I. Introduction and Context

Country Context

A. Country Context

1. Over the past decade the Indonesian economy has experienced positive economic growth, reduced poverty and made continued progress towards many of its Millennium Development Goal (MDG) targets for 2015. Indonesia has already met and surpassed projected reductions in the number of underweight children under five years old to below 18 percent, and is on track to meeting its targets for reducing overall child mortality. Still, 32.5 million Indonesians live below the national poverty line of US$22 per month and half of all households live clustered around the poverty line, remaining vulnerable to falling below it. Of the poor, 65% currently live in rural areas.

2. Strong macroeconomic fundamentals have brought only modest gains in health and education for poor households. For example, while maternal mortality has fallen from 350 to 240 per 100,000 live births (between 2000 and 2008) in Indonesia, the Indonesia rate remains far above
the 2008 average rate of 89 for all developing countries in the East Asia and Pacific (EAP) region. Likewise, under-five and infant mortality rates have fallen from 56 to 39 and from 40 to 30 respectively (between 2000 and 2009; per 1000 births), but those figures remain far above the average for all developing countries in EAP in 2009 of 26 and 21, respectively. Rates of immunization, of births attended by skilled health staff, and of access to improved sanitation facilities also remain behind the EAP developing country average, and an estimated 42% of rural households have stunted children. In education, primary school enrollment is near 100 percent for boys and girls of all income levels; however, only 55 percent of those enrolled from the bottom consumption quintile make it to junior secondary school, and from the same group less than a quarter enroll in senior secondary.

3. To accelerate the achievement of lagging MDGs in health and education, the Government of Indonesia launched two large-scale pilots in 2007: (i) conditional cash transfers (CCTs) to individual households, known as the Hopeful Family Project (Keluarga Harapan Project or PKH), and (ii) a “community CCT”, or incentivized community block grant program, known as PNPM Generasi Sehat dan Cerdas (PNPM ‘Healthy and Bright Generation’). PNPM Generasi builds upon the community-driven development platform of the Government of Indonesia’s National Program for Community Empowerment in Rural Areas (PNPM-Rural). PNPM Generasi began as a pilot project in five provinces. It is consistent with both the Indonesian government’s priorities, as articulated in its Medium Term Development Plan for 2010-14 (RPJM) and the Millennium Development Goals: to reduce poverty, maternal mortality, and child mortality, and to ensure universal coverage of basic education.

Sectoral and Institutional Context

4. Limited access to basic health and education services remains a critical factor in lagging achievement of MDGs in rural Indonesia. A recent analysis of PODES 2011 data shows, for example, that midwives are present in only 78 percent of rural villages, while 14 percent of rural villages lack a junior secondary school located within six kilometers. Indonesia has 36 doctors per 100,000 people, one of the lowest ratios in EAP. The ratio is as low as 6 doctors per 100,000 in rural areas. Shortages in the supply of facilities and skilled personnel are exacerbated by high levels of absenteeism. Up to 40 percent of doctors have been found to be absent from their posts during official public working hours. A 2010 survey found that 25 percent of teachers are absent in remote schools. As a result health and education indicators in rural areas, particularly eastern Indonesia, lag those of Bali and Java. In Bali and Yogyakarta, for example, fewer than 25 children out of 1,000 die before reaching their fifth birthday as compared to close to 100 in the province of Gorontalo in Sulawesi.

5. The government has for some time recognized the critical role communities play in improving MDG targets among the poor by increasing service utilization, facilitating the delivery of certain basic services, and promoting bottom-up accountability in the use of health and education resources. Over the past eight years the government has introduced a series of programs aimed at improving access among the poor to health services, including the National Community Health Insurance Program (Jamkesmas—2004), the PKH CCT program, and most recently the Health Operational Assistance Program (BOK) and the Childbirth Insurance Program (Jampersal), both introduced in 2011. In education, the School Operational Assistance Program (BOS), which provides grants to primary schools in part to assist poor students, includes a major role for school committees in decision-making and oversight of the use of BOS grants. The government’s Early Childhood Education and Development Project (PPAUD), supported by the World Bank, transfers
block grants to community-based user groups to establish and operate village-based ECED centers.

