**COMBINED PROJECT INFORMATION DOCUMENTS / INTEGRATED SAFEGUARDS DATA SHEET (PID/ISDS)**

**CONCEPT STAGE**

**Date Prepared/Updated:** 17-Dec-2015

**Report No.:** PIDISDSC16111

## I. BASIC INFORMATION

### A. Basic Project Data

<table>
<thead>
<tr>
<th>Country:</th>
<th>Indonesia</th>
<th>Project ID:</th>
<th>P157150</th>
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<tbody>
<tr>
<td>Parent Project ID (if any):</td>
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**Project Name:** Indonesia-Supporting Primary Health Care Reform (I-SPHERE) project (P157150)

**Region:** EAST ASIA AND PACIFIC

**Estimated Appraisal Date:** 10-Oct-2016

**Estimated Board Date:** 21-Feb-2017

**Practice Area (Lead):** Health, Nutrition & Population

**Lending Instrument:** Investment Project Financing

**Sector(s):** Health (80%), Public administration- Health (20%)

**Theme(s):** Health system performance (40%), Participation and civic engagement (10%), Population and reproductive health (15%), Nutrition and food security (15%), Decentralization (20%)

**Borrower(s):** The Republic of Indonesia

**Implementing Agency:** Ministry of Health

### Financing (in USD Million)

<table>
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<th>Financing Source</th>
<th>Amount</th>
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<td>Borrower</td>
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<td>International Bank for Reconstruction and Development</td>
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<td>Total Project Cost</td>
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**Environmental Category:** B - Partial Assessment

**Concept Review Decision:** Track II - The review did authorize the preparation to continue

**Is this a Repeater project?** No

**Other Decision**

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B. Introduction and Context

Country Context

1. Indonesia, the fourth most populous country (~250 million) in the world, has made significant gains in economic growth and poverty reduction. Relatively strong economic growth (5.5% per year since 2000) has been accompanied by a sustained decline in poverty rates: about 43% and 16% of the population lived on US$2 a day and US$1 a day, respectively, in 2011, down from 82% and 48% (respectively) in 1998. With a GDP per capita of about US$3,500, Indonesia is currently classified as a lower middle-income country and will transition to an upper middle-income country with continued economic growth. Its human capital indicators also show impressive gains, with adult literacy at almost 95%, gross enrollment of 100, 83, and 32% in primary, secondary and tertiary education, respectively, and the share of female enrollment exceeding that of males at each level.

2. Health outcomes and outputs in Indonesia have also improved in recent years. Life expectancy has increased from 68 in 2002 to 71 in 2013. Under-five mortality has declined from 48/1,000 live births in 2002 to 29/1,000 live births in 2013 and Indonesia is projected to meet the child-health related Millennium Development Goal (MDG). Pregnant women receiving four or more antenatal care visits have also increased from 81% in 2002 to 88% in 2012. Percentage of moderately/severely underweight under-five children has decreased from 23% in 2002 to 19.6% in 2013. Landmark legislations in 2004 and 2011 have helped realize a potential pathway to Universal Health Coverage (UHC). Health insurance coverage rates in Indonesia have increased significantly in recent years: from ~27% in 2004 and to ~65% in 2012. As of 2014, Indonesia has one of the largest single-payer social health insurance programs, Jaminan Kesehatan Nasional (JKN), in the world. By 2019, everyone in Indonesia is supposed to have coverage under the JKN.

3. However, key challenges remain, including slow progress on maternal mortality and chronic malnutrition, as well as inequalities in health outcomes. The maternal mortality ratio (MMR) is 190/100,000 live births, closer to low-income countries. Post-partum hemorrhage (PPH), eclampsia and infections are the key causes of maternal death with underlying lack of continuum of care, young age pregnancies, unsafe abortions and a stagnating family planning program. Thirty-seven percent of children under 5 are stunted and 12% are wasted. Key determinants of malnutrition are inadequate breastfeeding and young child feeding practices, and poor water and sanitation. Large regional and income-related inequalities remain across the country. Infant mortality rates (IMR) differ by two to three times between provinces and IMR in the poorest wealth quintile of households are more than double those in the richest. While overall coverage rates of key maternal health services are high, it varies widely across regions and income: there is a two-fold difference in skilled birth attendance (SBA) across some provinces and home delivery rates are six times higher in the lowest quintile compared to richest quintile. Sixty-four priority districts have been identified by the Ministry of Health (MOH) based on the number of maternal deaths. New challenges are rapidly emerging due to a demographic (ageing population) and an epidemiological transition (persistent communicable diseases with rising prevalence of non-communicable diseases). Indonesia is among few countries in the world that reported an increase of HIV incidence among key affected population groups. Tuberculosis (TB) is still the second cause of premature deaths and malaria remains endemic in some regions.
4. Decentralization has increased the complexity of fiscal transfers, blurred governance and accountability and strained sub-national capacity to achieve improved health outcomes. In 2001, responsibility of service delivery was shifted to the district level, with fund transfers being made directly to the district level, bypassing the provincial level. In principle, decentralized health sector decision-making, coupled with large fiscal transfers from center to sub-national levels, was intended to empower local governments (LGs) to efficiently and effectively design and implement health programs, especially by adapting to local contexts. However, in practice health financing flows are much more complex and difficult to manage, marked by seven vertical intergovernmental financing channels, each with different rules and procedures. This splintered model strains LGs capacities to plan, manage, and allocate funds efficiently in order to maximize results, and hinders governance and accountability systems. There are multifaceted and competing mixtures of central and sub-national regulations governing authority over key decisions which complicates health service delivery, and is one reason behind the disparity of human resources for health (HRH) distribution in the country. Finally, another challenge of decentralization in the health sector has been the disruption to and varying quality of monitoring, reporting, and data systems. Recent and planned decentralized reforms to intergovernmental financing, including for health, could significantly alter the sub-national budgeting landscape.

