat Stunting for reducing stunting. The release of funds based on recent district performance also serves as an incentive for district authorities to achieve the outcome.
- 57. **Accountability.** Frequent, credible, reliable, publicly accessible and independently verifiable measures of the achievements of districts in reducing stunting prevalence, for example, can play a very important role in increasing the accountability of the GoI towards its citizens. This is accomplished by minimizing doubts about the way in which public resources are allocated. At the same time, publications, shared data and research, knowledge sharing of best practices

in districts succeeding to reduce stunting provide the opportunity for learning from the practices and experiences of other districts.

58. Evaluation and Learning. Anthropometric measures can also serve the role of triggers for more in-depth evaluation. When the same programs and level of effort result in divergent performance in terms of outcomes such as reduction in stunting prevalence across districts, then there is a clear need for an evaluation of the program implementation process in lagging districts. Time and resources permitting, a similar evaluation of the program implementation process in the more successful districts offers the opportunity to learn from the practices of the more successful districts. Combined with other information collected from broader M&E system, TNP2K can better identify the factors behind slower progress, adapt the practices of the better performing districts to the new context, and increase the performance of the lagging districts.

Technical Soundness

59. The Program Assessment considered three options for delivering on the objectives outlined in the strategic relevance section above. This includes two national surveys: the health survey RISKESDAS, typically carried out by the MoH every 5 years, and the SUSENAS socio-economic survey carried out annually by BPS. It also considered the PSG (Pemantauan Status Gizi) surveillance system used by the MoH. Each is described in more detail in the Program Assessment. Box 1 details the options.

Box 1: Options for annual measurement of stunting representative at the district level

- Option 1 – Implement mini-RISKESDAS survey on an annual basis
- Option 2 – Utilize existing PSG system
- Option 3 – Add mini-anthropometric module to SUSENAS
 - Sub-option 3A – full integration into the March round of SUSENAS.
 - Sub-option 3B – add on module implemented in parallel with the March round of the SUSENAS by separate survey teams.
- Sub-options relevant to the above include:
 - Locations: 100 priority district only / all districts/cities
 - Cohort of children to be covered: 0-24 months, 0-36 months, or 0-5 years (up to 60 months of age)

60. The assessment analyzed the options along the following dimensions: (i) representativeness of the instrument at the district level; (ii) quality of the data collected; (iii) timeliness of production and publication; (iv) credibility of the implementation agency, and (v) public availability of the micro data.

Representativeness at the district level

61. **SUSENAS:** A two-stage stratified sampling method used to select subjects of this survey with the sampling for the March round designed to be representative at the district (kabupaten/kota) level. The sampling for the September round, is designed to be representative at the province (and not at the district) level. The March 2016 SUSENAS covered 300,000 sampled households spread over 34 provinces and 511 districts / municipalities Indonesia.
62. **RISKESDAS:** The 2007 and 2013 RISKESDAS used a multi-stage cluster sampling method to select the subjects surveyed (individuals and households). The samples are designed to be representative at the national, provincial, and district (kabupaten/kota) level. The 2013 RISKESDAS contained data from 294,959 households and 1,027,763 individuals. During the data collection process, an independent team from universities (UI, UNHAS, and UNAIR) helped validate the data.
63. The 2018 RISKESDAS is currently in the process of being integrated with the 2018 March round of the SUSENAS survey with the census blocks sampled by the RISKESDAS survey within the sample frame of the March 2018 SUSENAS survey.
64. The presentation by Ministry of Health (Balitbangkes) team in the December 2017 workshop stated that the sampling for the RISKESDAS survey will take into account the presence of 0-59-month old children in households, so as to ensure that there are sufficient observations for a reliable estimate of stunting prevalence among children 0-59 months of age at the district level. This implies that some households in addition to those interviewed by the SUSENAS survey will have to be interviewed by the RISKESDAS survey team. The current plan is that the SUSENAS survey will be held in March 2018 and followed by RISKESDAS in April 2018 with BPS local officers (PML) guiding the RISKESDAS interview teams to the households that were part of the SUSENAS survey a month earlier.
65. However, more recent communications between the Bank and the BPS have suggested that the households sampled by BPS for the SUSENAS survey may also be sufficient for the estimation of district level stunting rates. This implies that the sample of households interviewed by the RISKESDAS teams may be identical to the sample of households interviewed by the SUSENAS team.
66. Further clarification is needed about the sampling for the integrated RISKEDAS-SUSENAS survey in March 2018. The sampling for the SUSENAS does not automatically guarantee that estimates of indicators for specific demographic groups, such as the stunting rate among children 0-59 months of age will have an acceptable standard error. A reliable estimate (i.e., an estimate with a low standard error) of stunting prevalence at the district level can be obtained only through purposeful inclusion into the SUSENAS sample (oversampling), of households with children between 0 and 59 months of age.

67. **PSG (Nutrition Status Surveillance):** In 2016, PSG had been implemented in 34 provinces and in 511 districts/cities. Although this needs further verification, there are indications that the PSG is representative at the district level.

Data quality

68. A necessary condition for the acceptability by all stakeholders involved (districts, central government the press and civil society) of the annual estimate of the prevalence of stunting as an indisputable indicator of district performance (and thus as a DLI), is that the anthropometric data collected be of high quality. The quality of the data collected by the PSG is unknown, whereas the quality of the anthropometric data collected by the 2013 RISKESDAS survey is known to vary significantly across regions. For example, it is well known that the anthropometric measures in the eastern provinces of Indonesia (Nusa Tenggara, Maluku and Papua) are of lower reliability than the anthropometric data collected in other provinces. Authorities in the MoH (Balitbangkes) attribute this to the financial and time constraints encountered in providing adequate training to field staff with very heterogeneous skills and experience, hired on a temporary basis, solely for the purpose of the RISKESDAS survey carried out every five years.

69. In contrast the SUSENAS survey is collected by permanent BPS field staff, that have accumulated extensive skills and experience in implementing a limited number of questionnaires. The consequence of this the SUSENAS surveys have developed a respectable reputation worldwide regarding the quality of their data.

Timeliness production and publication

70. The strategic relevance of the district stunting rates as a DLI can be realized only if the district stunting rates become available in time before budget allocation decisions are made (i.e. are available by July of each calendar year). This timing would minimize the gap between “reward” in terms of budget and performance as measured by the district stunting rate.

71. Given that the March round of the annual SUSENAS survey is designed to be representative at the district level, this implies that an anthropometric module will have to take place in March each calendar year (CY), and that the stunting rates will have to be made publicly available by July each CY. The feasibility of this timing needs to be explored in more depth. However, preliminary indications are that this timing is quite feasible since the cleaning, and processing of the height for age measures of children and the estimation of the district stunting rates is not dependent on the progress of processing the full SUSENAS survey.

Credibility of the implementation agency

72. The strategic relevance of the district stunting rates as a DLI can be strengthened significantly if the child anthropometric data are collected, cleaned, processed, analysed and published by an institution that is not directly involved in the implementation and delivery of key programs of the P4R on stunting.

73. MoH, for example, is directly involved in the implementation and delivery of all nutrition-specific interventions supported by the PforR, and this may give rise to concerns about the possibility of conflict of interest. In contrast, BPS is not involved in the implementation and delivery of interventions supported by the PforR and its sizeable reputation and experience in handling national data on poverty, unemployment and inflation, among other key policy outcomes can directly contribute to the increased credibility of the published estimates of district performance on stunting reduction.

Public availability of micro-data

74. The strategic relevance of the district stunting rates as a DLI can be further enhanced by making available publicly the micro data collected as part of the anthropometric survey. This will offer the opportunity for third parties such as interested district authorities, the press, as well as academics, and civil society, to validate the published stunting rates, if so desired.

75. Ideally it will also be possible to identify children and their anthropometric measures from households that were also part of the annual SUSENAS survey in March in each calendar year which would provide for a more in-depth investigation and analysis of the determinants of child health and nutrition. BPS has a long and reputable track record of making micro data of the SUSENAS surveys and all other surveys it collects (such as the SAKERNAS) available to the public, given that data is collected with public funds. In contrast, the micro-data of the RISKESDAS surveys collected by the MoH, also collected with public resources, are not made publicly available, and accessible in part only after lengthy bureaucratic processes, such as signed MOUs, thus limiting the potential for public scrutiny of the quality of the data collected and the reliability stunting estimates reported.

76. In summary, the strategic relevance of the district stunting rates as a DLI can be strengthened significantly if the child anthropometric data are: (i) representative at the district level; (ii) of high quality; (iii) collected, cleaned, processed, analyzed and published by an institution that is credible and not directly involved in the implementation and delivery of key programs of the P4R on stunting; (iv) the district stunting rates made available annually in time (by July in each CY) for use as inputs in the budget allocation process; and (v) made available publicly the micro data collected as part of the anthropometric survey.

Recommendations

77. **In consideration of the above, the recommended option for the 100 districts for the duration of the PforR, is Option 3, subsection A, i.e., the addition of a mini anthropometric module to the March round of the SUSENAS.** The addition of a mini anthropometric module to the March round of the SUSENAS will have to first establish, in collaboration between BPS and MoH, whether there is a need for oversampling of households with children between 0 and 59 months of age. This would ensure that the number of children with height measures in each of the 100 districts yields a reliable estimate of stunting prevalence in each of the 100 districts. If an oversampling of households with children between 0 and 59 months of age is

required, the additional households with children between 0 and 50 months of age will have to be included and measured in a manner that entails minimal disruption to the process of collection of the regular SUSENAS survey and maintains comparability over time of the usual estimates obtained from the regular SUSENAS survey.

- 78. It is recommended that a mini anthropometric module be piloted in the September 2018 round of the SUSENAS.** The implementation of option 3A, combined with the other requirements that strengthen the strategic relevance of the district stunting rates as a DLI (such as having high quality measures, data collected, cleaned, processed, analyzed and published by an institution that is credible and not directly involved in the implementation and delivery of key programs of the P4R on stunting, and district stunting rates made available annually in time by July in each CY, for use as inputs in the budget allocation process), pose a number of challenges. Piloting the module will provide an opportunity for learning from the implementation problems encountered with the addition of the anthropometric measurements to the SUSENAS survey. The lessons learned from this pilot are to be compiled in a set of guidelines that will be issued before the March 2019 round of the SUSENAS and inform the coordinated implementation of the SUSENAS and anthropometric module applied to the sampled households in the priority districts.
- 79. It is also recommended that the collection of the anthropometric measurements be taken by well supervised and well-trained staff to ensure the collection of high quality data.**

5. Results Area 2: Strengthen delivery of sector programs

5.1 Nutrition-specific and -sensitive Health Interventions

Strategic Relevance

- 80. The nutrition-specific interventions seek to address the immediate determinants of malnutrition, namely food, health, and care.** A large body of evidence on the efficacy of nutrition-specific interventions exists and was recently reviewed in the 2013 Lancet series on Maternal and Child Nutrition. Indonesia has adopted a set of nutrition-specific interventions based on the recommendations from the global evidence. The PforR Program's scope include a sub-set of nutrition-sensitive interventions that include: (1) iron folic acid supplementation; (2) ANC/PNC; (3) Infant and young child feeding (IYCF) counselling; (4) basic immunization; (5) growth monitoring and promotion; (6) vitamin A supplementation; and (7) deworming.¹⁰

¹⁰ The selection of the interventions to include in the PforR Program was guided by 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 to leverage subnational transfers and Dana Desa to deliver frontline delivery platforms.

81. Global evidence suggests that in order to achieve stunting reduction, nutrition-specific interventions must be implemented at sufficient scale (90%). For many interventions, despite the long standing program, Indonesia still has low coverage of many nutrition-specific interventions, in particular iron and folic acid (IFA) supplementation (33%, Riskesdas 2013), complete postnatal visits (32%, Riskesdas 2013), early initiation of breastfeeding (34.5%, Riskesdas 2013), exclusive breastfeeding (42%, Riskesdas 2013), all recommended IYCF practices (37%, IDHS 2012), deworming for children 12-59 months (26%, IDHS 2012)¹¹. Table 14 details the coverage of priority nutrition-specific intervention indicators.

Table 14

Nutrition-Specific Intervention Indicators	%	Data source (most recent available)
Maternal and child health indicators:		
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
Postnatal care visit KFL(three visits, within 42 days postpartum)	32.1	RISKESDAS 2013
Children who were weighted in Posyandu at least 4 time in the last 6 month	77.0	RISKESDAS 2013
Children received 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
Nutrition, hygiene and stimulation counselling		
Early initiation of breastfeeding within 1hr after birth	34.5	RISKESDAS 2013

¹¹ The 2013 Lancet Series on Maternal and Child Nutrition found that 90% coverage of full-set of nutrition-specific intervention can reduce stunting by 20.3% globally.

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

82. Achieving stunting reduction will require improving access, but more importantly the uptake of the practices by caregivers, families and communities that these interventions entail. Improving uptake of caring and nurturing practices by caregivers, families and communities involve behavioral change, taking into account socio-cultural context and local practices. Strengthening Behavior Change Communication (BCC), which includes interpersonal communication (IPC), mass communications, advocacy, community mobilization coupled with strategic use of data, can help Indonesia motivate behavioral change and achieve better nutrition outcomes. Alive & Thrive studies have shown that at-scale intensive interpersonal communication (IPC) combined with mass media, community mobilization, and policy advocacy have greater positive impact on breastfeeding practices. Moreover, in Indonesia’s case, the heterogenous program implementation, weak program integration and coordination, inadequate scale up, and prevailing health system challenges contribute to the persistently high stunting prevalence across the provinces. See Annex B for a detailed summary of the delivery systems for primary health services in Indonesia.

Technical Soundness

83. A review of MoH health programs indicate insufficient focus on Behavioural Change Communication (BCC) including interpersonal communication (IPC), with unclear BCC strategies and weak IPC implementation between midwives, cadres and first 1,000-days households. This limit the effectiveness of intensive IPC delivery crucial for achieving behaviour change, especially for nutrition- and MCH- related interventions such as compliance to IFA supplementation and uptake of optimal IYCF practices. Several platforms for IPC delivery exist within the MoH programs, such as through the IYCF Program or through the Health Indonesia Program through Family Approach (PIS-PK), but to date the IPC components of the programs are not yet implemented at sufficient scale and intensity. In addition, the current incentive system is not set-up to enable at-scale, intensive IPC via home visits due to competing priorities and lack of operational resources. The status quo is to conduct reactive home visits, but there needs a change to shift the focus towards preventive home visits.

84. Limited focus on height measurement and promotion aspect of growth monitoring due to poor implementation of existing policies that encourage monthly weight measurement, and three-monthly height measurement (Permenkes No. 66 Tahun 2014 Tentang Pemantauan Pertumbuhan, Perkembangan, dan Gangguan Tumbuh Kembang Anak). Height measurements are generally only taken once or twice a year during Bulan Penimbangan Balita

(BPB) month. This results in missed opportunities to monitor height gains and create awareness of stunting during monthly *posyandu*¹² activities.

- 85. Challenges to nutrition service readiness include shortage of selected key inputs necessary for service delivery, such as length measurement board, child weighing scale, and laboratory equipment to test for anemia.** While nutrition-related pharmaceuticals, supplements and vaccines generally have good availability in puskesmas (>80 percent puskesmas¹³ reported having at least one item available and valid, QSDS 2016), the MoH must strive harder to achieve even higher availability to ensure resources are available for scaling up. The heterogenous implementation of health programs across Indonesia is a key reason for the insufficient scale up of nutrition-specific interventions.
- 86. Significant shortage and maldistribution of trained Human Resources for Health (HRH), in particular for key preventive and promotive HRH.** About 60 percent of puskesmas have at least one community health staff; 67% of puskesmas have at least one environmental health worker and 70% of puskesmas have at least one nutrition staff (BPPSDM, 2018). Not all nutrition staff in puskesmas are nutrition graduates, and another 5,990 nutrition staff is needed to meet minimum standards on staffing, taking into account the maldistribution of staffing (BPPSDM, 2016). Competency of HRH workers is generally low and variable: evidence from vignette responses indicates poor knowledge and awareness of diagnosis and treatment options in several parts of the country (HFSA, 2016). Anecdotal evidence from the field points to frequent errors in anthropometric measurements when done by non-nutrition staff.
- 87. Decentralization has resulted in fragmented supportive supervision for programs.** Directorates within MoH, as program holders, conduct joint supportive supervision and technical support visits (*bimtek*) to the sub-district and village, but are hampered by lack of manpower to sufficiently cover all sub-districts in Indonesia. Individually, the supportive supervision plans differ according to directorate/program and there is not a specific law, decree or guidelines that stipulates the amount, frequency, type and coverage of supportive supervision to be provided by the MoH. The district receives supportive supervision from the provinces, in addition to MoH. With the implementation of the NatStrat Stunting, MoH has started '*bimtek* stunting' visits specific for stunting interventions, initially focusing on 10 kabupaten/kota with highest stunting prevalence within the 100 priority districts.
- 88. Institutional arrangements of MoH and District Health Offices (DHO) have resulted in poor program integration and coordination within the health sector itself.** With the exception of integrated programs, such as mass deworming- Vitamin A campaigns, or Vitamin A-BPB programs, little effort has been made to coordinate the delivery of nutrition-specific interventions in a convergent manner. This is particularly apparent for health-WASH services, which is delivered by the same DG within MoH, and in most cases, same unit within DHO.

¹² Village health posts.

¹³ Public primary health center.

89. **Capacity building at the province, district and sub-district level is hampered by inadequate funds and lack of coordination, resulting in few, and non-optimal national-to-subnational capacity building activities.** At the facility level, data from QSDS indicate percentage of puskesmas with staff trained is still inadequate. Cascade training, using Training of trainer (ToT), remains the MoH's best strategy to expand training delivery to sub-districts, but opportunities exist to complement this with e-learning.
90. **Lastly, there is a misalignment of budget allocation for nutrition.** Close to 90% (961 billion IDR) of allocated budget for DG Community Nutrition in 2017 was spent on supplementary food (*Pemberian Makanan Tambahan*, PMT). While PMT is a necessary intervention for underweight children and energy-deficient pregnant mothers, MoH should shift **focus to ensuring optimal IYCF practices in the community by supporting and counselling first 1,000-days households** on early initiation of breastfeeding, exclusive breastfeeding, and adequate complementary feeding.

Recommendations

91. **Strengthening community-based delivery platforms and increasing the focus on IPC, combined with advocacy, mass communication and strategic use of data to drive behavioral change towards improved caring practices.** For example, equipping frontline workers with skills and resources to conduct age-appropriate and issue-specific counselling, coaching and demonstration will be the foundation for effective programming of all interventions, including interventions that address appropriate complementary feeding and compliance to iron folic acid supplementation. Existing community-based nutrition counselling platforms, such as *Kelas Ibu Hamil* and *Kelas Ibu Balita*, can also be further strengthened, not only in terms of technical and IPC competency of cadres and midwives, but also to increase its reach to first 1,000-days households.
92. **Improve tracking nutrition- and MCH-related program activities, key inputs and outcomes.** This requires significant negotiating and mapping of the current highly fragmented health management information systems. At least 11 separate reporting forms track the activities and coverage of the nutrition- and MCH-related programs at the posyandu and puskesmas level. The information is delivered to DHO either manually via *Sistem Pencatatan dan Pelaporan Tingkat Puskesmas* (SP2TP) or electronically into MoH's health information system, which over the years have been known as *Sistem Informasi Puskesmas* (SIMPUS) or e-Puskesmas. At the DHO level, *Sistem Informasi Kesehatan Daerah* (SIKDA Generik) enables the sub-district information to be collected, analysed and sent up to the PHO and subsequently to the MoH. A recent innovation, e-PPGBM, allows nutrition data (such as nutritional status, PMT beneficiaries) to be input into an app in the *posyandu*, upon which the data can be tracked by DHO, provincial health offices (PHO) and MoH; however, coverage of the e-PPGBM is unfortunately still at a low 15 percent nationally, with much variation across the region. Key inputs, such as pharmaceuticals, supplements and vaccines are tracked separately. e-Monev Obat, on the other hand, is used to monitor the planning, and

procurement of e-catalogue items. Despite having existing health information systems that could theoretically track nutrition-specific activities, outcomes and inputs, significant challenges in terms of data overlap, data duplication, incomplete data and most importantly, data validity remain and a careful exercise must be undertaken to assess quality of data, especially for the 100 priority districts.

93. **Improve the supply side readiness of key nutrition services related to supplies, equipment and pharmaceuticals availability.** The supply-side readiness will be incentivized through other World Bank's PforR operation, I-SPHERE (Indonesia-Supporting Primary Healthcare Reform), that aims at strengthening performance and quality of Primary Health Care nationally, mainly through its component on improving implementation of quality assurance program and *Puskesmas* (PHC facility) accreditation. INEY would focus primarily on the "last mile" delivery of nutrition-specific interventions at the village level. Particularly, INEY would focus on the demand and supply side interface through Village Convergence Scorecard (build on Generasi program) that aims at converging service delivery and performance monitoring system.
94. **Strengthen the collaboration with MoHA, MoV and sub-national governments to ensure nutrition-related policies and regulations are translated into actions.** This is particularly important in the context of a multi-sectoral approach towards stunting reduction. With the National Action Plan for stunting in place, MoH is ready to take a convergent approach towards stunting. For example, the Bureau of Planning and Budgeting within the MoH, is tasked with the internal coordination of programs that implement nutrition-specific interventions, and works across the DGs to do so. For cross-sectoral coordination, the DG of Community Health is taking the lead. However, at the sub-national level, further coordination is needed to ensure synergistic convergence.

5.2 Nutrition-sensitive ECED Interventions

Strategic Relevance

95. **According to *The Lancet*, adequate stimulation and good nutrition during the early childhood years are essential to ensure optimum development and drive longer-term gains in human capital.** However, not all parents are aware of the drivers of malnutrition, the importance of early stimulation, or research-based parenting practices that support healthy child development. For this reason, education plays an important role in equipping caregivers with the capacity and motivation to adopt healthy feeding, caregiving and hygiene practices in the home.
96. **High-quality education services improve children's physical and cognitive development through two pathways:** direct interactions between early childhood teachers and children (through learning in early learning facility), and indirect stimulation (through teaching

parents how to implement effective nutrition and early stimulation activities outside the classroom). In particular, for children ages 0-2, a growing body of research shows that parenting programs which integrate nutrition with a focus on early stimulation are likely to have a greater cumulative impact on nutrition outcomes, compared to single-sector interventions.

97. **ECED facilities are valuable community institutions that exist in more than 70 percent of villages in Indonesia.** They engage with parents of young children at a wide scale, and are staffed by cadres who are experienced in delivering early stimulation to children. These workers are well positioned to deliver nutrition-sensitive parenting education that is designed to improve caregiving practices. See Annex C for a detailed summary of the delivery systems for ECED services in Indonesia.
98. **The trust between mothers and their children’s ECED teachers is a valuable currency that can be leveraged as part of integrated behavior change communication at the village level.** Even though most children who are enrolled in ECED are ages 3-6, many mothers who spend time in ECED facilities are also parents of infants and toddlers, or are sources of guidance to other pregnant women and young mothers in the community.

Technical Soundness

99. **In the context of the INEY PforR, there are two parenting education interventions relevant for 1,000-day households.** The first: group-based parenting education classes for all pregnant mothers and caregivers of children aged 0 to 24 months. Trained village cadres facilitate this series of parenting education classes, utilizing a national curriculum and instructional resources. Sessions are one to two hours in length and include a mix of direct instruction and guided practice. They typically take place at a posyandu or ECED center. The second parenting education intervention – targeted to a smaller subset of households – is a set of follow-up home visits specifically for families with infants or toddlers who are stunted or at risk of stunting (as indicated by data from monthly posyandu clinics). Trained health cadres partner with ECED cadres to lead these home visits. Caregivers receive tailored guidance on how to implement nutrition and early stimulation practices, responsive to their unique family circumstances. Cadres demonstrate and model desired behaviors, and follow up to ensure that families adopt practices that result in accelerated physical growth and development for children.
100. **In addition to these two “formal” parenting education interventions, there is a third, “informal” intervention: the routine guidance that ECED teachers provide to mothers on early stimulation in the course of their daily work leading early childhood education for children ages 3-6.** With additional support from the government, this nutrition-sensitive communication with parents can be aligned as part of a broader campaign of coordinated behavior change communication in villages.
101. **MoEC is still in the process of developing new materials and resources to support the Parenting for the First 1,000 Days program.** The Directorate of Parenting Education implemented a version of the Parenting for the First 1,000 Days training program in late

2017 in eight priority districts. Based on this limited information, villages were expected to use Dana Desa to establish parenting education classes in their communities to promote model nutrition and early stimulation practices. The materials and training implementation were not piloted, and the ECED Frontline model of district-based training delivery was not leveraged in these eight priority districts. Without adaptation, it is unlikely that this model of training and socialization is likely to result in the widespread establishment of sustainable parenting education services that achieve the NatStrat Stunting objective. However, it is likely that the content of these materials will have at least some overlap with resources from other national programs that share the aim of educating parents on how to stimulate their children’s development (e.g. MoH’s *Kelas Ibu*, MoSA’s Family Development Sessions, and BKKBN’s *Bina Keluarga Balita*). MoEC’s new program can help fill the gap in villages that do not yet have access to parenting education implemented by health cadres, PHK facilitators or BKB cadres. However, it will be necessary to coordinate and synchronize behaviour change communications across these programs, so that caregivers are receiving consistent messages on nutrition and early stimulation regardless of the source of this information. This will require coordination at the national level that does not yet exist between officials in charge of these programs.

102. **At the national level, there are blurred lines of authority between three directorates that oversee different aspects of the early childhood education system.** The Directorate of ECED and the Directorate of ECED Teachers each sit under different DGs; they are responsible for overseeing compliance with different ECED quality standards. These directorates do not have a history of strong collaboration. Lack of coordination hinders the provision of effective capacity support for district education offices. Meanwhile, the Directorate of Parenting Education is new, and mostly appears to have operated in its own silo since being established in 2015, focusing on creating and disseminating information for parents. If the Directorate of Parenting Education is going to assume primary responsibility for early stimulation services tailored to children ages 0-2, it will need to work constructively with the Directorate for ECED, which has overseen these services in the past (despite de-emphasizing this in favour of expanded pre-primary education for children ages 3-6 in recent years). Likewise, strong collaboration will be necessary with the Directorate of ECED Teachers, which will manage the “infrastructure” of the district-based ECED training system.

Recommendations

103. To ensure the provision of universal, high-quality parenting education in priority districts, the following three activities are proposed at the national level, with MoEC leading.
104. **Activity 1: Strengthening and expanding the new, district-based training system for education personnel piloted by ECED Frontline in 2016 and 2017.** With support from the World Bank, MoEC implemented the ECED Frontline pilot in 2016 and 2017, which has developed a district-based system that delivers professional development to ECED teachers in order to improve their competency. In particular, MoEC provided funding to establish a

corps of district trainers in 25 pilot districts, and administered ToT that enabled them to implement a comprehensive professional development package for teachers in kindergartens and playgroups (serving children ages 3-6). According to preliminary evaluation results, the district-based training system has shown initial success in improving ECED teaching practices. With support from the INEY PforR, MoEC can scale up the district-based training system to benefit more teachers in priority districts. The curriculum of the professional development package implemented through this system will be strengthened through the inclusion of additional nutrition-sensitive content. In addition, as noted below in Activity #2, the district-based training system will be leveraged to deliver follow-up technical training for teachers that is focused exclusively on the implementation of parenting education services.

105. **Activity 2: Implementing MoEC's new Parenting Education program in priority districts by leveraging the district-based training system.** MoEC's Directorate of Parenting Education is in the process of rolling out a socialization program for village cadres, called Parenting for the First 1,000 Days (*Pengasuhan 1000 HPK*). The program prepares cadres to initiate new parenting education classes in their communities, focused on three target audiences: (i) pregnant mothers; (ii) caregivers of children ages 0-12 months, and (iii) caregivers of children ages 12-23 months. This set of eight parenting classes can be integrated within existing village delivery systems, including ECED and posyandu. The parenting education classes are led by trained village cadres, using Parenting for the First 1,000 Days modules and resources created by MoEC. The expectation is that villages will use Dana Desa to fund the classes.
106. **MoEC piloted this new program in eight districts in late 2017, in alignment with Rembuk Stunting.** During the pilot, MoEC delivered five days of ToT in Jakarta to a team of district facilitators. These facilitators, in turn, implemented training in their district capitals to one Village Head, one Bunda PAUD (spouse of village head), and one village cadre per village. MoEC plans to roll out training to an additional 92 districts in 2018. The World Bank will help MoEC to adapt the design of the program to improve the likelihood of villages adopting formal parenting education services (including classes and home visits), and to strengthen its training content so that teachers have the full suite of skills and resources to deliver it effectively at scale.
107. **Through the INEY PforR, the district-based training delivery mechanism established by ECED Frontline pilot will be used to implement the Parenting for the First 1,000 Days training program.** In other words, district trainers can be trained to implement not only the comprehensive professional development package for teachers (piloted by ECED Frontline, and enhanced to include nutrition-sensitive information), but also technical training focused exclusively on how to establish and implement formal parenting education services in villages. Working in partnership, MoEC's Directorate of ECED Teachers and Directorate of Parenting Education will ensure that district education offices have the capacity and resources they need to lead district-based training systems that can deliver both training packages effectively.