6. PNPM Generasi provides operational linkages between the PNPM-Rural platform and health, education, and social protection programs targeting poor, rural communities. The Ministry of Health (MoH) and the National Planning Agency (Bappenas) have identified PNPM Generasi as a vehicle through which to pursue national goals for reducing childhood stunting, and are working with the implementing agency for PNPM Generasi, the Directorate General for Community Empowerment (PMD) in the Ministry of Home Affairs (MoHA), to introduce activities to improve the quality of health and nutrition services in areas where PNPM Generasi incentivizes demand for such services. In education, the Directorate General for Early Childhood Education is working with PMD to pilot an approach to increasing participation among the rural poor in ECED services by adding a community target indicator in PNPM Generasi in two districts in eastern Indonesia. The Vice President’s Office for Accelerating Poverty Alleviation (TNP2K) is coordinating a working group involving PMD, the Ministry of Social Affairs, Bappenas, and the Coordinating Ministry for People’s Welfare (Menkokesra) aimed at improving targeting outcomes and access to assistance for poor households in areas in which PKH and PNPM Generasi operate. PNPM Generasi facilitators work closely with AusAID-supported health and civil society strengthening programs in East Nusa Tenggara and West Nusa Tenggara provinces to involve community-based organizations in health and education awareness-raising and service delivery monitoring activities.

7. In 2010 government initiated the process of scaling up PNPM Generasi as part of its suite of demand-side health and education programs. Unlike household CCTs approaches, PNPM Generasi enables communities to address both small-scale supply and demand issues. Demand-side problems may be addressed through activities such as providing village-based scholarships, or covering costs for health services and/or transportation costs to access services for the poor. Activities addressing small-scale supply side problems may range from providing transportation allowance to a midwife to regularly visit the village; to improving living and housing conditions for such a provider as a way of convincing her to stay in the village; or improving infrastructure and facilities for schools and teachers. Communities can also use the funds to contract private providers or NGO services if public provision of services is considered suboptimal. The government views the benefits of communities tackling common supply-side problems as one of the most compelling advantages of PNPM Generasi.

8. PNPM Generasi is an innovative adaptation of the PNPM-Rural community-driven development (CDD) platform. Through the PNPM Generasi pilot, government tested the hypotheses that (a) PNPM-Rural’s CDD approach could be adapted to enable communities to address a broad-set of demand and small-scale supply constraints to accessing health and education services more effectively than the standard PNPM-Rural model, and (b) that it could do so in ways that other programs, like household conditional cash transfers (CCTs), could not given the supply constraints that exist in remote parts of Indonesia. It therefore developed a hybrid model that incorporates performance incentives from CCT programs with the flexibility and adaptability of CDD. In PNPM Generasi communities are incentivized to reach targets for each of twelve health and education target indicators: the size of a village’s Generasi block grant in one year is based in part on the performance of that village in achieving targeted indicators in the previous year, thereby motivating communities to prioritize the most effective policies in their spending and activities. PNPM Generasi piggybacks on the architecture for community–level poverty targeting, participatory planning, block grant transfers, local level facilitation, and accountability mechanisms put in place by KDP/PNPM-Rural, thereby achieving important economies of scale. In addition,
PNPM Generasi takes full advantage of the social capital built through KDP/PNPM-Rural, enabling communities to act collectively to tackle common demand-side and supply side problems to improve access to services.