**Sectoral and Institutional Context**

5. Key challenges for health financing relate to low public health expenditures (PHE), high out of pocket expenditures (OOPE), complex intergovernmental fiscal transfer systems and lack of a results-based approach, as well as lack of clear integration with demand-side financing through JKN. PHE at 1.2% of the GDP (US$ 9.3 billion) is amongst the lowest in the world and forms only 39% of the total health expenditures (THE: 3.1% of GDP, US$107 per capita in 2013). Government revenue as a share of GDP is also low at 17% and PHE is only 5.3% of the national government expenditure. OOPE is very high at 46% of THE and is 1.2% of GDP. Both supply-side financing of public sector provision and demand-side financing through the JKN exists. On the supply-side financing, several intergovernmental fiscal transfer mechanisms exist: the main ones are general allocation funds (Dana Alokasi Umum, DAU), revenue sharing (Dana Bagi Hasil, DBH), and special allocation funds (Dana Alokasi Khusus, DAK). About 75% of DAU is tied to spending on personnel, so in reality districts have little discretion over their expenditures.

6. DAK is the largest transfer that is conditional on being used for a specific purpose, so it constitutes an important fiscal lever available to the national government to influence service delivery outcomes at the subnational level. DAK has traditionally been focused mainly on infrastructure investments, although in the health sector it also finances the purchase of medicines. Although DAK constituted only 6% of total intergovernmental transfers in 2012, it is planned to grow to 29% in 2016, partly because of increased funding for capital and partly because transfers to finance the operation of service delivery facilities have been folded into the DAK. DAK forms an important source of additional resources for the health sector in underdeveloped districts, and its importance is likely to increase in the future. DAK allocation for capital investment in health is expected to increase four fold from 2014 to 2016, and DAK allocation for operational financing of puskesmas is expected to increase nearly three-fold in the same period. However, DAK allocations are not strongly linked to results, although DAK transfers have been shown to crowd in spending on capital by district governments. The incorporation of operational funding for puskesmas as non-physical DAK from 2016 onwards presents opportunities to unify planning and budgeting for capital and recurrent financing.

7. For the JKN, key financing challenges include covering the informal non-poor, fiscal
sustainability, a non-explicit benefits package and poor integration with supply side financing. JKN needs to ensure the poorest 40% of the population are targeted better and that contribution collection among non-poor informal workers increases. Indonesia’s health sector has low dependency on external financing with the exception of some health programs. The problem owing to the fragmentation of supply-side financing is further compounded by a lack of clear integration with the JKN demand-side financing, which is rising as a share of resources for health and also harnesses private sector provision. JKN implementation is done through Badan Penyelenggaran Jaminan Sosial (BPJS) Health, which is not well integrated with other health authorities across all levels. JKN expenditures, at ~USD 3.6 billion, formed about half the PHE in 2014 with per member expenditures increasing every year raising concerns on sustainability. About 65% of the expenditure claims were hospital-based and another 20% were used for non-capitated fee-for-service payments to facilities. The overall claims ratio was 104% in 2014, with wide variations between different types of members. Even though JKN capitation forms a large source of revenue for puskesmas, its use for supply-side readiness continues to be problematic due to a lack of clear guidance on capitation spending.

8. Indonesia has a mixed model of public-private provision of health care services, with the private sector increasingly taking a more dominant role. The public sector is more dominant in inpatient services, especially in rural areas. There are about 2,400 hospitals in Indonesia and about two-thirds of them are private. The public health care system is decentralized to the district level with about 9,600 puskesmas forming the backbone of Indonesia’s health system. Private clinics increasingly provide primary care but there is no systematic information on their numbers, nature and distribution. The public primary care system also includes 23,000 auxiliary puskesmas (pustu) for outreach activities in remote regions, village-level delivery posts (polindes, often the home of the village midwife) and village health posts (poskesdes). Frontline service delivery at the ~75,000 villages is undertaken through posyandu and also by village midwives (who are formally part of the health system). Kader - who work on a voluntary basis - are not part of the formal health system and do not get paid (only minimum transport allowance). Additional community driven development (CDD) programs complement frontline service delivery at the village level in some provinces. Service delivery is challenging as Indonesia has over 6,000 islands and many Indonesians face significant physical and time barriers to accessing health care.