108. **Activity 3: Strengthening the DAK BOP-PAUD so that it drives increases in access to high-quality, nutrition-sensitive early education initiatives.** At the national level, the DAK BOP-PAUD is the largest source of funding for early childhood education service providers. BOP funds support facilities' operational costs (Rp. 600,000 per enrolled child in 2017), and are managed and administered by ECED principals. Currently, most facilities that receive BOP serve children ages 3-6.
109. **The INEY PforR provides an opportunity to strengthen this DAK so that it improves access to high-quality, nutrition-sensitive ECED and parenting education services.** The World Bank will focus on two areas. The first is TA to strengthen BOP guidelines, with a focus on funding nutrition-sensitive activities by ECED providers that are aligned with the PforR, and on funding the establishment of new parenting education services. The second is capacity building for MoEC so that it can support district education offices in effectively performing their monitoring and oversight roles for the BOP.

5.3 Nutrition-sensitive WASH Interventions

Strategic Relevance

110. **Inadequate sanitation can impact child nutritional status through multiple pathways, most importantly through reduction in diarrheal disease and infection from harmful parasites due to fecal contamination in the environment.** Improved WASH can also help reduce anemia and play an important role in preventing environmental enteropathy.¹⁴ Although WASH is not the only factor affecting stunting, Indonesian data have shown a strong relationship between improved sanitation and reduced stunting
111. **Lack of access to safe clean (contamination-free) drinking water, especially for young children contributes to the presence of pathogens in their gut, leading to environmental enteric dysfunction (EED) and diarrhea which prevents the proper absorption of nutrients leading to poor growth and eventually under-nutrition.** Approximately 70 percent of households in Indonesia have access to improved drinking water (SUSENAS, 2016), although the rate varies between rural and urban areas. Of note is that not all improved drinking water ensures that children are receiving contamination-free, safe, drinking water. How the water source is maintained, the water stored and handled will determine if the child receives "clean" water. Increasing access while improving water handling and including treatment of all drinking water for young children when contamination-free water cannot be assured will reduce children's exposure to harmful pathogens, reducing prevalence of gut infection and inflammation thought at this time to contribute significantly to child stunting.

¹⁴ A condition whereby the intestine has been damaged due to frequent infection which causes a reduction in nutrition absorption capacity.

112. **Fragmented multi-sectoral in WASH delivery services is the main challenge.** The delivery of WASH sector is fragmented in some ministries: Ministry of public Works and Housing (MoPWH) for infrastructure, MoH for behavior change and water quality, Ministry of Home Affairs (MoHA) for minimum service standard and district and village government' capacity in managing WASH as basic service, Ministry of Villages (MoV) for community and village empowerment. In urban and some peri-urban area, delivery of clean water is provided by local government owned enterprise (PDAM), while in rural areas the water supply system managed by community-based organization (BP SPAMS). This fragmentation is beyond geographical challenges (i.e. source of water, distance of water source to settlement) and demographic challenges (i.e. institutional approach to serve village, urban and peri-urban communities).
113. **Various types of WASH intervention financing imply a complexity in planning and results monitoring.** There are a number of ways the government provides financing to this sector: DAK Fisik (DAK water and DAK sanitation), DAK Non-Fisik (Health Operational Aid or BOK), APBN, APBD, APBDes, and grant (provincial aid/district aid). All of these have their own technical guidelines and requirements and are being implemented by different ministries and their corresponding district offices (dinas). These have created a complexity in planning and monitoring access, including post-construction supervisory to ensure quality and sustainability of services.
114. **While Indonesia has been decentralized since 2001, the sector is still heavily driven by central government due to weak fiscal and human resources of local government.** Local government financing to this sector is mainly relied on APBN and DAK. There is limited APBD and APBDes budget allocated and mostly driven by national programs. There are limited, if any, capacity building programs for this sector provided by local government. Planning for this sector is also heavily influenced by outside actors such as deployed national projects facilitators.

Technical Soundness

115. **There are two main platforms for rural WASH, namely Pamsimas and the Community-led Total Sanitation (STBM) Program.** These platforms provide instruments on: intervention strategy, institutionalization, planning and monitoring. As platforms, Pamsimas and STBM try to facilitate multi-sectoral financing to leverage access by forwarding those four instruments. **Both platforms apply a district-wide approach.** The district is encouraged to develop a District Action Plan for WASH (RAD AMPL) and integrate it into the district strategic plans and dinas' work plans. This institutional mechanism has resulted in higher trend increase of rural WASH access compares to urban in last couple years.
116. Since the water and sanitation as part of nutrition sensitive intervention will focus on priority villages, **design of WASH intervention should consider some issues thwarting sustainability of rural WASH sector development, as follows:**

- **Low quality of district planning** due to unclear demarcation of service coverage by BPS PAMS and PDAM/other operator, and unclear target setting for urban and rural areas.
- **High investment cost**, in some areas, there is an issue with quality of bulk water (quantity and quality) that requires high capital expenditure and operational expenditure.
- **Low willingness to pay** from community to finance service operational and maintenance due to limited household connections and low quality of service because of the operator's (BPS PAMS) limited capital and capacity to run the water system management.
- **Unidentified quality of water**, there are irregular and limited activities to ensure water quality. All Pamsimas systems have a check of the quality of water before delivering water to households, however there is low compliance to regular checking. Concurrently, health office/puskesmas allocates very limited budget, if any, for water quality check.
- **Limited support system from the district** (monitoring, capacity building, and incentives system) to sub-district and village level. In addition, there is no dedicated unit in sub-district level to support district or village level in managing water and sanitation issues.

117. **Besides infrastructure, WASH is closely related to behavior that needs soft intervention.**

This intervention is under the purview of MoH through its front liners such as Puskesmas, Posyandu and village health post (village midwife, cadres). **STBM has been an evidence of effective soft intervention to change behavior and leverage financing, however it also faces some obstacles:**

- **Human resources capacity and quality**, including availability of sanitarians in the Puskesmas, capacity building and corresponding operational cost and incentive to carry out their tasks.
- **Stagnant STBM intervention on Pillar 1 and 2 of the NatStrat Stunting**, although enacted in 2008, STBM intervention is still focused on eliminating open defecation and hand washing with soap, leaving pillar 3 to 5 of the NatStrat Stunting (proper handling of food and water, solid waste and waste water) behind.
- **Gap in addressing the poor**, the STBM adopts a non-subsidy principle which has left the poor behind. To close the gap and ensure universal access, soft intervention should be supported with a targeted subsidy. It calls for a modified in intervention approach and coordination in the implementation taking into account that mandate for soft and hard intervention lie on different ministries.
- **Low update and un-convergence data**, the STBM has developed a sound monitoring system, however updating data, particularly in non-intervened (non Pamsimas) villages is low. Moreover, sanitarians often collect sanitation data only, leaving data on water access. The data collected is also difficult to be merged with

nutrition data following different identification record (sanitation refers to head of family data while nutrition refers to name of stunted child or his/her mother or caretaker).

Recommendations

118. **Strengthen district institutions and planning convergence**, through WASH Working Group (Pokja AMPL) or Partnership Committee (Panitia Kemitraan) to converge and coordinate various financings and recording systems. This can be done by strengthening RAD and WASH working groups by providing appropriate incentives. Stunting related issues have to be the main consideration.
119. **Strengthen village ownership and responsibility in providing water supply services**. The institutional relation and demarcation of roles and responsibility and accountability line between BPS PAMS and villages must be clear to ensure monitoring of quality services. This shall also be a standard to evaluate village performance. In addition, BPS PAMS will be required to work closely with other cadres to ensure proper targeting for the service.
120. **Streamline national monitoring system**, Puskesmas has detailed data on village water and sanitation access. Access to sanitation has been recorded real-time through an online system and has been widely used, including by other sectors to profile district sanitation status. Corresponding promotion should be conducted for the water sector. Pamsimas has detailed data, however it is limited to its intervention locations and conducted by facilitators. While puskesmas has household data in all villages, it is essential to consider an integrated mechanism forwarding verified by-name-by-address data to ensure proper targeting.
121. **Extend soft intervention substances**, hygiene behavior is key to stunting prevention and reduction. Triggering and behavior change communication (BCC) promotion must be strengthened in term of quality and frequency to cover key behavior, not only on ODF and hand washing with soap. A joint intervention (i.e. between sanitarian and nutritionist) during posyandu and triggering should be considered.

5.4 Nutrition-sensitive Food Assistance Interventions

Strategic Relevance

122. **The delivery of food and, where possible, nutritious food is a critical core component within the PforR's focus on delivering services critical to stunting reduction and early years development**. Indeed, maintaining food security for poor households in particular has been a key priority of Indonesia's government since the late 1990s. In the wake of the Asian Financial Crisis, the government sought to reduce subsidies regressive subsidies for food, fuel and electricity, opting to redirect spending through a mix of targeted social safety net programs . In order to address soaring food price inflation that arose as a result, one of the

programs launched in 1998 was OPK (Operasi Khusus Pasar or a special market operation for rice) which mandated the sale of subsidized rice to poor families. The program allowed for poor and vulnerable households to purchase 10kg of low quality rice at prices far below market price (Rp. 1000 / kg).

123. **In the first phase of the program's operation, around 40 percent of Indonesia's population of 50 million households had purchased OPK rice.** However, leakage due to benefit sharing at the village level was high, which reduced the programs ability to increase food security and reduce malnutrition. This is a trend that has continued as the program has changed in name over the years to Raskin and most recently to Rastra. Like its predecessors, Rastra in its current form is an in-kind rice subsidy program that has targeted the poorest 25 percent of the population and provides 15 kilograms of medium quality rice per family per month. However, due to practices of 'bagi rata' (or the sharing out of the benefit level at the village level that has occurred since OPK), Rastra benefit level is diluted as more than half of the population reportedly receives Rastra rice. Recognizing these lingering implementation issues, the government launched an e-voucher program called BPNT (Bantuan Pangan Non-Tunai or non-cash food assistance) to replace Rastra.
124. **The 2017 roll-out of BPNT included 44 cities and involved 1.28 million poor families based on the Unified Database (BDT), which is a national social registry of poor and vulnerable households ranked as the bottom 40 percent of the population.** The objectives of BPNT are as follows:
- a. better target households in the bottom 25 percent
 - b. provide better access to nutritious food to targeted beneficiaries
 - c. give more choices and control for the beneficiaries on when, what type and how much they buy rice and other E-voucher eligible food commodities
 - d. encourage retail businesses at the grass-root level
 - e. give access to financial services to beneficiaries and
 - f. save government's budget from an improved efficiency of the business process
125. **While BPNT aims to expand to as many as 10 million families in 2018 from around 300 cities and districts, Rastra will continue to cover the remaining locations until BPNT is being rolled out.** Furthermore, Rastra is also modified to become Bansos Rastra, under which the beneficiaries are not required to pay the subsidized price to receive the 10kg of rice. Local authorities are still responsible for distribution of the Bulog rice from the 50,000 distribution points to the village level. When BPNT expands to 10 million families, Rastra/Bansos Rastra will come down from 14.5 million families to around 5 million families.
126. **The reform is significant because it addresses the cause of Rastra's leakage: over 50% of the total population reportedly purchased Rastra rice in 2016 and just 14 and 39 percent**

of program benefits are received by poor and vulnerable populations, respectively. Reform of Rastra to improve its allocative efficiency marks a watershed in the government's social protection strategy; in 2016 Rastra was the second largest social assistance program, accounting for IDR 22 trillion or over 30 percent of the governments total expenditure on social assistance in that year. If Rastra were to achieve its promise of 15 kg of medium quality rice sold well below market price to 15 million poor and vulnerable households, it would have a significant impact on household welfare, particularly in food insecure areas where market failure reduces the efficacy of local markets.

Technical Soundness

127. BPNT is relatively new and while its design promises significantly improved benefits in terms of food security and nutrition to the targeted population, two recent process evaluations have highlighted further improvements in both design and implementation are needed to deliver its objectives while it scales up to reach 10 million families over the course of 2018. The most recent business process review of BPNT reviewed BPNT's performance and formulated 16 recommendations to improve the operation of the program in lieu of its objectives. Of these 16, seven were considered critical to ensuring the program operates as expected:

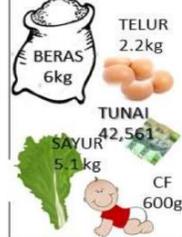
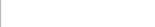
- a. Improve, strengthen, and endorse SOP, define key performance indicators
- b. Develop schedule and give more authority to local government regarding beneficiary household data to support better data verification process
- c. Apply appropriate incentive scheme for each stakeholder
- d. Improve capacity and capability of workforce
- e. Improve communication strategy and plan
- f. Deploy dedicated team for program monitoring
- g. Prepare alternative roll-out method for remote areas

128. MoSA responded to the results of these evaluations by agreeing to expand BPNT at a slower pace, reaching 10 million at the end of 2018 rather than at the start. Furthermore, MoSA has planned to set up a dedicated task force to oversee the programs implementation and has committed to begin working on accommodating the seven critical areas within the first quarter of 2018. In line with the governments general agenda to converge social assistance programs at the household level, BPNT roll out will prioritize beneficiaries that are already receiving PKH, Indonesia's flagship conditional cash transfer program.

129. BPNT is expected to have better targeting outcomes than Rastra as the benefit is restricted to those who have a KKS card (Prosperous Family card sent to the poorest 25 percent of households). By design, the benefit currently includes rice as well as eggs, which

can only be purchased by card holders in specified stores called E-Warong. Besides rice, BPNT’s procurement and sale of eggs would have an important impact on nutrition outcomes of targeted poor and vulnerable households. While the actual Rastra benefit was about 5kg per family per month on average, with qualities of purchased rice varying but often being of low quality, BPNT will allow for the targeted household to spend up to IDR 110,000 per month on either rice or eggs and allows the beneficiary choice of rice quality, where stocks are available. As shown in Figure 4, while future packages within BPNT may be considered by the Government, the basic Rastra package itself would provide a significant amount of the recommended daily protein intake of a household.

Figure 4 – The nutritional values of Rastra and BPNT with various package options

National		Rastra	BPNT rice + sugar	BPNT rice + eggs	Nutritious package 1	Nutritious package 2	Nutritious package 3
Subsidy paid by the government (IDR per month)		110,000	110,000	110,000	110,000	165,000	220,000
Ingredients							
% Recommended intake	Protein						
	Vit A						
	Iron						

Recommendations

130. **Given the significant impacts that would be due to the provision of rice and other foods under both BPNT and Rastra in its new form, BPNT / Rastra warrant inclusion in the PforR.** However, given the recent findings from the BPNT BPR, the government will need to address key issues in the current implementation of BPNT. The new form of Rastra will also require careful monitoring to ensure that Rastra beneficiaries receive the whole 10kg of rice.

131. Accordingly, the following recommendations are proposed as necessary steps that need to be taken by MoSA under the Program Action Plan:

- a. Establish a well-staffed Program Management Office (PMO) dedicated to the implementation of BPNT (ongoing). The PMO needs to be empowered by the BPNT Steering Committee for efficient administration of the program.
- b. Develop a robust Program Management Information System (PMIS) that supports the beneficiary management, e-Warung management, disbursement management, and

- inventory management related to e-Warung. The PMIS needs to be able to monitor both price and quantity of eligible food items that purchased by beneficiaries.
- c. Strengthen the program M&E mechanism and GRS to ensure the implementation quality.

6. Results Area 3: Strengthen Coordination of District Programs and Activities

Strategic Relevance

132. **Indonesia has a highly decentralized system of government under which most service delivery is the responsibility of local governments.** Most nutrition-specific and nutrition-sensitive interventions¹⁵ 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 to the village level from the central government, 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.
133. **Pillar 3 of the NatStrat Stunting focuses on strengthening regional and community level convergence, coordination and consolidation.** The Government's NatStrat Stunting proposes to encourage and support district governments to improve their management of nutrition interventions in five broad ways:
- a. **Introduce mechanisms to increase awareness and focus on stunting.** Districts will convene annual District Stunting Leadership Summits at which village leaders and senior district sub-district and sector heads will make commitments to increase the impact of nutrition interventions. In subsequent years, the annual stunting summit will be the venue for public dissemination of achievements against the targets set at the previous summit, and dissemination of good practices that have led to results. The key agency at the local level responsible for convening summits and facilitating commitments by village leaders will be the Secretary to the District head (Sekretaris Daerah, or SekDa).
 - b. **Multi-sectoral, multi-year perspective on planning and budgeting for stunting.** While the District Leadership Summits will generate awareness of how stunting is addressed, and stimulate the political commitment to take action, bureaucratic

¹⁵ Social protection programs (BPNT and PKH) and civil registration, including birth registration) are the responsibility of the Ministry of Social Affairs and Ministry of Home Affairs respectively.

- processes also need to change. Planning and budgeting at the district level is just as fragmented along sectoral lines as at the national level. To support a more joined up view of nutrition interventions, the local planning agency, Bappeda, should convene sector ministries to consider planned targets and budgets across interventions. Bappeda is also the organization best placed to undertake analysis of achievement at the end of each budget year, to inform the annual stunting summit.
- c. **Empower and enable the role of villages in service delivery.** Most of the key nutrition interventions are delivered at the level of villages, although inputs to these services may be provided at all levels including the national government. Within districts, villages are supported and managed by a department of villages and communities (BPMD). Synchronization of service delivery across villages, facilities and district departments is weak or non-existent. Moreover, villages have substantial funds which could be better mobilized to support nutrition interventions (see Results Area 4). There are various ways in which districts can support coordination with villages in delivery of nutrition interventions, including (i) creating the right enabling regulatory framework through district regulations on village authorities, and village planning priorities; (ii) providing capacity building for villages officials in planning and budgeting to support nutrition interventions; and (iii) requiring villages to report on aspects of service delivery within the village.
 - d. **More use of evidence in decision-making.** Planning and budgeting of stunting interventions at the local level should be based on evidence as to the rate of stunting and routine monitoring of the coverage of the nutrition interventions. In some cases, districts will have data collection systems in place, but the information may not be reliable, and in other cases systems may be lacking altogether. The NatStrat Stunting will support districts to improve the quality of information and to use it to analyze service gaps, determine the adequacy of available budgets, and develop responses to poor performance.
 - e. **Increased focus on geographic dispersal of service gaps and stunting incidence.** Districts will be encouraged to focus on the locations within the district where children are most vulnerable to become stunted and where service gaps are highest, or most intractable. Many districts still use a 'bagi rata' (equal shares) approach to allocating resources across sub-districts and villages, irrespective of the variation in the numbers of people being served, or variations in demand (for example some sub-districts or villages will have a greater number of stunted children or a higher proportion of poor residents).

134. **The changes in district practice that are needed to catalyze convergence are framed around eight convergence actions.**

- a. Implementation of district-level Stunting Summits to secure understanding and political commitment of village heads and district department heads.
 - b. Conduct of an initial diagnostic of the local drivers of stunting, and ongoing improvement or establishment of systems for monitoring interventions and stunting incidence by location.
 - c. Collection and publication of data on stunting surveillance and intervention coverage disaggregated to village or sub-district level.
 - d. Adoption of a multi-year stunting action plan including behavioral change communication strategy.
 - e. Issue of key regulations (Perbups/Perwalis) to enable mobilization of human development workers, and clarify village role in delivering nutrition interventions through regulations on village authorities and village priorities (as authorized in Law 6 of 2014 on Villages).
 - f. Recruitment and mobilization of HDW to support villages to support nutrition intervention and monitor convergence at the household level.
 - g. Implementation of an annual NatStrat Stunting performance review and analysis of changes in intervention coverage.
 - h. Provision of reports to central government to inform national monitoring and evaluation.
135. **Creating incentives for districts to change their existing systems will be crucial for effective implementation of the NatStrat Stunting at district level.** Performance measurement, capacity support and conditional transfers are the three main mechanisms the NatStrat Stunting will use to encourage and enable districts to implement these changes in the way they manage nutrition interventions, in particular by introducing new catalytic convergence actions that will improve the efficiency and effectiveness of existing intervention delivery and ensure interventions are better targeted to the priority villages and sub-districts where stunting is most prevalent.
136. **Holding districts accountable for their performance in implementing the NatStrat Stunting is the most powerful way to stimulate them to improve.** Evaluation of recent programs in Indonesia suggests districts are stimulated by knowing that their performance is being monitored, and that there are consequences for poor performance. District performance is currently measured in a variety of different ways, but none focus specifically on the implementation of individual programs like the NatStrat Stunting. The most effective performance incentives are at the level of individual programs, such as the performance scheme applied to the DAK for infrastructure under the World Bank's Local Governance and Decentralization Project. A performance assessment approach focused specifically on the

NatStrat Stunting will be more effective than generalized performance measurement of the district as a whole. A graduated approach to measuring performance in implementing the NatStrat Stunting will be adopted, with the focus initially on the catalytic district-level convergence actions that are aimed at producing more effective implementation of interventions. At present, data systems for measuring the coverage of service delivery are not sufficiently robust to form the basis for measuring year-on-year changes in performance. Accordingly, a key focus of the district-level convergence actions is to improve these systems, so that in subsequent years performance measurement can move progressively toward service delivery outputs (coverage) and ultimately to hold districts accountable for changes in stunting outcomes.

137. **Ministry of Home Affairs, through the DG for Regional Development (Bangda) will provide technical assistance support to districts to help them improve their performance.** A pool of technical assistance will be located at provincial level to provide support to districts in delivering the convergence actions, and improving intervention delivery. Expertise will be provided in areas of a) planning and budgeting, b) measurement of stunting, c) improving data systems for measurement of interventions, d) design and implementation of behavioral change communication programs.
138. **Conditional (specific purpose) transfers make up around 25 percent of the total transfers to district governments and are dominated by the special purpose transfer, Dana Alokasi Khusus (DAK) which has become an increasingly important funding source for district service delivery.** DAK is divided into several sector-specific transfers, classified as either fisik, for capital purposes, or non-fisik, for operational purposes.¹⁶ Seven types of DAK dominate the financing of the capital and non-wage recurrent inputs for nutrition interventions at local level: DAK fisik for water (air minum), sanitation (sanitasi) and DAK non-fisik for health services (BOK), child birth assistance (Jampersal), family planning (KB) and early childhood education (PAUD). The current government has moved to progressively convert service delivery inputs which had been allocated through line ministry budgets into DAK transfers. Examples are DAK Jampersal and DAK KB non-fisik, both of which were first implemented in 2016. Prior to that, these had been budget lines in the Ministry of Health budget. These reforms signal the commitment of the government to use intergovernmental fiscal transfers to drive service improvements at the local level, rather than delegated financing through line ministries.
139. **There are significant differences between DAK fisik and DAK non-fisik which are relevant to the role which both play in financing NatStrat Stunting interventions, translating incentives from central ministries to the local level, and creating opportunities for focused**

¹⁶ DAK Fisik is further sub-divided into three types; *regular*, *penugusan* and *afirmasi*. In key sectors like health, all three types of DAK may be allocated to a single sector, along with one or more types of DAK *non-fisik*. A single sector DAK maybe further divided into sub-sector DAK (for example, Regular Health DAK is divided into basic [facilities], referral [facilities], pharmacy and family planning. There are around 58 types of DAK in total.

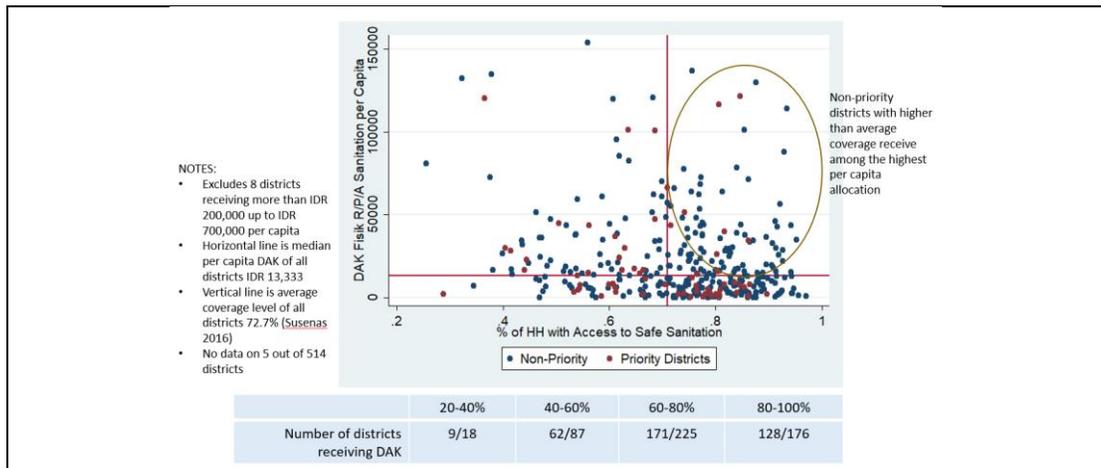
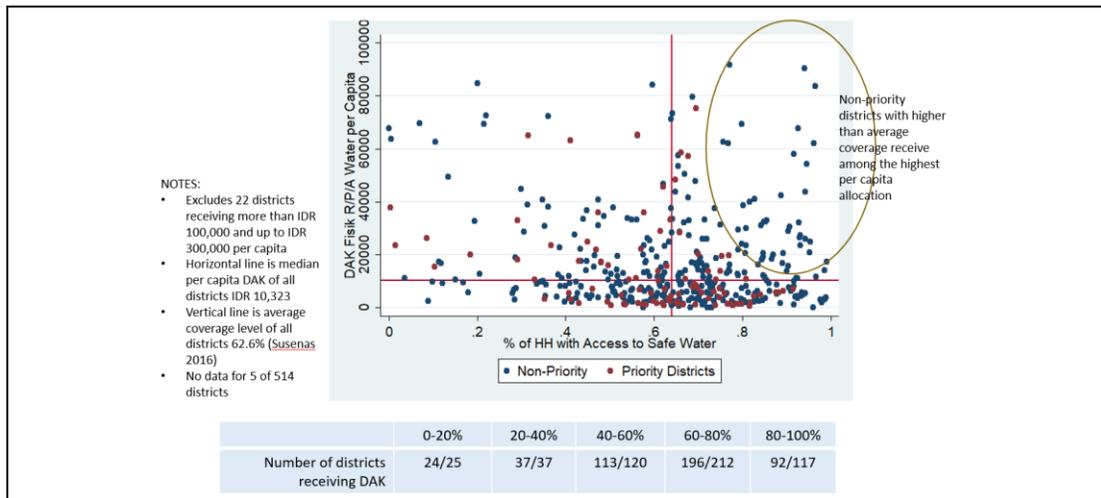
capacity building. First, the *allocation* of DAK fisik and DAK non-fisik across districts is decided in a different way. Whereas DAK non-fisik are allocated on the basis of a formula, DAK fisik are allocated through a bottom-up proposal process. Districts submit bids for the DAK projects they want to have financed, the proposals are evaluated by Bappenas, Ministry of Finance, Ministry of Home Affairs and the relevant line ministry, and from these approved projects the allocation for each district for each type of DAK is derived. Second, DAK fisik and non-fisik are *reported* in different ways. In the case of both types of DAK, there are parallel reporting systems to the relevant line ministry and the Ministry of Finance. In the case of DAK non-fisik the report to the Ministry of Finance is a paper based report showing absorption and utilization, and the case of DAK fisik, reports are uploaded to the Ministry of Finance OM-SPAN system (Online Monitoring of SPAN).

140. **DAK transfers are a potentially powerful lever for improved service delivery, but several aspects of design limit their effectiveness:**

- a. **Sectoral fragmentation.** DAK have traditionally been focused on single sectors such as health, education, water, roads and on capital investments. There is limited opportunity to consider how different DAK fisik and non-fisik could together contribute to the achievement of a single national priority. The emphasis on regulating upstream aspects of DAK via a detailed menu of allowable expenditures further weakens the potential for a more strategic impact if the focus were more on improvements to service delivery or increasing the supply-side readiness of facilities (to deliver services). The introduction of the new DAK Penugusan (“assignment” DAK) under the management of Bappenas provides a potential channel to program DAK in a more strategic way, by aligning it to identified investments that are required to implement specified national programs.
- b. **Siloing of capital and recurrent inputs.** The primary categorization of DAK is into capital (DAK fisik) and recurrent (DAK non-fisik) prohibits a joined-up approach to considering both capital and recurrent needs to implement a program. For example, effective community level water and sanitation services obviously depend on capital infrastructure investments, but international experience shows that the “soft” inputs in the form of behavioral change interventions are even more important. For the purposes of the NatStrat Stunting, the menu of DAK Penugusan water and sanitation will be opened up to include behavioural change activities.
- c. **Weak link to needs.** DAK non-fisik are allocated based on a formula. While formulae are broadly related to needs, there is considerable room for improvement. For example, DAK BOP Early Childhood allocates a per child amount for each student enrolled in early childhood education. There is no adjustment to reflect the higher costs of service delivery in remote locations. DAK fisik is allocated through a relatively opaque process of evaluating the proposals which districts submit. District proposals are assumed to accurately capture their needs, but these are not validated by external

verification against objective indicators such as the susenas survey, nor is the relative fiscal gap in meeting these needs assessed. For example, the allocation of DAK fisik in the water and sanitation sector should reflect a full assessment of needs, including the cost of service provision in that location, the coverage gaps and available financing from different sources such as the Pamsimas vertical national program. Analysis of how the allocation of Water and Sanitation DAK relates to the level of access in a district suggests that DAK allocation is not correlated with need. As shown in Figure 3 many districts with higher than average access receive among the highest per capita amount of DAK for water and sanitation, while many districts with the lowest coverage receive the lowest per capita amount of DAK. Districts with higher access to water are less likely to receive a DAK at all, but in the case of DAK for sanitation, the lower a district's access to sanitation the *less* likely it is to receive DAK for sanitation.