9. PNPM Generasi contributes to PNPM Mandiri Roadmap objectives of equipping rural communities with the skills and resources needed to facilitate the delivery of certain basic services, and promote bottom-up accountability. The PNPM Mandiri Roadmap defines the government’s vision for sustaining community-driven development as a key component of its poverty reduction strategy for 2014 onwards and focuses on issues including the integration of community empowerment programs, sustainability of facilitation assistance, accountability, and good governance. PNPM Generasi contributes to the first two objectives by training community empowerment cadres to collect data on and monitor local health and education status, thereby expanding the depth and scope of community planning exercises beyond small-scale infrastructure that are inputs to village medium-term development plans (RPJM-Des). In addition, PNPM Generasi promotes transparency in the use of local health and education budgets. Local service providers have an interest in knowing how communities will invest block grants to communities for health and education purposes, and therefore have an incentive to share information on local health and education budgets during project planning and monitoring meetings. At the sub-district and village levels, PNPM Generasi operates through existing user groups and service delivery structures, such as integrated community health posts (Posyandu) and school committees, rather than creating new structures.

10. PNPM Generasi uses a flexible community poverty targeting mechanism. PNPM Generasi’s targeting system applies geographical targeting combined with a local level participatory process that does not rely on central statistical systems. Indonesia’s poverty profile indicates that a large portion of the near poor is clustered around the poverty line. These near poor groups fall in and out of poverty with seasonal fluctuations and external shocks. PNPM Generasi takes a flexible and localized approach in creating the list of beneficiaries through a village-level participatory social mapping process. Unlike central statistical targeting systems, the beneficiary lists generated through the community poverty targeting mechanism can be adjusted as needed to deal with economic and other shocks. Recent analytical work conducted by the World Bank together with the Vice President’s Office for Accelerating Poverty Reduction (TNP2K) shows that community targeting methods selected more of the very poor, and led to higher levels of satisfaction in targeting outcomes relative to methods relying solely on central statistics data. The PNPM Generasi impact evaluation found that the program was successful at targeting assistance, particularly in-kind assistance, to households in the lowest two income quintiles. As such the TNP2K-led working group views the expansion of PNPM Generasi as a means to complement the expansion of social assistance programs like PKH to test mechanisms that utilize community targeting to vet and improve beneficiary lists developed through central statistical targeting mechanisms.

11. The proposed project will provide continued support to deepen strategic engagements with sectoral line ministries and complementary donor-supported sectoral and civil society strengthening programs at the national and sub-national levels. These engagements will provide the policy guidance needed to update PNPM Generasi community target indicators to reflect evolving community needs and government priorities. Likewise, closer coordination with sectoral agencies will facilitate the complementary expansion of demand-, supply-, and civil society strengthening programs, like AusAID’s ACCESS, Health Services Strengthening, and Maternal and Neonatal Health programs, in areas with poor health and education performance, thereby addressing the
complex set of constraints to improvements in human development indicators.

12. PNPM Generasi Impact Evaluation. To allow for a rigorous evaluation, the Government of Indonesia, working in consultation with the WB Social, HD, and PREM teams and evaluators from M.I.T, incorporated random assignment into the selection of PNPM Generasi and Household CCT locations. The evaluation was conducted over three rounds from 2007 to 2010 with quantitative and qualitative components. The Wave Three impact evaluation found that, on average over the 30-month implementation period, PNPM Generasi had a statistically significant positive impact on the indicators it was designed to address. The main long-term impact was a decrease in malnutrition. Childhood malnutrition fell by 2.2 percentage points, a 10% reduction from baseline levels in treatment areas. Education indicators also improved with the largest improvement observed in school participation rates among primary school students. On average, the project was about twice as effective in areas with very low health and education status (10th percentile of service provision).

13. The project had the greatest impact in areas with low baseline health and education indicators, like East Nusa Tenggara (NTT) province, where underweight and severe underweight rates fell by 20% and 33% against control, respectively. Stunting was decreased by 21% against control. Junior secondary school gross enrollment rate increased by 29% relative to control, while gross primary schools attendance rates increased by 4% for 7-12 year olds against control.

14. Overall, impact evaluation findings show that the PNPM-Rural mechanism was successfully modified to increase utilization of basic services and fill small-scale supply gaps. Community performance incentives improved project performance in health. Project impacts were not affected by differences in ease of access to health and education facilities. Generasi increased the probability that a junior secondary school was located in the village, and the number of junior second school teachers, including those receiving honoraria. Midwives also worked longer providing services in village receiving incentivized block grants.