9. There are wide variations in district-level performance on health facility service readiness to provide good quality health care services. The service readiness survey for health facilities across Indonesia revealed that not even one puskesmas had met all of the 38 tracer indicators. There is significant variation across districts - while districts in central Java had almost all puskesmas fulfill at least 80% of the readiness indicators, districts in eastern Indonesia such as Papua and Maluku had only half of the puskesmas fulfill 80% of these indicators. Puskesmas are more accessible than hospitals in terms of time taken to reach these facilities but this varies widely across districts. Only 62% of the puskesmas mandated to provide basic emergency obstetric and neonatal care (BEONC) had at least one staff trained in the last two years. More than half (57%) of staff were trained on growth monitoring and only 36% of puskesmas maintained child weight scales. About a third of puskesmas also lacked critical supplies such as vitamin A and zinc to support child development and there is a significant regional variation for these service readiness indicators. Only 39% of public hospitals and 3% of the 30 private hospitals surveyed, maintained all 23 basic obstetric care tracer items. Twenty percent of all public hospitals and none of the 30 private hospitals surveyed, maintained all six blood transfusion tracer items and there was a four-fold variation between some districts. A large
majority of provinces (25 out of 33) had less than 30% of public hospitals with all tracer items, including eight provinces with zero hospitals reaching this target. Referral systems are weak and primary care providers do not play a role in “gate-keeping” to integrated health care despite JKN capitation.

10. Despite having attained the minimum WHO norm, HRH remains a key challenge for Indonesia’s health sector that further impedes the ability to provide good quality services. The core HRH to population ratio in 2013 was estimated at 2.3 per 1,000, equal to the minimum recommended by WHO as necessary to attain an 80% skilled birth attendance rate. Key issues include unequal distribution, a shortage of specialists, and poor quality of HRH workers. For example, the physician to population ratio in Maluku-NTT-Papua is one-third of that in the Java-Bali region. The unequal geographic distribution for specialists is even worse than for general physicians. The shortage of nurses is especially acute in public facilities. Financial resources are often not the only factor to attract HRH in remote areas: good management and better facilities were viewed as equally important. Provision of continuing professional education and eventual opportunities for civil service employment have also been found to be important. Competency of HRH workers is generally low and variable: evidence from vignette responses indicates poor clinical knowledge and awareness in several parts of the country. ANC quality scores were below 40%, and generally lower in rural areas and amongst private clinics but quite similar across Indonesia. Only 8% of the 700 midwifery schools have gone through the accreditation process specific for midwifery program. MoH has introduced standard in-service training but there is no information on the quality of the training programs. An assessment on basic midwifery care at the puskesmas shows low compliance to quality standards: only 61% completed a medical history, only 57% completed a physical examination and only 68% used partographs. An opportunity to improve the quality of primary care has recently emerged with the establishment of a primary care accreditation commission, based on the two decades of experience in hospital accreditation. While the capacity of the primary care accreditation commission is very weak owing to it being in its incipient stages, its vision is to expand capacity, become fully independent, cover both public and private sector and eventually get accredited by ISQua

11. Institutional capacity of LGs and health facilities to plan, budget, provide and regulate health care is a key constraint for efficient and effective use of funds. Sub national level health expenditure accounted for more than 60% of government health spending but major constraints related to funding use and management at sub national level persist. Identified public financial management issues include inflexibility of the budgets, weak capacity in planning and executing budgets, limited financial autonomy of puskesmas, lack of accountability for results and poor public financial management at subnational government level. This situation is often exacerbated with delays in availability of funds and guidelines. There are minimum service standards for health but financing is not linked to attainment. There are deficiencies in data generation, collation and use of data for decision making. This includes sub-optimally functioning civil registration and vital statistics systems (CRVS), quality of data reported through the health management information system (HMIS), lack of systematic private sector data and the low use of data for decision making and program management at decentralized levels.

12. For frontline service delivery of maternal and child health (MCH) and nutrition services, there is low and ineffective use of the kader and posyandu programs. In many areas the monthly posyandu has ceased to be a focus for community participation and multi-sectoral community actions and attendance (at 45%) is not increasing. Of greater concern is the large increase in the
percentage of children who did not attend the posyandu at all in the last six months, which grew from 21% (2007) to 34% (2013). The quality of services provided at the posyandu is very variable and depends on the enabling environment at district level, as well as supportive supervision and monitoring at the health center level. The recruitment, retention and performance of kader is constrained by the lack of incentives and remuneration. There is little effective management of the work of the kader and in some areas they are overburdened with responsibilities. Posyandu kader have inadequate skills and knowledge to undertake quality counselling for nutrition and data interpretation. Recent program such as PNPM Generasi has made an attempt to revitalize posyandu activities and provides useful lessons for incentivizing maternal and child health results at local level using Community-Driven Development (CDD) platform.

13. An integrated behavioral change communication program, focused on interpersonal communication to improve public knowledge and application of positive nutrition, health, sanitation and hygiene behaviors is very weak at present. Past and ongoing interventions are fragmented, of poor quality and have largely relied on campaign style approaches that are not sustained for long periods of time. Particularly, there is a lack of focus on interpersonal communication skills, such as tailored personal counseling and home visits, that have been proven to improve caring practices (when combined with other communication channel such as mass media). Moreover, breastfeeding behavior continues to be negatively influenced by aggressive marketing of breastmilk substitutes (BMS) due to weakness in monitoring and enforcement of relevant laws and regulations. Complementary feeding practices are influenced by the marketing of processed foods for children aged one to two years, which is not prohibited in Indonesia.

