برنامج الأغذية العالمي | Programme Alimentaire Mondial | World Food Programme | Programa Mundial de Alimentos

Executive Board
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PROJECTS FOR EXECUTIVE BOARD APPROVAL

Agenda item 9

For approval

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PROTRACTED RELIEF AND RECOVERY OPERATIONS—INDONESIA 10069.2

Assistance for Recovery and Nutrition Rehabilitation	
Number of beneficiaries	845,000
Duration of project	3 years (1 January 2008–31 December 2010)
WFP food tonnage	125,341 mt
Cost (United States dollars)	
WFP food cost	56,212,330
Total cost to WFP	98,288,275

NOTE TO THE EXECUTIVE BOARD

This document is submitted to the Executive Board for approval.

The Secretariat invites members of the Board who may have questions of a technical nature with regard to this document to contact the WFP staff focal points indicated below, preferably well in advance of the Board's meeting.

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EXECUTIVE SUMMARY

Despite steady improvements since the 1998 crisis, socio-economic recovery in Indonesia has been hampered by increasing population, poorly developed infrastructure and insufficient resources for human development. In Eastern Indonesia, high levels of malnutrition, poor dietary education and micronutrient deficiencies, particularly among children and mothers, are common.

In line with Government policy, this operation addresses micronutrient deficiency through fortified food interventions targeting children aged 2–5, pregnant and lactating women and primary schoolchildren aged 6–13, combined with health, hygiene and nutrition education for beneficiaries and training for health staff and cooperating partners. It will seek greater convergence with government and donor-supported programmes in the same sectors: for example, complementary food for children aged 6–24 months will be a Government programme, with WFP offering training and technical assistance.

Food-for-work, food-for-training and community development projects funded by the *Operasi Pasan Swadaya Masyarakat* (subsidized rice safety net) trust fund will complement the operation. WFP will continue advocacy for improvements in budgeting for the social sector and assist in mapping food insecurity and in nutritional surveillance.

All food for the operation is produced and purchased locally; some imported in-kind wheat will be exchanged for biscuits and noodles. WFP has a unique opportunity to influence the use of micronutrient fortification in commercial products.

The programme focuses on rural and suburban areas of West Timor, Lombok, Madura, East Java and Greater Jakarta. A contingency reserve is held for earthquakes, flooding and landslides.

DRAFT DECISION*

The Board approves proposed PRRO Indonesia 10069.2 "Assistance for Recovery and Nutrition Rehabilitation" (WFP/EB.A/2007/9-B/2).

* This is a draft decision. For the final decision adopted by the Board, please refer to the Decisions and Recommendations document (document WFP/EB.A/2007/15) issued at the end of the session.

SITUATION ANALYSIS

Context

1. Indonesia has reduced poverty and strengthened democracy since the economic crisis and political transformation of 1997–1998, but problems remain. Of the population of 220 million, 39 million or 18 percent live below the national poverty line of US$1.55 per person per day in terms of purchasing power parity; if the World Bank's US$2 per person per day definition is applied, the percentage is 50 percent. Indonesia is a low-income food-deficit country ranking 108th of 177 countries in the United Nations Development Programme (UNDP) 2006 Human Development Report.

2. The December 2006 food security assessment by WFP, the Food and Agriculture Organization of the United Nations (FAO) and the Government indicates that poverty is most acute in *Nusa Tenggara Barat* (NTB), *Nusa Tenggara Timur* (NTT), Papua and Maluku; 75 percent of Indonesia's poor live on the Java Islands. Aceh still has many of Indonesia's chronic nutritional deficiencies, but it is a rice-surplus area and the inflow of post-tsunami aid has improved economic indicators.

3. The Common Country Assessment (CCA) identifies the main causes of poverty and hunger as insufficient budgets for human development, unemployment, poor nutrition, lack of livelihood opportunities, gender and cultural disparities, and exploitation of natural resources; these vary considerably among provinces and districts. Access to services such as health and education is impaired by limited local government capacity following decentralization in 2003.

4. Primary school enrolment rates and gender parity are almost 100 percent, but educational standards are low, particularly in rural areas, and basic infrastructures such as water supplies and sanitation facilities are lacking. Even in primary schools with no tuition fee, the cost of uniforms and books is a substantial burden for the poor.

5. Access to safe water and sanitation is only 48 percent in rural areas compared with 78 percent in towns; 80 percent of the rural poor and 59 percent of the urban poor have no access to septic tanks; only 1 percent of the population have piped sewerage.

6. Indonesia has the world's third largest – and increasing – number of tuberculosis (TB) patients; but HIV/AIDS prevalence is low. The Joint United Nations Programme on HIV/AIDS (UNAIDS) estimates 170,000 people living with HIV (PLHIV).

7. Since 2003, when healthcare was decentralized to provincial governments, routine health services have deteriorated. In many regions, 70 percent of households are more than 5 km from the nearest health facility. A recent study found absentee rates of 40 percent among health workers, with higher percentages in rural areas.[1] Since 1998, the Government has worked to revitalize the *posyandu* (local health posts), which are crucial to improving the health of mothers and young children.

[1] Chaudhury, N., *et al*. 2004. *Provider Absence in Schools and Health Clinics*. Available at http://neumann.hec.ca/neudc2004/fp/rogers_h_sept_30.pdf

Food Security and Nutrition

8. The Government and FAO describe current food production and supply as satisfactory. Food insecurity is a matter of reduced incomes and erosion of purchasing power. In 2006-2007, rain is expected to be late and insufficient, particularly in West and Central Java, possibly an effect of El Nino.

