

ASIAN DEVELOPMENT BANK

TAR:INO 33405

TECHNICAL ASSISTANCE

TO THE

REPUBLIC OF INDONESIA

FOR

PUBLIC HEALTH AND NUTRITION

April 2003

CURRENCY EQUIVALENTS

(as of 2 April 2003)

Currency Unit	–	rupiah (Rp)
Rp1.00	=	\$0.000112
\$1.00	=	Rp8,895

ABBREVIATIONS

ADB	–	Asian Development Bank
BAPPEDA	–	Badan Perencanaan Pembangunan Daerah (Regional Development Planning Board)
BAPPENAS	–	Badan Perencanaan Pembangunan Nasional (National Development Planning Board)
BKKBN	–	Badan Koordinasi Keluarga Buerencana Nasional (National Family Planning Coordinating Board)
DHS	–	Decentralized Health Services
MOH	–	Ministry of Health
NPAFN	–	National Plan of Action for Food and Nutrition
TA	–	technical assistance

NOTES

- (i) The fiscal year (FY) of the Government ends on 31 December.
- (ii) In this report, "\$" refers to US dollars.

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I. INTRODUCTION

1. The Asian Development Bank (ADB) fielded a fact-finding mission in November 2002 to formulate an advisory technical assistance (TA)¹ to improve the nutritional status of poor and vulnerable populations especially in urban areas. The mission² met with representatives of Government, development partners, and research institutions. The mission agreed with Government on the objectives, scope, cost estimates and financing plan, implementation arrangements, and terms of reference for the TA. The TA framework is attached as Appendix 1.

II. ISSUES

2. Indonesia's health and nutrition trends improved steadily from 1989 until 1999. The prevalence of protein-energy malnutrition among pre-school children decreased from 37.5% in 1989 to 8.1% in 1999³. This trend was reversed by the economic crisis,⁴ which reduced real incomes and left large segments of the population, particularly in urban areas, unable to afford adequate food and nutrition. The large number of malnourished populations during the economic crisis was largely caused by food insecurity at the household level, especially among the poor. Between 1996 and 1999 the number of people below the poverty line in urban areas increased from 18.0 million to 32.2 million.⁵ Rates of acute malnutrition among children under 5 years of age were as high as 5% in rural Java and almost 13% in Jakarta.⁶ According to Helen Keller International, rates of maternal and childhood anaemia are higher in urban slums than in rural Java. Maternal anaemia due to iron deficiency is associated with low birth weight and is largely responsible for a fourth of maternal mortality, a persisting problem in Indonesia.

3. There are several factors influencing nutrition trends in Indonesia. Urbanization in Indonesia increased from 22% in 1980 to 39% in 2000. The urban poor depend on income and low wages in insecure jobs. Slow economic recovery, high unemployment, and increasing costs for food and other essentials continue to undermine food and nutrition security for the urban poor. In the poorest Javanese urban areas, the poor spend more than 75% of their income on food. Potentially harmful changes in diets such as consumption of processed and prepared food also accompany urbanization. The rice-based diet of the urban poor is energy-deficient, is unbalanced, and lacks essential micronutrients. Vulnerable populations such as slum dwellers, internally displaced persons, and street children are more likely to be affected by health risks, life-cycle risks (birth, maternity, and death), and social and environmental risks. Many of them are not covered by formal safety nets. Lessons learned from ADB's two social sector development program loans⁷ show that the growing urban population is particularly at risk of malnutrition and diet-related diseases, and that existing public health and nutrition programs do not meet urban nutrition needs.

¹ The TA first appeared in *ADB Business Opportunities* on 22 February 2002.

² The mission comprised Barbara Lochmann (Mission Leader, Social Protection Specialist) and James Sonnemann (Nutrition Specialist, Staff Consultant).

³ SUSENAS 1999. Health and Information Center.

⁴ Steven Block, et al. 2002. *Did Indonesia's Crisis of 1997/98 Affect Child Nutrition? A Cohort Decomposition Analysis of National Nutrition Surveillance Data*. Medford: Tufts University.

⁵ UNDP. 2002. *Indonesia Human Development Report 2001*. Indonesia.

⁶ Helen Keller International/Indonesia. Data courtesy of Robert Bernstein, Management Sciences for Health.

⁷ ADB. 1998. *Report and Recommendation of the President to the Board of Directors on a Proposed Loan to Indonesia for the Social Protection Sector Development Program*. Manila.