14. Inadequate support from the health system further reduces the effectiveness of the community based program in addressing basic health and nutrition. Inadequate support is reflected by low availability and capacity of health workers (nutritionist, sanitarian, midwife) to provide supportive supervision to posyandu, inadequate resources (transport, materials), unclear mandates and an almost complete absence of incentives and accountability. There are unclear service standards for the health workforce for out-reach services at the community level. One in four puskesmas do not have nutritionists among their staff.

15. Malnutrition has multi-sectoral determinants and requires a multi-sectoral approach with coordination between sectors at all levels. Multi-sector and multi-stakeholder coordination forums for Gerakan 1,000 Hari Pertama Kehidupan (HPK) have been identified but are not yet fully functional. In the absence of effective coordination structures for inter-sectoral and vertical coordination across all levels, opportunities to ensure policy and program coherency between sectors are being missed. At district level, there is a lack of stewardship, a vacuum of nutrition leadership and lack of capacity to coordinate the delivery of nutrition interventions across sectors. Malnutrition is still largely perceived to be the responsibility of the health sector, and there is a lack of clear accountabilities for actions to reduce malnutrition in other sectors. Less than 10 percent of districts have developed a District Food and Nutrition Action Plan (district RAD-PG). Anecdotal evidence suggests that very little funding is included in nutrition budgets, even where district RAD-PG exist.

16. The World Bank has been actively supporting Indonesia’s health sector through lending operations and advisory and technical assistance since the 1970s. However, due to a change in Government policies for social sector borrowing, there has been no lending operation since the
last project closed in 2008. The Health, Nutrition and Population (HNP) practice engagement has primarily focused on relevant technical assistance (UHC, health financing, MCH, service delivery and nutrition) in the last few years. The World Bank’s Governance practice has had a long standing engagement in the area of decentralization, and has recently initiated a major program of technical assistance support aimed at improving local public service delivery through reform of intergovernmental financing arrangements. One part of that work focuses on the reform of the DAK, while another part focuses on assisting LGs to diagnose and address service delivery bottlenecks.

**Relationship to CAS/CPS/CPF**

17. The proposed project is consistent with and derived from the World Bank’s Country Partnership Framework (CPF)--which reflects government priorities as specified in the latest Medium-Term National Development Plan (RPJMN)--covering the period FY2016 through FY2020. The CPF emphasizes six engagement areas across two supportive beams (leveraging the private sector; and shared prosperity, equality, and inclusion). The proposed project falls under the fourth engagement area on delivery of local services and is consistent with both pillar 1 (strengthening the decentralization framework to support local service delivery engagement area) and pillar 2 (supporting the delivery of quality health services. Under this CPF pillar, the World Bank will also support efforts to reduce child malnutrition through the improvement of relevant health services. The proposed project is also consistent with several strategies under pillar 1, including development of a performance-oriented fiscal transfer system, strengthening the capacity of central government to support LGs, building capacity of LGs and developing tools for citizens to monitor service delivery. The proposed project is also consistent with the priorities outlined in the 2014 East Asia Pacific (EAP) HNP strategy which emphasizes a focus on UHC and on the unfinished MDG agenda related to maternal health and nutrition. EAP’s HNP strategy underscores the need for countries in the region to improve HNP outcomes and make progress towards UHC, especially among the poor and vulnerable, as well as enhance the performance and resilience of health systems in financially affordable and sustainable ways. The proposed project is also consistent with the World Bank’s Health, Nutrition and Population Global Practice’s overarching objective of ending preventable deaths and disability through UHC.

**C. Proposed Development Objective(s)**

**Proposed Development Objective(s) (From PCN)**

18. Strengthening governance, financing and frontline service delivery to improve access to quality primary health care and nutrition services in priority districts.

The proposed project will work within the context of supporting Indonesia’s UHC goals.

**Key Results (From PCN)**

19. The progress made on achieving the PDO will be measured by the following proposed indicators:

1. % of institutional deliveries (access to health services)
2. % of children between 6 months and 2 years old receiving adequate complementary feeding (nutrition and health behavior)
3. Number of primary health care facilities (public and private) accredited (quality of healthcare)
4. % of kader who conducted counselling as per infant and young child feeding (IYCF) guidelines (quality of frontline nutrition service delivery)
5. % of approved DAK health proposals per agreed criteria (governance, financing)
6.  % of districts with less than 10% difference between planned and actual expenditures (governance, financing)

All these indicators will be measured specifically in priority districts.