9. Trade in sugar, wheat and maize has been privatized, but the National Logistics Planning Agency (BULOG) regulates the rice market by maintaining a buffer stock for periodic release to stabilize prices. BULOG is responsible for ensuring that rice is available throughout the country.

10. The Government's main food-assistance programme, *Beras untuk Orang Miskin* (RASKIN), implemented by BULOG, entitles poor households to purchase 10 kg rice at 1,000 rupiah/kg per month. In fact only 57 percent of the poor benefit;[2] poor households often receive less than 10 kg per month because of faulty local distribution and lack of cash. WFP's 1998–2005 rice subsidy programme helped to address this issue in poor urban areas, but it was closed as labour opportunities increased; the lessons learned are part of current advocacy.

11. Despite improvements in the last decade, malnutrition is still at pre-2000 levels: the current figure for children under 5 is 28 percent; 44 percent of children aged 24–59 months are stunted.[3] Anaemia levels are high among schoolchildren, adolescents and women of reproductive age; anaemia prevalence among children under 5 is shown in Table 1.

TABLE 1. ANAEMIA PREVALENCE IN CHILDREN UNDER 5

Age (months)	Anaemia prevalence (%)
0–5	61.3
6–11	64.8
12–23	58.0
<24	61.4
24–35	54.4
36–47	38.6
48–59	32.1
24–60	41.7

Source: National Health and Household Survey (NHHS), 2001.

[2] WFP: Food Security Assessment and Phase Classification Pilot. Indonesia, December 2006.

[3] Figures from *Biro Pusat Statistik* (BPS, Indonesia Bureau of Statistics) 2005–2006. National Social and Economic Survey (Susenas), Government of Indonesia.

12. Exclusive breastfeeding rarely exceeds the third month; weaning practices are poor and family food is generally introduced immediately after breastfeeding. Maternal mortality at 307 deaths in 100,000 births is three times the rate in Vietnam and six times that in China.

Scenarios

13. Most resources of this protracted relief and recovery operation (PRRO) will go to the nutrition rehabilitation programme, but a reserve will address unforeseen emergencies: earthquakes are frequent in Sumatra and Java. Since the 2004 tsunami, WFP has responded to four emergencies involving earthquakes, floods and landslides.

14. The PRRO is based on access to emergency food stocks, staff and emergency equipment. WFP's regional contingency plans complement the 10 percent emergency contingency allocation of the PRRO of 70,000 beneficiaries. The country office will retain much of the storage and communications equipment used in the tsunami response.

POLICIES, CAPACITIES AND ACTIONS OF THE GOVERNMENT AND OTHERS

Government

15. The Government is committed to the United Nations Millennium Development Goals (MDGs); it has ambitious targets for 2010 to reduce malnutrition and low birth weight and promote breastfeeding. It launched a Poverty Reduction Strategy Paper (PRSP) in 2004.

16. The Government's blended food for nutrition programme (MP-ASI) for malnourished children of 6–11 months and fortified biscuits for those of 12–24 months for 90 days, has been replaced to promote nutritious local foods for children under 24 months in the same areas, implemented through cash grants to poor families. The Government is piloting additional micronutrient powder to sprinkle on food. The challenges are to (i) persuade provincial authorities to adopt the policy and budget accordingly, (ii) target the poorest people and (iii) increase the scale of the programme for national coverage.

17. The 2003 policy delegating decision-making and budgeting to provinces and districts created opportunities and challenges: even where budgets exist, local government has little experience in prioritization, and inter-sectoral coordination is often poor – for instance MP-ASI provisions are sometimes held in storage because there is no distribution budget.

Other Major Actors

18. The Asian Development Bank (ADB) supports MP-ASI in six provinces through a US$50 million "Nutrition Improvement through Community Empowerment" pilot programme for 2007–2012, complemented by a US$21 million Government counterpart budget; convergence with WFP operational areas is not expected until 2009.

19. The United States Government has a US$311 million programme in seven provinces for 2004–2008 to improve basic human services in terms of quality and access: it combines health, food and nutrition with environmental management and water services at the district and community levels and includes targeted supplementary feeding, nutrition education and nutrition awareness training.

20. The United Nations Children's Fund (UNICEF) health and nutrition programme focuses on poor rural areas. UNICEF supports the Government in improving drinking water and sanitation, particularly in schools.

Coordination

21. The Government goals may be met nationally, but will be missed in some remote areas. WFP will lobby local governments for pro-poor budget provisions in line with MDG goals and for coordination of donor-supported programmes.

22. A central pillar of the 2006–2010 United Nations Development Assistance Framework (UNDAF) for Indonesia is improvement of livelihood opportunities through support for MDG implementation, in which the PRRO will support the World Bank, UNICEF, the World Health Organization (WHO), FAO, UNDP, UNAIDS, the United Nations Educational, Scientific and Cultural Organization (UNESCO) and non-governmental organizations (NGOs). In East Java and NTB, WFP has joined Focusing Resources on Effective School Health (FRESH),[4] an innovative management approach for rural schools to obtain resources and improve teaching.

OBJECTIVES OF WFP ASSISTANCE

23. PRRO 10069.2 contributes to the rehabilitation of nutrition and health education following the 1998 economic crisis, providing nutritional and recovery support for vulnerable families.