ADB. 1999. *Report and Recommendation of the President to the Board of Directors on a Proposed Loan to Indonesia for the Health and Nutrition Sector Development Program*. Manila.

4. Increasing urbanization and nutrition transition to higher-fat diets, predisposing people to chronic noncommunicable diseases such as diabetes and cardiovascular disease in later life, demands a reorientation of nutrition programs in terms of service delivery structure and for curative, preventive, and promotive approaches. In Indonesia, adult obesity is twice as prevalent in urban areas as in rural areas. A unique issue emerging from this nutrition transition is the double burden of undernutrition and obesity in the same household; 9.8% of all households have both underweight and overweight members in the same household.

5. Given Indonesia's rapid social and economic changes, the implementation of nutrition programs in urban areas is lagging. While growth monitoring and promotion is still a cornerstone of Indonesian nutrition programs delivered by integrated health posts (*posyandu*),⁸ the growth of children under the age of 3 years is not fully monitored. *Posyandu* service delivery strategies are based on the rural nutrition situation. An appropriate service delivery strategy will be required to respond to the urban nutrition situation.

6. Central government is responsible for overall nutrition policy development. With decentralization, local authorities and parliaments are directly responsible for identifying local needs, mobilizing resources, and providing public services. Minimum service standards and obligatory functions, including nutrition-related health service interventions, have been defined.⁹ Healthy Indonesia 2010¹⁰ sets out the National Health Development Program intended to achieve the health-related Millennium Development Goals (MDGs). The National Plan of Action for Food and Nutrition (NPAFN)¹¹ emphasizes the need to adapt interventions to local conditions. These targets are not likely to be reached without a reorientation of policies, strategies, and partnerships addressing in particular urban nutrition issues.

7. ADB has taken the lead in improving nutrition in Asia and the Pacific through extensive work in the public and private sector. In Indonesia, ADB supported urban nutrition through two sector development program loans, food fortification, and three nutrition-related technical assistance¹² that emphasized the economic costs and benefits of malnutrition. ADB's Family Health and Nutrition Project¹³ promotes awareness about healthy diets for the rural poor and strengthens related household-level decisions and behaviour. Several funding agencies provide assistance to the nutrition sector in Indonesia. Building on ADB's nutrition sector work¹⁴ the World Bank provides TA for food fortification and micronutrient policy development. The United Nations Children's Fund (UNICEF) supports the Government in improving maternal and child health services, including growth monitoring at *posyandu* and food supplementation. The World Food Program (WFP) complements the Government's subsidized rice sale program. The United

⁸ *Posyandu* services are provided through a Government program for improving family nutrition called Usaha Perbaikan Gizi Keluarga (UPGK).

⁹ Minimum service standards include, among others, visits for pregnant women and infants, growth monitoring of under five years of age, supplementary food for elementary school children in poor areas, vitamin A supplementation for children under five years of age.

¹⁰ Healthy Indonesia 2010 is the National Health Development Plan.

¹¹ The NPAFN is the main guideline for policy makers in designing coordinative plan for food and nutrition programs at the central, provincial and district levels.

¹² ADB. 1996. *Regional Study on Reducing Child Malnutrition in Eight Asian Countries*. Manila.

ADB. 1998. *Regional Study of Nutrition Trends, Policies, and Strategies in Asia and the Pacific*. Manila.

ADB. 2000. *Regional Initiative to Eliminate Micronutrient Malnutrition in Asia through Public-Private Partnership*. Manila.

¹³ ADB. 1996. *Report and Recommendation of the President to the Board of Directors on a Proposed Loan to Indonesia for Family Health and Nutrition*. Manila.

¹⁴ ADB. 2001. *Regional Initiative to Eliminate Micronutrient Malnutrition in Asia through Public-Private Partnership*. Manila.

States Agency for International Development (USAID) supports micronutrient studies and surveillance through Helen Keller International.

8. There is yet no systematic approach for addressing nutrition transition, food, and nutrition security especially among urban poor and vulnerable populations in an integrated manner. A key challenge in decentralizing nutrition programs is to ensure that nutrition receives appropriate consideration in district planning and resource allocation. Unless local decision-makers are convinced of the social benefits in funding preventive and promotive nutrition programs, local governments may not invest in such interventions. Social cost-benefit and cost-effectiveness analyses of nutrition interventions can guide local decision-makers in determining priorities and maximizing limited financial resources for poor urban areas, including high-risk populations. Ensuring equitable and adequate nutrition service delivery for the poor will require pro-poor budget allocations prioritizing nutrition interventions based on local conditions as well as appropriate institutional and community-based arrangements for effective service delivery.