D. Concept Description

20. The proposed project takes a three-pronged approach to address the constraints impeding achievement of Indonesia’s goal of UHC for maternal and child health and nutrition services in priority districts. The first component focuses on key health financing constraints by improving LG capacity to more effectively allocate and utilize funds as well as build better accountability for results by making intergovernmental fiscal transfers, especially the DAK more performance oriented and needs based. Demand based technical assistance will also be provided to the JKN to improve its performance and also integrate better with supply side financing. The second component focuses on improving the regulatory environment as well as building capacity at all levels to support a quality improvement program for accreditation of primary care facilities. It will also focus on improving accountability of service delivery by strengthening the generation and use of data for program management and decision making. The third component focuses on strengthening the community-based platform to deliver preventive and promotive health and nutrition services by modernizing the kader using information, communication and technology (ICT), incentives and strengthening supportive supervision. This will also improve the design and use of behavioral change communication (BCC) programs to promote appropriate health and nutrition behaviors. For each component, the proposed project will support both specific investment inputs as well as Disbursement Linked Indicators (DLIs) relevant to the component. The specific investment inputs will focus on filling gaps or funding catalytic interventions that are not currently funded through domestic resources. The DLIs will focus on incentivizing achievement of more aggregate results by leveraging financing and reforms that are not limited to the scope of the specific investments. The mechanism of DLIs is explained later in this section under lending instrument.

Component 1: Improve efficiency and effectiveness of health financing by strengthening government capacity and linking fiscal transfers to results (proposed percentage of project financing: 15% IPF and 40% of DLIs)

21. A main objective of this component is to build government capacities at the central, provincial and district level to plan, allocate and spend funds efficiently based on their needs to maximize results. The proposed project would provide support in reforming fiscal transfers to ensure they are better targeted to needs, are predicable, efficient and transparent and create adequate incentives to achieve progress toward attainment of health-related minimum service standards (MSS), improvements in supply-side readiness of health facilities, and/or progress towards reaching RPJMN targets such as institutional deliveries, malnutrition, and immunization rates. Given that there are variations in district health status, performance rewards would be based on achievement incremental to their baseline status. This component will strengthen the enabling environment to ensure that activities financed through components 2 and 3 works more effectively. Reforms are likely to be implemented incrementally, and an appropriate roadmap and sequencing of reforms will be explored during preparation.

The following sub-components, with indicative activities, are proposed:
Sub Component 1.1: Capacity building for local governments (LGs) for planning, budgeting, and management

22. The focus of this subcomponent will be to strengthen capacity of LGs for planning, budgeting, and management of the use of all health resources, including DAK and JKN, for improved service delivery. Key activities could include: (a) building capacity for LG at district level for improved utilization of capital and recurrent health funds; (b) developing capacity of LGs to identify and address constraints to appropriate use of funds by puskesmas; (c) strengthening financial management, procurement, and supply chain management capabilities of LGs and health facilities; (d) training for health managers and local planners for strategic use of the data for planning and budgeting of health funds; (e) development of health proposals financed through DAK and other sources; (f) improving capacity for monitoring health spending by improving data reporting and use, and linking spending to results; and (g) increasing LGs’ capability to use demand-side financing to complement supply-side financing to improve supply side readiness.

Sub Component 1.2: Strengthening central and provincial government capacity to oversee budgeting and utilization of district health funds to achieve results

23. The focus of this subcomponent is to strengthen capacity of Ministry of Health and provincial health offices to improve effectiveness of health financing sources, including DAK to produce results. The activities could include: (a) improving MOH and provincial health office capacity to review health funding proposals to ensure that they reflect robust needs assessment to fulfill service delivery gaps; (b) developing a performance assessment system to review whether districts are meeting their targets as per their proposals and reward better performing districts; (c) strengthening the system for monitoring and evaluation of reports on utilization of health financing sources, including DAK; and (d) increasing governance and stewardship capacity of central and provincial governments (e.g., coordinating with LGs and BPJS as well as incorporate feedback from civil society on health performance).

Sub Component 1.3: Reform of intergovernmental transfers and demand side financing to ensure funding is targeted to district needs and structured to incentivize improved service quality and availability

24. The focus of this subcomponent will be on developing and implementing reforms to improve the allocation and management of the DAK. The objective of the reform is to make the allocation of the DAK both more responsive to district needs (their capacity to meet the minimum service standards) and oriented to incentivize performance. Building on work already underway in the MOF with support from the Governance practice, the proposed project would finance implementation of reforms on a pilot basis in the target districts to support government to test, evaluate and learn from implementing reforms in practice before rolling out across the whole country. Based on feasibility, the project would also support improvements in JKN capitation payments to primary care facilities and its utilization. The activities would include: (a) design, pilot and evaluate reform of DAK in the health sector to better fulfill districts’ needs and incentivize better performance; and (b) technical support for improving JKN’s capitation payment as well as ensuring its efficient use in primary care facilities.
25. The specific inputs to be financed under this component includes: consultant services (conducting studies, providing technical assistance for various capacity building initiatives, hiring of contractual staff) and operating costs (workshops, training and other operating costs)

26. Possible DLIs (in priority districts): (i) Percentage of approved DAK health proposals per agreed criteria; and (ii) Percentage of districts with less than 10% difference between planned and actual expenditures.

Component 2: Improving availability and quality of services provided at primary health care facilities (proposed percentage of project financing: 50% IPF and 30% of DLIs)

27. This component would support the implementation of MOH’s 2015-2019 strategic plan for strengthening primary health care to ensure service availability and quality. Activities would focus on improving and/or expanding initiatives introduced by MOH during the last few years. These include: improving technical and managerial competencies of puskesmas staff, building the capacity to implement and scale up public and private primary health care facility accreditation, introduce continuous quality improvement mechanisms, supporting public health facilities to attain accreditation, and strengthening health management information system (HMIS) to improve data quality and utilization. The component would also support the strengthening of the referral system particularly for improving the management of maternal and neonatal complications.