Figure 3: Per capita allocation of DAK for water and sanitation



- d. **Limited focus on results.** The focus of conditions is on restricting the types of inputs that DAK can be used to purchase, which limits the focus on results. The proposal-based approach to DAK Fisik did increase the focus on results for some DAK, by requiring districts to develop a plan to spend the DAK before the amount of allocation was decided. However, it may also result in greater uncertainty about how much DAK a district will receive from year to year. No DAK currently incorporates any type of performance incentive which might give districts reason to focus on how investments are contributing to service delivery. Instead the focus of accountability is almost entirely on effective absorption.
- e. **Weak and fragmented reporting arrangements.** The limited focus on results also reflects weaknesses in reporting, including a heavy emphasis on compliance rather than performance. Line ministries have a greater interest in the actual impact of the DAK, but have difficulty making districts comply with their reporting arrangements. The Ministry of Health, for example, achieves less than a 10 percent compliance rate of DAK fisik reporting through its Monev (monitoring and evaluation) system. The key reason is that line ministries do not control the release of DAK funds. Districts are also reporting to the Ministry of Finance, which achieves a much higher compliance rate by withholding the first tranche of DAK each year until the previous year report has been received. MoF reporting is mainly focused on compliance—ensuring that DAK funds are fully expended and used for their intended purpose and that the Ministry can account to Parliament for the outputs that were purchased. Reporting of DAK fisik has improved recently with the introduction of a requirement to report both expenditure and outputs through an online system, OM-SPAN, which allows aggregate reports of expenditure and outputs to be generated at the national level. However, OM-SPAN reporting is so far limited to capturing the number and type of physical outputs.
- f. **Unpredictability.** At the level of an individual district, DAK allocations for a single sector typically fluctuate significantly from year to year. Not only is the amount unpredictable but districts do not find out how much they will receive until after the national budget is adopted and publicized, less than a month before the start of the local government fiscal year. Because of this uncertainty, in practice DAK is managed separately from the district planning and budgeting process and the potential to use DAK and local resources to achieve better service delivery is lost. Together, these shortcomings undermine the scope to use the different sector DAK in a joined-up way to drive improvements in the delivery of interventions at the local level.

141. **To support more effective use of DAK as a lever for improved delivery of interventions, the program will introduce changes to the DAK arrangements from 2019, under the umbrella of a Programmatic DAK.** Three changes to the DAK are proposed:

- a. **Stronger link to national priorities.** A program guideline for the implementation of the NatStrat Stunting at the district level will be issued, to provide clear guidance to districts on the changes to current practice that are needed to catalyze change.
 - b. **Address service gaps.** Adjustments to the technical guidelines to ensure that DAK can be used to finance all the key inputs needed to deliver the interventions and increase the focus on nutrition in planning DAK expenditure.
 - c. **Address allocation gaps.** Some key DAK, including Water and Sanitation DAK, are not available to a number of the priority districts. DAK will be reformed to ensure that these key DAK are available to all districts in the NatStrat Stunting program, and that where appropriate other DAK are topped up to ensure there is sufficient funding to cover all the needed interventions.
 - d. **Integrate recurrent and capital expenditures.** This will provide more flexibility to combine operational and capital expenditures to address the full range of interventions.
 - e. **Finance key non-sector inputs.** DAK financing should be available for a defined, time-bound period of the NatStrat Stunting program, to finance the delivery of convergence actions at the local level, targeting activities like leadership, cross-sector coordination, diagnosing service gaps and establishing or improving district level monitoring systems. A key input to be financed from DAK will be the engagement of village level Human Development workers, who are critical for the delivery of results under Results Area 3.
142. **Effective use of DAK by local governments is not only constrained by unpredictable allocations from central government, but also by weak local planning and budgeting systems.** Identification of needs through a bottom-up participatory process (the musrenbang) is not always balanced with data-driven identification of the relative needs of different villages (desa) and sub-districts (kecamatan) within the district. DAK offers a potential entry point for central government to provide guidance and support to local governments in implementing the programs that DAK finances, but this potential has been variably exploited until now. A key constraint to effective provision of guidance and support is the limited number of central government staff relative to the more than 500 local governments in Indonesia. The program will introduce a pool of technical assistance based at the provincial level to address weaknesses in local government capacity to diagnose drivers of stunting and translate stunting reduction targets into plans, budgetary allocations and improved implementation of programs.
143. **Annual adjustment of the Programmatic DAK to reflect performance during the previous year will reinforce the incentives of the performance assessment.**

144.

145. **The design of the performance assessment of district implementation of convergence and the way this is linked to the Programmatic DAK will be key to creating an effective incentive environment.** International experience with the use of performance linked funding arrangements suggests the following are critical elements:

- a. **Clarity on performance expectations.** Use of Guidelines for districts to implement the NatStrat Stunting, specifying key results expected in terms of the implementation of convergence actions, will provide this clarity.
- b. **Reward tailored to incentives.** Evaluation of other performance-linked transfers used in Indonesia suggests a negative reward may be more effective than a positive reward. Instead of providing additional funds for better performers, it is proposed to reduce funding in line with the scores on the performance assessment. The performance assessment will be on the basis of a self-assessment by districts, validated by Bappenas, and a selection of the validated performance reports will be subject to verification by the World Bank before disbursement of program funds.
- c. **Clear signaling of performance in the amount of the DAK.** Districts need to understand exactly how their performance is reflected in the calculation of their P-DAK allocation. Early notification of the maximum possible amount of DAK will provide the baseline against which subsequent allocations calibrated to performance will clearly signal how the performance score has affected the actual allocation. **Providing tailored capacity support to help districts improve their performance score.** International experience suggests that subnational governments are most likely to respond to performance incentives if they have access to capacity building support to help guide them toward improving their performance, and thus their score in the annual assessment.

146. **The performance elements of the P-DAK will be linked to the convergence activities which districts are required to undertake,** to provide an evidence base for program management, enhance the joined-up planning and budgeting of other DAK and local budget for interventions, and strengthen results-informed resource allocation. Proposed performance criteria are set out in Box 2. In the third year, additional performance criteria will be added to reflect performance at the outcome level – in terms of how districts implement interventions.

Box 2: Performance approach built into the programmatic DAK for stunting reduction

Indicative criteria for measuring performance will start with key processes and systems that are critical for effective management of the NatStrat Stunting:

- 1) **District Stunting Summits**—implementation of district-level summits to secure understanding and political commitment of village heads and district department heads.
- 2) **Stunting Diagnostic**—conduct of an initial diagnostic of the local drivers of stunting and ongoing.
- 3) **Data Systems Improvement**—implement progressive improvement to systems for monitoring intervention coverage to increase the accuracy and consistency of measurements both within and across districts, incorporate data quality assurance mechanisms, and ensure that data is readily available to program managers, not just evaluators.
- 4) **Data Publication**—collection and publication of data on stunting surveillance and intervention coverage disaggregated to village or sub-district level.
- 5) **Multi-Year Action Plan**—adoption of a multi-year stunting action plan, including local BCC strategy (see DLI 8).
- 6) **Village Enabling Regulations**—issue key regulations (Perbups/Perwalis) to clarify village role in delivering nutrition interventions through regulations on village authorities and village priorities (as authorized in Law 6 of 2014 on Villages).
- 7) **HDW Mobilization**—recruitment and mobilization of HDW to support villages to implement nutrition interventions and monitor convergence on 1,000 day households.
- 8) **Annual Performance Review**—Implementation of an annual NatStrat Stunting performance review and analysis of changes in intervention coverage.
- 9) **Consolidated Reports**—provision of reports to central government to inform national monitoring and evaluation.

For each of the eight criteria, a small set of indicators will be developed which reflects the characteristics necessary for the process or system to be functional. For example, for the Stunting Summit, indicators could include (i) more than 50% of village heads attending, (ii) stunting data and intervention coverage data, disaggregated by location, presented to the Summit, (iii) 80% of village heads attending enter into documented public commitments to achieve intervention coverage targets (for village level services). The indicators would be scored using a simple point system adding up to a total maximum score for full achievement. Indicators will be designed to facilitate validation through a simple desk review approach, with districts providing evidence of achievement.

Performance assessments will be most effective if undertaken during the implementation year, and translated into the second year allocation. A suggested approach is to conduct the annual performance assessment in September, measuring indicators that would expect to have been completed before the end of the first semester. In the following year, the four criteria from the second semester of the previous year will be measured, along with the four criteria for the first half of the current year. The scheme will need to be adapted to accommodate adding new districts as the scheme is expanded.

2019 (160 priority districts)	Performance is assessed in September 2019 based on criteria 1) – 4) completed during the first half of 2019. Allocation of P-DAK in 2020 is based on 2019 performance.
2020 (160 priority districts)	Performance is assessed in September 2020 based on criteria 5) – 8) completed during the second half of 2019 and criteria 1) – 4) completed during the first half of 2020. Allocation of P-DAK in 2021 is based on 2020 performance.

2020 (230 additional priority districts added to the NatStrat Stunting in 2020)	Performance is assessed in September 2020 based on criteria 1) – 4) completed during the first half of 2020. Allocation of P-DAK in 2021 is based on 2020 performance. .
2021 (390 priority districts)	Performance is assessed in September 2021 based on criteria 5) – 7) completed during the second half of 2020 and criteria 1) – 4) completed during the first half of 2021. Allocation of P-DAK in 2022 is based on 2021 performance.
2021 (124 additional priority districts added in 2021)	Performance is assessed in September 2021 based on criteria 1) – 4) completed during the first half of 2021. Allocation of P-DAK in 2022 is based on 2021 performance.

147. **The proposed changes to DAK address several of the weaknesses in the existing DAK arrangements, which together undermine the potential for DAK to translate national priorities to the local level.** The changes strengthen the potential impact of DAK in several ways:

- a. **Link to national priorities.** Provision of a national guideline, and adjustments to existing DAK menu and planning processes will strengthen the framework for aligning these important existing sources of funding to the program as a whole, and not just the individual interventions, and ensure that all needed inputs are provided for.
- b. **Predictability.** Provision of an indicative ceiling for the P-DAK earlier in the fiscal year.
- c. **Integration of capital and recurrent inputs.** The adjustments to DAK penugusan will allow both capital and non-capital aspects of water and sanitation programs to be financed from a single DAK.

148. **The NatStrat Stunting will promote local innovation and learning to improve services in an iterative way.** Top-down and detailed specification of “cookie-cutter” programs rolled out in a uniform way was useful when the challenges of service delivery were primarily related to inadequate infrastructure, and therefore amenable to relatively uniform across the country. The remaining challenges to service improvement are more likely to be “high hanging fruit”, including increasing access of vulnerable and marginalized groups, overcoming demand-side resistance, and breaking down managerial risk aversion. These problems are more likely to be solved locally, and so the approach should be one of supporting districts to identify challenges and develop local solutions.

Recommendations

149. **In order to support effective convergence, planning for intervention deliver at the district level needs to adopt a more location specific approach.** Districts need to plan and budget nutrition interventions by location, identifying those villages which are vulnerable to stunting and those where intervention coverage is low. The focus of the multi-sectoral planning and budgeting should be prioritizing intervention coverage in line with need at the

sub-district or village level. Provision of adequate technical assistance advice to districts to help them with this new way of doing business will be vital.

150. **The effectiveness of the P-DAK and technical assistance to districts can be reinforced in four ways:**

- a. **Secure the place of the P-DAK in national plans.** Including the P-DAK in the 2019 annual plan (RKP) and subsequently in the five-year plan (RPJMN) due to be launched in 2019, will provide a sound footing for provision of indicative allocations of DAK early in the budget process.
- b. **Improve the quality of reporting systems.** DAK non-fisik is currently reported manually, through paper reports. Districts provide reports of utilization, but the categories of activities are not standardized. The utility of reporting information could be increased by (i) agreeing standard activities against which districts should report and (ii) incorporating the non-fisik aspects of the P-DAK into the OM-SPAN reporting systems.
- c. **Establishing a technical secretariat in Bappenas to manage the performance assessment.** Bappenas has not been responsible for the management of transfers previously. It will need institutional capacity to develop and promulgate technical guidelines, and manage performance assessments.
- d. **Develop an operational program for the provincial TA pool.** The effectiveness of technical assistance will likely depend on the availability of a “toolkit” to help districts implement convergence actions, for example including methodology for determining the variance in stunting incidence at the village level, preparing action plans that are specific as to location and intervention, and assessing the effectiveness of district level data systems for measuring intervention coverage. The focus of TA should be on supporting districts to adjust existing systems, rather than adopt a projectized approach of creating new parallel systems.

7. Results Area 4: Prioritize convergence of village service delivery

Strategic Relevance

151. **Villages are critical to both the delivery and convergence of the priority nutrition-specific and nutrition-sensitive interventions for three main reasons:**

- a. **Village-level institutions are involved in frontline delivery of key nutrition-specific and nutrition-sensitive interventions to beneficiaries**—village institutions involved in the delivery of nutrition interventions include posyandu (almost all nutrition-specific

- interventions in collaboration with sub-district Puskesmas including community-based growth promotion as well as family planning interventions), PAUD (nutrition-sensitive parent counselling and early learning services more generally), and BP SPAM and similar community organizations (construction, maintenance and management of water and sanitation facilities). Village governments are also involved in the oversight of the government's national social assistance programs (PKH and BPNT).
- b. **Villages have significant financial resources available in the form of Dana Desa and other revenues (e.g., ADD, PAD) that they can use for frontline delivery of priority nutrition services**—Under Law 6/2014 on Villages, fiscal transfers to villages are substantially increased compared with previous years. Transfers are financed partly from the national budget through an envelope (Village Fund, Dana Desa, DD) equivalent to ten percent of transfers to regions, and partly by districts redirecting 10 percent of their untied revenue sources. On average villages now receive about Rp. 1.4 billion (\$110,000) each per year, although the exact amount varies depending on the characteristics of the village (e.g., population) as well as the size of district revenues, a portion of which they are required to pass on to villages.
 - c. **Convergence of priority interventions at the village level is critical to addressing stunting**—an analysis of stunting variation across regions, districts and villages found that there is much more variation within villages than there is between villages, districts and regions.¹⁷ This suggests that a fundamental challenge to accelerating stunting reduction is identifying and delivering the priority interventions to all 1,000-day households within a village. Although it is important to identify the poor, stunting remains very high amongst all income quintiles and therefore universal “whole-of-village” approaches are particularly important.

152. **The Government's NatStrat Stunting Implementation Framework proposes to deploy Human Development Workers (HDW) to support convergence of the priority interventions at the village-level.** Building on the government's Generasi project for increasing access to basic health and education services in the villages, the government proposes to deploy at least one HDW in each village in the priority districts. HDW are members of the community and are generally senior posyandu cadre, ECED teachers or women's leaders. The role of HDW is to work across sectors to increase and improve village delivery, monitoring and uptake of key nutrition-specific and nutrition-sensitive interventions in the health, ECED, social protection, and water and sanitation sectors. The model, which the government is implementing in 31 of the 100 priority districts in 2018, focuses the HDW on three core tasks:

¹⁷ Emmanuel Skoufias and Katja Vinha, “The Case for Convergence in the Effort to Eradicate Stunting in Indonesia”, Internal memo, January 2018.

- a. **Social Mapping and Stunting Diagnostic**—the HDW will support villages to conduct a social mapping of all 1,000-day households in their assigned village, and identify their current access to and use of the NatStrat Stunting’s priority interventions.
- b. **Community Growth Promotion**—in collaboration with Puskesmas midwives and Posyandu, the HDW will support all Posyandu to implement height-based community growth promotion and visualization activities using length mats, and ensure this information is available to all village-level institutions that deliver nutrition-sensitive interventions (e.g., PAUD, BP SPAM and PKH and BPNT facilitators).
- c. **Village Convergence Scorecard**—building on the Generasi experience of tracking 12 performance indicators monthly, HDW will support villages to monitor delivery of the priority interventions to all 1,000-day households in the village, and to report on progress in quarterly community meetings and overall performance in semester-based village reports. Table XX below summarizes how MoV has adapted the Generasi performance monitoring system to implement the Village Convergence Scorecard. It is piloting the scorecard in 31 of the 100 priority districts in 2018 to track 14 indicators relating to NatStrat Stunting’s priority interventions.

Table XX: Village Convergence Scorecard

Generasi Scorecard		2018 Village Convergence Scorecard	
Sector	Intervention	Sector	Intervention
Health	1. Four prenatal care visits for pregnant women	Health	1. Four prenatal care visits for pregnant women
	2. Iron folic acid supplementation		2. Iron folic acid supplementation during pregnancy
	3. Delivery assisted by a trained professional		3. Monthly growth monitoring and promotion (including height using length mats)
	4. Three postnatal care visits		4. Six-monthly height monitoring by health official
	5. Complete childhood immunizations		5. Three postnatal care visits
	6. Monthly growth monitoring and promotion (infant)		6. Complete childhood immunizations
	7. Monthly growth monitoring and promotion (under 3)	Nutrition	7. Nutrition counselling class
	8. Vitamin A supplementation		8. Integrated home visits for stunted/at risk children
Nutrition	9. Nutrition counselling (pregnant women)	WASH	9. Access and use of clean water facilities
	10. Nutrition counselling (parents)		10. Access and use of sanitation facilities
Education	11. Primary enrollment	Social Protection	11. Birth certificate for 0-2-year-olds
	12. Junior Secondary enrollment		12. Household health insurance card (JKN, BPJS or local equiv.)
		ECED	13. ECED parenting class (0-2-year olds)
			14. ECED attendance (3-6 years)

Technical Soundness

153. **The Technical Assessment at the village level consisted of two parts: first, it considered the mandate, capacity and incentives for villages to support the convergence of NatStrat Stunting priority nutrition interventions at the village-level; and second, it considered whether the HDW convergence instrument was “fit for the purpose” of supporting villages address the gaps identified in the first part.** The assessment considered whether village officials and community leaders were aware of stunting and understood the role of village systems, whether they had the capacity to use the systems to achieve the NatStrat Stunting’s objectives, and whether they had the incentives to effectively use the systems for the purposes of stunting reduction. It then considered whether the proposed HDW convergence instrument was suitable for addressing the identified weaknesses. The assessment involved reviewing laws and regulations, consultations with national and district government officials as well as field visits to districts and villages.

National Development Priorities in Village Planning Budgeting, Implementation, and Reporting

154. **Village Mandates.** Although the Village Law emphasizes that villages (specifically Village Heads) have the final decision on village development plans (RKPDes) and budgets (APBDes), villages are required to take into consideration national and district development priorities in the preparation of their annual plans and budgets. The Village Law (UU 6/2014) does not *require* villages to adopt national priorities, but it does state that, “village spending is to be prioritized for addressing development needs as agreed in Village Discussions and that are appropriate with District, Provincial and National Government priorities.”¹⁸ The Village Law’s implementing regulations also emphasize that villages reference district priorities in their village development plans.¹⁹

155. **The mandate for villages to include nutrition interventions in their village plans and budgets is reinforced in MoV’s annual ministerial regulation on priority uses of Dana Desa.** For example, the regulation for 2018 includes several nutrition-specific and nutrition-sensitive activities were stated in the regulation:²⁰

- a. Improved basic social services access and quality in “village development” category (*bidang*), which includes infrastructure and facilities relating to village-scale clean water, environmental sanitation, toilet, village ambulances, health village post (posyandu, polindes), and ECED facilities, etc.

¹⁸ Article 74, Clause (1), Law 6/2014 on Villages.

¹⁹ Pasal 2 (1) and Pasal 7 (2) in Permendagri 114 of 2014; Pasal 28 (1) Permendes 114 of 2014.

²⁰ MoV Regulation No. 19 of 2017 on Priority of Use of Village Funds.

- b. Improved basic social services access and quality in “community empowerment”, including provision of clean water, environmental health services, promotion of clean and healthy living, salary for health cadres of growth monitoring and provision of healthy food, promotion of rights and protection of children, assistance of pregnant women, cadre training, ECED teachers, etc.
156. **There is, however, no clear requirement for villages to report spending on national priorities, such as priority stunting interventions, nor for villages to report on the delivery of these interventions or services.** Villages are required to submit to three main types of reports to districts. MoHA Regulation 113/2014 on Village Financial Management requires villages to submit a first semester and annual financial realization report for the entire village budget. MoHA 114/2014 on Village Development also requires Village Heads submit an annual activity report. These reports are usually required before districts will endorse subsequent year budgets and disburse tranches. In general, these reports do not include any requirement for villages to report on spending and activities on national and/or district priorities. In addition, the Ministry of Finance requires that villages also submit a specific report on Dana Desa, which is fiscal transfer from the central government but that is passed through districts to villages. MoF Regulation No 50/2017 requires villages to report on the specific use of the Dana Desa, including the list of activities by type, the implementing institutions at the village-level, the funding source, budget realization per activity, and photos of implementation progress.
157. **Village spending on nutrition intervention occur under two main village spending categories.** As required by the Village Law, village spending is grouped into four main categories: village administration, village development, community empowerment and community affairs. Village spending on water and sanitation infrastructure as well as on posyandu and PAUD building and facilities is categorized under “village development”; whereas, village spending on operational costs associated with the delivery of nutrition interventions are categorized under “community empowerment”.
158. **Village Capacity.** Village governments have experience in executing basic planning and budgeting processes, however, their knowledge of national priorities (including stunting) is low and their capacity to identify, plan and implement nutrition-related interventions is generally low. The quality of village planning and budgeting is highly variable due to
159. **Limited knowledge of national priorities, target groups and appropriate interventions constraints mobilization of villages to support stunting reduction efforts.** Generally, villages are receptive to include stunting reduction interventions in their plans and budgets once they are aware of the problem and have a basic technical understanding of what to do about it. For example, the village government of Sukabungah village (Cianjur District, West Java) received training and guidance twice in 2017 from district departments of health, finance and agriculture on nutrition. This prompted the Village Head and Secretary to enroll in stunting-reduction workshops outside of the village using their own Dana Desa. Because of this effort

to seek knowledge themselves, Sukabungah village has allocated 25% of its 2018 village budget to stunting interventions that it has decided are most relevant to village needs.

160. **The experience of integrating the Generasi Project into village plans and budgets indicates that clear district regulations (Perbups) are critical to providing information and authorization for villages to include national priorities, such as stunting, in their annual budgets.** For example, in Lombok Tengah, Bupati Regulation No 34/2017 on Guidance for Village Budgets specified that villages allocate up to 30% for village administration and 70% for village development and community empowerment activities. It also required villages to spend at least 35% (of the 70%) on community empowerment. This amounted to about 25% of the village, which is far higher than the average of about 5-6%, and triggered villages to seek out opportunities for increasing spending health and education activities including those relating to nutrition such as posyandu supplementary feeding, cadre incentives as well as toilet facilities. This is consistent with the findings from the districts visited as part of the Technical Assessment (see Box XX).

Box XX: Detailed Bupati Regulations as Guidance for Village Planning and Budgeting in Gorontalo and Maluku Tengah

In Gorontalo, Perbup No.2/2017 on *Jasa Global dan Distribusi* was implemented to support clean water development, which involved relevant technical sectors as well as Bappeda and Dinas BPMD. There is also a 2016 PerBup on using 10% of Dana Desa funding for health activities, including medical treatment for deworming and nutritional health posts.

In Maluku Tengah District, a number of supportive Bupati Regulations and Instructions were enacted:

1. Sanitation programs through Bupati Instructions for STBM on ODF.
2. Local Health Insurance/Jamkesda through APBD.
3. PerBup on 10% ADD allocation to support BPJS for non-users in 2018.
4. Perbup for village budgets to conduct Proper House and latrine Rehabilitation, Solar Cell Energy, PAUD Holistic Integrative Program, including incentive for PAUD teachers as well as Educational Equipment Tools.

161. **Villages understanding of malnutrition as a weight issue is a significant constraint on empowering villages to prioritize nutrition interventions.** The field visits conducted across nine districts²¹ consistently found that village official, village health cadres as well as ordinary citizens (as well as many sub-district health officials) have a rudimentary or inaccurate understanding of stunting. This is partly because height measurements that are collected from villages but analyzed at the sub-district level are not adequately explained at the village level (see Box XX below). It is also because for the most part community-based growth promotion activities have predominantly focused on weight. Indeed, it was not uncommon

²¹ In the districts of Nganjuk, Dombu, Kaimantan Barat, Sulawesi Barat, Lombok Barat, Cianjur, Maluku Tengah, Gorontalo and Lombok Tengah.

that children labelled as healthy by the village posyandu cadres were identified as stunted if measured for height using length mats or anthropometric tools.

162. **However, even if villages have data on children’s height, they often don’t know the standards for stunting nor what actions are required to prevent growth faltering.** For example, in Polewali Mandar District, Sulawesi Barat, village health cadres had complete measurement information on birth weights, height, weight, age, along with names and addresses of children in the village. However, due to a lack of quality and quantity of human resources, decision makers and cadres did not know how to utilize that information in planning, budgeting, and implementation. High cadre turnover due to non- competitive wages exacerbates this problem for villages located close to cities.²²

Box X: Maluku Tengah District Cadres’ Limited Understanding of Stunting

In Maluku Tengah District, Maluku, health cadres still have limited knowledge on height-measurement and why it is required. Cadres recorded height measurement without being able to know whether a child is categorized as stunting or not. Measurement results from posyandus are later calculated by Puskesmas staff using anthropometric software or WHO standard tables. Cadres do not get feedback from Puskesmas staff. Some false beliefs still occur among the cadres about child shortness being hereditary.

163. **Village capacity to monitor and report on nutrition interventions is generally, and most reporting disproportionately focuses on financial information.** The financial reports receive the bulk of attention at both the village and district (and sub-district level). This is because disbursement is tied to their preparation and submission. Village governments (especially villages with much lower capacity) are typically not accustomed to collecting, consolidating and reporting data on outputs or other indicators of service delivery. This also means that villages have less incentive to monitor activities and collect this information. This presents a considerable challenge for implementing monthly convergence scorecards without capacity support (discussed further below).
164. **Incentives.** The inclusion of national priorities in district Perbups on village development priorities and their enforcement are critical to incentivizing villages to spend Dana Desa on national priorities and to trigger villages to identify priority beneficiaries, needs and activities.
165. **The Village Law, and its implementing regulations, establish a mechanism for district governments to enforce the alignment of village and districts plans.** The Village Law requires districts to review and endorse annual village budgets before village approve them. In those districts where this mechanism was used effectively (see Box XX below), village

²² World Bank BTOR Cianjur, West Java, February 2018.

spending on health and education activities was much higher. The Technical Assessment concluded that this was the most effective way to systematically align village spending with the NatStrat Stunting interventions. The Assessment also found that these minimum requirements empowered those village-level groups that had knowledge about nutrition interventions, which is most women and parents with young children. The requirement meant Village Heads reached out to these groups for activity proposal and/or were more open to their inclusion plans and budgets. It also meant that villages reached out more to district sector departments for technical assistance.

Box 3: Nganjuk District Enabled HDWs as Agents of Change

In Nganjuk District, East Java, Generasi facilitators advocated for the districts to create regulations minimum APBDes allocations requirements (30%) for health and education activities. Well-timed training of facilitators at the village level also created “bottom-up pressure” for villages to allocate budget for health and education. Trainees were given template proposals of Dana Desa and its priorities, trained in conducting social mapping, assigned to present findings in village forums (Musdus), and supported to formulate draft village plans and budgets for the following year. Nganjuk district also implemented a strict village budget verification process in which sub-districts returned village budgets for review if they did not comply with minimum allocation amounts for health and education. This combination of a clear mandate, capacity support and enforcement of regulation ensured consistency with district priorities. Village communities and workers mobilized to push for increases in health and education services to achieve the 30% minimum budget allocation target, with some villages allocating up to 50%.