24. In line with PRSP and MDG priorities, the objectives are: (i) to improve the micronutrient status of children aged 24–60 months and pregnant and lactating women, and their nutrition-related behaviour; (ii) to improve the micronutrient status of primary schoolchildren aged 6–13 and their cognitive performance, attendance and knowledge and practice of nutrition-related behaviour; (iii) to provide a food incentive for TB patients to increase uptake of directly observed treatment with short-course chemotherapy (DOTS); (iv) to contribute to improved food security for vulnerable food-insecure families through food for work (FFW) and food for training (FFT) to build community capacities; and (v) to provide short-term food aid for families in emergencies. These objectives contribute to WFP's Strategic Objectives 1, 2, 3 and 4; Strategic Objective 5 is met through advocacy and partnership with the Government in mapping and monitoring food insecurity. Enhanced Commitments to Women (ECW) I, III, IV and V will receive special attention.

WFP RESPONSE STRATEGY

Nature and Effectiveness of Food-Security Related Assistance to Date

25. In line with the external mid-term evaluation[5] of PRRO 10069.1 and the December 2006 food security assessment, this PRRO expands the programme by concentrating most resources in eastern Indonesia, where food insecurity is most prevalent and where recovery has been slowest. WFP has undertaken four consecutive PRROs and an emergency

[4] Started in 2000 by UNESCO, UNICEF, the World Bank, WHO and Education International.

[5] 28 August–17 September 2006; to be presented at EB.A/2007.

operation (EMOP) responding to drought and economic crisis since re-opening the country office in 1998.

26. As the economy recovered and rice production increased, WFP shifted in 2002 from food aid as income support to greater emphasis on targeted nutritional interventions, particularly micronutrients, for vulnerable populations.

27. *Operasi Pasan Swadaya Masyasakat* (OPSM; Subsidized Rice Safety Net) in poor urban areas ended in 2005; the caseload was taken over by RASKIN. The proceeds from OPSM, managed by WFP and the Government in a trust fund, will continue to be used at least until 2009, mainly for community development projects.

28. General food distribution in Aceh and Nias, included in PRRO 10069.1 in January 2006, was phased out in mid-2007; the carry-over funds for the Nutrition Rehabilitation Programme (NRP) will be exhausted by mid-2008, when the Aceh programme will be closed.

29. Although poverty-related malnutrition persists in some towns, WFP will increasingly use its limited resources in rural areas, where infrastructure and administrative needs are greater, notably in eastern Indonesia: WFP's presence, particularly at the *posyandu* level, will influence district and national policies.

Strategy Outline

30. The proposed PRRO continues to emphasize micronutrient interventions, advocacy and training and flexible response to emergencies. Its main element is the NRP in rural areas, focusing on enhancing education and health services; success depends on convergence with donor-supported Government priorities in health and education. The five PRRO components are:

- mother-and-child nutrition (MCN) services at *posyandu*: fortified food, and education in health and nutrition;
- primary school feeding: fortified food, and curriculum-based training;
- support for TB patients: food incentive for DOTS;
- FFW and FFT in food-insecure rural areas; and
- community development projects funded from the OPSM trust fund in parallel with MCN and school feeding for greater project convergence.

31. Fortified food will be distributed to mothers and children at *posyandu* monthly or fortnightly. The "*posyandu* day" is an opportunity for nutrition and health classes given by midwives and NGO partners, who will receive refresher courses.

32. In line with Government policy, PRRO 10069.2 will make two changes from the previous PRRO:

(i) MCN will concentrate on children aged 2–5; the Government will run the complementary MP-ASI programme for those aged 6–24 months, supported by WFP, which will ensure that national and local authorities can use cooperating partner staff, facilities and training equipment on distribution days.

(ii) To prevent fortified noodles from being shared in families, which reduces their effectiveness for pregnant and lactating women, the level of fortification will be increased and packaging will state more clearly that they are for pregnant and lactating women. This will be reinforced at *posyandu* nutritional training and during household visits.

33. To find sustainable approaches to micronutrient supplementation based on local foods, WFP will pilot the use of micronutrient powder on staple foods for children aged 2–5 and coordinate its findings with Government and NGO pilot programmes. WFP will train household members in the use of micronutrient powder to ensure effectiveness.

34. Fortified biscuits will be retained for school feeding because other options such as school-based porridge production and take-home rations are less cost-effective.

35. The correlation between TB and HIV/AIDS is an opportunity to introduce stigma-free HIV/AIDS prevention education alongside nutritional and treatment classes for TB patients and their families. In 2007, UNAIDS undertook to pilot education and HIV testing in TB centres where WFP works. PRRO 10069.2 beneficiaries will be incorporated into the National Aids Commission (NAC) programme; an expanded education/testing programme is envisaged, with technical assistance from UNAIDS and WHO. WFP's primary input is a food incentive to attend prevention education and undergo initial treatment; it is not a nutrition programme for AIDS patients. Malnutrition is a risk factor in TB infection, so this support is also intended to improve the nutritional status of patients.

36. Changes in staffing and resources have enabled WFP to scale up as emergencies arise. The PRRO will allocate at least 10 percent of existing resources for this purpose, to be supplemented by appeals as required.

37. In cooperation with *Badan Bimas Ketehanan Pangan* (BBKP, National Food Security Agency), WFP published a *Food Insecurity Atlas* in 2005 and a district nutrition map in 2006. The vulnerability analysis and mapping (VAM) unit and BBKP will continue to train and support 150 provincial and district staff on food and nutrition surveillance; the impact of this countrywide information and advocacy programme will be felt beyond WFP's operational areas.