Sub Component 2.1: Strengthen capacity of LGs to enable service availability and quality at primary health care facilities.

28. Key activities could include: (a) strengthening LG capacity for stewardship of primary health care facilities, including private providers, through training, benchmarking and other awareness building activities, in order to achieve MSS; (b) building LGs’ capacity to improve supply-side readiness for primary health care services; and (c) building LGs’ capacity to facilitate health facility accreditation and build continuous quality improvement mechanisms.

Sub Component 2.2: Implement continuous quality improvement at primary health care facilities and associated referral network

29. Key activities could include: (a) supporting public health facilities to achieve accreditation by improving management and clinical processes and also ensuring availability of inputs – infrastructure upgrading, equipment, medicines, and commodities; (b) supporting central governments in the training and operational costs of assessors for implementation of health facility accreditation; (c) implementing post-training competency assessment (scaling-up an integrated training module that has already been piloted) that focuses on building skills and competencies of health care providers in public health facilities; (d) Strengthening referral systems for comprehensive care, including ensuring availability of critical services such as blood supply; (e) Piloting and scaling up contextually relevant service delivery innovations (like mobile primary care units) and harnessing private sector participation through partnerships; and, (f) Financing mentoring and supportive supervision following implementation of integrated training for health care providers in public health facilities.

Sub Component 2.3: Develop health information systems to improve primary health care facility performance monitoring
30. Key activities could include: (a) developing an IT system to support accreditation of health facilities; (b) strengthening the implementation of Sistem Pencatatan Pelaporan Terpadu Puskesmas (SP2TP), a public health facility reporting mechanism; (c) establishing reporting mechanism from private facilities, including private maternal health facilities, to puskesmas and LGs, through support for introduction of new reporting regulations; (d) generating relevant data in order to assess primary health care facility performance; and (e) implementing regular surveys to assess the compliance of health care providers in delivering maternal and child health, and nutrition services.

31. The specific inputs to be financed under this component includes: consultant services (conducting studies, providing technical assistance for various capacity building initiatives, developing information systems, handholding of facilities to achieve accreditation), non-clinical equipment (Information Technology related hardware and networking equipment), contracting of additional human resources for clinical services and community level facilitation, inputs for health facilities (infrastructure rehabilitation, equipment, supplies) and operating costs (workshops, training and other operating costs of project).

32. Possible DLIs (in priority districts): (i) number of primary health care facilities (public and private) accredited; and (ii) percentage of districts benchmarking facility performance using standard service delivery indicators.

Component 3: Strengthen the community-based platform to improve basic health and nutrition services (proposed percentage of project financing: 35% IPF and 30% of DLIs)

33. The component would focus primarily on improving the implementation capacity and accountability of kader and health staff at the local level where the availability and quality of the services can make the difference in improving nutrition outcomes. The activities would support central and local government efforts to change the paradigm from treating acute malnutrition to building capacity to prevent chronic malnutrition and to focus on intensive interpersonal communication (IPC) that have been proven elsewhere to be effective in reducing stunting rates. The activities would build on the ongoing community-based posyandu program that provides an essential platform which will be reformed and modernized. This will also include strengthening health sector support for the community-based efforts and improving accountability to promote multi-sectoral collaboration.

Sub Component 3.1: Working with central and local government to strengthen the posyandu system and approach for promoting better health and nutrition behaviors

34. Key activities could include: (a) establishing a system and operational support for implementing interpersonal communication through tailored home visits and peer support; (b) systematizing quality pre-service and frequent refresher training for kader delivered by district government and district health office; (c) establishing a knowledge platform on the framework for preventing chronic malnutrition for local stakeholders (kader, village officials, community leaders); (d) developing IEC materials using innovative ICT and local cultural activities; (e) strengthening BCC campaign that targets local level stakeholders through grass-roots and faith-based organizations engagement; and (f) strengthening the existing Sistem Informasi Posyandu (SIP) into two-way real time monitoring system.
Sub Component 3.2: Strengthen health sector support for community-based health efforts at district and primary health care facilities level:

Key activities could include: (a) scaling up quality supportive supervision training and implementation for health staff; (b) strengthening ICT-based maternal and child health and nutrition surveillance and a referral system building on existing programs; and (c) creating incentives mechanisms for health staff to support village planning and budgeting process to ensure prioritization of health and nutrition services.

Sub Component 3.3: Improve accountability and enabling environment for prioritization and implementation of health and nutrition programs at the community level:

35. Key activities could include: (a) piloting and scaling up a social accountability system for better health and nutrition behaviors through citizen education on rights to services, community score card and regular forum between community and providers; (b) strengthening the multi- and inter-sectorial coordination platform to optimize the use of the village fund for better health and nutrition outcome; and (c) supporting the oversight, policy development and monitoring functions of Gerakan 1,000 Hari Kehidupan secretariat.

36. The specific inputs to be financed under this component includes: consultant services (providing technical assistance for various capacity building initiatives, developing information systems, ICT for kader and frontline workers), non-clinical equipment (ICT equipment for kader), hiring of non-governmental organizations to implement social accountability pilots and behavior change communication, contracting of additional human resources for nutrition services and community level facilitation, inputs for posyandu (equipment, supplies) and operating costs (workshops, training and other operating costs of project).