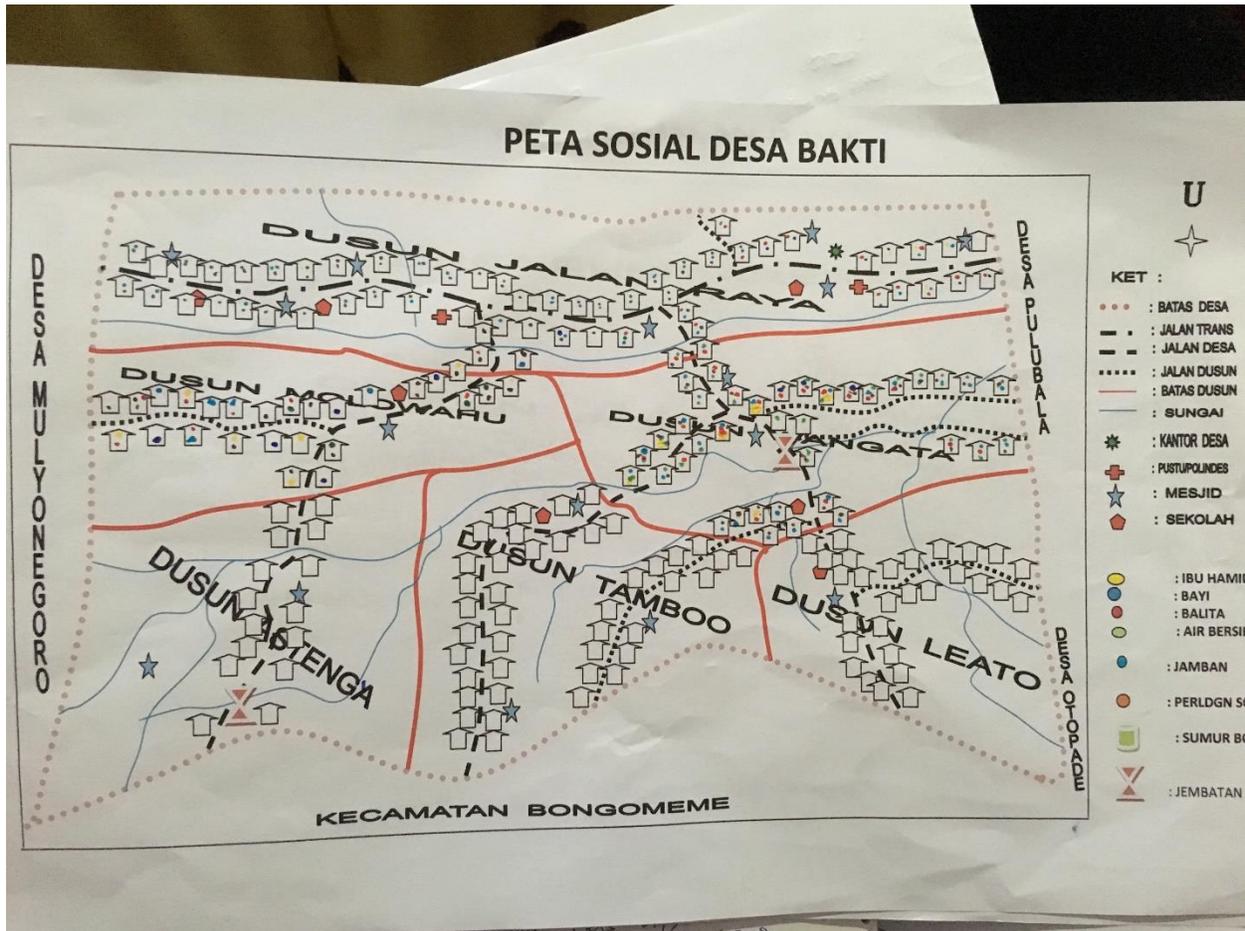
166. **The assessment found that villages have little incentive to systematically monitor activity implementation and report on outputs and other services indicators.** As noted above, this is largely because village reporting focuses on financial realization information. Because of the scrutiny of village accounts and financial reports, villages have a significant incentive to invest in extra personnel to manage financial accounts and prepare financial reports. Indeed, it is not uncommon for village governments to hire former PNPM financial management consultants or cadres for this purpose. It is, however, rare for villages to invest resources and effort in tracking service delivery and outputs, and consolidating this into reports. This creates a “chicken-and-egg”: without demand for non-financial information backed by a serious threat (such as delayed disbursement) villages won’t invest in this capacity, but without the capacity it is difficult expect them to provide such reports.

Human Development Workers (HDW)

167. **The Technical Assessment determined that HDWs as a convergence instrument was “fit for the purpose” in supporting village planning and budgeting, village delivery of priority interventions and village monitoring and reporting.** HDWs will address the lack of basic

understanding of stunting and its drivers in village planning,²³ support villages do conduct systematic social mapping to identify 1,000-day households and their nutrition needs as part of the annual village planning processes (see Maps 1 & 2 below), and improve monitoring and reporting of intervention delivery convergence.

Map 1: 1,000-day Household Map – Desa Bakti, Gorontalo



168. **The assessment found that HDW introduction of length mats packages (including cue cards and pocket books) were an excellent tool for raising awareness of stunting in the village.** Although the effectiveness of the length mats and related materials require further monitoring, the length mats generated a lot of interest about stunting, its causes and what can be done. The role of HDW in introducing the length mats to posyandu cadres will also help to ensure that the mats are used effectively. Specifically, they will help to ensure the length mats are accompanied with appropriate explanation of each child’s situation, advice on where to get further assistance, as well as help avoid stigmatization. The HDW, who have a role in supporting village planning processes, can also help to ensure that the height data is

²³ Field assessments found that although village regulations and guidelines include many activities relevant to stunting reduction (including both nutrition-specific intervention such as posyandu and nutrition-sensitive such as water and sanitation and PAUD), there was little information on how they contributed to stunting and malnutrition.

used to inform village planning and budgeting as well as other village service providers such as PAUD and community water groups.

169. **The selection and recognition of HDW is critical to ensure they have the legitimacy and authority to support villages in relation to nutrition interventions.** The HDW selection process involves three parts: community selection, Village Head approval, and authorization under formal contracts with the Camat (Sub-district Head). This approach was effective in ensuring the right community members were selected (i.e. generally posyandu cadre, Generasi, ECED as well as village development cadres) and that their role in village planning and budgeting processes legitimate. Although some districts suggested that villages could directly contract HDW, the assessment concluded that it was critical that Camat contract HDW and assess their performance to undertake key tasks relating to aligning village spending and the introduction of new information and tools.
170. **The assessment identified the need to improve the training provided to HDW as well as the quality of the materials.** The current materials are largely adapted from Generasi materials, which focused on a narrower set of health and education interventions, not all of which related to the NatStrat Stunting priority interventions. The materials also need to put more emphasize on multi-sectoral coordination and make more effort to explain convergence in simple way.
171. **The sub-district operational funds were important to finance village capacity building efforts and to incentivize coordination.** The pilot also provides operational funds to support HDW activities, such as ‘Bootcamp/Rembuk stunting’ activities at the village and sub-district level, as well as increasing capacity building activities for village apparatus. These operational funds, the guidelines for which are based on Generasi, were used for a range of activities that have helped women’s groups and posyandu prepare proposals for village plans and budgets, increase information about stunting, and facilitation knowledge transfer of knowledge between levels. Further analysis on the effective used of these funds, and how to channel them to sun-districts, is required.

Recommendations

172. **The overall conclusion of the assessment is that the HDW convergence instrument is well suited to strengthening the ability of villages to drive convergence of priority nutrition interventions for 1,000-day households.** In relation to village planning, the field assessments found that villages lack basic understanding of stunting and its drivers, and do not understand how villages initiatives can contribute to stunting reduction. It also found that although village regulations and guidelines include many activities relevant to stunting reduction (including both nutrition-specific intervention such as posyandu and nutrition-sensitive such as water and sanitation and PAUD), there was little information on how they contributed to stunting and malnutrition. The field visits also confirmed the findings of the Sentinel Village

longitudinal study that most villages do not conduct systematic social mapping as part of the annual village planning processes. Basic knowledge and capacity for mapping, diagnostic and activity planning was higher in Generasi villages. This was particularly the case in those villages where Generasi had successfully integrated into the Village Law.

173. **However, the assessment also noted three key challenges that the government is likely to face in implementing the HDW instrument effectively:**

- a. **District Mandate and Coordination.** The assessment found that a clear district mandate will be essential to the successful implementation of the HDW tasks. The assessment found that those districts that provided clear guidance on the use of technical facilitators (Generasi consultants and cadre, for example) to villages on the use Dana Desa more generally as well as
- b. **HDW Capacity Building Quality.** MoV has experience implementing large-scale capacity building activities for technical consultants and facilitators stationed at the district level and below. However, the quality of the capacity building activities (including the curriculum, materials, trainers and evaluation arrangements) is often variable.
- c. **HDW Incentives.** It will be critical that HDW are given, this could be achieved through incentive based allowances, performance-based competitions, and non-financial incentives.
- d. **Operational issues.** There also remain several operational challenges to transitioning the HDW pilot, which continues to rely on some key PNPM-era financing mechanisms. This includes the relationships between Generasi Sub-district Facilitators and Village Facilitators (PD), the channeling of operational funds (BOK) of capacity building activities, and program management.

174. **The assessment identified four key actions to include in the Program Action Plan to address these challenges:**

- a. **Retain a streamlined PIU at the MoV**—it is recommended that MoV retain a PIU consisting of 15 high-caliber technical consultants to support capacity building and oversight.
- b. **Integrate HDW into the Programmatic DAK**—this should include both financing of HDW allowances, village capacity building activities (DOK), as well as require. It should also feature in the DAK performance criteria.
- c. **Institutionalize the scorecards**—modify the semester and annual Dana Desa report to include template on village convergence and technical support scorecards.

- d. **Utilize existing village facilitators**—Revise the TORs for the P3MD district TA consultant (Basic Service Delivery) and sub-district Village Facilitator to clarify their role supporting the NatStrat Stunting.

8. Monitoring & Evaluation

Strategic Relevance

175. **The Government Program for the Reduction of Stunting aims at reducing stunting by 25 percent by 2019.** The proposed World Bank Investing in Nutrition and Early Years (INEY) Programme for Results aims at increasing the simultaneous utilization of priority nutrition and early learning services in 100 priority districts. The PforR will use existing Government systems to monitor budget execution and progress towards the overall Program results.
176. **Monitoring implementation and progress towards higher-level development results will require effective government data collection and M&E systems.** The objectives of the technical assessment were therefore to: i) assess how the existing Government M&E systems function, ii) establish their readiness to monitor and evaluation the Government Program, and ii) to identify areas where the existing systems and capacity needs to be strengthened.
177. **The technical assessment of Government M&E Systems was carried out in February 2018 and informed by consultations with Government counterparts in five districts.**²⁴ The assessment covered the national, district and village levels of Government. Information was collected through interviews with key Government officials, mainly M&E, Finance and Planning Officers, using a structured questionnaire. The assessment covered the following five M&E system dimensions: i) the planning foundation for the M&E system, ii) the design of the M&E system, iii) establishment of the M&E function in government, iv) use of the established M&E system, and v) dissemination of results information and citizen engagement. Lastly, the assessment also included the decentralized data collection systems that will inform monitoring at the village and district levels.

Technical Soundness

178. **Monitoring and evaluation systems.** The detailed findings of the technical assessment are presented below. They are structured across the five dimensions of a well-functioning M&E system.
179. **Strategic planning foundation for the M&E system.** In general, the strategic planning foundation for effective M&E is robust at all levels of government. For monitoring and

²⁴ The five districts were Cianjur, Lombok Tengah, Gorontalo, Ketapang and Maluku Tengah.

evaluation purposes, development plans mostly contain result frameworks of good quality with indicators, baselines and targets. The private sector and citizens are generally consulted on development priorities in the plan formulation phase. However, strategic plans mostly do not contain an outline of the M&E arrangements required for effective implementation monitoring, including taking corrective action when progress is off track. Nutrition and early childhood development outcomes are also frequently omitted from the strategic plans reviewed.

180. **Development of the M&E System.** Elements of M&E systems are present at all levels of Government. These include monitoring plans, data collection and reporting templates and committees that review progress in plan implementation. M&E Guidelines and evaluation plans are largely non-existent and reporting templates are not standardized and contain different information across districts. The M&E systems are largely informal and require formalization and structure, particularly at the national level, to be able provide reliable and timely information on nutrition and early childhood development for decision-makers at all levels of government.
181. **Establishment of the M&E function in Government.** There are M&E departments at national level of government while at lower levels the M&E function is mostly co-located with finance and planning. This is also reflected in staff responsibilities. At the national level institutions have dedicated M&E Officers while at lower levels Planning and/or Finance Officers have been allocated the responsibility for M&E. There are generally budget allocations for data collection and monitoring while evaluation is only budgeted for at national level in one institution. M&E is not established as a separate cadre in the government scheme of services with a generic M&E Job Description. Generally, staff have little or no formal training in M&E. A formal M&E training curriculum is needed as part of an effort to train staff across government in M&E methods.
182. **Use of the M&E system.** Health and education data is collected and reported frequently at all levels of government. Administrative data collection systems are complemented by Statistics Indonesia's survey program. There is ample monitoring information to enable effective use of the established M&E systems. However, use of the M&E system vary across institutions. There limited use of M&E systems at national level. An annual progress report on the implementation of the National Medium-Term Development Plan, which would form the basis for annual reviews, is not compiled. Progress reports and performance information is used more frequently at lower levels of government. At the district level, progress reports and reviews are most frequently annual. For M&E to be an effective management tool progress reports and review meetings need to be undertaken quarterly. At village level, input/output information is reviewed and discussed by the Village Development Committee and corrective actions are identified when performance is off track. Evaluations of priority programs are undertaken at national level only.

183. **Dissemination and citizen engagement.** Results information is generally not disseminated, neither in hard- nor electronic copy, for citizens to provide their feedback. However, citizens provide feedback on the quality of services provided at the planning phase and through structured feedback mechanisms such as suggestion boxes and complaint handling mechanisms. In the education sector, citizen feedback occasionally leads to teachers being summoned by the District Head of Education to answer questions about lacking performance – mostly absence from class.
184. **Administrative data collection systems.** Data collection and reporting systems are in place at all levels of government. In the health sector, most administrative data is available on a quarterly basis while in the education enrolment data is only collected on an annual basis. Both the health and education sectors face challenges of late or non-reporting, reporting biases and weak data quality assurance mechanisms. However, the nutrition data collection system is generally more advanced than the education data collection system.
185. **Health sector:** Administrative data is collected from three main sources: i) the Maternal and Child Health Handbook (the pink book), ii) monthly Posyandus held at the village level, and iii) community health clinics (Puskesmas). The data collected includes the personal identifiers, the child height and weight and vaccinations received. The collected data is transmitted to the district level quarterly. At the district level, the data is further quality assured, aggregated and used to produce annual district health profiles. Quarterly, the compiled data is transmitted to provincial level with copy to the national level.
186. **Education sector:** Administrative data is collected annually through reporting templates that were developed at the district level. The reporting templates are sent to primary schools and filled in by the headmasters. Data collection methods are not standardized across districts and data quality assurance are generally weak. Collected data covers primary education and no data is currently collected from early childhood institutions (PAUD).
187. **Statistics Indonesia.** The administrative health and education data collection systems are complemented by Statistics Indonesia's census and survey program. The ten-year Population and Housing Census Program form the basis for estimating the number of children in each district. In-between the censuses a survey program provides information on a number of indicators in both the health and education sectors. The main surveys for monitoring progress against the Government Program indicator targets are the *Susenas* and *Riskesdas* surveys. These are undertaken annually and every five years respectively.

Recommendations

188. **The essential building blocks for monitoring the simultaneous nutrition and early childhood education service are largely in place.** However, to function effectively the system needs to be focused more sharply on monitoring both nutrition and early learning outcomes.

This is a particular challenge in the education sector where there currently is no routine information collected on early childhood education. Whereas elements of M&E systems are in place at all levels of government, they need to be further strengthened and formalized through the development of M&E Guidelines, including uniform reporting templates, and institutionalized through the establishment of standard performance review committees. Progress reports, currently compiled in some units, need to be compiled routinely and reviewed on quarterly (brief) and annual (comprehensive) at all levels of government. M&E is currently not used as a management tool, this needs to be the case during implementation. Dissemination of results information and soliciting citizen feedback on service delivery is currently not practiced widely. During Program implementation such systems should be institutionalized and made standard practice.

189. There are two main areas for improvement:

- a. **Monitoring and evaluation.** Strengthening the following five areas are particularly important for effective monitoring and evaluation of the Government Program: i) review (and revision if needed) of existing strategic plans to ensure nutrition and early childhood learning outcomes are included, ii) development of simple M&E guidelines, including reporting templates, and establishing performance review committees at all implementing agencies, iii) development of an M&E capacity development plan for M&E, Planning and Finance Officers, iv) systematic use of the collected progress information to improve performance, including trouble-shooting and taking corrective action when performance is off track, and v) systematic dissemination of performance information and soliciting feedback on service delivery from citizens.
- b. **Data collection.** The main gap in data collection is in education where routine administrative data on early childhood education is not currently collected. Ministry of Education should work with lower levels of government to develop both systems for data collection from PAUDs and a reporting template. The reporting frequency should also be increased to quarterly as annual enrolment data hide variations in enrolment across the year and is not sufficient for decision-makers to take corrective action if education outcomes are off track. Both Ministry of Health and Education need to ensure that statistical staff and data collection clerks are sufficiently trained in data collection and data quality assurance methods.

Annex A: Detailed Expenditure Framework

Expenditure Framework (Central Government level)

Expenditure Framework Evaluation Background

1. Indonesia is a G20 country with a large and expanding Government budget. It has identified stunting as a major problem, initiated a National Action Plan and is directing resources to addressing the issue. **Policy recognition** is not a problem.
2. This assessment paper looks at the practicalities combatting stunting by funding a convergent program (or in Government terminology, a 'super program') in the context of the existing Indonesian planning and budgeting framework. Addressing stunting in simple terms requires up to 5 independent interventions. The more interventions a single family receives, the less likely children are to be stunted. The interventions vary widely in nature and consequently it is unlikely that more than 2 come from any one area. This means that coordination and cooperation are key to delivering effective assistance. This means working together across K/Ls, sharing information and clever use of resources. In many nations this would include trading budgets (within limits) but this is not possible in Indonesia.
3. Beyond that, the World Bank is seeking to apply a Programming for Results (PforR) philosophy. The idea is to reward successful performance. Ever greater levels of performance result in more of the budget being directed to successful areas.

Institutional Set-up for State Budget Planning, Budgeting, Accounting and Reporting

4. As part of the planning and budgeting reforms, the Government issued Law 17/2003 on State Finance and Law 25/2004 on National Development Planning System. There are several central government agencies involved in the planning and budgeting process. These include the Ministry of National Development Planning (Bappenas), several Directorates General (DG Budget, DG Treasury, and DG Fiscal Balances) in the Ministry of Finance (MOF), and the Ministry of Home Affairs (MOHA). At present, there are 88 (eighty-eight) line ministries/agencies at the central government, 34 provinces and 514 regencies/cities in Indonesia. The central government line ministry/agency is headed by a Minister/Head of Agency while a governor heads a province and a regent or mayor heads a regency or municipal level of government.
5. The primary responsibility for the management of the state finances rests with the Ministry of Finance. Within the Ministry, there are two separate directorates-general responsible for budget: one for budget preparation and allotment (DG Budget) and the other (DG Treasury)

for budget execution, cash management, and accounting. In addition, DG Fiscal Balance is responsible for inter-government fiscal transfers. Meanwhile, the state planning agency/ the Ministry of National Development Planning, Bappenas, plays a role, particularly for the development of the government's long-term (20-year), medium-term (5-year) and annual (RKP) plans that articulate the priorities of the President. Bappenas has another role for reviewing the annual work plans prepared by line ministries (Renja K/L) as the basis to prepare the line ministry's annual budget (RKA-K/L). The national budget is referred to as the APBN, while transfers to provinces, cities, or municipalities are captured under the Balancing Fund (see below, referring to block grants, revenue sharing and earmarked grants).

6. The State Planning Agency (Bappenas) continues to play a prominent role particularly for capital expenditure prioritization. In practice, Bappenas takes a lead role in reviewing the preparation of the line ministry's capital budget expenditure and on expenditure prioritization in general. The recent issuance of government regulation (PP) 17/2017 requires Bappenas and DG Budget to work jointly to synchronize the process of national development planning and budgeting more effectively and efficiently. Bappenas is granted a new role to, jointly with MOF, set the line ministry budget ceiling (previously called temporary ceiling), review or assess line ministries budget proposals, RKA-KL, to ensure consistency of RKA-KL targets with Renja K/L and RKP. It is expected there will be a strong alignment between the planning (RKP and Renja K/L) and budgeting (RKA-K/L) documents.

Box 1: The Implementation of PP 17/2017

The government regulation No. 17/2017 was recently issued by the government of the Republic of Indonesia to synchronize the process of national development planning and budgeting effectively and efficiently. Synchronization of the process of national development planning and budgeting means a process to integrate and strengthen the formulation of the national development plan and budget as well as the control of development target achievement.

This regulation is intended to solve the problem on inconsistency between the annual program planning and budget. Many programs/activities that are listed in the government work plan (RKP) and line ministry work plan (Renja-KL) could not be funded by the state budget (RKA-KL). The disconnect between planning of the program and its annual budget is also caused by the lack of consistent data between the planning, budgeting, and realization of budgets since the Ministry of Finance and the Bappenas manage and implement stand-alone Information Systems with different formats, classifications, and database structures.

The synchronization of the process on program planning and budgeting between Bappenas and MOF was introduced earlier, on 19 June 2009, when both finance and planning ministers agreed to sign a joint circular letter on the planning and budgeting reform guidelines. At that time, the guideline introduced a 'money follows function' approach to the programmatic classification structure in Indonesia, in which the budget is allocated and linked to the organizational units, and one program is implemented by one echelon I level or a line ministry/agency, depending on the

size of the work and budget, while each activity is usually linked to the lower level implementing units (Director level or Spending Unit). The money follows function structure was introduced since it is believed that the existence of organizational unit is more stable while a program can be changed at any budget year depending on the priority of the government. While also focused on strengthening the plan-budget link, the government regulation No. 17/2017 principles are consistent with a different approach, i.e. “money-follow-program” budgeting.

7. State Finance Law No. 17/2003 is the main legal basis to regulate the budget and accounting classification system of the Government. In 2010, full accrual based accounting standards have been developed (Government Regulation No 71/2010) that are aligned and consistent with IPSAS and GAAP.
8. The national Chart of Accounts (CoA) provides the framework for electronic budget and expenditure execution tracking for central agencies (“APBN”). For the central government agencies, the detailed budget classification is regulated under MOF Regulation No. 127/2015 and its amendment on Regulation No. 114/2016. According to this regulation, the state budget is appropriated and allocated based on organizational units, functions (sub-functions), programs (activities), and economic classifications. The programmatic classification structure is linked with the organizational units, in which one program will consist of some activities and measurable outputs to be implemented by one echelon I (Directorate General) level in one specific line ministry. Each of those activity is mapped to the corresponding functional and sub-functional classification. MOF Regulations No. 214/2013 and 275/2014 regulates the detailed accounting classification or Chart of Accounts (COA) that is embedded into the central government’s Financial Management Information System – FMIS or SPAN. The economic classifications on expenditure and revenues in COA is aligned with GFSM 2014 to record full accrual accounting information with eight type of expense categories (employee’s salary, use of goods and services, consumption of fixed capital, interest, subsidies, grants, social benefits, and other expense) and four main revenue categories (taxes, social contributions, grants, and other revenue) that are structured in six (6) digit levels to enable capturing all different types of transactions.
9. SPAN (FMIS) is designed with 12 segments and 62 digits of COA covering all budget items that allow direct comparison between realization and original budget, since a single accounting classification is consistently applied throughout the planning, budget formulation, execution, and reporting cycle. Having 12 segments of COA in SPAN, any individual transaction will be recorded with information on Spending Unit, KPPN, Accounts, Program, Output, Funding Source, Bank Account, Fund Authority, Location, Budget, Intra-entity, and reserves. Therefore, SPAN has made it easier for the government to track any expenditure per the purpose of the report.

10. DG Treasury is assigned to maintain the COA references in the SPAN. The COA can be updated based on the request of the line ministry and/or directorate generals in MOF with the arrangements as follow:
 - a. DG Treasury is authorized to update COA for changes in the account (economic classification), source of funds and fund withdrawal codes and the segments of Bank, KPPN, budget, intra-agency, and reserves;
 - b. DG Budget is authorized to update COA for changes in the spending unit, program, (activity) output, and location codes and segments;
 - c. DG Debt Management is authorized to update COA for changes in grant registration code.
11. The Planning Ministry (Bappenas) is given the flexibility and authority to propose, establish and update code for priority and focus priority programs. This classification code is used to differentiate a program that receives additional budget allocation in a year since they are classified as a government priority for that year.
12. Soon after the Parliament's approval of the Central government budget for the next fiscal year, DG Budget is responsible for preparing the budget allotment document (DIPA) that must be distributed to all over 24,000 spending units of the central government line ministries across Indonesia, which by law must be done before the start of next fiscal year. The DIPA document includes budget allocation with detailed information on function/sub-function, program and outcome, activity and output, economic classification, and monthly cash disbursement forecasts. DIPA imposes a ceiling on expenditure commitment or funds available for each spending unit's commitments for the whole fiscal year. The availability of funds in DIPA is guaranteed by law (State Treasury Law No. 1/2004), therefore it ensures sustainability, predictability and execution of budget since the spending units can plan activities, commit expenditure, procure inputs for effective service delivery, and avoids disruption of the implementation of these plans once they are underway within a fiscal year.
13. The government's annual financial report (LKPP) is prepared in accordance with Government Regulation No. 71/2010 regarding Government Accounting Standards (SAP). Since FY 2015, the report has been made on an accrual basis, that is complied with the international standards (IPSAS). There has been an improvement in the quality of the government's annual financial reports (LKPP), shown by the achievement of an unqualified audit opinion from Supreme Audit Institution (BPK) for the first time in 2016. This unqualified opinion is the first such opinion achieved since the first annual financial accountability report was prepared and initiated in 2004. Based on audit results, BPK confirms that LKPP 2016 was presented fairly on all aspects in accordance with Government Accounting Standards (SAP).
14. When Indonesia began piloting SPAN, MOF officials foresaw a major impending challenge. The SPAN system, which was set to streamline the country's financial management systems,

was only going to be accessible to around 3,000 finance ministry staffers in around 200 treasury offices (KPPN) of the central government around the country. More than 24,000 Spending Units (SU) of the central government's line ministries and agencies are not directly accessible to SPAN since giving a direct access for those SUs to SPAN appears to be very expensive, especially since most SU spending will be limited to predictable items like salaries and office operations cost only. The cost of a license was not cheap as it was at least US\$1,500 per user so, it would have cost up to around \$450 million if all 300,000 users from more than 24,000 spending units were given access to SPAN. To address the problem, DG Treasury developed an online monitoring SPAN (OM-SPAN).

Box 2: On-Line Monitoring SPAN (OM-SPAN)

In 2014, the Ministry of Finance developed an open-source, web-based application platform being used to monitor any transactions and present any information that is processed by SPAN and to upload the replicated SPAN data, which the government called "Online-Monitoring SPAN" or OM-SPAN. OM-SPAN could be accessed by spending units anytime anywhere using any electronic device (including mobile phones, PCs, laptops, and tablets) capable of accessing the internet.

The Government's spending units and other stakeholders could access different levels of data from OM-SPAN based on their authorized access level from the OM-SPAN database which was continuously uploading data from the SPAN database in almost real time.

OM-SPAN's functionality provides various data information to the SU including:

- (i) the budget allotment left unspent and budget realization status of each spending unit for managerial decision;
- (ii) the status of payment request (any approval or rejection due to short budget ceiling- pagu minus);
- (iii) the budget absorption by unit, by activity, by authority, by source of funds and by region area or location of spending;
- (iv) the contract commitment data for each echelon 1 or spending unit, by activity, by authority, by source of funds and by region area or location of spending;
- (v) the funds availability (unspent budget) by each detail economic classification code;
- (vi) the short of budget (pagu minus) on salary expenditure;
- (vii) the data on disbursement notice (SP2D) or payment request that is being approved or unapproved;
- (viii) the information on amount of petty cash (cash advance) position by each spending unit; and;
- (ix) the Information on revenue collected by each account code, echelon 1, and spending unit, along with the information on return/rejection on revenue due to wrong account code.

OM-SPAN is currently being accessed by more than 100,000 users all over Indonesia. User levels are provided for all levels of the Government including the President of the Republic of Indonesia, the Minister of Finance, line ministries and agencies, sub-national governments, and banks (Central Bank and commercial banks). Officials of line ministries and agencies received authorization to instantly access data in the OM-SPAN system, a significant cost efficiency than

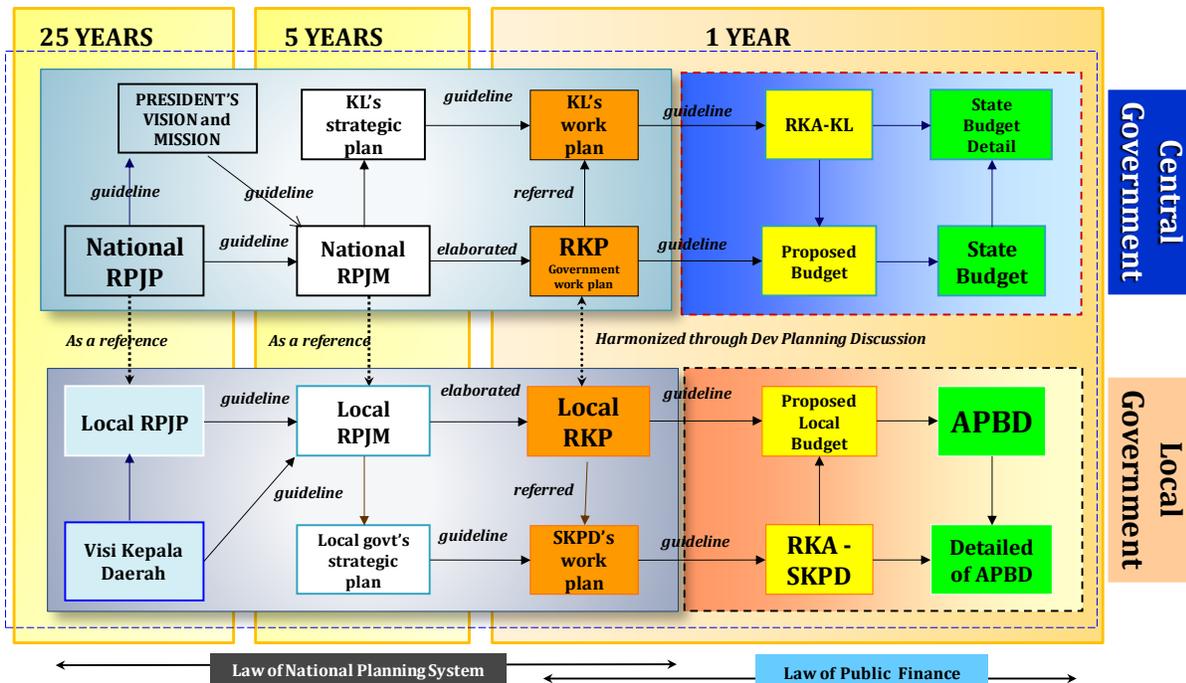
they previously had to access the information. Previously they had to physically come and ask the status of payment requests. Now, with OM-SPAN, they could check online if the payments were approved and received by the beneficiaries.