Exit Strategy

38. WFP's focus on nutrition rehabilitation and capacity-building is in line with Government priorities. The challenge is to commit resources at the provincial and district levels and align them with other donor-supported programmes. Transfer of ownership of school feeding programmes to provinces and districts will be sought. PRRO 10069.2 will enhance the viability of *posyandu* health and nutrition services, but it should not be a stand-alone programme for an indefinite period. Progress has been made in terms of building capacity; the Government will start to take responsibility for nutritional interventions for children aged 6–24 months in *posyandu* from 2008. WFP plans to phase out completely if complementary resources are committed and a Government strategy is in place before the end of the PRRO.

BENEFICIARIES AND TARGETING

39. Initial geographic targeting down to the district level is informed by the recent Integrated Food Security and Humanitarian Phase Classification pilot by WFP, FAO and others using BPS data and other studies. Geographic targeting decisions are based on the types of indicators and data sources used in *A Food Insecurity Atlas of Indonesia* and the *Nutrition Map of Indonesia*. Chronic food insecurity and vulnerability to natural disasters are considered in identifying areas needing food assistance. WFP uses data and advice from ministries, provincial authorities, specialized agencies and health centres to determine the clusters of intervention areas.

40. WFP assistance will focus on rural areas of acute poverty, food deficits and high undernutrition – currently East Java, Madura, Lombok, West Timor and slums in Java – to enhance synergy with other United Nations programmes, an UNDAF 2006–2010 priority, and donor-supported bilateral programmes.

41. The *posyandu* are the ideal location for MCN. The NRP raises awareness and adds to people's knowledge of health and nutrition requirements; it is an entry point for addressing the challenge of nutrition education and dietary habits. WFP will work to increase on-site collaboration with other specialized agencies in this respect.

42. School feeding will cover all primary schools in targeted districts, including areas of Greater Jakarta. Children aged 6–13 will receive fortified biscuits to mitigate micronutrient deficiencies, increase learning capacities and enhance attendance. There is no significant gender bias in primary schools. WFP will target the poorest areas prioritized by the Government that are not supported by school feeding. As a counterpart commitment, WFP will seek local government and donor allocations for deworming.

43. Private and public TB clinics will be identified in the poorest communities of Greater Jakarta, East Java and West Timor, where the highest TB rates occur. Local NGO partners will be contracted to deliver food, monitor beneficiary registration and report the impact of WFP food rations on detection and cure rates. As noted above, a programme for HIV/AIDS prevention education and testing will be developed with the National Aids Commission (NAC), UNAIDS and WHO.

44. FFW will target poor communities in Madura, Lombok and NTT, mainly to rehabilitate/create assets to improve people's resilience to disasters. The involvement of women in identifying and managing projects will be encouraged; women in poor areas generally constitute over 50 percent of the workforce.

45. Community water and sanitation development projects funded through the OPSM trust fund will be concentrated in NTT, NTB, East Java and Greater Jakarta alongside NRP schools and *posyandu* to ensure an integrated approach.

TABLE 2. PLANNED BENEFICIARIES, BY OPERATIONAL AREA

WFP activities	Greater Jakarta	East Java	NTB	NTT	Relief	Total
School feeding	40 000	80 000	100 000	100 000	-	**320 000**
MCN programme						
Children of 2-5	-	48 000	61 000	61 000	-	**170 000**
Pregnant and lactating women	-	14 000	18 000	18 000	-	**50 000**
TB	80 000	20 000		20 000	-	**120 000**
FFW/FFT	-	40 000	25 000	50 000	-	**115 000**
Relief	-	-	-	-	70 000	**70 000**
Total	**120 000**	**202 000**	**204 000**	**249 000**	**70 000**	**845 000**

NUTRITION CONSIDERATIONS AND RATIONS

46. Micronutrient deficiency is a public health problem: it reduces immunity, leading to increased morbidity and mortality, and reduces growth. Anaemia causes lethargy, retards mental development – iodine deficiency is another cause – and increases maternal mortality, to which vitamin A deficiency also contributes. In Indonesia, 50 percent of the population have deficits in vitamin A, iron and iodine.[6]

47. In *posyandu*, the 1.5 kg of fortified biscuits for children aged 2–5 provide 50 percent of the recommended daily allowance (RDA); the 5 kg of fortified noodles provide 100 percent RDA for pregnant and lactating women, an incentive for women with young children to attend nutrition classes. Women will be assisted throughout pregnancy and for the first six months of breastfeeding.

48. Under the primary school feeding programme, children will receive a morning snack of 50g of locally produced fortified biscuits.

49. The 10 kg of rice per month family ration for each TB patient is an enabler to undergo the six-month treatment and offsets opportunity costs such as transport to attend the clinics.

50. Current FFW norms include 2.5 kg of rice and 150 g of oil per person per day, the market value of which is US$1.5.

TABLE 3. FOOD BASKETS (g)

Activity	Ration per person per day				Duration
	Biscuits	Noodles	Rice	Vegetable oil	
School feeding	50	-	-	-	240 days
MCN programme	50				
Children aged 2–5	-	-	-	-	12 months
Pregnant and lactating women	-	167	-	-	
TB	-	-	67	-	12 months
FFW/FFT	-	-	500	30	60 days
Relief	-	-	333	-	4 months

[6] Atmaritha, M.P.H. 2005. *Nutrition Problems in Indonesia*. Jakarta, Ministry of Health. Based on National Health and Household Survey (NHHS) 1995 and 2001 anaemia rates: children under 5: 47 percent in 2001; schoolchildren: 47.2 percent in 1995; pregnant women: 40.1 percent in 2001; and lactating women: 45.1 percent in 1995. Iodine deficiency disorders (IDD): 11.1 percent in 2003 (estimated). Vitamin A deficiency (VAD): 0.33 percent in 1992, but 50 percent of children under 5 had low serum retinol (20 ug/dl).