15. The proposed grant of US$31.7 million represents the fourth Installment of a PNPM Support Facility (PSF) Grant of US$105 million to support PNPM Generasi Scale-Up. Armed with evidence of the success of PNPM Generasi, the government decided to expand program coverage over the period 2010-2014. Approximately US$220 million will be invested in PNPM Generasi over this five-year period. US$115 million in government financing is complemented by a US$105 million grant from the PNPM Support Facility (PSF). Table 1 provides details on PNPM Generasi scale-up and associated additional financing contributions.

<table>
<thead>
<tr>
<th>Year</th>
<th>GOI Financing (US$m)</th>
<th>PSF Financing (US$m)</th>
<th>Sub-districts</th>
<th>World Bank Approval</th>
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<tr>
<td>2010</td>
<td>21.6</td>
<td>10.2</td>
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<td>212 Additional Financing to PNPM-Rural III (TF097410) approved by Regional Vice President on August 3, 2010.</td>
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<td>500 (tbc)</td>
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Total 115  105
16. The performance of the ongoing additional financing operation for PNPM-Rural III (P122032, TF097410) has been satisfactory. PNPM-Rural III will close on December 31, 2012, and therefore no further additional financing can be channeled through this operation. As such, the proposed grant of $31.7 million would be channeled through a stand-alone trust fund. This arrangement has the added advantage of introducing a stand-alone results framework for PNPM Generasi, thereby allowing outcomes of interest specific to PNPM Generasi to be tracked more easily.

Relationship to CAS

17. The project is consistent with Indonesia’s FY2009-2012 Country Partnership Strategy (CPS) for Indonesia which emphasizes engagement with government counterparts, including at the sub-national level, and other stakeholders to address critical governance and institutional challenges. The project’s CDD approach is consistent with the CPS’ core focus areas of Community Development and Social Protection, as well as Education. Health is another area of potential increased engagement. As befitting a middle-income country, Indonesia is building a more effective social safety net under the coordination of the Vice President’s office. PNPM Generasi contributes to these important engagement areas by promoting multisectoral interaction at the village, district, and national levels. In addition to providing incentivized block grant resources to communities to overcome constraints to accessing services, PNPM Generasi promotes transparency in the use of health and education resources at the village level by facilitating planning forums in which community implementation teams, village government, teachers, and health workers discuss and agree upon ways to utilize local health and education budgets. The implementing agency is exploring ways in which community data local health and education status and service provision generated through PNPM Generasi can be fed back to district governments to spur action where health and education performance does not meet community expectations. At the national level, PMD is working with the Ministries of Health and Education and Culture to update PNPM Generasi’s community-level health and education targets to reflect evolving local needs and government priorities.

II. Proposed Development Objective(s)

Proposed Development Objective(s) (From PCN)

18. The PDO is to improve access to and utilization of health and education services in poor, rural sub-districts through empowerment of local communities and improved community capacity to foster improvements in service delivery.

Key Results (From PCN)

19. Key performance indicators for the PDO include:

(a) Improved access to and utilization of selected health and education services that contribute to the improvement of maternal and child health and basic education outcomes in targeted villages.

(b) Improved community capacity to provide feedback on the status of health and education service delivery to front-line providers in targeted areas (villages and sub-districts).

(c) Improved community capacity to facilitate the delivery of basic services through the provision of training and operational support in targeted villages.
III. Preliminary Description

Concept Description

20. The proposed PNPM Generasi project is a continuation of the ongoing Additional Financing to Indonesia’s Third National Program for Community Empowerment in Rural Areas for PNPM Generasi Scale-up (P122032, TF097410), which was established in 2010 to channel US$105 million in PSF grant funding to support the scale-up of the PNPM Generasi project. Thus far US$73.3 million has been committed to the project. During the Additional Financing discussions for the third additional financing top-up held on June 6, 2012, it was agreed with government that future installments of PSF grant financing for PNPM Generasi would no longer be processed as additional financing to the PNPM-Rural operation. In addition to the proposed amount of US$31.7 million, government and PSF donors have indicated an interest in supporting PNPM Generasi beyond 2014, with pledges of at least US$140 million anticipated. Future funds cannot be processed as additional financing as the parent project, PNPM-Rural III closes on December 31, 2012, thereby necessitating the establishment of a stand-alone TF.