The system had the potential to create large cost savings for the Indonesia government, though as of 2018 the actual amount of savings has not been measured. If all government units used the OM-SPAN data instead of making trips to treasury offices to request information, the government could save tens of millions of dollars per year in printing, transportation, and internal communication costs. The government could also potentially optimize their existing staff by shifting from clerical into analytical roles, since obtaining further savings by reducing staff numbers for dealing with administrative issues is not a politically sensible option.

15. In term of the performance orientation of budget, DG-Budget MoF is required by law (e.g. PP 17/2017) to provide an analysis of the efficiency and effectiveness of Government expenditure and this is to be taken into account in budget discussions between line ministries, MoF and Bappenas. But, MoF tends to place a heavy emphasis on confirming costings and on accountancy. Historically, this choice has meant fewer resources are available to build up institutional knowledge on sectors.
16. In public financial management (PFM), efficiency refers to the cost of an activity, and effectiveness to the impact of that activity in achieving an outcome. Efficiency is not simply costing an activity – it asks whether the same action could be done more cheaply, or at the same price but to a higher effect, and whether a different activity with the same or lower price but higher effectiveness exists.
17. This provides a starting point for discussions about analysing the efficiency and effectiveness of coordinating existing interventions for a much higher impact, and the role that MoF is envisaged to fill by PP17/2017.

Fiscal Relationships Between Central and Sub-National Governments

18. Law 25/2004 and 17/2003 mandate planning and budgeting between central and Sub-national are implemented synergistically. Although the planning approach is comprehensive, at the implementation level there are still many national development planning programs that are not reflected into the regional planning priorities and are not aligned with annual budgeting of both the central and sub-national governments. Furthermore, with decentralization the Bappenas coordinating role and network with Bappeda (Regional Development Planning Agency) is not directly formalized.



19. The Fiscal Balance Law 33/2004 outlines the responsibility of subnational governments for managing their own public finances. Provinces, cities, and regencies therefore enjoy a significant degree of autonomy in prioritizing expenditures under the local budgets (APBDs). The subnational governments, however, have very limited own fiscal resources. They depend on transfers from the national government. In line with the principle of local autonomy, a large share of vertical transfers is in the form of unconditional block grants (DAU) and the revenue sharing fund (DBH). In addition, there are conditional specific purpose grants (DAK) which is an earmarked grant targeted to finance national priorities that is implemented under local government authority. DAK consists of DAK Fisik, mainly for financing capital expenditures, and DAK Non Fisik, mainly to provide additional financing for operational cost of service delivery, for instance through school and health center operational assistance (BOS and BOK). Apart from fiscal balance to fund decentralization, the fiscal transfer from the Central Government to the regional government can take the form of Central Government line-ministry spending channelled to the provincial governments through deconcentrated funds (dana dekonsentrasi-Dekon) and to the districts or municipalities governments through assistance task fund (dana tugas pembantuan-TP). Reports of the Dekon and TP funds utilization are embedded in the Central Government financial report.

20. Under Indonesia's 2001 decentralization, the Ministry of Home Affairs (MOHA) was assigned in setting up the financial management arrangements for sub-national governments. The Ministry of Finance is no longer responsible for public finance management at the sub-national governments. Under the fiscal decentralization, all the sub-national government financial management arrangements (including the chart of accounts) are governed by the

MOHA's rules and regulation. It could be implemented better if there is a close coordination and harmonization between the role of the Ministry of Finance in setting the financial management regulations for central government agencies and the Ministry of Home Affairs for sub-national governments, but conflicting and different directives of both ministries have hampered the implementation of the country's public financial management reform.

21. For the sub-national governments, the most important PFM regulations are the government regulation (PP) 58/2005 on the Management of Sub-national Government Finance and minister of Home Affairs (MOHA) regulation (Permendagri) No 13/2006. PP 58 addresses five primary areas of Sub-national government budgetary and financial management: planning and budgeting, revenues, budget execution, accounting and reporting, and budget administration while Permendagri 13/2006 provided, among other things, the chart of accounts for sub-national governments with program and activity codes as well as forms and procedures for implementing it. The issuance of PP58 and Permendagri 13 are good examples of the lack of coordination between the Ministry of Finance and Ministry of Home Affairs, which creates a significant difference not only in the formats but also in the budgetary and accounting classifications between the financial reports of the Sub-national governments and the central government financial statements.
22. The COAs that Sub-national governments are required to use are different. MOHA regulation (Permendagri) 13/2006 requires Sub-national governments reporting at the program and activity level with 5 digits' code of economic classifications which is differ from 6 digits' code for central government's economic classifications. It also divided the expenditure side of Sub-national governments into direct and indirect categories and introduced the obligatory and selected functions, the differences that create a burden of conversion if the country wants to have a consolidated financial statement between central and sub-national governments since it requires a conversion table to consolidate per the government accounting standards. The process of consolidation for developing the government finance statistics (GFS) reporting is done manually and is problematic. Consequently, it is almost impossible to have a consolidated general government financial statements. The latest year in which the consolidated general government financial statistic (GFS) report is available on the MOF website (<http://www.gfs.djpbk.kemenkeu.go.id/>) was for 2015 as of February 2017.

Stunting Program Planning, Budgeting, Reporting and Accounting

23. Despite of the clear legal and regulatory on PFM which support the performance based outlook, the Indonesian program budgeting system is actually an institution-based budgeting system, which in turn is a standard form of input budgeting. Because the Director General (Echelon I) generally have a single program, their budgeting is focused on the inputs necessary. Before the Supreme Court's decision (to prevent the Parliament to scrutinize

budget at the detailed activity level) this was also a matter of considerable interest to Parliamentarians, who wished to know exactly by line item budget on what was being bought where, and who continue to challenge the economic parameters provided in order to expand the level of Budget available for purchases.

24. At the national level, the budget allocation is made at the level of a DG, Director or a Spending Unit as an accountable authority. The primary budgetary unit is the program, usually executed at the DG level. Each DG is usually set to have one single program only, meaning that a program is sensibly confined to a single DG and the budget allotment of a program are often in the accounts form an identity (i.e. the DG is the program and vice-versa). Each program is divided into activities, designed to give effect to the program. The activities have outputs, measurable services or products that the activity produces, and the outputs have indicators (i.e. measures of success) and may also have components and subcomponents (inputs to the level above).
25. Each level of each program in each K/L has a unique, traceable identification code. These codes enable MoF to control allocations and track expenditure by type at a granular level. It also enables Bappenas to track outputs and results for planning purposes.
26. However, there is less flexibility during the course of the year for shifting (vire) between budget allocation units either across Ministries or within the same Ministry (but different program), even where this would prevent underspends or achieve a mutually reinforcing outcome. Shifting budget between programs (and hence between satkers from different programs) require formal Parliamentary approval. This is a legal constraint and cannot be avoided or ignored. In practice, program level budget shifting does not often occur in the mid-year budget. This is largely used to make broad-brush changes to K/L appropriations resulting from parameter changes, with the redistribution left for K/Ls to make, especially in the case of reductions. This means that intra-year budget shifting among different programs are best ignored as a possibility.
27. There are 24,000 such spending units (satkers) which receive direct budget allocations. To become an accountable and eligible unit for managing budget, each spending unit requires certain requirements and standards are being met, including having a full complete staff establishment able to fill the roles of four officers (the head of spending unit, treasurer, commitment maker, payment verifier and authorizer), of whom at least 3 must be different people. Each satker is separately appropriated, so there is a great deal of fragmentation in the purposes for which funding is allocated. The large number of direct budget allocation units implies:
 - a. The system has been deliberately designed to be rigid. One advantage of a highly rigid system with a good level of transparency is to fight potential corruption at several points in the system. Any proposed change to the system carries wide ramifications.

- b. The objective of program budgeting is not being met and line ministries are a blockage. The main (legally sound) responses to an increased or changing need would be to either increase the number of programs and resources within an existing unit if it were seen to facilitate program outcomes, or create yet another unit to permit direct funding.
 - c. The system is increasing in rigidities and fragmentation due to the increase in spending units.
28. It is a standard problem in all Governments that individual units form silos, between which communications are difficult and cooperation hard won. It is also standard that where money or workload are at stake, cooperation becomes more difficult and low communication is a tool of early resort.
29. In summary, the Indonesian system is working much as designed. The key to its success is the DG/program identity which makes tracking and performance information collection possible. However, the proliferation of budget allocation units and expansion of budget shifting (virements) or “pergeseran anggaran” and shifting (virement) systems indicates that the system leaves various need unaddressed.

Converging Programs for Stunting Interventions

30. In strictly fiscal terms, **Indonesia has adequate planning and budgetary processes strength** to address the Stunting problem on a nationwide basis. Choosing to pilot 100 districts rather than 5 or even 20 may be overambitious for the capability of delivery agents but is monetarily feasible for the Government. Naturally, this does not take account of competing priorities which may mean that the Government can afford a major program, but does not choose to do so.
31. The Central Government has a very powerful **budget control and tracking system** down to the transaction level. For an adequately specified program, it will have no difficulty in tracking expenditures.
32. All of the above being said, there are practical problems which arise because the expenditure framework is not well suited to a **convergent** program. In the case of stunting, more than one Ministry or Agency (K/L) is involved, and more than one area in some K/Ls. This is more of a problem in Indonesia than in many countries.
33. **Convergence Programs** require coordinated action, strong information flows and budget flexibility so that priorities for action can be determined dynamically, investments and policy action can be concentrated in higher priority areas and the central coordination function has the strongest and most recent data available. Ongoing Monitoring and Evaluation (M&E) is critical for Convergence Programs. This flexibility, communication and responsiveness

between programs is the defining aspect of a Convergent Program. If these were not important factors, it would be easier in Indonesia to set up individual programs, each based on a single intervention.

34. The eight problems listed work directly against Convergence Programming including the issues as of the following:

- a. **Rigidity:** The Budget is specified down to the spending unit level, of which there are 24,000 at the Central Government level. Shifting budget between units range from difficult at low levels to impossible at higher levels (e.g. between Directorates General or K/Ls) without Parliamentary intervention. Intra-year results based responses to performance are for practical purposes not achievable.
- b. **Entitlement Budgeting (1):** At the central level, spending units get what they were allocated in previous years (incremental basis), adjusted for parameter movements, unless the relevant Minister successfully intervenes for a redistribution. That redistribution is a zero-sum game within the Ministry (since the indicative budget is distributed by line ministry level), with an increase in one area requiring a decrease in others. This permits a certain amount of flexibility once per year, but does not advance the cause of inter-Ministerial convergence on a common aim. Generally, the entitlement works against driving innovation to improve performance.
- c. **Entitlement Budgeting (2):** Since the default is to provide a set amount to spending units, there is no pressure to analyse performance unless the unit is seeking an increase in resources beyond parameter increases. Even then (anecdotally) the typical response is to encourage the unit to reduce its request to the prior established levels, at which stage it can be approved without performance analysis. In short, there is no requirement to analyse program achievements or unit performance.
- d. **Over Budgeting:** There is a state finance law limitation preventing more a combined (central and sub-national) budget deficit of more than 3% of forecast GDP being budgeted. Standardly, this full amount is budgeted, meaning that there is little flexibility to introduce new programs as given that Entitlement Budgeting (1) results in a pre-allocation of all legally available funds. The converse is that this becomes an advantage when the Convergent Program is linking and coordinating existing programs. This means that the funding is in place and less likely to be disturbed.
- e. **Poor Output Specification:** Outputs are not necessarily linked to outcomes. Some have a very high level of specificity and measurability, but little relevance. The Climate Change tagging exercise proved that this need not remain the case, with extra outputs added to existing activities which more realistically targeted the objectives of meeting Indonesia's Climate Change commitments.

- f. **Trilateral (not multilateral) consultation:** At present, there is a requirement for Each K/L to meet with Bappenas and MoF in a trilateral meeting. This at least joins operations, planning and budgeting, but is still not adequate for the purposes of national level convergent strategies. Simultaneous consultation with all relevant K/Ls (and quite possibly DGs) is required, so that needs and performance can be assessed and balanced. It should be noted that trilateral meeting does permit consideration of some convergence measures where a K/L is responsible for more than one.
- g. **Poor internal communications (“siloining”):** It is normal for siloining to happen between and within organisations, partly as a means of influence trading, partly as a result of natural competitiveness, but very often simply because high communication levels represent extra effort for busy people with no real payoff. The Indonesian Budget, with its high level of specification and low ability to shift (‘vire’) funds within or between organisations, vastly emphasises this tendency. Not only does this prevent the flow of money, it also de-emphasises the flow of information and the importance of cooperation.
- h. **Extended Budgeting timescale:** K/Ls begin work on the Budget for year T in year T-2 using baseline information from the report of the Supreme Audit Institution (BPK) report produced in year T-2. That information refers to the January to December T-3 operations of government. This information will be two to three years old by the time the Budget comes into force. In June of T-1, BPK’s T-2 becomes available, and may be used to adjust matters, but this is very late in the process with the Budget being due to the President the same month. Any Budget will be based on information that is from one to three years old with older information playing the major part.

Can Indonesia deliver a Convergence Program?

- 35. Yes, it can, but all the difficulties mentioned above must be recognized and addressed. It is worth noting that no change is being proposed to the existing system solely to facilitate the anti-stunting program. However, different attitudes must be brought to the existing processes if Indonesia is to deliver a successful Convergent Program.
- 36. In summary, practices which are set down in law, or are the direct consequences of current laws and regulations are only those under the headings **Rigidity** and **Extended Budgeting timescale**. The laws and regulations around these must be observed, but it is important to note that laws tend to ban highly specified actions or prescribe minimum actions that must be taken. Additional actions, consistent with the law, are rarely forbidden. In other words, K/Ls are free to take actions above the statutory minimum which assist the operation of government.

37. All the other actions listed above are matters of practice and expectation, rather than legal requirements. Obviously, changes to these practices involve changes to culture and procedure and have a cost in political capital to execute. Some of the new procedures set down in PP17/2017 could have been put into practice before – the new law made them a requirement, rather than an option.
38. As noted before, it is not the intent of this project to suggest new laws. This assessment paper is setting out the steps by which, using present laws and regulations, a Convergent Program can be operated.

How a Convergent Program can be achieved.²⁵

39. Assumptions

- a. The Government of Indonesia (GOI) will not dedicate any more funding to nutrition/anti-stunting than it already does
 - b. World bank funding will be aimed at redirecting inefficient funding use to increase the level and impact of GOI funded interventions
40. Recalling that preparation for a Budget year (“T”) starts in late T-2, ideally that is the latest time when preparation of a Convergent Budget for T should start. In fact, later start times are possible, particularly because there is a negotiation period from April to June (T-1) when changes can be made.
41. The following are the steps to take to achieve Convergent Programming.

Step 1.

42. The program itself must be made a priority in Government. In the case of stunting this has occurred with the declaration of the National Action Priority Plan. As part of this plan, the Government has identified the priority interventions which must occur.

Step 2.

43. **Locate and structure relevant activities.** Each K/L needs to identify the activities which impact on nutrition by supporting the priority interventions. For each activity, there must be at least one relevant, well-structured output. The definition should not be narrow – relevant policy and monitoring are just as important as capacity development, transfers or grants to deliver on an intervention or in some cases direct delivery of an intervention. To the greatest extent possible, outputs should be identically phrased as similar outputs right across Government, to allow enriched data analysis. This may mean the definition of new outputs

²⁵ The paper has been phrased without reference to specific years. For the purpose of the Investing in Nutrition and Early Years Program, T-2 = 2017, T-1 = 2018, T = 2019, T+1 = 2020 etc.

or redefinition of existing outputs towards an object of higher quality and uniformity.²⁶ There will need to be a table reconciling old and new outputs for baseline work. This single step should overcome the **Poor Output Specification** difficulty.

Step 3.

44. **Gain Commitment.** All relevant K/Ls, Bappenas, MoF and TNP2K will need to meet and set down commitment to the anti-stunting program as a priority and also agree to
- a. The output structure negotiated with Bappenas and MoF
 - b. The retention of (at least) existing funding to anti-stunting programs
 - c. The concept of performance targets and evaluation
 - d. The application of tagging to outputs to assist performance evaluation

Step 4.

45. **Establish a baseline.** For the program to be convergent, there must be a responsiveness to analysis which requires data. The most easily gained relevant data is expenditure at the output level. In year T-1, the first data against the new outputs will be generated. All identified outputs can be 'tagged' i.e. have a collective identifier applied for easy extraction and aggregation of data. There will be data from years T-2, T-3 etc which will be capable of being reconciled to form an approximate baseline of expenditure. Much or all of the data analysis can be done by MoF, overcoming this specific aspect of the **siloi**ng problem. It is possible that Bappenas can do a similar job with outputs and indicators, which would assist in laying the grounds of a results framework. For both expenditure and indicators there is going to be a contribution/attribution problem: how much of the output had an impact on nutrition and what was the level of that impact. It is hard to compare the impact of policy or monitoring against the direct provision of services.

46. Note that this is important since BPK (Supreme Audit) data up to 3 years old has traditionally been used for baseline purposes.

47. It is possible that detailed expenditure reviews in particular interventions (e.g. Early Childhood Education and Development) could be performed within the present Public Expenditure Review of Indonesia.

Step 5

48. **Establish other data systems.** The national systems do not collect data (generally) disaggregated to district level. Putting in district level identifiers may well result in overburdening information systems and severely adding to the fragmentation and rigidity of budget allocations. As an exception, Dekonsentrasi (DEKON) and Tugas Perbantuan (T/P)

²⁶ This is presently an objective of MoF.

funds are sent to particular areas and are traceable. It is not unknown for K/Ls to make direct purchases to benefit areas, but MoF is starting to crack down on this practice. In some cases (policy making) the benefits will be strictly national, whereas in other cases (capacity building) some of the outputs (e.g. trained trainers) will clearly be assignable to specific districts. Because it may be impracticable for the national systems to trace these, K/Ls may need to keep parallel systems capable of providing data to measure interventions by district.²⁷

Step 6

49. **Baseline allocations are compared with baseline success indicators before April T-1.** Any analysis possible is completed. Trilateral meetings with K/Ls, Bappenas and MoF are held to clarify results. The data, though fairly rough and largely or completely being sourced from Year T-2, will at least provide some source of comparison. Noted that the dated nature of the information is a result of the **Extended Budgeting timescale** which is set down in legislation, and hard to avoid. In April T-1, indicative ceilings for Year T are released.

Step 7

50. **Negotiate Year T Budget.** If outstanding exceptions appear in the Step 5 analysis, further negotiations for Year T should commence to direct more funding to successful interventions and less to ineffective programs. The default position will be no change, as more accurate information based on better defined outputs will be being gathered in year T-1 and most information available will be based on outdated outcomes. It will be important that MoF and Bappenas act as partners in this step, challenging assertions by K/Ls and establishing a strong arbitration role. As part of this late negotiation, targets will be set for Year T.

Step 8

51. **Define progress into Year T+1.** In September T-1, begin the Year T+1 budget process with a Conference to examine progress to June T-1. Topics for discussion would be

- a. YTD T-1 performance vs Year T-2 performance (noting different output structures)
- b. Discuss how apparently improved performance could be rewarded in Year T+1
- c. Discuss targets for Year T+1

Step 9 (untimed)

52. **Analytical work by TNP2K.** In the course of Year T-1, MoF and Bappenas to provide information on finance (for all tagged outputs, original budget, revised budget and outturn) and on performance (numerical production of outputs/meeting of indicators). This will enable reports on whether expenditure has been up to allocation, whether allocations were

²⁷ NB. Extraction of priority vs. non-priority districts will best be done manually as the districts which are priority districts are expected to expand annually. This means that tagging of the information would have to be re-done every year, and year to year comparisons would be largely meaningless.

cut mid-year, cost of output and performance. This information will help with the Step 8 conference, but a later production (e.g. in March) could help with the April-June negotiation of the T+1 Budget.

Other considerations

53. **Cooperation between DGs and K/Ls.** As noted above the system has a bias against cooperation and in favour of siloing, rather than sharing. This is not a legal requirement and the leadership must work towards achieving greater cooperation if the program is to operate more as an incentive program and less as a program of compulsion.
54. **Years T-1 and T.** These will be the most difficult years as the system will not have been in place long, the database will be deficient and there will be no 'bureaucratic inertia' to keep the system running as before. After that, the inertia of the Budget cycle will work towards retaining the program.
55. **Socialisation.** The process of socialising the concept of Convergent Programs with K/Ls has begun but must continue. It is a concept alien to many of the underlying assumptions of the Indonesian financial system and familiarising government workers with the concept and the effectiveness of Convergent Programs is vital.
56. **Summits:** Summits have not been entered above in the sequenced frame, but several types of summits will be critical. Ministerial level summits will provide political buy-in for the Convergent Program. DG level summits, across all relevant programs, will be vital to gain a perspective on which programs are doing better than others, and areas where programs might work together to achieve better outcomes. Although this paper is focused on national level systems, subnational summits will also be needed. TNP2K would be ideally placed as a secretariat that could bring together the proceedings of all of these summits.
57. **Monitoring:** Without adequate monitoring, the program will fail. Convergent Programming requires detailed information to indicate that resources are being used in their most effective combination. Monitoring requires both high levels of check-back activity and appropriate data systems. At present, Indonesia has a low level of expenditure on monitoring, and separate data systems for national planning, national budgeting, national human resources and non-national activities. Upgrading monitoring activity and automating handshakes between systems are a minimum requirement.

Conclusion

58. A Convergent Program is achievable in Indonesia without great changes to the way K/Ls operate, and with no changes at all to the legal and regulatory public financial management system. The first year of operation (T-1) which precedes the first active Budget year (T) will

be difficult and T will similarly be a struggle, as information bases, modes of practice and simple understanding of the system are established. Beyond that, matters should settle into track. Government commitment and funding should be viable and sustainable, absent a shock like 1998.

Attachment 1: Possible Solutions for NatStrat Stunting

The expenditure program must be:

- Results focused: It must aim to achieve the desired outcome, in this case a multi-pronged early childhood health and nutrition intervention funded through a Program-for-Results (PforR) financing mechanism
- Realistic: It must have a reasonable chance of success and not require systemic changes including operational changes, legal changes or behaviour changes unless these can be presented and accepted as desirable *per se* (not simply for the sake of INEY)
- Robust: Once put into action it must be sustainable

The set of possible solutions does not include:

- Revising the budgetary system
- Building another, parallel system for INEY activities and components

Both would be expensive, disruptive and unlikely to find support. They would also involve the investment of political capital at high risk. There are other, easier options. These options would be used at all stages of the process – budget allocation, funds allotment, reporting, and monitoring and evaluation. Within the current system this solution can be achieved in at least three ways (particularly), and another option for the longer-term solution:

1. 'Tagging' of activities, outputs or components, such that tagged outputs or components can be aggregated and analysed within the current KRISNA and SPAN systems for expenditure and outcomes against financial and policy targets.
2. Extra, unified performance indicators implemented in KRISNA and SPAN to specifically report on INEY performance and outcomes
3. Establishing a competitive environment for achievement of existing targets which have been assessed as contributing to the INEY outcomes.

Option 1: Tagging

This option can be implemented in a very basic form and refined in a modular form.

Under this option, all activities related to the INEY program are identified and given a 'tag'. This could be done by specifying them at the activity level in SPAN and KRISNA. Whether the two systems can produce linked results remains to be seen, but the overall activity expenditure against budget and achievement against policy targets ought to be able to be determined with some degree of success. Even at this basic level, trends can be discerned.

The more detailed and the more closely linked the breakdown (e.g. numbers of combined interventions by district, as a time series), the richer the analysis possible and the more central policy makers can distinguish between funding needs and press for improvements in lagging interventions.

A refinement would be to require all tagged items to have a specified INEY reporting format, allowing automation of analysis. It is also possible to actually tag items as a separate field, at least in SPAN, which

would enable highly automated processing in a separate dimension along with database processing and reporting. The ultimate form would be a tool uniting SPAN and KRISNA outputs for preplanned reporting, tracking and allocation purposes.

Option 2: Unified Performance Indicators

An effective, in-system method of tracking INEY activities for all purposes would be to ensure that every activity or component had a relevant performance indicator attached. Because INEY is multifactorial, these would not be identical (e.g. “contributed to the INEY outcome”) but specific (“x% of priority district results reviewed”, “Ry used to establish [INEY-relevant] ToT courses” etc).

Note that these very preliminary indicator suggestions can be used identically across applicable DGs. All DGs with a district review capability and function can use the first (regardless of what INEY intervention they are responsible for. All DGs with a ToT responsibility can use the second.

Implementing highly similar indicators (using exactly identical language) across all heads of allocation would be immensely powerful for data analysis. It is important that a reasonable set of indicators be agreed between stakeholders. This would not be a trivial undertaking and might require Presidential backing and ministerial level negotiation followed by fait accompli implementation by MoF and Bappenas in their systems.

MoF has in the past tried and failed to unite duplicative indicators. The alternative is to have a vast proliferation of new INEY specific indicators. This would carry a high processing cost and would be less robust than a solution with a minimum number of common indicators.

Option 3: Competitive Implementation

Both of the above solutions focus on ease of technical implementation. Another approach is to focus on incentivizing implementation. Based on the Team Based Performance Management (TBPM) methodology, every team would report, in a standard format, to a panel of reviewers. The reviewers would report to the INEY project on the outcomes of all work done, but would also prepare a performance table. The teams who did very well would get official recognition. Those who did poorly would be reviewed, in the first instance to see if some form of assistance would help them to improve.

In the spirit of a competition there would be a ‘league table’, ranking the performance and impact of each team.

This option does require some level of behavioural change and it remains to be seen if the incentive of recognition would be a sufficient motivator. It requires the investment of resources. The benefit (beyond motivating teams to perform well in the INEY context) is that the principle can be more widely applied. In Timor-Leste and Afghanistan, the Ministries of Finance apply TBPM across their entire range of activities, from revenue collection, through budget and payments, to institution backbone issues.

All options should be relatively simple add-ons to the present system. They do not require a change to law. The add-on for each is in the area of administration, which any solution will require. It can be argued that tagging is a tool that Bappenas should already be using, and that target analysis is legally required of the Ministry of Finance (MoF) by PP17/2017 and previous legislation. The options are not mutually exclusive.

Option 4: Creating of a new unique “Cross” Program Code for the longer-term solution

The national and local planning, budgeting, and expenditure arrangements related to stunting reduction could be strengthened in specific ways. While the existing Chart of Accounts structure, coupled with electronic an FMIS, provides a solid platform for prioritizing and tracking expenditures, currently no single program code existing to reflect a close match to expenditures in the convergence plan. Key codes for current stunting related expenditures at the national level are scattered in many different organizational, functional, and program codes. At the national level, there is a feasibility of the Bappenas’ and Ministry of Finance to propose a creation of “unique” programs and/or activities in the planning and budgeting structure to easy tracking expenditure framework of INEY. This included ensuring that the budget-expenditures codes could be made consistent with the strategic plans, but also identify any issues of environmental and social safeguard (ESSA) considerations for the (PforR) Program.

In current practice following to the 2009 program planning and budgeting manual guideline, the word ‘program’ is refer to the entire set of activities managed by a single organizational unit (e.g., a DG-level office). The programmatic classification structure in Indonesia is designed as ‘money follow function’ where the budget is linked to the organizational units, in which one program links to those activities and measurable outputs that are implemented by one echelon I level (Director General, Deputy, Secretary General or Inspector General) of a line ministry, while each activity is usually linked to the lower level implementing units (Director level or Spending Unit). The example of current budgetary structure as follows:

Table 2. Coding Example for APBN in SPAN

033	04	08	2409	001	01
3-digit Code of line ministry (i.e., Ministry of Public Works)	2-digit Code of Echelon 1 (DG Highway)	2-digit Code of Program (i.e., Road management)	4-digit Code of Activity (i.e., Road preservation)	3-digit Code of output (i.e., planning)	2-digit Code of Source of funds (01 for Rupiah Murni and 02 for Loan)

Code #033.04.08.2409.001.01 means the activity of “pelaksanaan preservasi dan peningkatan kapasitas jalan nasional (#2409)” is under the program of “penyelenggaraan jalan (#08)” with the output of “layanan penyelenggaraan penanganan jembatan” (#001) to be managed by DG Highway (#04) within Ministry of Public Works (#033) and funded by “rupiah murni (#01)”. Hence, the current practice for budgetary classification is “money follow function” where the activity code of #2409 is uniquely used for “pelaksanaan preservasi dan peningkatan kapasitas jalan nasional” and exclusively owned by DG Highway in Ministry of Public Works without allowing the other organization unit from another line minister to use the same activity code even if they have a similar activity in nature.