IMPLEMENTATION ARRANGEMENTS

Capacity-Building and Participation

51. Capacity-building is central to the PRRO in terms of effectiveness and sustainability. The main elements are:

52. *Food Insecurity Atlas*. Launched in August 2005, the atlas guides decision-makers in improving social safety-nets and planning for disaster mitigation, preparedness and response; it has become a tool for monitoring district food security.

53. Nutrition Mapping and Surveillance. In 2006 BPS, the Menkokesra (Ministry for People's Welfare), AusAid and WFP collaborated to produce the first *Nutrition Map of Indonesia*. With further support from the Department for International Development (DFID), WFP will continue to help food security agencies to collect and update data on food and nutrition.

54. Developing an early-warning system. In collaboration with the Government, the VAM unit produces a monthly *Early Warning Bulletin* of information on natural disasters, weather and crop forecasting. It is used by development agencies and will be continued during the PRRO.

55. Nutritional awareness at schools and *posyandu*. The PRRO includes the production of nutrition education materials and training for NGO partners, local groups and teachers in their use.

56. Community development projects (CDPs). WFP will train local NGOs to implement small-scale projects such as hiring technical staff to carry out assessments.

57. Gender. Implementing partners and government counterparts will be trained in ECW. Women will continue to be equally represented on committees for selecting beneficiaries and identifying and implementing projects.

Partnerships

58. Menkokesra, WFP's principal government counterpart for policy and programming, partners WFP in approving projects financed under the OPSM trust fund. A steering committee of government counterparts and WFP will review PRRO progress, provide guidance and be responsible for government contributions.

59. The Ministry of Health is responsible for coordinating provincial and district authorities in WFP's operational areas to ensure that MP-ASI allocations for children aged 6-24 months are budgeted. WFP will provide a list of the *posyandu* in its programme. For capacity-building through food and nutrition surveillance and the *Food Insecurity Atlas*, WFP collaborated with the ministries of agriculture, health and family welfare.

60. On the basis of established partnerships, NGOs will be selected for their experience, capacity and satisfactory implementation of gender policies; they will be responsible for logistics, distribution, monitoring and reporting.

61. Building on the 2005–2006 deworming programme in primary schools in Aceh, WFP will work with UNICEF to address helminthic infections in operational areas.

62. WFP has selected companies based in Indonesia to produce and deliver fortified biscuits and noodles. The commercial potential of fortified products will be advocated by WFP through its partnership with private-sector companies.

Non-Food Inputs

63. These include nutritional, hygiene and health education materials supplied to *posyandu*, primary schools and TB clinics. Environmental responsibility is encouraged through the re-use of packaging where possible.

Logistics Arrangements

64. WFP will continue exchanges with BULOG rice stocks, and will obtain rice, wheat and oil through the ports of Jakarta or Surabaya. Wheat will be exchanged for biscuits and noodles produced by local food companies in line with barter agreements.

65. For wheat and oil shipments, clearing and milling is arranged by WFP in coordination with Menkokesra. Unloading of ships and delivery to designated companies and WFP warehouses will be carried out by contracted agents; biscuits and noodles are delivered to extended delivery points (EDPs) under the same arrangement. EDP warehouse management will gradually be outsourced.

66. The nature of the programme requires partners to transport commodities from warehouses to a large number of final delivery points (FDPs), which increases landside transport, storage and handling (LTSH) costs. LTSH transactions are handled by the country office; the Commodity Movement Processing and Analysis System (COMPAS) is operational in all sub-offices.

Procurement

67. Food will be purchased on the basis of best value and approval of the procurement authority. The Government approves local milling of in-kind shipments of wheat for biscuits and noodles.

68. New producers to make biscuits and noodles will be sought to increase competition. The PRRO will encourage commercial fortified products for the local market; the domestic market for other products will also be explored.

PERFORMANCE MONITORING

69. Programmes will be monitored by the country office in Jakarta, the Surabaya area office, sub-offices in Mataram (NTB) and Kupang (NTT), and field offices in Madura (East Java) and Atambua (NTT). Government counterparts and cooperating partners will be trained in results-based monitoring; outputs and outcomes will be jointly monitored.

70. An RBM toolkit will be employed for all programme categories, focusing on data collection, accountability, beneficiary contact monitoring and reporting. Information will be processed in the web-based monitoring and evaluation (M&E) database and shared with Government counterparts and partners to improve programme performance.

71. The impact of nutrition rehabilitation, particularly the reduction of anaemia in target groups, will be assessed through a haemoglobin baseline survey and annual follow-ups. A mid-term knowledge, attitude and practice (KAP) survey will assess behavioural improvements in target groups in nutritional and nutrition-related health practices. There will be an external mid-term evaluation in 2009 and a subsequent needs assessment to forecast WFP's future involvement in Indonesia.

RISK ASSESSMENT AND CONTINGENCY PLANNING

Risks

72. The following risks are recognized:

- limited capacity or budgets among cooperating partners and government and civil society groups;
- adverse weather affecting harvests and requiring a shift from rehabilitation to relief;
- lack of counterpart commitment as WFP phases out; and
- uneven sharing of individual rations in households or communities, limiting the impact of nutritional interventions.