37. Possible DLIs (for priority districts): (i) Percentage of kader who conducted counselling as per infant and young child feeding (IYCF) guidelines; (ii) Percentage of kader using new ICT tools to report frontline service data; and, (iii) Percentage of posyandu recording growth monitoring data (weight and height) based on sampled audits.

38. The lending instrument is investment project financing (IPF) for a duration of five years, consisting of both specific investments in project inputs as well as a results-based financing mechanism using Disbursement Linked Indicators (DLIs). The proposed project will use DLIs as an incentive to achieve project results by disbursing a portion of the total project financing upon achievement of key results related to the implementation of the project components. Lessons from other health projects indicate that financing of inputs by themselves may not provide the necessary incentives to achieve results as many processes that supplement these inputs may lay outside the direct control of the project. The financing for achieved DLI targets would be done against an eligible expenditure program (EEP), which is a pre-identified budget line for reimbursing eligible expenditures. The agreed set of indicators that measure project performance will be independently validated. Given that the focus will be on broader sector reforms and the fact that funding is fungible within the sector, the EEP and the DLIs do not necessarily need to be linked on a one-to-one basis. For example, the EEP could be salaries but the DLI itself could be based on the results on the proposed project components such as number of facilities accredited for quality. Each DLI is independent of the other, i.e., non-achievement of some DLI targets for a year will not hold up disbursement against other DLI targets that have been achieved for that year.
The EEP to reimburse against the DLIs will be identified during preparation and DAK health (physical or non-physical) is a possible budget line for this.

39. The exact amount shared between specific investments and DLIs will be determined during project preparation. The current amount identified for specific investments is US$150 million, with an additional US$150 million as DLIs. The additional funds are likely to be available from a proposed World Bank loan to support DAK reform. Increased project funding could be used to finance more ambitious reform through DLIs or by increase of geographic scope. The project financing leverages the larger financial resources available to the sector through national and sub-national budgets by strengthening organizational performance to deliver better results. There is a possibility of co-financing by the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) to enable transitional financing for donor-funded programs, such as HIV, TB and malaria.

II. SAFEGUARDS

A. Project location and salient physical characteristics relevant to the safeguard analysis (if known)

40. The project will include national and sub-national level activities focused in 64 districts prioritized by the Ministry of Health due to high number of maternal deaths, high Maternal Mortality Ratio (MMR), and undernutrition among under-fives. The potential environmental impacts would source from the physical infrastructure activities of the Component 2.2 which include rehabilitation of puskesmas and its network, medicine and equipment for primary health care services. The impacts will be localized, in-adverse and relatively easy to be prevented and mitigated.

41. In relation to social safeguards on Indigenous People (IP), several kabupaten priorities such as kabupaten Tapanuli Selatan, Ogan Komering Ilir, Lampung Barat, Lebak, Pati, Pasuruan, Malang and Bulukumba have IPs in their areas. While there is not much background data on their status at present, the ESMF will look more carefully into this.

42. Helping IPs, the poor and the vulnerable group on maternal health and nutrition is implicit in the project objective and there will be a focus on UHC and unfinished MDG agenda related to maternal health and nutrition especially among the poor and vulnerable. IPs mostly are part of these vulnerable groups and face maternal and child health, nutrition problems and poor access to quality frontline health services.

43. There are opportunities to focus on the poor and vulnerable, including the IPs through the various project components. While the improvements seen through financing and systemic changes will benefit improved service delivery in general, more specific opportunities for reaching the poor and vulnerable could include:

a. Improving district capacity for developing, implementation and monitoring of health financing proposals, including on identifying and reaching vulnerable groups;

b. Strengthening JKN capitation, including for increased utilization by the poor and vulnerable groups;

c. Strengthening information systems to generate data of primary care facility performance in delivering maternal and child health, and nutrition services, including for remote areas and to the poor;

d. Strengthen posyandu system, tailored home visits and peer support especially for the poor
and vulnerable groups and engaging faith-based organizations that has long experience in supporting remote areas;

e. Strengthening community-based platforms for better health behaviors health seeking by the poor and vulnerable and by improving provider responsiveness through social accountability and community mobilization efforts, including with involvement of NGOs and CSOs. This will also include optimizing the use of village funds by promoting transparency.

44. Disaggregated indicators related to the poor and vulnerable will be attempted to be captured, wherever feasible.

45. Since DAK and the project fund will not fund a new puskesmas in a new land that an OP/BP 4.12 will not be triggered.

46. These potential impacts will be carefully assessed and the measures to mitigate them will be prepared based and the Bank’s environmental and social safeguard operational policies in an integrated ESMF.

B. Borrower’s Institutional Capacity for Safeguard Policies

47. The implementing agency of the project will be the Ministry of Health which is not likely to be familiar with the Bank’s safeguards requirements and related instruments. On IPs, MoH is not familiar with the safeguard instrument terminology but is well experienced in targeting the vulnerable groups in the remote areas. The vulnerable groups have always been a priority for MoH although this tends to get diluted due to constraints during implementation in a decentralized environment. The MOH should also consult with a broad range of civil society stakeholders forum, especially from experienced and reputed frontline service delivery NGOs.