9. Decentralization provides opportunities for new public-private partnerships to improve the nutrition status of the urban poor. The TA will focus on developing locally appropriate nutrition interventions reaching especially poor and vulnerable populations in selected urban areas of the Decentralized Health Services (DHS) II Project and the Shelter Project.¹⁵ The TA will especially draw on lessons learned from the Family Health Nutrition Project and complement efforts of DHS I and DHS II.

III. THE TECHNICAL ASSISTANCE

A. Purpose and Output

10. The project aims to improve and sustain nutritional status of the urban poor. The purpose of the TA is to assist the Government to design a model of public-private partnership operations for improved nutrition management in urban areas¹⁶ and to prepare a project proposal focusing on improved nutrition management.

11. The main outputs of the TA will include (i) reviewing lessons learned from nutrition projects and national policy guidelines for urban nutrition and feeding practices based on a life-cycle approach¹⁷ including recommendations to improve the nutrition status of the poor; (ii) assessing the prevalence and incidence of malnutrition particularly of the poor in the selected urban areas; (iii) examining nutrition policy and implications of decentralization for community-based programs in urban areas and making recommendations for decentralized urban nutrition management; (iv) identifying appropriate options for equitable and cost-effective interventions in the nutrition transition and examining approaches and schemes for targeting subsidies for the poor; (v) identifying and estimating costs of core components for enhanced service delivery and community-based nutrition interventions; (vi) identifying institutional and public-private partnership options that integrate nutrition improvement as part of their poverty reduction and social protection programs; (vii) developing a project proposal, including rationale, expected outcomes, benefits, logical framework, geographic scope, assessment of executing and implementing agencies, estimates of inputs and costs, and implementation arrangements and schedules; (viii) developing a comprehensive nutrition policy plan with specific and sequenced

¹⁵ ADB. 2001. *Technical Assistance to Indonesia for the Second Decentralized Health Services*. Manila.

ADB. 2002. *Technical Assistance to Indonesia for the Shelter Sector Project*. Manila.

¹⁶ Urban area in this document refers generally to a location that could be part of municipalities (kota) or regencies (kabupaten).

¹⁷ Life cycle approach identifies key health risks throughout life: pregnancy, infancy, birth, reproductive years, adulthood and aging. Interventions aim to break the cycle of poverty and ill-health.

policy actions to feed into the next NPAFN (2004-2009); (ix) determining capacity building needs for institutional development of nutrition assessment, as well as planning and program implementation in the decentralized environment; (x) identifying strategies for strengthening local institutions through capacity building in urban areas; and (xi) mobilizing urban communities to advocate, plan, manage, and monitor nutrition interventions.

B. Methodology and Key Activities

12. The TA will require systematic involvement of stakeholders¹⁸ in identifying priority needs and local solutions in (tentatively) three urban areas including Greater Jakarta (Tangerang), Makassar, and Medan.¹⁹ The TA will be carried out in two phases over 6 months. In the first phase (2 months), the TA will address activities outlined in para. 11 (i) to (iii). In the second phase (4 months), the TA will address activities outlined in para. 11 (iv) to (xi). Based on the results and recommendations of phase 1, two types of decentralized workshops will be organized in collaboration with urban authorities and the private sector. Advocacy workshops will aim at generating commitment among key decision-makers, including members of the Local People's Representative Assembly for investing in nutrition. Participatory planning workshops will involve stakeholders to define key components of an urban nutrition management model, considering (i) key interventions based on the life-cycle approach focusing especially on children under 5 years and women of reproductive age, (ii) public-private support structure for nutrition interventions, (iii) capacity-building requirements for urban nutrition management, (iv) nutrition awareness, and (v) coordination of external funding for urban nutrition management.

13. The TA consultant team will consolidate findings and recommendations produced by the situation analysis and planning workshops to develop an operations model for urban nutrition management including a project proposal. Based on workshop results, the TA consultant team will (i) analyze project components, as appropriate, for technical, financial, economic, social, and institutional viability and sustainability; and (ii) provide policy recommendations on urban nutrition for the NPAFN.

C. Cost and Financing

14. The total cost of the TA is estimated at \$625,000 equivalent, comprising \$299,000 in foreign exchange and \$326,000 equivalent in local currency. The Government has requested ADB to finance \$500,000 equivalent, covering the entire foreign exchange cost and \$201,000 equivalent of the local currency cost. The TA will be financed on a grant basis by ADB's TA funding program. The Government will provide \$125,000 equivalent in the form of office accommodation, counterpart and support staff, and other operational costs including local ground transportation. Detailed cost estimates and financing plan are presented in Appendix 2.