Contingency Planning

73. Capacity constraints will be addressed through refresher training in nutrition for partners, local government staff and village groups, combined with re-packaging and increased fortification to prevent pregnant and lactating women from sharing noodles in households. Government budget allocations for micronutrient programmes will depend on continuing advocacy at the national and regional levels.

74. Earthquakes and floods are anticipated: a 10 percent contingency for 70,000 beneficiaries is included in the PRRO. Additional donor funds have to date been made available on a case-by-case basis. Under the cluster system and its associated financial provisions, currently held at Headquarters, arrangements are being made to enable the country office to stockpile non-food items as a reserve.

75. The country office and sub-offices hold regular meetings with the Office for the Coordination of Humanitarian Affairs (OCHA), NGOs and other United Nations agencies to review needs. Negotiations with BULOG will seek to draw on their rice stocks in emergencies in locations distant from WFP stocks. Contingency arrangements for an avian influenza outbreak will soon be in place, focusing on staff safety and security.

SECURITY CONSIDERATIONS

76. Security is regularly reviewed by the United Nations Security Management Team. Except for areas beyond Kupang in West Timor (phase II), there are currently no serious security risks in operational areas. WFP has high-frequency (HF) radios, handsets and satellite telephones in all sub-offices and is compliant with minimum operating security standards (MOSS) and minimum security telecommunications standards (MISTS).

RECOMMENDATION

77. The Board is requested to approve the proposed Indonesia PRRO 10069.2.

ANNEX I-A

BREAKDOWN OF PROJECT COSTS			
	Quantity (mt)	**Average cost per mt (US$)**	**Value (US$)**
WFP COSTS			
A. Direct operational costs			
Commodity*			
- Rice	58 432	400	23 372 640
- Vegetable oil	2 484	740	1 838 800
- Biscuits	15 524	1 075	16 688 650
- Noodles	6 764	870	5 884 680
- Wheat	42 137	200	8 427 400
Total commodities	**125 341**		**56 212 330**
External transport			6 347 508
Total LTSH			**13 780 545**
Other direct operational costs			3 084 882
Total direct operational costs			**79 425 266**
B. Direct support costs[1] (see Annex I-B)			**12 432 937**
C. Indirect support costs[2] (7 percent)			**6 430 074**
TOTAL WFP COSTS			**98 288 275**
*This is a notional food basket for budgeting and approval. The contents may vary.			

[1] Indicative figure for information purposes. The DSC allotment is reviewed annually.

[2] The ISC rate may be amended by the Board during the project.

ANNEX I-B

DIRECT SUPPORT REQUIREMENTS (US$)	
Staff	
International professional staff	4 413 690
National professional officers	1 034 267
National general service staff	2 673 777
Temporary assistance	75 000
Overtime	75 000
Incentive	150 000
International consultants	225 000
Staff duty travel	1 040 000
Staff training and development	300 000
Subtotal	9 986 734
Office expenses and other recurrent costs	
Rental of facility	680 000
Utilities (general)	170 000
Office supplies	217 523
Communication and IT services	539 804
Insurance	16 260
Equipment repair and maintenance	172 423
Vehicle maintenance and running cost	223 392
Other office expenses	79 097
United Nations organizations services	137 203
Subtotal	2 235 702
Equipment and other fixed costs	
Furniture tools and equipment	135 000
Vehicles	Nil
TC/IT equipment	75 500
Subtotal	210 500
TOTAL DIRECT SUPPORT COSTS	**12 432 937**

ANNEX II: LOGICAL FRAMEWORK

Outcomes	Outcome indicators	Assumptions, risks
MCN programme, Strategic Objective 3: 1.1 Micronutrient deficiencies in children aged 2–5 and pregnant and lactating women are reduced in assisted local health posts. 1.2 Knowledge and practice among pregnant and lactating women and children's caregivers regarding nutritional and nutrition-related health behaviour are improved.	1.1.1 Reduced prevalence of anaemia among children aged 2–5, by sex. 1.1.2 Reduced prevalence of anaemia among pregnant and lactating women. 1.2.1 Percentage of targeted women regularly using MCN services at community health posts. 1.2.2 Percentage of targeted women applying improved nutritional and nutrition-related health practices.	Government's commitment to mitigate malnutrition remains high. Diseases affecting nutritional status of the targeted population are controlled. Government's commitment to achieve education for all remains high. Health care, water and sanitation systems are rapidly re-established in disaster-affected areas. Government's commitment to support all programmes in targeted areas continues. Further disasters are not of unprecedented magnitude.
School feeding programme, Strategic Objectives 3 and 4: 2.1 Micronutrient deficiencies among primary schoolchildren are reduced in assisted schools. 2.2 Capacity of boys and girls to concentrate and learn in assisted schools is improved. 2.3 Attendance rates of boys and girls in assisted schools are improved. 2.4 Student's knowledge and practice of basic health, nutrition and hygiene are improved.	2.1.1 Reduced prevalence of anaemia among schoolchildren, by sex. 2.2.1 Teachers' perception of children's improved concentration and learning as a result of consuming fortified biscuits. 2.3.1 Percentages of girls and boys in targeted primary schools with at least 80% attendance. 2.4.1 Percentage of students applying safe hygiene behaviour.	
Support for TB patients, Strategic Objective 3: 3.1 Increased participation of TB patients in DOTS in targeted health centres/clinics.	3.1.1 Percentage of TB patients completing DOTS, by sex. 3.1.2 Improved % of TB detection rates.	