C. Environmental and Social Safeguards Specialists on the Team

Isono Sadoko (GSURR)

D. POLICIES THAT MIGHT APPLY

<table>
<thead>
<tr>
<th>Safeguard Policies</th>
<th>Triggered?</th>
<th>Explanation (Optional)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Environmental Assessment OP/BP 4.01</td>
<td>Yes</td>
<td>The collateral environmental impacts mainly result from activities around possible construction, rehabilitation and operation of primary health care facility networks (puskesmas and auxiliary units). This would primarily be from rehabilitation of health facilities and its operations that will produce healthcare waste. Primary health care facilities or puskesmas are typically small buildings with an area of 200 sq. mt., approximately. There may also be rehabilitation of associated network clinics and obstetric and neonatal care units in referral hospitals, which will be similar in size. The rehabilitation will typically be minor civil works (for example, roof and wall repair, drainage, addition of some rooms, etc.) and will vary from place to place based on need. There is no new primary health center building</td>
</tr>
</tbody>
</table>
construction that is envisaged. The proposed activities would primarily affect localized areas at or around the existing puskesmas sites subject to physical works.

A healthcare waste management (HCWM) plan will be prepared and implemented in accordance with the EHS guidelines and the Government of Indonesia’s Ministry of Health decree number 75, which includes guidelines for HCWM in puskesmas.

The project will prepare the environmental impacts mitigation measures that will be incorporated in the ESMF that will be reviewed and approved by the Bank, then disclosed in local language prior to project appraisal. This process will begin in February 2016 and will be completed by July 2016.

Hence, the project is unlikely to have significant irreversible adverse environmental impacts that are sensitive, diverse or unprecedented.

Furthermore, as the implementing agency is not familiar with the Bank’s safeguards procedures, the necessary institutional capacity building should be undertaken during project implementation according to the procedures specified in the ESMF.

<table>
<thead>
<tr>
<th>Natural Habitats OP/BP 4.04</th>
<th>No</th>
<th>The project will not affect any natural habitat as it will be implemented in the existing health center facilities.</th>
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<tbody>
<tr>
<td>Forests OP/BP 4.36</td>
<td>No</td>
<td>The project will not finance any activity in the forest areas.</td>
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<tr>
<td>Pest Management OP 4.09</td>
<td>No</td>
<td>The project will not procure or lead into the procurement of pesticides. No pesticide will be used for healthcare waste management.</td>
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<tr>
<td>Physical Cultural Resources OP/BP 4.11</td>
<td>No</td>
<td>The project will not impact any PCR in the existing health center facilities.</td>
</tr>
<tr>
<td>Indigenous Peoples OP/BP 4.10</td>
<td>Yes</td>
<td>In several priority districts there are some IPs, except in West Java and DKI provinces.</td>
</tr>
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</table>

Given the broad geographical scope of the project and that the overwhelming majority of direct beneficiaries will not be IPs, the team proposes taking a framework approach through which the project will identify, consult and provide mechanisms to address potential positive and
negative impacts that project activities may have on Indigenous Peoples or Isolated and Vulnerable Peoples. The Isolated and Vulnerable Peoples Planning Framework (IPPF) to be prepared under the project will draw from experiences from Indonesia’s community driven development projects (PNPM) which use good practices to ensure: (a) IP participation in project related decisions; (b) that IPs benefit from project activities in the same way as other groups; and (c) that IPs are in no way negatively impacted by project activities. For implementation arrangements under component 3 of the proposed project, these would include: indigenous peoples’ participation and recruitment as facilitators/community health volunteers; tailored training for facilitators/community health volunteers from the same ethnic groups; the use of local languages where needed; and, modifications to project socialization activities to ensure free prior and informed consultations with broad community support. The project will draw on the Safeguards instruments, including tools for district level screening for IPs groups prior to implementation, and training materials for local facilitators developed under the PNPM projects.

The ESMF would include local consultations with relevant communities and implementing agency staff in targeted districts to confirm that the proposed measures are sufficient, and identify additional actions as needed.

| Involuntary Resettlement OP/ BP 4.12 | No | There is no new primary health center building construction and no land acquisition that is envisaged under the proposed project. |
| Safety of Dams OP/BP 4.37 | No | The project not related to development of dam. |
| Projects on International Waterways OP/BP 7.50 | No | The project locations are not expected to affect international waterways. |
| Projects in Disputed Areas OP/ BP 7.60 | No | The project is not located in any known disputed areas as defined under the policy. |

**E. Safeguard Preparation Plan**

1. Tentative target date for preparing the PAD Stage ISDS
   22-Aug-2016

2. Time frame for launching and completing the safeguard-related studies that may be needed. The specific studies and their timing should be specified in the PAD-stage
ISDS.
The process of preparing the ESMF will begin in February 2016.

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V. Approval

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<thead>
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<tbody>
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<td>Safeguards Advisor:</td>
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<td>Country Director:</td>
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1 Reminder: The Bank’s Disclosure Policy requires that safeguard-related documents be disclosed before appraisal (i) at the InfoShop and (ii) in country, at publicly accessible locations and in a form and language that are accessible to potentially affected persons.