The example of exclusive and unique activity code within Ministry of Public Works is the following:

- #033.01.02.2389=kegiatan **dukungan manajemen** dan pelaksanaan tugas teknis Kementerian PU
- #033.04.08.2403=kegiatan **dukungan manajemen**, koordinasi pengawasan (DG Highway)
- #033.05.07.2417=kegiatan **dukungan** pengembangan sistem air minum (DG Cipta Karya)
- #033.06.10.2421=kegiatan **dukungan manajemen** dan pelaksanaan tugas (DG water resources)
- #033.07.11.5578=kegiatan **dukungan manajemen** penyediaan perumahan (DG Housing)

Thus, nevertheless it is within one ministry, the same “in nature” activity of dukungan manajemen (administrative managerial support) should have 5 (five) different activity codes (#2389, 2403, 2417, 2421, 5578) since the code is uniquely linked with its respective Echelon I. Meanwhile, if it is within one DG (i.e., DG Highway of Ministry of Public Works), a same activity code can be used by two or more spending units. The example is when the same activity code of #033.04.08.2403 for “Dukungan Manajemen, Koordinasi, Pengaturan, Pembinaan dan Pengawasan” or managerial support for coordination, regulation, supervision, and oversight activity is used by 4 (four) different spending units of #384661; #497004, and #497010; and #654624, as long as those spending units who use the activity code is positioned under the same Echelon 1 unit (i.e., Directorate General of Highway).

The government program (the “program”) is reflected in the government’s annual work plan (RKP) but is hard to track in the budget. Thus, it is deemed important for GOI to be able to track its expenditure and ensure alignment of planning, budget, and accounting across ministries for stunting reduction in a consistent way.

Hence, the creation of a single budget and accounting classification for stunting would strengthen budget prioritization and execution monitoring over the life of the Pfor and beyond (for the wider government program). Since a single and identical budget and accounting classifications is consistently applied throughout the budget formulation, execution, and reporting cycle, it is possible to review the performance of a program across period. But, since the activity code is uniquely used by a single organization (Echelon 1) unit, it requires hard work to have an information of “cross-program” that is implemented by many directorates general of different line ministries.

The current practice to budget the cross program is for Bappenas and DG Budget to establish a “thematic” budgetary code through creating a “reference table” identifying all activities codes that contribute to the target achievements of that thematic program (for example, the priority and focus priority programs). However, the reference table has a weakness that it requires a continued monitoring outside of the system and might be changed at any time in the future depending on the priority of the government.

The INEY is designed for multiple expenditure categories to be implemented by different (Echelon 1) organization units across line ministries, therefore the money follow function is not a practical approach and the best solution to design and track the future planning, budget and expenditure realization of INEY related expenditure should be a “cross-program” code, where the relevant set of programs and/or activities and its budget may be organizationally located in more than one-line ministry. This is a shift from the current practice of money follow function where 1 program is done by 1 DG while 1 activity is done by 1 director. Furthermore, the old issue when it was difficult for the government to measure individual ministry or agency accountability and performance when one Program was used by several Ministries/Agencies can be resolved with the implementation of Sistem Perbendaharaan dan Anggaran Negara (SPAN) since SPAN is designed to capture information of all 12 segments that allow a direct comparison between original budget and realization. In SPAN, a single accounting classification is consistently applied throughout the budget formulation, execution, and reporting cycle.

Bappenas/DG Budget/DG Treasury must agree to create the new cross program and/or activity codes, consistently applied in the government’s work plan and budget documents (RKP, Renja-KL, and RKA-KL). The new cross program code can be used by different line ministries to capture all expenditures to be spent on stunting reduction. Furthermore, under the activity code there is another 3-digit level code for output, where the government can design the unique output code to capture the different locations.

In example: output code of #001 is created for the routine maintenance at District A, #002 for routine maintenance at District Z, and so on.

The article 34 of Government Regulation No. 17 year 2017, requires both the minister of Finance and the minister of National Development Planning (Bappenas) to formulate a (consistent) format, classifications and database systems of Renja-KL and RKA-KL. It also requires both ministries to implement an integrated planning and budgeting information system. To realize those requirements, the Directorate of Funding System and Procedures in Bappenas shall take the lead to include the new cross program and/or activity codes of INEY into the KRISNA application. The KRISNA (*Kolaborasi Perencanaan dan Informasi Kinerja Anggaran* or collaborated planning and budgeting performance information) application is built by Bappenas to be used by the line ministry when they develop Renja-KL. Therefore, when the relevant line ministries applying new cross program and/or activity codes for INEY in their annual work plan (Renja K-L) at KRISNA application, it will be consistently reflected in the line ministry annual budget plan (RKA-KL) since the formats and classifications of Renja-KL and RKA-KL should be similar.

To realize cross program, it is recommended for the government to take the steps as follow:

- (i) To apply the approach of “money-follow-program” budgeting (consistent with the principle under the Government Regulation (PP) No. 17/2017 on the synchronization for the process of national development planning and budgeting) by establish the new cross-program and/or activity code that can be used by various Echelon 1 and/or line ministries (i.e. MPWH, Ministry of Health, others) that are contributing to the expenditure category under the Stunting Reduction programs. Furthermore, under the activity code there is another 3-digit level code for output, where the government can design the unique output code to capture the different locations. In example: output code of #001 is created for the routine maintenance at District A, #002 for routine maintenance at District Z, and so on.
- (ii) Bappenas to propose to MOF for the creation of “unique” cross-codes for Stunting Reduction. A single cross-code classification for stunting would strengthen planning, budget prioritization and execution monitoring over the life of the program and beyond. SPAN will help to track the Program performance achievement by individual agency (organizational unit), function, sub-function, and economic classification. Hence, if an identical classification is consistently applied throughout the budget formulation, execution, and reporting cycle, it is possible to review the performance of a specific program across period.
- (iii) If necessary, two ministers (Bappenas and Finance) to repeat a same procedure when they issued a join circular letter in 2009 (attached). In the letter, both ministers shall instruct all respective line ministries to apply the new cross code for stunting program and activity in their planning and budgeting documents (Renja-KL, and RKA-KL).

Attachment 2: The Complementary Roles of MOF and Bappenas

PP 17/2017 may be a genuine game changer, working very much in favour of multisector projects.

Normally, Finance and Development ministries are natural competitors, both seeking to challenge the plans of line ministries to achieve their ends. A focus on efficiency and economy can lead to very different directions to a focus on developmental expansion, leading to conflict between the two. In the end, the relationship becomes one about control of Government funding. Governments often establish a separate development or planning authority to help administer separate funding sources. If competition between the authority and the Finance Ministry becomes too severe, they are frequently merged.

It appears that this is not the case in Indonesia. At least for the funds relating to development, and a literal reading of PP17/2017 seems to indicate for all funds, MoF and Bappenas work together, with Bappenas providing sectoral expertise and MoF providing financial and accounting skills.

As noted above, MoF may not be performing its full role in analysing expenditure, and in this Bappenas can help by providing sectoral expertise and having some of the background knowledge to evaluate proposals on their policy and/or technical merits. Most of the efficiency, effectiveness and development analysis requires a level of sectoral knowledge as well as costing and accounting expertise. In other words, the skills are probably present in a combined Bappenas/MoF team, but not by either agency on its own.²⁸

Suggested Process Steps

In the case of INEY, it would be desirable for budget, policy/project and progress discussions to take place with all ministers concerned, functioning along the same lines as the March to June trilateral hearings. This could be held as part of the summit (i.e. in advance of formal budget hearings with individual Ministries).

A preliminary outline of the objectives of this timetabling would be:

Time	Activity	Objective	Who	Notes
4 th quarter, year 1	Summit	Gain picture of progress of each INEY intervention and holistic progress.	MoF, Bappenas, all K/Ls, Provincial and lower levels of govt, NGOs and civil society	Information would only YTD year 1 at best. Budget process to follow is for year 3
1 st quarter, year 2	Policy/program review	Detailed technical review of individual activities	Bappenas, K/L	Technical merits of alternatives can be discussed

²⁸ There is no suggestion here that a merger of Bappenas and DG Budget is needed.

2 nd quarter, year 2	Trilaterals	Key review of policy options and costings	MoF, Bappenas, K/L	Main opportunity to select most efficient and effective option (including no change)
3 rd quarter, year 2	Budget	Consideration by Parliament	President, Parliament, MoF	Changes in parameters may allow expansion of activities
4 th quarter, year 2	Promulgation of Budget	Set out INEY related funding for Year 3	MoF, President, Parliament	As per normal process.
4 th quarter, year 2	Summit	Gain picture of progress of each INEY intervention and holistic progress.	MoF, Bappenas, all K/Ls, Provincial and lower levels of govt, NGOs and civil society	Information would only YTD year 2 at best. Budget process to follow is for year 4
Etc.				

Attachment 3: Monitoring and Evaluation of INEY

INEY is a perfect demonstration of the weakness of the system's design – a system designed to prevent collusion is going to make cooperation harder. A World Bank note from 2012 detailed the many false starts in Indonesian performance monitoring, and the problems of coordinating and incentivizing reporting. Its recommended approach was in part to look at standardization, but noted that in general, the opposite had occurred.

The burden of reporting is already heavy. Each unit, or at least ministry, has its own M&E plans and methodology. The program will depend on results reporting in a way that shows comparability. Adding an extra reporting requirement is not a new development. It has happened many times before. It is also not a change to the system. But it may meet with active or passive resistance if there is no clear incentive.

(It has been observed that reporting requirements place on lower levels of government are also highly burdensome, to the point where neither accuracy nor even reporting can be guaranteed. This note does not address non-national reporting problems further, except to point out the conundrum that if the at-source data is questionable or absent, it casts into doubt any linkage between national actions and program outcomes. That presents a fiduciary risk in paying for results.)

It seems highly likely that at the allocation level, a complete lack of reporting against formal requirements would be noted and investigated by MoF in the case of financial reporting, and Bappenas and possibly MoF as well in the case of performance indicators.

At the national level, several interventions will cut across program/DG lines. All interventions must be assessed on a basis of coherent, or at least cooperative, implementation. The systems for this do not exist. As operated, INEY faces major problems.

Possible solutions

Alternative implementation approaches are to implement solely for INEY outcomes, or to look at wider implementation by piloting the approach with teams that perform INEY related activities. This would need to be discussed with the Ministry of Bureaucratic Reform.

Attachment 4: A proposed cycle of Expenditure and Performance Reporting, reinforced with reporting on how those reports have influenced the annual budget

Six monthly and annual rolling reports of Performance and Execution

The first report will be a six-monthly report covering April 2019 to September 2019, due in December 2019. This report has three functions:

- As an input to the 2021 Budget process, using the most recent Budget information available
- As an information source to the World Bank's M&E processes.
- As an input to TPN2K consideration of the best use of funding taking into account the broader, cross-Government priority of delivering convergence instruments.

The second report, and all reports thereafter, be delivered at 6 month intervals and will cover the previous 12 months. This means that the first full year report will be available in June 2020, very late in the 2021 Budget Process, and a full year report will be available in December 2020 at the start of the 2022 Budget Process.

December 2019	6 monthly report covering April – September 2019
June 2020	12 monthly report covering April 2019 to March 2020
December 2020	12 monthly report covering October 2019 – September 2020
June 2021	12 monthly report covering April 2020 to March 2021
December 2021	12 monthly report covering October 2020 – September 2021
June 2022	12 monthly report covering April 2021 to March 2022

The rolling 1 year report model smooths out problems such as late release of funds, periods of intra-year unevenness in program activity and execution, and the like. Six monthly reports for yearly budget cycles are less reliable in this regard.

These reports will cover performance, execution, analysis and final recommendations and should be subject to a quality assurance check.

(a) Performance:

Bappenas will have some information relating to outputs and possible indicators tagged in KRISNA. These will be insufficient on their own to report. Working with each K/L charged with delivering convergence products, preferably at the satker level, Bappenas should assemble a database of outcomes, indicators, proven progress, and (where possible) district breakdown of effective delivery of program objectives. Bappenas and the K/L or satker should attempt to reach agreement on the extent of delivery of the program outcomes. There should be room for explanation where program outcomes are not being achieved and suggestions for improvements or corrections to current practice in order to win better outcomes in future. The database should also have slots for expenditure and allocation data [advice needed from MoF] by month or quarter. These slots are to be left blank.

(b) Execution

Execution is made up of allocation (provision of funding to the satkers) and expenditure (use of funding by the satkers). In general, satkers cannot legally spend funds they do not have. Thus the record of allocation is in fact a performance test of MoF and a record of a potential performance constraint on satkers. If the records prove the satkers had funding, expenditure delays only reflect on the K/Ls or satkers. Expenditure will be expected to start slowly and bunch up at the end of the calendar year, as with most annual budgeting systems. These figures should be directly downloadable from SPAN.

At this point, the report needs to be jointly signed by MoF and Bappenas to provide accountability for the correctness of the data and database. Reservations on data provided by K/Ls and not able to be checked in the timeframe can be noted.

(c) Analysis and final recommendations

This job might well be suited to TPN2K. The task is to look principally at the agreed levels of output performance, recommendations made, crosscheck that funding was supplied and applied in a timely manner and assess the whole both individually and potentially in a 'league ladder' to determine which areas were using their funding most effectively. Effectively in this context means that the outcomes achieved were in line with those proposed. The final recommendations may be to adjust, up or down, the Budget amounts going to satkers in view of their performance. Broader recommendations such as rebalancing the entire program would need to be taken through the TPN2K consultative processes, although this report would be an important input to those considerations.

(d) Quality assurance

The report needs to be informally audited for

- Gross arithmetical errors
- Spot checks on data, some random and some on outliers
- Systemic database and spreadsheet errors
- Erroneous reasoning and conclusions
- Resultant ranking errors

The quality assurance can take place after the delivery of the report, but should be concluded within three months so that the budget is not based on incorrect information.

Report on how the Performance and Execution Report was taken into account in budget formulation

The Budget is required to be constructed to make efficient and effective use of funds. In December 2019 there will be a report on the use of funds (the Performance and Execution Report) covering 6 months, and in June 2020 a report covering 12 months. June is very late for influencing the Budget process, although the Budget does not go to Parliament until mid August.

By December 2020, MoF will know the DIPA allocations for satkers with tagged outputs and should be in a position to produce a basic **Report on Utilization of the Performance and Execution Report in Formulating the Budget** indicating:

- (a) Original positions for appropriations (in the 2020 budget process)
- (b) Final allocation (in the 2020 budget)
- (c) Changes suggested by the Performance and Executions report that were adopted

- (d) Changes suggested by the report which were *not* undertaken
- (e) Reasons why some recommendations for changes were not adopted, including K/L representations, changes to programs by Parliament, disagreement with the Report's conclusions (bearing in mind the data has MoF sign-off) and other reasons
- (f) An evaluation of the gross level of changes (increases, decreases and reassignments) driven by the report.

A relatively low level of sophistication and success should be expected of the 2020 report and it should be treated as an opportunity for training, learning and analysis by both GoI and WB as to how the system is functioning.

The **Report on Utilization of the Performance and Execution Report in Formulating the Budget** due in 2021 should be expected to be considerably higher quality and the influence on the Budget greater, based as it will be on 2 rolling reports of 12 months. As the reports get more sophisticated, variance analysis and similar tools should allow some patterning analysis to see where systemic allocation problems may be arising.

Annex B: INEY Delivery Systems: Primary Health Care

All nutrition-specific interventions (as well as some nutrition-sensitive interventions) to address Indonesia's stunting crisis are delivered through the nation's primary health care system.²⁹ Indonesia has a mixed model of public-private provision of primary care, with the public sector more dominant in rural areas (Mahendradhata et. al., 2017). The provision of public health care is decentralized to the district level based on Law 23/2014, with about 9,700 community health centers (*puskesmas*) forming the backbone of Indonesia's primary care system.

A range of primary care units exists to meet the health needs of individuals throughout Indonesia's approximately 75,000 villages. These include community health centers (*puskesmas*) themselves, satellite and mobile health facilities that are under the direct management of the *puskesmas*, as well as community-based health units that receive technical supervision and resources from the *puskesmas* but are managed and implemented by villages and community organizations. These latter units, most notably *posyandu*, are the first point of service delivery for many pregnant women, mothers and young children.

Types of Primary Care Providers

Puskesmas and Networked Clinics

Puskesmas are community health centers that are responsible for delivering a comprehensive set of curative, rehabilitative and preventative health services. According to Ministry of Health (MoH) Regulation 75/2014 on *Puskesmas*, they serve as the first-level public health and clinical care provider in their catchment area. Within a district, there is at least one *puskesmas* for every sub-district, with each one having a catchment area of about 30,000 individuals (Mahendradhata et. al., 2017).³⁰

In line with MoH Regulation 75/2014, each *puskesmas* focuses on six essential service areas: health promotion; maternal, child and family planning services; community nutrition; environmental health (including water and sanitation); communicable disease control; and ambulatory care.

Through their role as public health manager, *puskesmas* carry out advocacy and socialization of public health policies and initiatives, train health personnel, and evaluate the access, quality and coverage of health services. Meanwhile, in their role as clinical primary care provider, *puskesmas* have a number of related responsibilities. In particular, they organize and deliver basic health

Box 1: Nutrition-specific interventions targeted by INEY

1. Comprehensive prenatal visits (including multiple micronutrient supplementation, nutrition counseling, bed net provision, and preventative treatment for malaria)
2. Balanced energy protein supplementation
3. Attended delivery of newborns
4. Exclusive breastfeeding
5. Immunizations
6. Promotion of appropriate complementary & hygiene practices
7. Public provision of complementary foods
8. Zinc supplementation & ORS for diarrhea
9. Treatment of severe acute

²⁹ Primary health care is defined as health care services that provided by a non-specialist health care worker and accessible on a first point of contact basis.

³⁰ The number of individuals in a *puskesmas* service area tends to be lower in rural regions, and outside of Java.

services, and implement screening and referral systems in accordance with national guidelines. For serious medical issues, *puskesmas* will provide patients with referrals to hospitals or specialist clinics.

Since *puskesmas* operate at the sub-district level, they are not physically located in a majority of villages. For this reason, many mothers tend not to seek them out for routine care that is readily available in more convenient locations, often for free (particularly at *posyandu*). Even so, they play a key role in the direct provision of at least two of the nutrition-specific interventions indicated in Box 1: attended delivery of newborns, and treatment of severe acute malnutrition (SAM). Several midwives are typically stationed at the *puskesmas* facility, and obstetrical exam and birthing rooms equipped with basic equipment are available (National Research Council, 2013). In addition, nutritionists are meant to work at each *puskesmas*; they verify cases of SAM that are referred by village-based health workers and treat these families. However, many of these positions are unfilled; a 2013 report found that about 35% of *puskesmas* employed a nutritionist (WPHNA, 2013).

Puskesmas extend their reach through satellite health facilities called *pustu*, which are permanent clinics that offer a similar suite of services, including prenatal care and treatment of simple childhood illnesses and first aid. These are operated by a midwife and/or nurses who report to the main *puskesmas*. Meanwhile, many villages without permanent physical facilities are served by mobile *puskesmas*: motor vehicles and/or boats that provide care to individuals in the more remote parts of the service area. Table 1 offers a summary of these institutions.

Table 1: Types of Public-Sector Primary Health Care Providers in Indonesia³¹

Type of Facility ³²	English Translation	Level of service	Estimated Number of Facilities ³³	Schedule of Service	Service
<i>Puskesmas</i>	Community Health Center	Sub-district	9,731	Daily office hours	Primary care
<i>Pustu</i>	Auxiliary <i>Puskesmas</i>	Village	23,000	Daily office hours	Primary care
<i>Pusling/ Puskeling</i>	Mobile <i>Puskesmas</i>	Village	Not known	1-4 times per month	Replacing <i>puskesmas</i> and <i>pustu</i> for villagers in remote areas
<i>Poskesdes</i>	Village Health Post	Village	55,517	Daily office hours	Maternal and child health care from village midwife
<i>Polindes</i>	Village Birth Facility				
<i>Posyandu</i>	Integrated Health Services Post	Village and sub-village	289,635	1 day per month	Maternal and child health care, serving children up to age 5

³¹ Table adapted from National Research Council, 2013.

³² *Puskesmas* (*pusat kesehatan masyarakat*); *Pustu* (*puskesmas pembantu*); *Pusling* (*puskesmas keliling*); *Polindes* (*pondok bersalin desa*); *Poskesdes* (*pos kesehatan desa*); *Posyandu* (*pos pelayanan terpadu*)

³³ Estimated number of *puskesmas* and *pustu* are from the Indonesia Health Financing System Assessment (2015). Meanwhile, reported number of *posyandu* and *polindes/poskesdes* are from the Indonesia Health Profile 2014, published by MoH.

Polindes/Poskesdes

Village midwives (*bidan di desa*) were deployed across Indonesia in the 1980s to improve the delivery of frontline maternal and child health services. To this day they remain a vital part of the primary health care system. Village midwives provide pre- and post-natal care and assist with deliveries at a permanent facility (*polindes* or *poskesdes*) provided by the government. Typically she also lives in this facility – the idea being that, by providing housing, the government ensures that midwives can be on standby at their posts, providing delivery assistance and primary care to villagers exactly when it is needed. All villages are supposed to have their own midwife, but this is not yet true in practice (Global Health Workforce Alliance, 2010),³⁴ and only two provinces have already met the central government’s target for 120 midwives per 100,000 population by 2019 (MoH, 2016).

Village midwives are employees of the *puskesmas*, and provide free care to the public. That said, they are allowed to operate a private practice in conjunction with their obligations to the state in this capacity.

Conventionally, the facility in which the village midwife works is called a *polindes*. In recent years, MoH has also introduced the concept of a “village health post” (*poskesdes*). The purpose of a *poskesdes* is to promote basic preventative and curative measures to a broader population of villagers, delivered by trained health workers and volunteers (not unlike a *pustu*), with *polindes* focused more squarely on baby deliveries and maternal and child health (Aspalter et. al. 2017). MoH regulations state that new *poskesdes* are supposed to have at least two volunteer health workers (*cadres*), in addition to the midwife or trained health worker.³⁵ In practice, however, the difference between a *polindes* and *poskesdes* appears to be negligible – particularly with regard to nutrition-specific interventions. Midwives are providing the same services to women, infants and toddlers regardless of the name used to describe their facility.

Posyandu

The *posyandu* (integrated health service post) is a form of community-based health care established and organized by community members with the specific purpose of strengthening maternal and child health. *Posyandu* exist in the vast majority of villages across the country, and are a leading delivery platform for the majority of nutrition-specific interventions in Box 1.

The heart of the *posyandu* is the monthly health clinic event, attended by pregnant women, mothers and children under the age of five. Activities at *posyandu* clinics are administered by voluntary health workers (*cadres*) who cater to the five essential tables at each post. The first table is for registration, the second is for weighing and monitoring children’s growth, and the third is for recording the growth into the monitoring card called the *Kartu Menuju Sehat* (KMS) and filling out the KMS book. The fourth table is for counseling and education, particularly in nutrition. The fifth table is for health workers from the *puskesmas*, who provide medical examinations, immunization, vitamin supplementation, family planning services, and other services or education that are based on the needs of the community. The

³⁴ While the village midwife is supposed to live in the village itself, there are reports that some maintain a residence outside of the village (perhaps in a town where private practice is more lucrative), reporting to the village to execute her duties as an employee of the *puskesmas*. See Heywood and Harahap (2009).

³⁵ MoH Regulation 55/2012, on Technical Guidelines for use of DAK Health in 2013: Section 5, letter (b), number 4.

village midwife delivers many of the primary care services at the fifth table, together with a nurse (and perhaps a nutritionist) from the *puskesmas*.

In addition to organizing and managing health and nutrition activities at the first four tables, cadres are meant to conduct “sweeping” to increase mothers’ attendance, and to ensure that those who do not come still receive needed services.

Under Permendagri 19/2011, the Ministry of Home Affairs established guidelines for integrating a number of additional basic social services into *posyandu* activities and outreach. In addition to standard health and nutrition services that already were a staple of monthly *posyandu* clinics,³⁶ these integrated services include early childhood education (ECED), household economic improvement services,³⁷ counseling and home visits to promote clean and healthy living behaviors, and family-toddler groups that are part of the National Board on Family Planning’s Bina Keluarga Balita (BKB) program.³⁸ Despite this regulation from MoHA, *posyandu* are not required to integrate these activities and programs, and many do not.

According to MoH, about 45% of children under the age of 5 attended *posyandu* at least four times in the last six months.¹¹ However, there is evidence of declining attendance, as evidenced by a large increase in the percentage of children who did not attend the *posyandu* at all in the last six months between 2007 (21.1%) and 2013 (34.3%).³⁹

Institutional Arrangements

National Government Role

Law 23/2014 on Regional Administration assigns the central government significant responsibilities for overseeing the country’s health system. The central government manages national public health programs, including for nutrition and immunization. It organizes the registration and accreditation of health care facilities across the country, and sets minimum service standards for quality.⁴⁰ Furthermore, it registers and establishes standards for personnel in the health system (including direct service providers and administrators), plans and supports capacity development for these personnel, and helps to ensure that an adequate number are deployed to disadvantaged parts of the country. The provision of drugs, vaccines, medical equipment, and health supplements for national programs also falls under the authority of the central government.⁴¹

³⁶ Permendagri 19/2011 (on guidelines for integrating social services in *posyandu*) mentions the following nutrition and maternal child health services: vitamin and micronutrient supplementation; nutrition services, education and counseling; pre-natal checks for pregnant women; growth monitoring; intervention for child health and development issues; supplementary feeding; counseling for new mothers; immunization; and education on danger signs for newborns, infants and toddlers.

³⁷ This includes support for women’s savings and loans groups, cooperatives, and training and skills to support household wealth.

³⁸ For more information on BKB, see the 2015 World Bank report [Parenting Education in Indonesia](#) (p. 28-30).

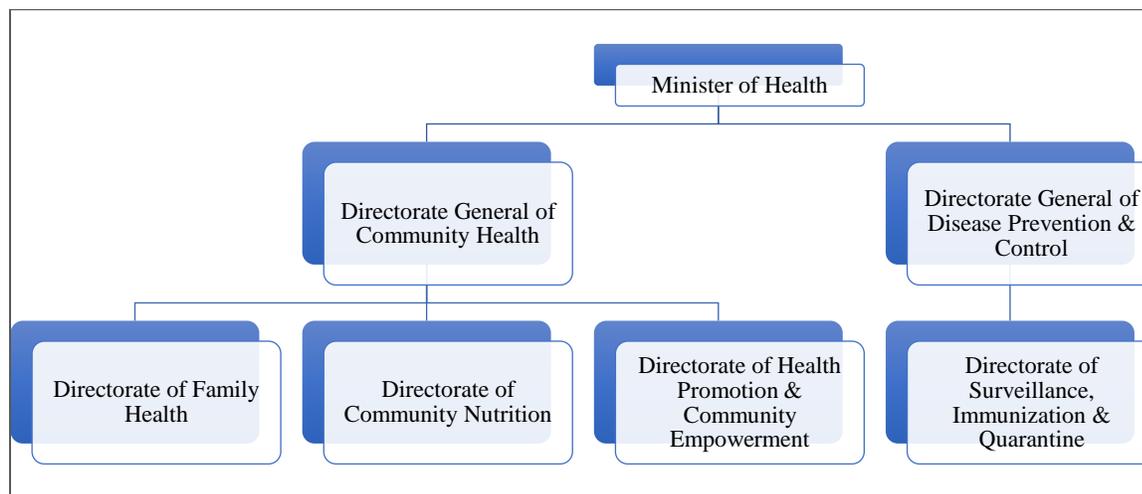
³⁹ RISKESDAS, 2013

⁴⁰ See MoH Regulation 43/2016, on minimum service standards in the health sector.

⁴¹ This is not an exhaustive listing of the central government’s responsibilities; activities that are less directly connected to maternal and child health have been omitted. For more information, see Law 23/2014 on Regional Administration, Attachment 1, Section 1(b): Division of Government Affairs in the Health Sector.

For nutrition-specific interventions, the most significant national actor has traditionally been the Ministry of Health. In particular, the Directorate General for Community Health oversees policy, planning, implementation, technical supporting and monitoring for all but one of the interventions in Box 1. The exception is the national immunization program, which falls under the Directorate General for Disease Prevention and Control. Figure 1 shows these directorates.

Figure 1: MoH Directorates that Oversee Nutrition-Specific Interventions



MoH, in turn, works closely with health offices at the provincial and district levels to execute its responsibilities. However, the relationship is not a hierarchical one. Each level has its own mandates and areas of authority, and district and provincial governments ultimately report to their Bupati/Mayor and Governor, respectively, rather than MoH.

MoH recruits, deploys and regulates health workers who are civil servants (*Pegawai Negeri Sipil* or PNS) and nonpermanent staff (*Pegawai Tidak Tetap* or PTT). PTT are recruited to fill the demand for health workers, mostly in remote areas, that cannot be fulfilled by existing PNS. MoH retains control of all issues related to hiring, paying and firing of permanent civil servants working at the district level, including those paid by local governments (Heywood and Harahap, 2009; Mahendradhata et. al., 2017).

Despite the vital importance of *posyandu* to the achievement of MoH's minimum service standards, MoH does not play a direct role in the management of this delivery platform. Rather, since *posyandu* are community-led institutions, there is a national cross-sectoral operational working group under the Ministry of Home Affairs that oversees the program. It is composed of representatives of MoHA, MoH, Bappenas, local government, the Family Planning and Population Board, and Family Welfare Union (PKK) (National Research Council,

Box 2: Other National Actors that Influence Nutrition

There are many additional public agencies at the national level that influence health and nutrition-related policies. For example, Bappenas and the National Team on Poverty Reduction Acceleration (TNP2K) both support strategy and efforts to reduce inequalities and better serve the poor. The Social Security Agency for Health administers the national health insurance program (JKN). The National Population and Family Planning Board (BKKBN) plans and implements the national family planning program, which provides nutrition-sensitive interventions that are relevant for INEY but beyond the scope of this brief. In addition

2013). MoH produces producing training materials and guidelines for frontline health workers, including *posyandu* cadres and village midwives.