ANNEX II: LOGICAL FRAMEWORK

Outcomes	Outcome indicators	Assumptions, risks
FFW/FFT, CDPs and emergency general food distribution (GFD) programmes, Strategic Objectives 1 and 2: 4.1 Livelihoods of vulnerable groups are improved through the creation or rehabilitation of communal/individual assets and skills. 4.2 Preventing deterioration of the nutritional status of disaster-affected populations.	4.1.1 Actual number and % of supported assets that are in use and maintained, by type. 4.1.2 Local contribution of land and labour made for infrastructure projects. 4.1.3 Proportion of household expenditure allocated to food. 4.2.1 Prevalence of global acute malnutrition among children under 5 in the target population, by sex (wasting and/or clinical signs of oedema). 4.2.2 Prevalence of malnutrition among children under 5 in the target population, by sex (weight-for-age).	
Outputs	**Output indicators**	
1.1.1 Local health posts in areas with high rates of malnutrition are targeted. 1.1.2 Timely provision of fortified food in sufficient quantities for targeted children and women.	1.1.1.1 Number of health posts with high prevalence of malnutrition reached as % of planned. 1.1.2.1 Actual quantities of fortified food distributed as % of planned, by type of commodity. 1.1.2.2 Actual number of children aged 2–5 receiving fortified food as % of planned, by sex. 1.1.2.3 Actual number of pregnant and lactating women receiving fortified food as % of planned.	Donors provide timely resources. Cooperating partners and Government departments provide sufficient qualified personnel. Free access to implementation areas is granted.
1.1.3 Skills-based nutrition and health education training implemented by village health volunteers and health staff.	1.1.3.1 Actual number of people trained, by type of training and sex. 1.1.3.2 Percentage of health posts implementing skills-based nutrition and health education training.	Stakeholders' commitment remains high. Inter-agency cooperation and enhanced common strategies pursued. Partners/suppliers provide timely and cost-effective inputs. TB drugs are readily available for distribution at the health centres/clinics.
2.1.1 Primary schools in areas with high rates of malnutrition are targeted. 2.1.2 Timely provision of fortified biscuits in sufficient quantities for targeted primary schoolchildren. 2.1.3 FRESH is implemented in targeted schools, with focus on implementing skills-based nutrition and health training.	2.1.1.1 Number of schools with high prevalence of malnutrition reached. 2.1.2.1 Actual number of primary schoolchildren receiving fortified biscuits as % of planned, by sex. 2.1.2.2 Actual quantities of fortified biscuits distributed as % of planned. 2.1.3.1 Number of schools implementing FRESH .	