21. The proposed project continues to utilize the existing PNPM-Rural implementation structure with additional technical assistance and capacity building support provided to government, specialist, consultant, and facilitator teams operating at the national, provincial, districts, sub-district, and village levels. There are no changes to disbursement arrangements. Safeguards policies and mitigating measures as well as Procurement policies, procedures, and oversight systems will be updated to reflect latest best practice from the PNPM-Rural 2012-14 program.

22. The objective of improving access to and utilization of health and education services in poor, rural sub-districts through empowerment of local communities and improved community capacity to foster improvements in service delivery will be achieved through: (a) provision of direct grants to communities in a transparent manner to finance an open menu of activities aimed at achieving target health and education indicators. The community block grant allocation is in part based on performance towards achieving the target indicators during the preceding year of project implementation; (b) support to communities’ participation in open and inclusive planning processes; and (c) enhancing the capacity of communities to engage with front-line service providers and local governments to diagnose and overcome constraints to service utilization and provision.

23. The basic architecture of the project will remain the same but government has indicated the need to (a) improve the capacity of project facilitators to assist communities to diagnose constraints to service utilization and identify solutions, and to engage with local government and civil society actors involved in basic service delivery; (b) adjust community target indicators to reflect evolving Government priorities in nutrition and education; (c) strengthen core systems for fiduciary oversight and reporting; and (d) promote greater accountability of service providers to communities. To this end a new, recipient-executed component is proposed to complement government-executed training activities by providing intensive training and mentoring to village and kecamatan facilitators.

24. The proposed financing will support the following PNPM Generasi activities in up to 400 new and existing sub-districts in 2013-2014. Financing will supplement GOI commitments of at least US$30 million to support project activities in 2013-2014.
Component 1 (Government recipient-executed): Kecamatan (sub-district) Grants (approximately $24.5 million). The bulk of the financing would be used to provide kecamatan grants for investments that improve use and access of health and education services and administrative costs associated with local planning meetings.

Component 2 (Government recipient-executed): Technical Assistance (approximately $5.1 million). These funds would strengthen the management and oversight capacity of the PNPM Generasi Secretariat in the Directorate General for Community Empowerment (PMD), Ministry of Home Affairs (MoHA). Funds will support additional project technical assistance for health and education planning, and district, provincial and national database management. Sustained database support is needed to improve the performance of the program’s innovative information management system.

Component 3 (Government recipient-executed): Training and Capacity Building (approximately US $1 million). These funds would support training for PNPM Generasi facilitators at all levels of program delivery. This would include refresher training for existing staff, pre-service training for new staff, specialized training for district database operators, and regional evaluation workshops.

Component 4 (Government recipient-executed): Project Management Support (approximately US $99,000). These funds would be used to support and expand the operations of the PNPM Generasi Secretariat in PMD. Funds would cover government-sponsored workshops, coordination with other ministries, and field supervision.

Component 5 (Non-government recipient-executed): Training and Mentoring for Village Stakeholders (approximately US$900,000). The implementing agency has requested PSF support to engage an Indonesian university, think-tank, or NGO to deliver a training and mentoring program for village facilitators to support program objectives of (a) adapting program target indicators to evolving needs and priorities; (b) build linkages with local actors that can strengthen community capacity to facilitate the delivery of basic services, (c) supporting community efforts at targeting resources to those that miss out on other programs; and (d) raising awareness of less “visible” constraints to service utilization, like gender relations.

IV. Safeguard Policies that might apply

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<td>Environmental Assessment OP/BP 4.01</td>
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V. Tentative financing

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