D. Implementation Arrangements

15. The Directorate General of Public Health in the Ministry of Health (MOH) will be the Executing Agency for the TA responsible for all technical and administrative aspects in collaboration with other departments and ministries. Suitably qualified and experienced counterpart staff will work full time with the TA consultants. To oversee implementation of TA activities, a steering committee, chaired by the Director General of Public Health, will be constituted by the end of the first month and will meet every 2 months. Members will include

¹⁸ Stakeholders include local government, academic institutions, civil society, and program beneficiaries.

¹⁹ Target areas have been selected from two projects, DHS II, and the Shelter Project, which are included in the 2003 lending program.

local government representatives, the National Development Planning Board (BAPPENAS), the Directorate of Community Health and Nutrition, the Ministry of Home Affairs, the Ministry of Social Affairs, the Ministry of Settlements and Regional Infrastructure, the Center for Nutrition Research and Development, and the National Family Planning Coordinating Board (BKKBN).

16. A central technical team will be established to work closely with the TA consultant team. The central technical team will include representatives from (i) the Decentralization Unit in MOH; (ii) the subdirectorate for Urban Health in the Department of Public Health; (iii) the Directorate General of Communicable Disease Control; (iv) the BAPPENAS Directorate of Community Health and Nutrition; (v) the Center for Nutrition Research and Development; (vi) the Ministry of Education; and (vii) the Ministry of Agriculture. At the municipal level, a local advisory team will be established composed of the head of the Department of Health, Regional Planning Board (BAPPEDA), nongovernmental organizations, universities, and the private sector to oversee and coordinate planning activities. The local advisory teams will be constituted in time to take part in the TA inception workshop and will provide advice to the consultant team.

17. The TA will require 12 person-months of international and 25 person-months of domestic consultants with expertise in health systems development and decentralization, maternal and child nutrition, food policy and nutrition, urban anthropology, community development, health economics, financial analysis and planning, surveillance, budgeting, and workshop facilitation. They will be recruited in accordance with ADB's *Guidelines on the Use of Consultants* based on quality- and cost-based selection and other arrangements satisfactory to ADB for the engagement of domestic consultants. The consultant team, in collaboration with MOH counterparts, will organize workshops in target urban areas to ensure participation of all stakeholders. Any procurement under the TA will be conducted in accordance with ADB's *Guidelines for Procurement* (outline terms of reference are given in Appendix 3).

18. The TA is expected to commence in June 2003, will be implemented over 6 months, and should be completed by December 2003. The team leader will provide (i) an inception report by the end of the first month, (ii) reports on each workshop, (iii) a midterm report after three months, (iv) a draft final report by the end of 5 months, and (v) a final report to be circulated and finalized 10 days before the end of 6 months.

IV. THE PRESIDENT'S DECISION

19. The President, acting under the authority delegated by the Board, has approved the provision of technical assistance not exceeding the equivalent of \$500,000 on a grant basis to the Government of Indonesia for Public Health and Nutrition, and hereby reports this action to the Board.

TECHNICAL ASSISTANCE FRAMEWORK

Design Summary	Performance Indicators/Targets	Monitoring Mechanisms	Assumptions and Risks
<p>Goal</p> <ul style="list-style-type: none"> ▪ Improve and sustain the nutritional status of the poor urban population 	<ul style="list-style-type: none"> ▪ Prevalence of underweight among children < 5 years and infants is not higher than 20% ▪ Low birth weight prevalence is less than 7% ▪ Prevalence of anemia among children < 5 years is reduced to 30% 	<ul style="list-style-type: none"> ▪ Monthly surveys of malnutrition (wasting, anemia) in poor segments of the urban population 	
<p>Purpose</p> <ul style="list-style-type: none"> ▪ Design a nutrition management model that ensures equitable, quality services based on a life-cycle approach in the decentralized context ▪ Prepare a project proposal for implementing the nutrition management model 	<ul style="list-style-type: none"> ▪ 50% of health services had carried out nutrition counseling among families. ▪ Local parliament support financing nutrition improvement schemes 	<ul style="list-style-type: none"> ▪ Periodic growth monitoring statistics of under 5 years of age by area ▪ Anemia rates by area ▪ Nutrition surveys ▪ Relation of fund allocation to indicators, e.g., prevalence of anemia, undernutrition ▪ Project management unit and consultant reports 	<ul style="list-style-type: none"> ▪ Services can reach marginalized poor ▪ Local parliaments give priority to improving nutrition including adequate budget allocation and utilization ▪ Adequate human resource capacity for nutrition interventions
<p>Outputs</p> <ul style="list-style-type: none"> ▪ Elaborated model for urban nutrition management ▪ Established project framework including core components and costs for enhanced 	<ul style="list-style-type: none"> ▪ Appropriate mechanisms for urban nutrition service delivery identified ▪ Number of core interventions established and costs assessed 	<ul style="list-style-type: none"> ▪ Progress reports and review missions 	<ul style="list-style-type: none"> ▪ Components of model applicable in other urban environments ▪ Political commitment to improve nutrition status and prevent nutrition-related illness