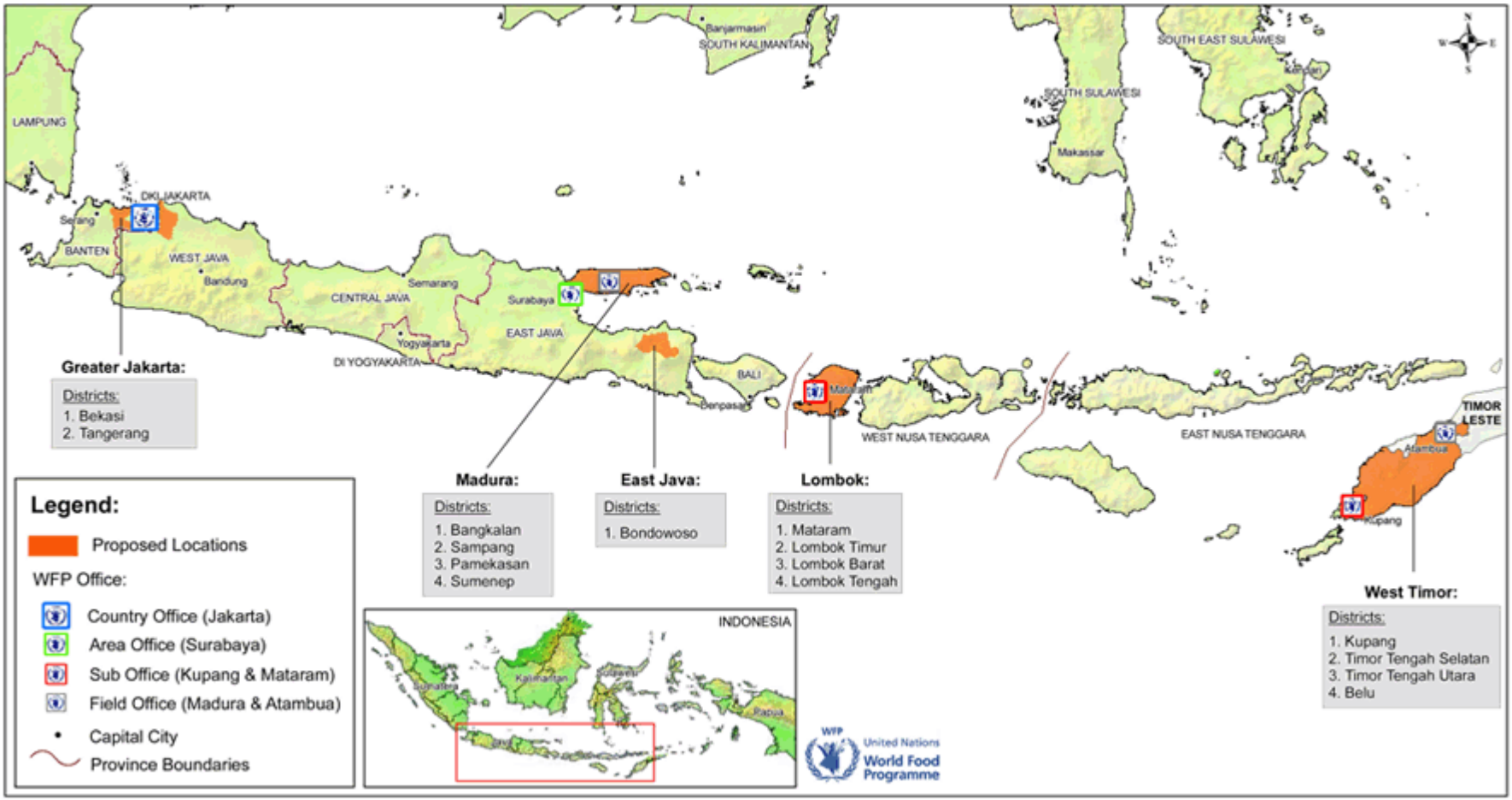
ANNEX II: LOGICAL FRAMEWORK

Outcomes	Outcome indicators	Assumptions, risks
	2.1.3.2 Actual number of people trained, by type of training and sex. 2.1.3.3 Percentage of schools implementing skills-based nutrition and health education training. 2.1.3.4 Number of schoolchildren receiving deworming tablets, by sex.	Trust fund money is released as needed. Needs assessments are resourced and implemented in a timely way.
3.1.1 Registered TB patients received the monthly food ration. 3.1.2 Timely provision of food in sufficient quantities for targeted beneficiaries.	3.1.1.1 Actual numbers of TB patients in DOTS as % of estimated beneficiaries, by sex. 3.1.2.1 Actual quantities of food distributed as % of planned.	
4.1.1 Creation and rehabilitation of individual and communal infrastructure assets are supported.	4.1.1.1 Actual numbers of FFW projects/schemes supported, by type. 4.1.1.2 Actual numbers of CDP projects supported in poor communities, by type. 4.1.1.3 Number of household/people benefiting from the supported assets.	
4.2.1 Knowledge and skills training activities are facilitated. 4.3.1 Timely provision of food commodities in sufficient quantities for targeted beneficiaries. 4.4.1 Establishment of village implementation, maintenance or food distribution groups are supported. 4.5.1 Needs assessment conducted in cooperation with government and other agencies.	4.2.1.1 Actual number of people trained through FFT/CDP programme as % of planned, by training type and sex. 4.3.1.1 Actual number of FFW/FFT/GFD beneficiaries receiving food as % of planned, by sex. 4.3.1.2 Actual quantities of food distributed through FFW/FFT/GFD as % of planned, by type of commodity. 4.4.1.1 Actual number of FFW/CDP/GFD committees assisted with information on women in leadership positions. 4.5.1.1 Actual number and % of needs assessment recommendations implemented on targeting aspects or ration adjustments etc.	

ANNEX II: LOGICAL FRAMEWORK

Outcomes	Outcome indicators	Assumptions, risks
Common output indicator for all programmes		
5.1.1 Cooperating partners are contracted and stakeholders' capacity in assessment and implementation management is enhanced, including logistics and M&E.	5.1.1.1 Number of contracts signed with cooperating partners, by programme. 5.1.1.2 Number of cooperating partner staff trained, by training type, programme and sex.	

Proposed Intervention Areas for Indonesia PRRO 10069.2 (2008–2010)



ACRONYMS USED IN THE DOCUMENT

ADB	Asian Development Bank
AIDS	auto-immune deficiency syndrome
BBKP	*Badan Bimas Ketehanan Pangan* (National Food Security Agency)
BPS	*Biro Pusat Statistik* (Indonesia Bureau of Statistics)
BULOG	National Logistics Planning Agency
CCA	Common Country Assessment
CDP	community development project
COMPAS	Commodity Movement Processing and Analysis System
DFID	Department for International Development
DOTS	directly observed treatment with short-course chemotherapy
ECW	Enhanced Commitments to Women
EDP	extended delivery point
EMOP	emergency operation
FAO	Food and Agriculture Organization of the United Nations
FDP	final delivery point
FFT	food for training
FFW	food for work
FRESH	Focusing Resources on Effective School Health
GFD	general food distribution
HF	high frequency
HIV	human immunodeficiency virus
IDD	iodine deficiency disorders
ITSH	internal transport, storage and handling
KAP	knowledge, attitude and practice
LTSH	landside transport, storage and handling
M&E	monitoring and evaluation
MCN	mother-and-child nutrition
MDG	Millennium Development Goal
MISTS	minimum security telecommunications standards
MOSS	minimum operating security standards
MP-ASI	government blended food for nutrition programme
NAC	National Aids Commission
NGO	non-governmental organization

NHHS	National Health and Household Survey
NRP	Nutrition Rehabilitation Programme
NTB	*Nusa Tenggara Barat*
NTT	*Nusa Tenggara Timur*
OCHA	Office for the Coordination of Humanitarian Affairs
OPSM	*Operasi Pasan Swadaya Masyasakat* (Subsidized Rice Safety Net)
PLHIV	people living with HIV
PRRO	protracted relief and recovery operation
PRSP	Poverty Reduction Strategy Paper
RASKIN	*Beras untuk Orang Miskin* (food-assistance programme)
RDA	recommended daily allowance
TB	tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNICEF	United Nations Children's Fund
VAD	Vitamin A deficiency
VAM	vulnerability analysis and mapping
WHO	World Health Organization