Provincial Government Role

In line with Law 23/2014, provincial health offices (PHOs) are responsible for managing individual and public health efforts at the province level, as well as for overseeing and supporting districts' implementation of health programs (including nutrition policies and initiatives). They do this in coordination with Bappeda, which works across sectors to develop and monitor strategic plans, including the five-year Provincial Plans of Action on Food and Nutrition (RAD-PG).

District Government Role

District health offices (DHO) are responsible for the management of individual and public health at district level. Districts are mandated to provide basic health care, and they set fees for public health services. Based on Law 23/2014, they also plan and develop human resources in the health sector and issue licenses for health workers.

Puskesmas are technical units under the DHO. The DHO manages planning and budgeting for the *puskesmas* that operate in districts, and hold *puskesmas* accountable for meeting minimum service standards. Maternal and child health units within the DHO work with *puskesmas* staff to support effective implementation of nutrition-specific programs and services. That said, MoH's 2011 Health Facility Survey (*Rifaskes*) revealed that only 46% of *puskesmas* had completely adequate program resources (including activities, officers, training, and technical guidance from DHOs) to support community nutrition improvement.

Puskesmas employees directly manage the operation of *pustu* and mobile *puskesmas* (*puskesmas keliling*). Their role in operating the *polindes/poskesdes* is somewhat less clear. It is typical for DHOs to fund the construction of facilities for the village midwife, for the midwife coordinator at the *puskesmas* to manage her performance, and for the *puskesmas* to provide medical supplies (McLoughlin, 2014). Indeed, in some districts, the *polindes/poskesdes* appears to be functionally equivalent to the *pustu*. Yet, in its 2014 national health profile, MoH states that *poskesdes* (a service unit that includes *polindes*) are a community-based health service alongside *posyandu*. This may be more aspiration than reality. Additional field research would be needed to clarify how these arrangements are working on the ground.

As mentioned earlier, *puskesmas* are critical to the effective operation of *posyandu* because they deploy staff to provide administer services at monthly clinics, provide health supplies (such as scales, health materials, drugs and vitamins), and give technical assistance. However, *posyandu* are not directly accountable to the *puskesmas*, but rather the village head. Because of this indirect line of accountability, there is significant variation in how much support *puskesmas* provide to *posyandu*. For example, some centers actively partner with communities on efforts increase attendance at monthly clinics. Meanwhile, other *puskesmas* take a more punitive and deficit-based approach, trying to sanction cadres for poor performance despite their status as volunteers without formal training.⁴²

⁴² According to McLoughlin (2014), in areas where sanctions have been put in place, they are applied either through village regulation, or by the *puskesmas* or village *bidan* (with an unclear regulatory basis). This practice reflects ambiguity about which actors are ultimately responsible for service delivery at *posyandu*.

A cross-sectoral *posyandu* operational working group is supposed to exist at the district level to prepare yearly plans and provide other forms of facilitation, advocacy and monitoring of *posyandu* activities. Where it exists, this group is accountable to the Bupati or Mayor. However, as of 2013 less than 9% of districts had established this working group (McLoughlin, 2015).

Finally, Bappeda and DHOs are meant to collaborate to develop five-year District Plans of Action on Food and Nutrition (RAD-PG). However, relatively few districts have developed a RAD-PG.

Sub-district Government Role

According to the General Guidelines for *Posyandu* Management (hereafter referred to as *Pedoman*), the Camat is meant to provide support and guidance for implementation of *posyandu* activities. Also, when directed by the Bupati or Mayor, a *posyandu* working group can exist at the sub-district level, with the Camat exercising oversight responsibilities. However, research suggests that in most locations the role of the Camat in health service delivery is limited.

Village Government Role

The Village Head is meant to play a meaningful role in the implementation of *posyandu*, according to the *Pedoman*. In particular, these duties and responsibilities include: providing policy, infrastructure and financial support for *posyandu* activities; coordinating among various stakeholders (including cadres, *posyandu* managers and community leaders) to ensure orderly and effective implementation; and motivating community members to attend *posyandu*. He or she is also intended to support oversight of the *posyandu*.

According to McLaughlin (2014), many Village Heads see the core part of their role as encouragement: urging women to go to the *posyandu*, and to give birth with a village midwife at an approved health facility. Many do not see themselves as empowered to, or responsible for, oversight of village health services. According to the author, this is due in part to their lack of specialized health knowledge and insufficient efforts by *puskesmas* to engage them. It also reflects the structural arrangements governing health service delivery: it is challenging for Village Heads to hold the *puskesmas* or the village midwife accountable for their performance because these health centers operate beyond their direct authority.

Posyandu arrangements

Posyandu are institutions that are governed collaboratively by community members with support from the village government, community-based organizations and other partners. While *posyandu* can take a flexible form based on community needs, the *Pedoman* specifies that the management unit should have at least have a head, secretary and accountant, with cadres as members.⁴³ This management unit is charged with managing *posyandu* data and information, proposing yearly activity plans, seeking funding to support activities, and ensuring effective implementation. It sits under the village head. Either the village head or the management unit selects cadres.

Private Sector & Civil Society Roles

⁴³ Each *posyandu* must have at least 5 cadres to be recognized as “complete”. According to guidelines, there is no requirement that the village midwife or other staff from the district health office participate in the group.

Nationally and locally, the PKK takes an active role in the implementation of *posyandu*, with members serving as cadres and volunteer managers. MoH also encourages other community organizations to contribute to the successful operation of *posyandu* activities. Many private businesses and NGOs provide funding and resources to support specific *posyandu* clinics.

Financial and Human Resources

Funding for Health & Nutrition Services

Since *puskesmas* coordinate the provision of primary health care across their catchment areas, they receive the bulk of funding for implementing nutrition-specific interventions. Much of this supply-side financing comes from the district health office. The DHO channels DAK Non-Fisik BOK (*Bantuan Operasional Kesehatan*) funds from the central government directly to *puskesmas*. The DHO also shares some money from other funding streams, including APBD allocations from the district government. In terms of demand-side financing, *puskesmas* receive JKN payments from the national insurance program, and out-of-pocket payments from patients who do not participate in this program.

Of all these funding streams, the largest one for *puskesmas* has traditionally been the BOK. In 2017, the government allocated Rp. 6.6 trillion to the BOK. According to the BOK technical guidelines, these funds are intended to provide operational support for promotive and preventive health efforts that fulfill the targets set in the government work plan and MoH's minimum service standards. *Puskesmas* have discretion in how they use these funds. That said, the 2017 regulation does spell out the BOK's intended support for distribution costs for drug and vaccine provision, partnerships with community-based health units, and *puskesmas* accreditation efforts (among other purposes).⁴⁴

Under Law 36/2009 on health, district governments are expected to allocate a minimum of 10% of annual budget revenue on health. This results in additional money for district health offices, funded from DAU transfers (*Dana Alokasi Umum*) from the central government and from other district revenue sources. These funds can be channeled to *puskesmas* for primary health care services. Significantly, local governments pay salaries for civil servants assigned to *puskesmas*, including nurses, nutritionists and midwives stationed at the sub-district. They can also fund nutrition programs, though not all districts allocate sufficient funds for this purpose.

⁴⁴ See MoH Regulation 71/2016, on Technical Guidelines for Use of Special Allocation of Non-Physical Funds in Budget Year 2017.

Puskesmas receive a growing share of rupiah from demand-side funding streams. The first is from the Social Security Agency for Health (BPJS Kesehatan) via the national health insurance program, JKN. Under the JKN scheme, payment to *puskesmas* comes in two forms: (1) a fixed, monthly capitation payment for each member enrolled in the catchment area; and (2) fee-for-service reimbursement for inpatient and outpatient care. This includes prenatal care, delivery and family planning services that are administered at *puskesmas* facilities for individuals who are covered by the program. The second revenue stream is out-of-pocket payment from patients who are not covered by insurance. Performance-based payment to health facilities by BPJS is not yet in place.

Most village midwives are contracted, deployed and paid by the central government. While the government is considering a plan to change this, so that current contracted midwives would become civil servants paid out of APBD, for the moment their salaries continue to be paid by MoH (Pinto et. al., 2016).

The *puskesmas* provides in-kind support to *posyandu* through vaccines, medication and nutritional supplements that are distributed at clinics, and through health workers who administer primary care.

Meanwhile, community members who organize *posyandu* are responsible for funding operational expenses, including transportation costs for volunteer cadres and supplementary food for families. Depending on the village, this money can come from diverse sources: for example, door-to-door collections by community members, donations by the PKK or the private sector, voluntary donations from women who attend the *posyandu*, and/or funding from the village government.⁴⁵ A 2012 study found that *posyandu* function more effectively when an external funding source or program supports them, and that many *posyandu* go into decline once external support is withdrawn (Mize, 2012).

Personnel Development

In-service learning opportunities for Indonesian health workers are highly variable in a decentralized context. Only some workers receive them, and the training they do receive often is not high-quality. For example, a report commissioned by WHO found that village midwives have few opportunities for job support and learning, with weak processes from the *puskesmas* contributing to an environment that “hardly complies with requirements for a supportive and effective supervision process.” The same study

Box 3: Additional MoH Funding Sources for Local Governments

Beyond the BOP, the central government has two main health funding streams for local governments. The first is the deconcentrated fund (Dekon). This is channeled to provincial health offices, which in turn share some resources with district health offices. Part of this flow consists of transfers of goods in kind rather than cash: for example, vaccines and drugs from MoH are procured centrally and then distributed to the *puskesmas* in a supply chain that runs through the provincial and district health offices. In addition to immunization, Dekon provides funding to district health offices for a handful of other national priority programs, including nutrition. Most Dekon funds do not reach *puskesmas* directly, though they can influence them indirectly.

⁴⁵ The recent Village Public Expenditure Review, led by the World Bank, found that villages allocated an average of 3% of their village budgets on health spending. Of this, approximately 40% went to operations, incentives and capacity building for *posyandu* cadres.

identified multiple studies showing that midwives lack access to continuous professional development training, resulting in self-identified skill deficits in many areas (Global Health Workforce Alliance, 2010).

It appears that other staff at *puskesmas* may experience similar challenges. All training programs, which prior to decentralization were run by the center and funded out of the central budget, have now been transferred to the districts as a part of the decentralization process. The training budget is now financed by the DAU. Districts set funding levels and plans for in-service training experiences. Yet these are often jettisoned in favor of other priorities. This reality can pose particular challenges with regard to nutrition. A 2015 World Bank diagnostic on key nutrition bottlenecks in Indonesia found that only a limited percentage of *puskesmas* staff (including heads of nutrition sections) were properly trained in nutrition, and that minimal nutrition training at the district level has taken place since decentralization.

Given mixed access to job training at the *puskesmas*, it is unsurprising that there is generally a dearth of meaningful and structured learning opportunities for *posyandu* cadres. Unclear accountability for cadre training partially accounts for this. MoH has produced a detailed step-by-step guide (“*Buku Satu*”) for *posyandu* cadres to educate them about their responsibilities. However, the Pedoman for *posyandu* is silent on the specific issue of cadre training. Cadres do not formally report to the *puskesmas*, and many *puskesmas* see *posyandu* as beyond their area of explicit authority (McLoughlin, 2014). As a result, many cadres do not receive any training at all before being thrust into their role; those that do may receive a handful of days of training with minimal follow-up (Mize, 2012). Moreover, while many donors and local government invest in cadres’ skill development through training, there remains an issue with retention of skills once the training is done (Mize, 2012).

Databases and Reporting Systems

MoH decree 511/Menkes/SK/V/2002 mandated the development of the national health information system, called SIKNAS. The system is managed by MoH’s Center for Data and Information. It includes administrative information on health services, health financing, workforce, drugs and medical devices, community empowerment, and health management (Mahendradhata et. al, 2017). SIKNAS is built on bottom-up reporting. Primary care units at the village level submit data on immunization, nutrition, delivery assistance, mortality, etc., to *puskesmas*, which in turn share monthly reports with the district health office. Data are submitted to the provincial health office, which compiles data from across districts and sends reports to MoH.

There is significant duplication in upward data reporting by *puskesmas* and district health offices. In addition to the reporting that feeds into SIKNAS, *puskesmas* officials complete separate data reports on immunization, nutrition and maternal health that go to program teams at the district, provincial and central government levels. Also, provincial health offices sometimes request additional reports with very similar data.

There are numerous issues with the quality of administrative data on health and nutrition. At the village level, child-level data from *posyandu* are collected from registration books that are filled in during monthly sessions. Multiple studies have found that cadres do not report child growth and development information consistently across districts, which compromises the quality of aggregated data. Also, there is a heavy reliance on manual transcribing and calculation at the village and sub-district levels. A more foundational issue is that Indonesia continues to use child underweight as the principal indicator to track

malnutrition; routine data on stunting or overweight/obesity is lacking. As a result, RISKESDAS surveys from MoH have been the main source of data on stunting.

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Annex C: INEY Delivery Systems: PAUD

The term PAUD (Pendidikan Anak Usia Dini) is commonly used to refer to both early childhood education and development (ECED) as a sector, as well as a specific facility that delivers childcare and early learning services to children aged 0-6 years old in Indonesia. This note uses the term “ECED” when referring to the former, and “PAUD facility” in referring to the latter. According to the Ministry of Education and Culture (MoEC), 72% of children ages 3-6 utilized ECED services in 2016.⁴⁶ This is a major increase from 20% in 2005, and has been driven by a national effort to establish at least one PAUD facility in every village in the country.

Indonesia’s system of early childhood education is highly decentralized, with provision mainly taking place through communities, religious institutions and private providers of ECED. Approximately 196,000 PAUD facilities are registered with MoEC,⁴⁷ while approximately 28,000 Islamic kindergartens operate under the oversight of the Ministry of Religious Affairs (MoRA).⁴⁸ These numbers do not include other groups dedicated primarily to the study of the Quran or Bible, informal childcare arrangements, or early learning facilities not registered with the government.

ECED Services & Types

ECED Services

According to the government, the purpose of early childhood education is to stimulate children’s physical, emotional and spiritual growth and development, in order to prepare them for further education.⁴⁹ In particular, MoEC’s 2013 national ECED curriculum emphasizes programming that supports child development in six domains: (i) religious and moral values; (ii) physical and motor skills; (iii) cognitive skills; (iv) language; (v) social-emotional development; and (vi) artistic development. The ministry promotes an active learning pedagogy that includes learning through play. MoEC encourages PAUD providers to provide at least 15 hours of programming each week for children ages 4-6, at least six hours for children 2-4, and at least two hours for children 0-2.⁵⁰

As part of its focus on children’s physical development, the national MoEC curriculum sets out age-appropriate benchmarks for children for their development of gross and fine motor skills; usage of the toilet; adoption of cleanliness behaviors; and choice of clean, healthy and nutritious foods and beverages.⁵¹ These targeted competencies provide an entry point for reinforcing and strengthening ECED programming focused on child health and nutrition in order to address the stunting crisis.

Types of PAUD Facilities

While many forms of ECED exist in Indonesia, two types are dominant: playgroups and kindergartens. Playgroups (*kelompok bermain*, KB) are intended for children ages 2-4, and tend to focus on play-based learning. Kindergartens (*taman kenak-kenak*, TK) and Islamic kindergartens (*raudhotul atfal*, RA) are

⁴⁶ MoEC does not collect data on ECED enrollment among children younger than age 3.

⁴⁷ According to Directorate of Early Childhood Education, MoEC, as of [12 June 2017](#)

⁴⁸ According to Directorate General of Islamic Education and ACDP Indonesia, [November 2016](#)

⁴⁹ Law 20/2003 on the National Education System

⁵⁰ MoEC Regulation 146/2014, on 2013 National Curriculum

⁵¹ It is not known how much time is devoted to these topics in the typical PAUD classroom.

intended for children ages 4-6, and often have a more structured approach to learning. Table 1 includes typical characteristics of PAUD facilities. (Note that, in practice, intended age groupings are sometimes ignored, and hours of operation vary across facilities and geographies.)

Table 1: Types of PAUD Facilities in Indonesia

Type of PAUD Facility	Intended Age	Primary Ministry Responsible	Number of PAUD Facilities	Sample Timing/Duration	Notes
Playgroups (KB)	2-4	MoEC	81,523	3 hours/day, 3 days/week	Can be center-based or home-based
Kindergarten (TK)	4-6	MoEC	89,680	3 hours/day, 5 days/week	Center-based
Islamic kindergarten (RA)	4-6	MoRA	27,999	3 hours/day, 5 days/week	Center-based
Quranic kindergarten & playgroups (TKQ/TPQ)	0-6	MoRA	Not known	Variable	TPQ typically operate in afternoons; children can attend after KB/TL/ RA in the morning
Child care facilities (TPA)	0-6	MoEC	3,059	8 hours/day, 5 days/week	Care for children of working parents
Other early childhood units (SPS)⁵²	0-6	MoEC	22,545	Variable	Some SPS integrate PAUD with existing community services (e.g. Posyandu, parenting classes, TPQ)

Indonesia has historically considered these services as falling into two categories: the formal system (for kindergarten, i.e. TK and RA) and the non-formal system (for other types of ECED). These two systems were merged under one MoEC directorate in 2010. However, differences remain in how ECED personnel are funded and managed across the two systems, and many districts continue to distinguish between formal and non-formal ECED.

Institutional Structures

National Government Role

⁵² Forms of SPS (*Satuan PAUD Sejenis*) include Pos PAUD, Taman Posyandu (TP), Taman Anak Anak Muslim (TAAM), PAUD Taman Pendidikan Al Qur'an (PAUD TPQ), PAUD Bina Iman Anak (PAUD BIA), PAUD for Christian Child Development (PAUD PAK), and Nava Dhamma Sekha.

In line with Law 24/2014 on Regional Administration, the central government's roles for ECED include establishing national quality standards, developing a national curriculum, developing the capacity of education personnel, and accrediting PAUD facilities.⁵³ In line with this law, MoEC has eight quality standards for facilities (see Figure 1). Most of these fall under the management of the Directorate General of Early Childhood and Community Education. That said, a separate directorate is responsible for maintaining and helping stakeholders meet standards regarding the ECED workforce (under the Directorate General for Teachers and Education Personnel).⁵⁴

Figure 1: Eight ECED Standards
(according to MoEC Decree 137/2014)

Standards of:

1. Achievement of child development
2. Content
3. Processes
4. Assessment
5. Educators and education personnel

Meanwhile, Islamic kindergartens facilities operate according to policies and standards set by MoRA. As with MoEC, responsibility for regulating, funding and supervising religious education is divided between two directorates: one that oversees teachers and education personnel, and another that oversees most other aspects of the religious education system (including curriculum; facilities and infrastructure; funding; quality assurance; and technical assistance and supervision).

While standards for quality are specified in numerous regulations and decrees,⁵⁵ compliance is not strong. For example, the vast majority of PAUD facilities lack national accreditation, and only 35% of teachers met MoEC's minimum competency standards as of 2015. Relatively low levels of government spending on early childhood education have contributed to this, with funds for capacity building (as opposed to infrastructure) particularly limited. In addition, the complexity of the regulatory framework has been difficult to communicate in a decentralized system. In a 2015 survey in four districts, only 60% of regulators and less than 50% of PAUD providers said they understood the regulations governing early childhood education.⁵⁶

In 2015, a new Directorate for Family Education was created in MoEC (under the Directorate General for Early Childhood Education). This directorate has the ability to create relevant information on early childhood development for parents.

District Government Role

Under Law 24/2014, district governments are responsible for managing the local system of ECED services and for issuing operating licenses for private facilities. The district education office fills this role for facilities that under the jurisdiction of MoEC. Some districts have a Division Head (*Kabid*) specifically

⁵³ See Law 23/2014 on Regional Administration, Attachment 1, Section 1(a): Division of Government Affairs in the Education Sector

⁵⁴ Responsibilities for these DGs are established in PerPres 14/2015 on the Ministry of Education and Culture, and in MoEC decree 11/2015 on the Organization and Work of the Ministry.

⁵⁵ The legal basis for the implementation of quality assurance in PAUD includes one law, one government decree, two presidential decrees, and numerous ministerial decrees. Two decrees of note are (i) MoEC decree 137/2014, which revised national standards for PAUD; and (ii) MoEC decree 146/2014, which sets out the 2013 national early childhood curriculum.

⁵⁶ See [Development of Quality Assurance for Early Childhood Education](#) report (2015), funded by Education Sector Analytical and Capacity Development Partnership (ACDP)

dedicated to ECED, while others have Division Heads who also oversee primary or community education. Section Heads (*Kasi*) sit under the Division Head.

ECED Supervisors (*Penilik* or *Pengawas*) are employed by the district but work at the sub-district level. They intended to be the first level of contact with ECED service providers, and manage “caseloads” of PAUD facilities that vary in size based on the resources of the education office. Regulations stipulate that ECED Supervisors are responsible for conducting quality assurance and evaluating the effectiveness of ECED services.⁵⁷ These responsibilities include review financial reporting and other information from PAUD facilities. In theory, they also can provide technical assistance to facilities, but a number of constraints prevent this from happening in practice.

When it comes to faith-based ECED, districts are structured in a slightly different way. Religious education was not decentralized under Law 24/2014, and district religious affairs offices act as outposts of MoRA, rather than independent entities. Supervisors within these local offices are responsible for overseeing compliance with MoRA’s national quality standards and guidelines.

PAUD-level Governance

According to MoEC regulations, a number of legal entities are authorized to establish and operate PAUD facilities: these include non-profit organizations, village governments, district governments, individual Indonesian citizens, or groups of individuals who establish a “civil alliance” without forming a non-profit. Any motivated person with sufficient start-up funding can apply to start a new PAUD facility as long as they are willing to meet basic regulatory requirements that are established by the central government and verified by the district.⁵⁸

A principal runs each PAUD facility, managing teachers and overseeing general operations. Principals vary in their prior experience, their knowledge of ECED, and their level of engagement in teaching and instruction. Technically they are under the oversight of the ECED Supervisor in their sub-district. However, given typical capacity constraints within district education offices, monitoring activities tend to be somewhat limited. At the very least, principals complete and share reports with district officials in order to comply with legal requirements and maintain their government funding.

Financial and Human Resources

Figure 2: Sample ECED Organizational Chart for District Education Office

Head of Office	Echelon 2
Division Head (<i>Kabid</i>) for ECED and Community Education	Echelon 3
Section Head (<i>Kasi</i>) for ECED	Echelon 4
Section Head (<i>Kasi</i>) for Teachers & Education Personnel	Echelon 4
Section Head (<i>Kasi</i>) for Community Education	Echelon 4
Supervisors (<i>Pengawas</i>) for Kindergarten	-
Inspectors (<i>Penilik</i>) for Non-Formal ECED	-
Inspectors for Community Education	-

Note: Community Education does not specifically relate to ECED but often falls under the jurisdiction of the relevant Division Head

⁵⁷ Permenpan/RB/No. 14/2010

⁵⁸ MoEC Regulation 84/2014

Costs and Funding

As part of its drive to expand children's access to ECED across Indonesia, there have been significant investments across Indonesia in infrastructure for new PAUD facilities. These have come through many initiatives including time-bound government projects, DAK utilization, community empowerment grant funds, and private and NGO-funded provision. Construction costs differ, but MoEC's competitive block grant program for new facility construction allocated Rp. 45 million per facility to 2017 awardees.⁵⁹

All existing PAUD providers under the guidance of MoEC are able to register with the government to receive an annual funding allocation from the DAK Non-Fisik BOP PAUD (Rp. 600,000 per enrolled child in 2017). These funds support facilities' operational costs. In order to get this money, facilities must meet some basic criteria and agree to reporting requirements and conditions on how they will use the funds.⁶⁰ Islamic kindergartens are eligible for a similar funding allocation from MoRA, called the BOP RA (Rp. 300,000 per enrolled child in 2017). MoEC and MoRA establish the technical guidelines for the BOP, while districts channel the funds to facilities' bank accounts. Most PAUD facilities have the capacity and incentive to access BOP funding, but there are at least some unregistered facilities that do not.

In addition to this relatively predictable funding stream, MoEC oversees many competitive block grant programs, through which PAUD providers can submit applications through their district to get financial support for renovations, new learning materials, or classroom expansions. The scale of these programs is small compared to the demand, however, and the largest of them served only 3,000 PAUD facilities in 2017.⁶¹

A simple ECED costing model done by the World Bank in 2014 estimated average salaries for kindergarten teachers (Rp. 36 million annually) and playgroup teachers (Rp. 12 million annually), based on national teacher registry data and data from a prior ECED project. Kindergartens have a two-tiered personnel system: some teachers are civil servants who receive salaries funded by the central government (irrespective of whether they work at a government-run or privately operated PAUD facility), while other teachers do not get these salaries and benefits. For Islamic kindergartens, most government support for teachers comes from MoRA via district offices.⁶² Salaries for teachers at non-formal PAUD facilities (e.g. KB, SPS, TPA) are not funded by the central government. Some district education offices allocate APBD to support financial incentives for ECED teachers (from Rp. 150,000 to 600,000 per month), while other districts do not.⁶³

A majority of facilities collect tuition or fees from parents, those these are often scaled or waived based on family need (particularly for community-run PAUD facilities). Additional PAUD funding streams

⁵⁹ In 2017 MoEC did not allocate substantial sums of money toward the construction of new PAUD facilities. More research is needed to analyze the relative size of different funding streams for PAUD construction in prior years.

⁶⁰ According to MoEC regulation 4/2017, recipients of BOP PAUD must meet four criteria in order to access the funding: (1) have a National Education Unit Number; (2) have at least 12 registered learners; (3) have a bank account registered in the name of the PAUD facility; and (4) have a taxpayer ID number.

⁶¹ MoEC's Educational Learning Tools (*Alat Pembelajaran Edukatif*, or APE) grant program awarded funds to 2,956 PAUD providers in 2017, with each provider receiving a grant of 10 million Rp.

⁶² While government regulation and ministerial guidelines allow provincial and district governments to disburse funds to religious education institutions (including RA), in practice, relatively few appear to do so. For more information on regulation and funding for Islamic education institutions, see MoRA's [Overview of Islamic Education Sub-Sector in Indonesia 2014](#).

⁶³ This range is based on reports from World Bank technical consultants supporting implementation of the ECED Frontline pilot program in 25 districts.

include philanthropic donations (including from individuals, community organizations, companies, foundations, and/or international NGOs), as well as allocations from Dana Desa (though its use for education is not yet widespread).

Beyond the arrangements mentioned above, MoEC announced two small grant programs in 2017 whose focus is aligned with that of the INEY initiative. The first is a supplementary food program to assist PAUD facilities in providing healthy food at least once a week to children in poor communities. Approximately 3,500 children in 100 facilities were expected to benefit in 2017 (with each provider receiving Rp.15 million). The second program is designed to give start-up funding to new PAUD facilities that serve children ages 0-3 (at Rp.15 million per facility). It is unclear whether grant funds have been allocated or disbursed for this program.

ECED Personnel Development

MoEC administers multiple block grant programs to fund ECED teacher associations and private education institutions to conduct teacher professional development. One of these is a tiered training program called *Diklat Berjenjang*, which offers an upgrade to educators' qualifications. It manages a basic-level 48-hour course, an intermediate-level 64-hour course, and an advanced 80-hour course. These courses cover health, nutrition, cognitive development, social and emotional development, inclusive education, parenting, curriculum, and lesson planning. The ministry also makes block grants to districts for teacher meetings, known as ECE cluster meetings. These are coordinated at the sub-district level. Teacher from neighboring villages will gather in groups on a recurring basis to share experiences and discuss issues of common concern.

National teachers associations play a significant role in supporting PAUD teachers and facilities in Indonesia. The largest of these are IGTKI (for kindergarten teachers) and HIMPAUDI (for other ECED teachers). In addition to implementing training programs such as *Diklat Berjenjang* using government grants, many run training events that are self-funded through teacher fees.

While Law 24/2014 gives districts significant scope to manage ECED, many district education offices have yet to create well-functioning professional development systems for teachers at the local level. Typically, limited district training funds have been used for one-off training sessions. The World Bank's ECED Frontline pilot attempts to strengthen these systems by funding and training a dedicated corps of district trainers, and by coordinating national, district and village stakeholders to deliver an enhanced version of MoEC's basic-level teacher training course.

ECED Databases

MoEC's Directorate of Early Childhood Education maintains a national ECED database, called the Dapodik. It collects basic information on all PAUD facilities with operating licenses, including physical location, operating status, number of teachers, and number of children enrolled. Staff members from district education offices input data into the Dapodik from their own ECED data systems. Data from the Dapodik is linked to BOP PAUD payments.

Other National Policy Umbrellas

Holistic and Integrated Early Childhood Development (HI-ECD)

HI-ECD is the Government of Indonesia's existing multi-sectoral early childhood development policy. It encompasses health, nutrition, social protection, parenting support, and education for children from birth to age six. The foundation of this policy is the 2013 Presidential Regulation on Holistic and Integrated Early Childhood Development. While the Indonesian translation of the HI-ECD acronym is PAUD-HI (Pengembangan Anak Usia Dini Holistik Integratif), early childhood education (Pendidikan Anak Usia Dini) is only one of a number of community services intended by policy-makers to benefit from more integrated planning and implementation.

