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Indonesia's *PNPM Generasi* Program:

Interim Impact Evaluation Report

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Glossary

ANC	Antenatal care
ARI	Acute respiratory infection
Buku KIA	Mother and child health book
CCT	Conditional cash transfers
Gotong royong	Semi-volunteer public labor service at the village or community level
KDP	Kecamatan Subdistrict Development Project
MIT	Massachusetts Institute of Technology
NTT	East Nusa Tenggara province
PKH	Program Keluarga Harapan (Hopeful Family Program)
PNC	Postnatal care
PNPM	Program Nasional Pemberdayaan Masyarakat (National Program for Community Empowerment)
PNPM Generasi Sehat dan Cerdas	PNPM Healthy and Smart Generation
PODES	Village potential statistics
Posyandu	Village integrated health post (monthly community weighing post)
Puskesmas	Community health center
SUSENAS	National Socioeconomic Survey
SD	Sekolah Dasar (primary school)
SD	Standard deviations
SMP	Sekolah Menengah Pertama (junior secondary school)
SPADA	Support for Poor and Disadvantaged Areas Project
UPP	Urban Poverty Project

Notes:
All $ = U.S. dollars, unless otherwise noted

Executive Summary

Over the past decades, Indonesia has made remarkable strides in key human development indicators. Primary school enrollment is close to universal for both boys and girls, and the child mortality rate has declined rapidly. Nevertheless, infant mortality, child malnutrition, maternal mortality, and junior secondary school enrollment have all remained problematic in Indonesia compared to other countries in the region. Furthermore, achievements in these indicators reveal large geographical disparities, with poorer outcomes in rural and remote provinces and districts. These indicators are strongly associated with levels of poverty, suggesting that a program providing the poor with the means to access basic health and education services could be a key component of a poverty strategy for Indonesia.

In 2007, the government of Indonesia launched two large-scale pilots of programs designed to tackle these issues: (1) conditional cash transfers (CCTs) to households, known as the Hopeful Family Project (*Keluarga Harapan* Project or PKH), and (2) an incentivized community block grant program, known as the National Community Empowerment Program—Healthy and Smart Generation (*Program National Pemberdayaan Masyarakat—Generasi Sehat dan Cerdas,* or *PNPM Generasi*). These two pilot projects are being implemented in six provinces and are designed to target the same health and education indicators. They are consistent with both the Indonesian government's priorities and the Millennium Development Goals: to reduce poverty, maternal mortality, and child mortality, and to ensure universal coverage of basic education. This study reports on the interim evaluation of the incentivized community block grant program, PNPM Generasi. The household CCT program (PKH) will be the subject of a separate evaluation in 2010.

PNPM Generasi, the incentivized community block grant program, differs from a traditional household CCT (and therefore from the PKH program) in that block grants are allocated to communities rather than to individual targeted households. The Generasi project began in mid-2007 in rural areas of five Indonesian provinces selected by the government: West Java, East Java, North Sulawesi, Gorontalo, and East Nusa Tenggara. In 2007, the Generasi project covered 1,605 villages in 129 subdistricts, with a total budget of $20 million. Under the program, villages received an annual block grant, which each village could allocate to any activity that supported one of 12 indicators of health and education service

delivery. To give communities incentives to focus on the most effective policies, the government bases the size of the village's Generasi block grant for the subsequent year partly on the village's performance on each of the twelve targeted health and education indicators. The Generasi project thereby takes the idea of performance incentives from conditional cash transfer programs and applies it in a way that allows communities the flexibility to address supply constraints, demand constraints, or some combination. To the best of our knowledge, the Generasi project is the first health and education program worldwide that combines community block grants with explicit performance bonuses for communities.

To allow for a rigorous, randomized evaluation of Generasi, the government of Indonesia incorporated random assignment into the selection of Generasi locations. Each Generasi location was further randomly allocated to one of two versions of the program: one "incentivized" treatment with the pay-for-performance component (treatment A) described above, and a second, otherwise identical "non-incentivized" treatment without the pay-for-performance incentives (treatment B).

This document describes the findings from the interim evaluation survey conducted between October and December 2007, after 15 to 18 months of Generasi implementation in 129 treatment subdistricts. Since one full year's project cycle had been completed, we refer to this survey as the one-year interim evaluation survey. A final evaluation survey is planned for October–December 2009, after the program will have been in operation for 27–30 months.

The main findings of the one-year interim Generasi impact evaluation are as follows:

1. **The Generasi program improved health indicators**. The strongest improvements were in the frequency of weight checks for young children and use of iron tablets for pregnant women. The program also appears to have improved the frequency of deliveries by trained midwives (particularly in Java and Sulawesi). These improvements were supported by dramatic increases in coverage of all types of maternal and child health services through village health post (*posyandu)* activities. The Generasi program may have cut infant mortality by as much as half, and appears to have reduced malnutrition in both NTT and Sulawesi.