Design Summary	Performance Indicators/Targets	Monitoring Mechanisms	Assumptions and Risks
nutrition service delivery <ul style="list-style-type: none"> ▪ Established public-private partnership for urban nutrition interventions ▪ Established community mobilization to plan, manage, and monitor nutrition interventions ▪ Policy recommendations for the National Plan of Action for Food and Nutrition 	<ul style="list-style-type: none"> ▪ Number of public-private partnership networks identified ▪ Number of communities in target areas and mechanisms for community mobilization identified ▪ Policy inputs in the National Plan of Action for Food and Nutrition 		
Activities <ul style="list-style-type: none"> ▪ To be developed by implementing the technical assistance (TA) 	<ul style="list-style-type: none"> ▪ Over 6 months, provide TA support to Ministry of Health ▪ Develop project framework for public-private partnership operations for nutrition management in urban areas 		<ul style="list-style-type: none"> ▪ Local authorities and the private sector will participate fully
Inputs <ul style="list-style-type: none"> Consultants Workshops Equipment 	<ul style="list-style-type: none"> \$ 349,000 \$ 39,000 \$ 10,000 	<ul style="list-style-type: none"> ▪ TA implementation progress reports ▪ Review missions 	<ul style="list-style-type: none"> ▪ Counterpart staff are available ▪ Counterpart budget is available on a timely basis

COST ESTIMATES AND FINANCING PLAN
(\$)

Item	Foreign Exchange	Local Currency	Total Cost
A. Asian Development Bank Financing^a			
1. Consultants			
a. Remuneration and Per Diem			
i. International Consultants	249,000	0	249,000
ii. Domestic Consultants	0	100,000	100,000
b. International and Local Travel	20,000	20,000	40,000
c. Reports and Communications	0	10,000	10,000
2. Equipment ^b	0	10,000	10,000
3. Training, Seminars, and Workshops			
a. Facilitators	0	20,000	20,000
b. Training Program	0	19,000	19,000
4. Transport (Local)	0	5,000	5,000
5. Miscellaneous Administration and Support Costs	0	6,000	6,000
6. Representative for Contract Negotiations ^c	5,000	0	5,000
7. Contingencies	25,000	11,000	36,000
Subtotal (A)	299,000	201,000	500,000
B. Government Financing			
1. Office Accommodation, Transport and Supplies	0	40,000	40,000
2. Remuneration and Per Diem of Counterpart Staff	0	40,000	40,000
3. Project Office Costs	0	15,000	15,000
4. Operational Costs	0	25,000	25,000
5. Contingencies	0	5,000	5,000
Subtotal (B)	0	125,000	125,000
Total	299,000	326,000	625,000

Note: For items A.2 and A.3, allocated amounts cannot be modified and need to be taken over in financial proposals.

^a Financed by ADB's TA funding program.

^b Purchase of one computer, one printer, one photocopier, and one fax machine, and rental of all other office equipment. At the conclusion of the TA, the equipment will become the property of the Government.

^c Includes cost of travel and per diem for Government observers for contract negotiations at Asian Development Bank headquarters.

Source: Asian Development Bank estimates.

OUTLINE TERMS OF REFERENCE FOR CONSULTANTS

1. The consultant team will comprise five international and nine domestic consultants. Consultant services will be provided by an international consulting firm selected in accordance with the *Guidelines on the Use of Consultants* of the Asian Development Bank (ADB). The consulting firm will provide 12 person-months of international and 25 person-months of domestic consultants as individuals or in collaboration with an Indonesian consulting firm. The specific technical tasks associated with each consultant are outlined in the following paragraphs.