The regulation established a National Task Force to develop and socialize norms, standards, procedures and criteria for HI-ECD service coordination and integration. It meets every three months and is led by Kememko PMK, with Bappenas and the Ministry of Home Affairs serving as vice leads. Other participating ministries and institutions include MoEC, MoRA, the Presidential Secretariat, Ministry of Health, Ministry of Home Affairs, Ministry of Social Affairs, Ministry of Women's Empowerment and Child Protection, and the National Board for Population and Family Planning.

The 2013 regulation also directs provincial and district governments to establish their own multi-sectoral HI-ECD task forces. The role of these coordinating bodies is to provide technical assistance, supervision, advocacy, training, reporting and evaluation of HI-ECD implementation. Provincial task forces are intended to report to the governor, with district task forces reporting to the bupati/mayor.

In practice, a number of districts and villages have embraced HI-ECD by establishing regulations that complement the national policy, engaging in multi-sectoral planning efforts, and/or establishing and supporting community institutions that integrate multiple services (e.g. PAUD, Posyandu, parenting classes). Where this has happened, civil society organizations often have played a valuable role. That said, many districts have not yet fully implemented the HI-ECD policy, and the central government has not issued technical guidelines to support them in doing this.

Annex D: Construction of an Aggregate Index to Estimate Delivery of Nutrition Interventions to Target Beneficiaries

This note outlines the construction of an aggregate index that is composed of different indicators of access to basic services by children between 0 and 2 months of age, that are relevant for monitoring the different activities of the INEY PforR, and are available in the 2015, 2016 and 2017 SUSENAS surveys.⁶⁴ The year to year change in the value of the index in the priority districts supported by INEY (initially consisting of 100 districts but increasing in number annually until complete national coverage in 2020), in relation to the historic year to year change (the trend) at the national level can be used to structure the partial disbursement of PFORR funds (or as a Disbursement Linked Indicator DLI #5) in the INEY PFORR.

Table 1 below contains the list of available indicators in the 2015, 2016 and 2017 SUSENAS surveys. These indicators have been classified into more aggregate categories corresponding to different sectors such as Health, WASH, with each category not necessarily containing the same number of indicators.

⁶⁴ The 2014 Susenas is not used for 3 main reasons: (i) The sample technique is different. Before 2015, BPS did not use PPP sampling; (ii) Susenas 2011-2014 were collected four times (quarterly). In 2014, during the collection of Susenas 2014, there was a budget cut, preventing BPS from collecting the fourth round of data. As a means of dealing with the 25 % of missing data, the fourth round of Susenas 2013 data, was merged to the Susenas 2014; (iii) The questions between 2014 and 2015 are different for some indicators: a) the Immunization question in 2014 is only for general type, so that complete immunization cannot be not defined in the same way; b) There is no question about 24 hour food of children.; and c) JKN in 2014 is at the household level, and not at the individual as 2015.

Table 1: List of the different indicators for children 0-23 months of age used in the construction of the Aggregate Index

Sector	Indicators	Description	Weight
Health-primary	Basic immunization*	Had complete set of immunization (BCG, polio, HB, DPT, measles)	2/8
Health-Nutrition	a. Exclusive Bfeed >= 6 months for 0-23 mo	Exclusively breastfed for >= 6 months	1/8
	b. Dietary diversity of 7-23 mo children	Consume 3 out 6 food groups (beans, dairy products, meats, eggs, vegetables, fruits)	1/8
WASH	a. Safe Drinking water	Household has access to safe drinking water	1/8
	b. Improved Sanitation	Household has improved sanitation	1/8
Social Protection	Birth certificate	Has birth certificate	2/8
Additional indicators available in the current SUSENAS Surveys			
Food security/Agriculture	Household Food Insecurity (in Access)	HFIAS (Household Food Insecurity Access Score) above or equal to 3	0 (for now, because available only in the 2017 SUSENAS; also in 2018 SUSENAS)
Education	Early Childhood Education (for 24-59 mo)	Attend early childhood education	0 (for now because this indicator currently collected only for 24-59 mo children)
Notes: * The BPS seems to have defined complete immunization with Hep. B 3 times and not 4 times. Therefore, we have carried out the analysis and the construction of the index using 2 different definitions of complete immunization leading to index1 (with Hep. B 4 times) and index2 (with Hep. B 3 times as done by BPS.)			

The aggregate index $I(x_1, \dots, x_6)$ is constructed based on the following formula using 6 different indicators from 4 different categories (sectors).

$$I(x_1, \dots, x_6) = [w_1 I_1(x_1) + \dots + w_6 I_6(x_6)]$$

where $I_1(x_1), \dots, I_6(x_6)$, denote a transformation of the value of the individual indicators and w_1, \dots, w_6 , are the weights assigned to each of the transformed indicators respectively (that are assumed to sum to one). A more detailed discussion of the implications of this formula regarding the trade-offs and possibilities of substitution between different indicators is contained in the annex of this note.

Given that the 6 indicators used in this case are all proportions of children in the district with access to different services, there is no need to transform the value of the individual indicators, i.e. thus, the rescaling function applied is the identity function, $I_i(x_i) = x_i$.⁶⁵

The weights w_1, \dots, w_6 , assigned to each of the indicators respectively and assumed to sum to one, are also adjusted to take into account of the fact that progress should be made at the sectoral level and that progress in only one of the indicators of any given sector does not substitute for lack of progress in the other indicator of that sector. Specifically, the weights are chosen so that the aggregate weight of each category/sector is the same (see Table 1 below).⁶⁶

Based on the above Table 2 below presents the annual value of the index at the national level as well as in the 100 priority districts and all other districts as well as the average value of the year to year change in the value of the index at the national level, in the 100 priority districts and in all other districts.

⁶⁵ In the event that different indicators are added into the index that happen to be measured in different measurement units, standardization to a common basis would be necessary before they can sensibly be aggregated. In that case, each district level indicator x_i would need to be expressed as a ratio relative to national mean value of the same indicator (i.e., rescaled by multiplying by a factor a_i which equals the inverse of the national mean value of the same indicator; thus, the rescaling function applied is $I_i(x_i) = a_i x_i$ with $a_i > 0$).

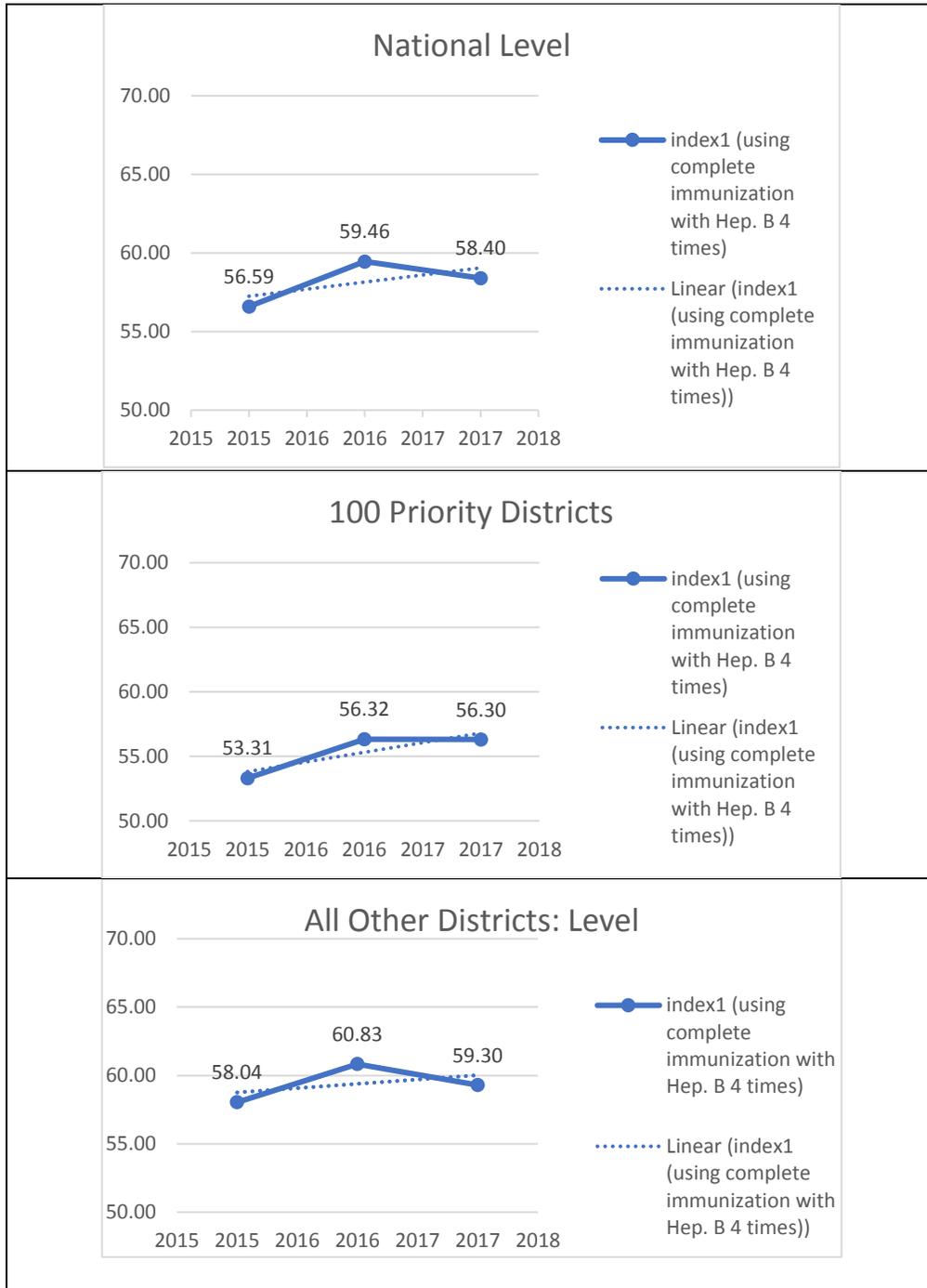
⁶⁶ Note that the addition of new indicators in the index entails the assignment of new weights for each indicator so as to ensure that weights sum to one.

Table: 2: Children 0-23 months: Mean values of indicators and Index by year

2015			
Indicators	National	100 Priority Districts	All Other Districts
Complete immunization (Hep. B 4 times)	0.49	0.50	0.48
Complete immunization (Hep. B 3 times)	0.52	0.54	0.52
Exclusive breastfeeding	0.42	0.42	0.42
Dietary diversity	0.67	0.65	0.68
Access to safe drinking water	0.59	0.50	0.62
Access to sanitation	0.62	0.52	0.67
Has birth certificate	0.62	0.59	0.64
index1 (using complete immunization with Hep. B 4 times)	56.59	53.31	58.04
index2 (using complete immunization with Hep. B 3 times)	57.44	54.18	58.88
2016			
Indicators	National	100 Priority Districts	All Other Districts
Complete immunization (Hep. B 4 times)	0.56	0.58	0.55
Complete immunization (Hep. B 3 times)	0.59	0.61	0.58
Exclusive breastfeeding	0.45	0.47	0.44
Dietary diversity	0.68	0.66	0.69
Access to safe drinking water	0.60	0.50	0.64
Access to sanitation	0.68	0.59	0.72
Has birth certificate	0.61	0.55	0.63
index1 (using complete immunization with Hep. B 4 times)	59.46	56.32	60.83
index2 (using complete immunization with Hep. B 3 times)	60.10	56.90	61.50
2017			
Indicators	National	100 Priority Districts	All Other Districts
Complete immunization (Hep. B 4 times)	0.51	0.54	0.49
Complete immunization (Hep. B 3 times)	0.52	0.56	0.51
Exclusive breastfeeding	0.48	0.48	0.48
Dietary diversity	0.50	0.51	0.50
Access to safe drinking water	0.75	0.70	0.76
Access to sanitation	0.68	0.59	0.72
Has birth certificate	0.62	0.57	0.65
index1 (using complete immunization with Hep. B 4 times)	58.40	56.30	59.30
index2 (using complete immunization with Hep. B 3 times)	58.78	56.70	59.68

Figure 3 below presents the evolution of the Index (index 1) at the national level, for the 100 priority districts and all other districts based on the data from Table 2. Figure 3 also presents a trend line which shows clearly that the trend in 100 priority districts is greater than the national trend as well as the trend prevailing in all other districts. .

Figure 1:



Lastly, Table 3 below present the average change in the value of the index (Index 1) at the national level, as well as for the priority and all other districts. These numerical estimates of the average change in the value of the index are consistent with the trend patterns prevailing in Figure 3.

Table 3: Average yr to yr change in the value of the index

	2016-15	2017-16	Average yr to yr change
National level			
index1 (using complete immunization with Hep. B 4 times)	2.87	-1.06	0.9009
index2 (using complete immunization with Hep. B 3 times)	2.66	-1.32	0.6687
100 Priority Districts			
index1 (using complete immunization with Hep. B 4 times)	3.01	-0.02	1.4960
index2 (using complete immunization with Hep. B 3 times)	2.72	-0.20	1.2599
All Other Districts			
index1 (using complete immunization with Hep. B 4 times)	2.79	-1.53	0.6301
index2 (using complete immunization with Hep. B 3 times)	2.62	-1.82	0.3996

Attachment: Constructing an Aggregate index of different indicators

The aggregation of the different components into one index involves a number of decisions that implicitly impose numerous restrictions on the role that individual components play in the value of the aggregate index, or in the relationship or possible substitution between components of the index. For the sake of transparency, it is useful to adopt a framework that allows one to appreciate the different factors involved in generating an aggregate index based on different components. Consider equation (1) below:⁶⁷

$$I(x) = [w_1 I_1(x_1)^\beta + \dots + w_m I_m(x_m)^\beta]^{1/\beta} \text{ for } \beta \neq 0 \quad (1)$$

This equation reduces the decisions to be made to three: the transformation functions $I_1(x), \dots, I_m(x)$, the value of the parameter β , and the weights w_1, \dots, w_m , (that are assumed to sum to one).

Examples of a transformation function are the identity $I_i(x) = x$, or a rescaling function such as $I_i(x) = a_i x_i$ with $a_i > 0$.⁶⁸ Appropriate transformation functions for indices are generally used for two reasons. First, the different indicators are often measured in different measurement units—such as income in dollars and health in years—they need to be transformed or standardized to a common basis before they can sensibly be aggregated. Second, if the original distribution is skewed, the transformation functions can be employed to avoid that excessive relative importance is given to outliers or extreme values. To achieve that goal, concave monotone increasing functions such as the logarithm can be very useful.

The other component of equation (1) above is the parameter β . One useful interpretation of β is related to the elasticity of substitution between the transformed indicators, σ , where $\sigma = \frac{1}{1-\beta}$. The smaller β the smaller the allowed substitutability between components, that is, the more one has to give up of one component to get an extra unit of a second component while keeping the level of the aggregate index constant. Generally, for $\beta < 1$ the aggregate index is a concave function, which reflects a preference for a more equal vector of (transformed) indicators.

Expression (1) above assumes a common degree of substitution β for all pairs of components. This was done for simplicity of exposition, and it is important to bear in mind, that this might not always be a sensible assumption to make. There is no reason to believe that, for instance, the degree of substitutability between components 1 and 2 (for example, between basic immunizations and improved sanitation) is exactly the same as the degree of substitutability between components 2 and 3 (e.g., improved sanitation and exclusive breastfeeding).

For $\beta = 1$, the weighted mean of order β is reduced to the standard weighted arithmetic mean of the following form:

$$I(x) = [w_1 I_1(x_1) + \dots + w_m I_m(x_m)]$$

Given the simplicity and clarity of procedure, expression (2) above is used frequently in practice to construct aggregate indices. However, the consequence of setting $\beta = 1$, might not always be desirable.

⁶⁷ See Decancq K., and Lugo, M.A. (2013) "Weights in Multidimensional Indices of Wellbeing: An Overview" *Econometric Reviews*, 32:1, 7-34.

⁶⁸ Many other transformation functions are possible (see Decancq and Lugo, 2013).

Setting $\beta = 1$, implicitly sets the elasticity of substitution between transformed components to infinity, and the different components of the index are in effect perfect substitutes, meaning that there is a fixed rate at which transformed components can be exchanged which is constant for all possible levels of all components.

The last component of equation (1) above is the weights w_1, \dots, w_m . The weights play an important role in the determination of the trade-offs between the different components, and, hence, they implicitly convey a specific view on how the aggregate index should look like. Inherently, the choice of the most appropriate weighting scheme is one with a normative (how it should be) implication. The survey paper by Decancq and Lugo (2013) identifies eight different approaches to setting weights that can be classified into three broader categories: *data-driven*, *normative*, and *hybrid approaches*. The most commonly used approach for weighting in multidimensional indices of wellbeing is equal or arbitrary weighting. Equal weighting has often been defended by its simplicity or from the recognition that all indicators are equally important or from an agnostic point of view.

It is important to bear in mind that an equal weighting scheme implies, in interplay with choices about the transformation and substitutability, specific trade-offs between the components, that is always important to make explicit. The role of weights becomes more transparent when one focuses on the marginal rate of substitution (MRS) which is the amount of component 2 that one is willing to give up for an extra unit of component 1, while maintaining the same value of the aggregate index.

Annex E: Lessons from the Long-Term Generasi IE

In 2007, the Government of Indonesia (GoI) launched an incentivized community block grant program, known as Bright Health Generation (Generasi Sehat Cerdas). Generasi is consistent with both the Indonesian government's priorities and the Sustainable Development Goals: to reduce poverty, maternal mortality, and child mortality, and to ensure universal coverage of basic education.

To allow for a rigorous, randomized evaluation of Generasi, the GoI incorporated random assignment into the selection of Generasi locations (Olken et al. 2011). Within the districts selected by the government for the program, entire sub-districts (*kecamatan*) were randomly assigned to either participate in the program or to be in a control group. The randomized assignment of subdistricts into treatment and control has remained intact after nine years of programming allowing for a long-term impact evaluation (IE) of Generasi. An evaluation carried out in 2016 assessed Generasi's long-term impact on 12 health and education targets and stunting. Over 46,000 household members, village heads, and school and health facility staff were surveyed in the final round.

The main findings of the Generasi IE are as follows.

- 1. Since 2009, the overall health and education environment in Generasi IE districts has improved dramatically, even in control areas.** Vital health indicators, such as deliveries attended by a doctor or midwife, have increased substantially since 2009 and now account for over 92 percent of births in our sample area. Similarly, school participation rates have risen significantly since 2009: enrollment for school years 7–12 was 98 percent in 2016. These improvements likely reflect both substantial policy changes and improved household incomes throughout Indonesia.
- 2. There is now significantly less room for improvement in many Generasi target areas.** For example, Generasi's impact on reduced malnutrition and school enrollments that were present in Wave III are no longer observed in Wave IV, but there have been substantial improvements in precisely those indicators in both treatment and control areas compared to 2009.
- 3. Generasi still helps mobilize community members to attend the *posyandu* (health clinic) for infant weighing and maternal health and parenting classes.** Treatment areas experienced 0.13 more weight checks, on average, for young children in control areas (a 6 percent increase compared to control areas) and a 73 percent increase (8.5 percentage points) in attendance of parenting classes compared to control areas, particularly among mothers of young children. Pre-natal class attendance also increased by 8 percentage points (24 percent increase compared to control areas) in treatment areas.
- 4. In the lowest-performing districts, Generasi has continued to be effective at encouraging community members to attend the *posyandu* and increasing immunizations and vitamin A distribution.** Eight years after implementation, treatment areas in the lowest-performing tercile continue to experience a 0.19 increase in weight check frequency. In the same tercile, immunization rates increased by 3 percentage points (roughly 4 percent higher than control areas), while vitamin A uptake increased by 0.15 supplements (11 percent increase compared to control areas).
- 5. Generasi's initial impact on stunting, concentrated in NTT province, has not been sustained beyond the 2009 IE.** There are three possible reasons for this. First, Generasi programming in IE locations did not include interventions targeting water use, hygiene, sanitation, or other factors that are thought to reduce stunting. Second, implementation issues and delays in the maternal health and parenting classes may have weakened any potentially positive impacts on behavioral change. Finally, the overall substantial improvements in stunting in NTT – in both treatment and control areas – may have exhausted the 'low-hanging fruit' that Generasi was able to accomplish in earlier periods.

The evaluation results have two main policy implications.

1. **One of Generasi's greatest accomplishments is the sustained revitalization of the *posyandu*, which was accomplished through program facilitation, community participation, and a targets/incentive system.** The *posyandu* are monthly local health clinics for mothers and children that distribute snacks and vitamin A tablets, measure children's height and weight, immunize kids, and provide nutrition and health advice. This system has been central to the GoI's efforts to curb infant/child mortality and provide citizens with family planning services since the early 1980s (Leimena 1989). By the late 1990s attendance at *posyandu* had decreased from 52 percent to 40 percent in both urban and rural areas, but with a greater decline in rural ones. Reasons for the decline include a loss of support from NGOs and changing preferences for private providers in Indonesia (Marks 2007). Despite these setbacks, in Generasi villages, community participation in *posyandu* activities continues to improve eight years after program implementation. This participation has been sustained in part by communities choosing to allocate portions of their Generasi block grants to fund interventions that incentivize participation at the *posyandu*, such as providing nutritional supplements to mothers who attend, funding subsidies for pre- and post-natal care, and remunerating *posyandu* volunteers.
2. **Future GoI health-related programming needs to consider how to sustain the *posyandu* and ensure that mothers continue to bring their children for weight/height measurement, PAUD attendance, and basic maternal and infant health services after Generasi exits.** The 2015 disruption in Generasi programming underscores the difficulty of maintaining *posyandu* participation without offering incentives. The disruption meant that funding could not be spent on nutritional supplements which according to qualitative field reports led to a reduction in *posyandu* attendance. The future of *posyandu* success depends on villages continuing to support participation in the *posyandu* in the absence of Generasi.

At the same time as the Long Term Generasi IE quantitative survey was rolled out, the IE team collected qualitative data in geographically distinct treatment and control communities to answer two questions. First, are Generasi's three components – facilitation, community participation, and the target and performance bonus system – functioning as intended? Second, what is the program's long-term impact on village governance and service delivery, and how can it influence Village Law implementation?

The qualitative findings related to the first question can be summarized as follows. First, Generasi *facilitators* were found to have technical knowledge about health and education issues, experience in mobilizing communities around basic social service delivery, and creative problem-solving skills. They maintain communication and cooperation with a variety of actors in the community and at different levels of government to assess community needs and address problems. Generasi facilitators were found to be better informed than Village Law facilitators about their roles and responsibilities as well as the technical aspects of their jobs, and were better integrated into the areas in which they work. Second, the fieldwork revealed that many facilitators and beneficiaries interpret *community participation* as attending meanings and utilizing services, which fails to advance the program's goal of empowering communities to plan, implement, and monitor the delivery of basic services and influence village governance. Community oversight of service delivery appears to be focused on the distribution of Generasi assistance rather than on monitoring the quality of service delivery. Third, the study found that while facilitators at all levels were aware of the 12 health and education related targeted indicators, few understood how they related to the *performance bonuses*. Public accountability appears to serve as a more important motivation to achieve the targets: village leaders wish to avoid the embarrassment of reporting at inter-village meetings that they failed to meet them.

In regards to the second question, the study found that Generasi has had a significant impact on village governance, but not on the delivery of basic social services. Several program actors have taken on important roles in their communities, which has helped embed Generasi-style consultation and implementation approaches in village planning processes and encouraged villages to allocate funds for health and education in their budgets. Yet there have been fewer contacts with (or advocacy efforts targeted at) service providers, which may explain the program's uneven impact.

Based on the qualitative findings, the following recommendations can be made in two main areas.

Facilitation

- Posyandu volunteers and other community-based volunteers should continue to receive training in health service delivery. Puskesmas staff could deliver complete and routine training for posyandu cadres and all community-based health volunteers starting with curriculum the Ministry of Health has already developed for this purpose.
- While it is important for Village Law facilitators to continue collecting health, education and other basic indicators, the Ministry of Villages should reduce their data collection burden. The Ministry of Villages and other community-based programs should consider training and paying community volunteers to collect routine data, which would free up facilitators' time for outreach and enlarge the network of community volunteers.
- Given the important role that *posyandu* volunteers play in providing maternal and infant health services, the village governments should continue to ensure that *posyandu* are sufficiently staffed (at least five per village and one per hamlet) and that they are compensated appropriately.

Targets and incentives

- Generasi's target system was effective in motivating facilitators to mobilize communities around the 12 health and education targets. In line with the Generasi MAD meetings and the Reporting Day forum, *kecamatan*s should continue coordinating village-wide meetings post-Generasi in which village actors discuss community problems and exchange advice. The continuation of a target or ranking system and the announcement of results at these *kecamatan* forums would put pressure on Village Law facilitators to ensure that their villages include health and education activities in their budgets and deliver results.
- Even in the absence of targets, *kecamatan* administrations could routinely bring together Village Law facilitators, village government representatives and puskesmas and *Dinas Pendidikan* staff to discuss villages' achievements and obstacles in health and education service delivery at *kecamatan* forums. Puskesmas and *Dinas Pendidikan* staff could use these meetings to raise awareness about health and education issues, respectively.
- Programs that adopt a Generasi-style performance bonus may want to consider simplifying the system, and to ensure high levels of awareness of the process among program actors and community beneficiaries throughout the project cycle. The monetary rewards associated with the bonus should also be more substantial.

- Future programs should consider rewarding individual facilitators with non-monetary bonuses (e.g., a package of household supplies) as a possible alternative to a community-level performance bonus. Evidence from the qualitative study suggests that informal rewards help KPMDs and other village actors feel appreciated and motivated.

Collection of Stunting Data

The WHO provides clear standards for measuring and analyzing anthropometric nutrition data (stunting, wasting and overweight).⁶⁹ Specifically, it establishes measurement protocols (tool calibration, measurement precision) and provides the distributions of human development patterns used for processing the original anthropometric data and estimating national and subnational trends in malnourishment.

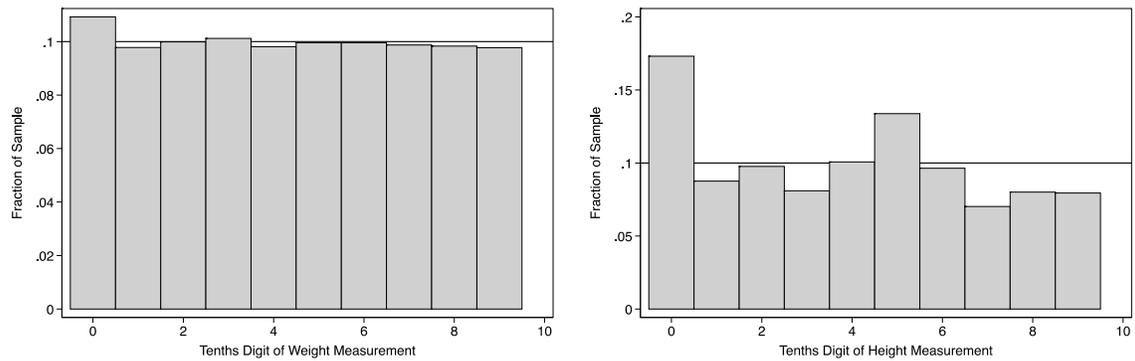
When collecting anthropometric data, enumerators should adhere to WHO standards for measurement precision. The WHO baseline study draws on and assumes measurements precise to 1 millimeter and calibrated to .1 kilograms (see Mercedes de Onis et al 2006, pg. 4). When enumerators round or truncate height or weight anthropometric measurements to the nearest whole measure (centimeter, kilogram), any subsequent calculations of the subject's malnutrition status are inaccurate. Potential biases in corresponding malnutrition indicators may be relatively more problematic among younger subjects.

The direction of bias due to rounding or measurement truncation is unclear. If enumerators exhibit tendencies to round up but not down, the frequency of malnourished children will be relatively lower than is true. Enumerators that consistently round correctly will produce measurements that cause the negative and positive ends of the distribution to become thicker while the center of the distribution becomes flatter. Overall rates of stunting may change marginally, but the intensity of a given subject's stunting is more likely to be exaggerated.

As an illustration, the Generasi IE team turns to the anthropometric measurements from the Indonesia Family Life Survey (IFLS). The IFLS puts a lot of upfront investment into the training of enumerators to ensure for high-quality anthropometric data investment. We utilize data from the latest round currently available (2014). In the figure below, we plot histograms of the tenths digit of weight (left) and height (right) measurements. In each plot, a simple horizontal line indicates the uniform distribution (where all tenths digits are equally likely). For weight measurements, the digits are nearly perfectly distributed indicating that there was no rounding or measurement truncation of the weight data. For height measurements, notice that the zero and five values are more frequently observed than all other values. Higher values (those closer to the next whole number) appear to occur less frequently than lower values, just above the closest whole number. This indicates that enumerators may have been more likely to round heights up, but not down. This example shows that even with a high-quality survey that invests significantly in enumerator training, there is still a degree but significantly less than other surveys of rounding in the height data.

⁶⁹ Mercedes de Onis et al. 2006. WHO Child Growth Standards. World Health Organization. Geneva.

Figure 1 - Precision of measurements in 2014 IFLS survey



To ensure for high quality data collection of anthropometric height and weight data, the Government of Indonesia should invest in: the the training of enumerators; equipping enumerators with WHO-compliant weight and height measurement equipment; ensuring that there are sufficient enumerators; improving the quality of data collection monitoring; and providing better training for data entry.