A. International Consultants

1. Team Leader and Health System Development Specialist (6 person-months)

2. The team leader and health systems development specialist will be engaged for 6 months and will be responsible for (i) coordinating team activities and ensuring efficient implementation of the task; (ii) coordinating technical assistance (TA) activities with national and local government, including Ministry of Health, Ministry of Social Welfare, National Development Planning Board (BAPPENAS), academic institutions and civil society representatives; (iii) ensuring coordination of external funding for urban nutrition management; (iv) taking overall responsibility for timely preparation and submission of required reports; and (v) ensuring high quality and completeness of reports. Reports will include a detailed work plan for the TA; an inception report by the end of the first month that includes a detailed work plan, activity schedule, and staffing plan; a midterm report after the first 3 months; a draft final report after 5 months; and the final report after 10 days, with revisions based on the tripartite review, before the end of the 6 month period; and (v) regularly briefing the ADB project officer, the relevant sector officer at ADB's Indonesia Resident Mission (IRM), and the Executing Agency. As a specialist, the consultant will work with the consultant team to (i) examine nutrition policy and implications of decentralization for community-based programs in urban areas, and make recommendations for decentralized urban nutrition management; (ii) determine capacity-building needs for institutional development of nutrition assessment, planning, and program implementation in the decentralized environment; (iii) identify management needs from nutrition-related surveillance, including monitoring of situations that might affect nutrition status; (iv) assist the team to develop measurable indicators that are meaningful to nonhealth institutions for program decision-making; and (v) support the team in all aspects of developing the nutrition management model including project components for the project framework and make recommendations on integrated service packages for under nutrition and communicable disease control, strengthen capacity of urban health posts as well as the referral for maternal and young child health and nutrition related illnesses.

2. Maternal and Child Nutrition and Nutrition Program Management Specialist (2 person-months)

3. The specialist will address health and nutrition problems of vulnerable groups and recommend preventive, curative, and rehabilitative strategies to enhance maternal and child nutrition in urban areas. The consultant will (i) review lessons learned from nutrition projects and national policy guidelines for urban nutrition and feeding practices in the context of the life-cycle approach, and recommend strategies for improving the nutrition status of the poor as well as prevent nutrition-related illness; (ii) review *posyandu* and child-feeding programs and recommend methods to strengthen and revitalize these programs through better targeting of poor and at risk groups and through improved quality of services; (iii) examine programs for micronutrient malnutrition detection and response, with special attention to programs for

pregnant women and infants, and recommend strategies for improving iodine, vitamin A, and iron foliate coverage; (iv) examine community-based methods to identify and assist underweight women and children, recommending ways to strengthen community-based outreach for counseling and possible food supplements; (v) examine needs and the scope for expanded food fortification of salt, wheat flour, and cooking oil and recommend strategies for potential private-public partnerships; (vi) examine core nutrition education programs for modification of nutrition-related behavior in school age children, mothers, other caregivers, and women of reproductive age and make recommendations to improve the effectiveness of such programs and their communication strategies with support of the private sector; and (vii) identify appropriate project components.

3. Food and Nutrition Policy Analyst (2 person-months)

4. The nutrition and food policy analyst will examine interactions between food and nutrition policy affecting the most vulnerable populations in the decentralized urban environment and, based on the inputs of the surveillance and information specialist, make recommendations on policy and implementation of urban nutrition interventions. The consultant will (i) review surveillance systems that monitor factors affecting nutrition status, populations at high risk of malnutrition, and the epidemiological and nutrition transition as they relate to food and nutrition policy in urban areas, and provide policy recommendations; (ii) examine the relationship between poverty and malnutrition, and make recommendations for food and nutrition policies; (iii) examine the appropriateness of nutrition policies and food security with regard to nutrition of the urban poor, and prepare policy recommendations; (iv) identify existing and potential public-private partnerships addressing food availability, affordability, quality (including fortification); and recommend operation modalities linking public and private service providers in target areas; (v) provide policy inputs for the National Plan of Action for Food and Nutrition on urban nutrition focusing on integrated service packages for control of undernutrition and communicable disease, health communications, and role of the private sector; (vi) examine the efficiency with regards to targeting and distribution of food subsidies for the very poor, and provide appropriate policy and program recommendations; (vii) evaluate the effectiveness and impact of external assistance to nutrition and recommend strategies to improve financing and coordination of funders; (viii) assess food production trends in the target areas and related policies in terms of availability, affordability, seasonality, dietary quality, and impact on consumption patterns of the urban poor; (ix) recommend how food policies can improve the nutritional quality of affordable foods favored by the urban poor; and (x) provide inputs for the project framework.

4. Health and Nutrition Economist (1 person-month)

5. The health and nutrition economist will have extensive working experience in the nutrition sector and will consolidate background information on levels of nutrition investments by central and local governments, funding agencies, and the private sector; estimate additional requirements in relation to the economic burden of malnutrition and nutrition-related illness; identify appropriate options for cost-effective interventions in the nutrition transition; and define the role of investment planning in public nutrition across the life-cycle to improve health and productivity especially of the urban poor. The consultant will (i) review public national and local expenditure on nutrition; (ii) review available information relating to private expenditure for nutrition; (iii) review national and local health accounts with regards to nutrition; (iv) summarize the financial requirements of nutrition programs responsible for protecting the extremely poor from malnutrition due to economic factors beyond their capacity to avoid; (v) examine the role of national nutrition accounts in life-cycle investment planning to identify critical needs and vulnerable groups affected, particularly in urban areas; (vi) recommend resource reallocation

based on equity, efficacy, and cost-effectiveness; (vii) quantify externalities of proposed nutrition interventions; (viii) assist the Government nutrition programs to identify methods to monitor economic factors affecting the vulnerability of the poor in urban areas; and (xi) undertake cost-effectiveness and cost-benefit analysis of proposed project interventions and provide appropriate recommendations.

5. Surveillance and Information Specialist (1 person-month)

6. The specialist will (i) define information required by decision makers to support critical nutrition-related programs and policies; (ii) examine information systems and possible alternatives for sources of information linking nutrition with poverty data; (iii) recommend a streamlined approach for using existing surveillance and information systems to the extent possible; (iv) in collaboration with the nutrition specialists (paras. 3, 7, and 8), develop strategies to ensure the immediate interpretation and use of growth monitoring findings at the health post level or other possible service levels where weighing takes place; and (v) recommend project components.

B. Domestic Consultants

1. Maternal and Child Nutrition Specialist and Team Coleader (6 person-months)

7. As coleader, the domestic specialist will (i) assume primary responsibility for coordinating TA workshops with local governments and participants; (ii) monitor team activities to ensure that they integrate appropriately with the Indonesian urban and health program environment and access data sources effectively; and (iii) assist the international members of the team to examine and understand the Indonesian environment and tailor their activities appropriately. The specialist will also (i) collaborate with colleagues to ensure that nutrition, including nutrition-related disease recommendations, conform to life-cycle approaches; (ii) identify significant institutions, civil society, and programs relating to maternal and child nutrition in the urban environment and ensure that they are considered in the work of the team; (iv) support the team in all aspects of project framework design, and (iii) assist the international maternal and child nutrition specialist.

2. Food Policy and Nutrition Specialist (2 person-months)

8. The specialist will examine interactions between food and nutrition policy affecting the most vulnerable populations in urban areas and make recommendations as appropriate. The specialist will (i) in collaboration with the international counterpart, review surveillance systems and factors affecting nutrition status and food security, populations at high risk of malnutrition, and the epidemiological and nutrition transitions that can be used to set food and nutrition policy in urban areas; (ii) examine the appropriateness of current nutrition policies and strategies with regard to decentralization and needs in urban areas; (iii) examine the appropriateness of current nutrition and food security and supply policies and recommend appropriate strategies for the decentralized context; (iv) recommend options linking public and private service providers to enhance the nutrition status of the poor and prevent nutrition-related illness; (v) examine financial assistance for affordable food prices and stability in relation to programs that benefit and protect the very poor; (viii) review commitments of funding agencies to public nutrition in Indonesia and evaluate the effectiveness and impact of external assistance; (ix) assess food production trends and related policies in terms of their availability, affordability, seasonality, dietary quality, and impact on consumption patterns of the very poor, especially the urban

vulnerable populations; and (x) determine how food policies can improve the nutritional quality of affordable foods favored by the poor.

3. Health Economist and Financial Planner (2 person-months)

9. The health economist will have extensive working experience in the nutrition sector and will assist the international health economist to consolidate background information on levels of nutrition investments by national and local government and by funding agencies, estimate additional requirements for improving nutrition status in relation to the economic burden of malnutrition and diseases, focusing on the nutrition transition; identify appropriate options for cost-effective future public-private nutrition interventions; and define the role of investment planning in public nutrition across the life cycle to improve health and productivity especially of the urban poor. In collaboration with the international health economist, the consultant will (i) review local expenditure on nutrition; (ii) review available information relating to private expenditure for nutrition and make appropriate recommendations; (iii) review national health accounts with regard to nutrition and make appropriate recommendations; (iv) summarize the financial requirements of nutrition programs charged with protecting the extremely poor from malnutrition due to economic factors beyond their capacity to avoid; (v) examine the role of national nutrition accounts in life-cycle investment planning to identify critical needs and vulnerable groups affected, particularly in urban areas; (vi) recommend resource reallocation based on equity, efficacy, and cost-effectiveness; and (vii) assist national nutrition programs to identify methods to monitor economic factors affecting the vulnerability of the poor in urban areas.

4. Surveillance and Information Specialist (4 person-months)

10. The domestic specialist will collaborate with his or her international colleague to develop indicators that assist nutrition program managers to target their work and monitor its effectiveness. The specialist will (i) define critical pieces of information required by decision makers to support nutrition-related programs and policies; (ii) examine existing information systems and possible alternatives for sources of critical pieces of information; (iii) recommend a streamlined approach for using existing surveillance and information systems, including private sector providers and communities; and (iv) in collaboration with nutrition consultants, develop strategies to ensure the immediate interpretation and use of growth monitoring findings at the health post or alternative services where weighing takes place.

5. Community Development Specialist (2 person-months)

11. The specialist will (i) conduct participatory workshops at the community level to assess needs and priorities in improving the urban nutrition and health of the poor, and formulate interventions for community-based nutrition schemes; (ii) evaluate the impact of urban community development projects with regards to the nutrition and health of the poor in selected target areas; (iii) assess the coverage of poor communities with social service and safety net programs, including rice subsidies, and recommend options to improve coverage and accessibility; (iv) identify community self-help schemes and recommend options to link such schemes with public nutrition interventions; (v) recommend strategies to improve communication channels for public and private sectors; (vi) recommend strategies to assist communities in planning, financing, and monitoring nutrition and nutrition-related health activities; and (vii) recommend project components for community-based nutrition interventions.

6. Urban Anthropology Specialist (2 person-months)

12. The anthropologist will assist the team to understand the target population (the poor and most vulnerable in urban areas) and to target interventions in ways that intersect effectively with their lives in order to prevent malnutrition and promote and sustain good health. The anthropologist will cooperate with the community development specialist and will be responsible for (i) assembling relevant information concerning the socioeconomic situation, nutrition status, and behavior of the urban poor with a focus on proposed target areas; (ii) identifying at-risk populations and recommending appropriate approaches; (iii) examining the social support structure, including nonformal safety nets among the poor; (iv) examining the access to social safety nets, public health services, the role of charity organizations in the survival of the urban poor; (v) assisting the team members at central and selected city levels to maintain a focus appropriate to the specific characteristics of the populations in the selected areas; and (vi) recommending strategies that ensure effective approaches to reach the target population and promote the behavior modification needed.

7. Decentralized Planning and Specialist (2 person-months)

13. The specialist will work with his or her international colleagues to (i) examine the roles of national, provincial, district, and subdistrict levels to support and sustain nutrition service delivery, including budget implications, and strengthen community-based solutions to local problems; (ii) recommend strategies to establish nutrition management, budget, and quality assurance at national level to support local government management; and (iii) provide recommendations in cooperation with the maternal and child nutrition specialist on standards, guidelines, performance reviews in health facilities, supervision, monitoring, evaluation, and inputs for project design.

8. Budgeting Specialist (3 person-months)

14. The specialist will ensure that financial support mechanisms to establish urban nutrition interventions are in place and are coordinated with no significant gaps to threaten potential implementation. Specifically, the consultant will (i) examine government budgets at central and local levels to identify appropriate sources for the financial support required for public sector services and make appropriate recommendations, (ii) identify national and local budget gaps in financing public nutrition programs, (iii) identify potential financial contributions from the private sector, and (iv) prepare detailed budgets for the components of the nutrition management model and all TA components.

9. Workshop Facilitator and Coordinator (2 person-months)

15. The coordinator will have special responsibility for coordinating the TA team's collaboration with local advisory technical teams and additional stakeholders at decentralized levels. The coordinator will (i) maintain coordination with the team leader and coleader to plan and facilitate workshops, (ii) facilitate collaboration with stakeholders and partners at decentralized level, and (iii) ensure that the results from workshops are fully recorded and reported to be utilized in the preparation of the project framework.