2. **PNPM Generasi led to no improvements in education, and appeared to have reduced enrollments for certain groups.** In contrast to health, the first 15–18 months of Generasi has led to no improvement in education. In fact, the program shows negative impacts on enrollment and attendance of 13–15 year olds who would otherwise have been completing primary school.

   In interpreting this result, it is important to note that junior secondary gross enrollments were increasing in this period in both treatment and control areas. In control areas, junior secondary gross enrollment increased from 82 percent at baseline to 91 percent in the interim survey just 18 months later. School participation rates for 13–15 year olds actually increased in Generasi areas, from 82 percent at baseline to 87 percent in the interim survey; it just increased at a slower rate than in the control areas. There may be several reasons for these rather surprising results, especially on the junior secondary indicators. First, overall government expenditures for education during that period were undergoing rapid changes, so it was a fluctuating situation. Over the past few years, the government has significantly increased overall public spending on education, from 17.2 percent of the total national budget in 2007 (World Bank 2007) to an estimated 20 percent in 2009. Second,

the program missed the registration period for the school year and Generasi funds only were released to communities halfway through the school year, making new enrollments for the ongoing school year difficult. Third, there may be issues regarding the Generasi's targeting only 13–15 year olds and not other age groups. Since Generasi's junior secondary school enrollment indicator was age-specific, one hypothesis is that communities prioritized their support for children in the 13-to-15 year age range who had already graduated from primary schools and thus could potentially enroll in junior secondary school, and did not support 13-to-15 year olds who were still in primary school. Fourth, in the first year of implementation, field and supervision reports were finding that communities were favoring more assistance toward children already in school, rather than focusing on out-of-school children who proved to be more difficult to reach. Supervision missions indicate that during the first year especially, communities chose to benefit the majority who were already in school and therefore easier to assist, rather than pursue the minority of children who were not yet enrolled in school.

3. **Community incentives were effective in improving the health indicators as well as health outcomes, as evidenced by the incentivized version of PNPM Generasi (Treatment A) consistently outperforming the non-incentivized version of the program (Treatment B).** The incentivized version of the program had higher levels of prenatal visits, postnatal visits, and weight checks. The incentivized version of the project also had larger reductions in acute morbidity (acute respiratory infections and malnourishment). The incentivized version translated into increased work effort on outreach and public services on the part of midwives. The incentivized version of the program also resulted in increased targeting of program impacts to poorer households.

4. **Regional heterogeneity in PNPM Generasi impacts suggest that the program allowed communities to adapt to different local needs.** In NTT province, seven of the eight targeted health indicators showed little change. However, the project led to large reductions in malnutrition and in neonatal mortality. The focus on malnutrition in NTT is consistent with the fact that the province had the highest malnutrition rates, and was experiencing a surge in malnutrition in the time period of the study (malnutrition in control areas in NTT increased from 24.7 percent at baseline to 35.3 percent in control areas by Wave II). In Java, where there is more heterogeneity in service levels at baseline, stronger impacts were found in places where baseline levels were weakest. In Sulawesi, which had moderate-to-low baseline levels for all indicators but no acute malnutrition problem like NTT, strong effects were seen across the board.

5. **PNPM Generasi affects service provider work effort.** Midwives who are the frontline workers in the provision of maternal, neonatal, and child health services increased their working hours, most notably in Sulawesi. Particularly in Java, midwives spent considerably more time providing outreach services.

6. **The program also significantly increased community engagement.** The evaluation found that PNPM Generasi increased the number of volunteers at village health post activities and the number of parents participating in health education meetings. We also found greater participation in monitoring meetings and spillover effects on participation in community groups and village activities more generally. On average, Generasi had positive impacts on community efforts, mostly due to its effects on community activities related to health activities.

The aforementioned results are preliminary and much more data will be forthcoming in the next round of evaluation scheduled for 2009–10. However, these findings already point to several policy implications to explore further in the coming years.

First, PNPM Generasi piggybacked on the Kecamatan Development Program/PNPM, a community-driven development program that had already been in place in Indonesia since 1998. Unlike in Mexico and other countries, it was not clear that Indonesia had the administrative capacity and supply-side services to make an individual CCT program work in certain areas of the country. Generasi thus provides a unique example of how an established national community program can be adapted to address certain education and health targets using a community approach.

Building the evaluation into the design of the program from the outset has been critical to learn lessons from the program for possible expansion in the future. To allow for a rigorous, randomized evaluation of Generasi, the government incorporated random assignment into the selection of the locations. Each location was further randomly allocated to an incentivized versus non-incentivized treatment, thus allowing for comparison of effects. As this is a pilot program, it was important that the evaluation prove robust and provide empirical evidence as to whether the intervention was having its desired impact.

Preliminary results from the interim evaluation reveal significant impacts in health and little impact in education. The evidence from this interim survey points to community mobilization as potentially a significant factor in explaining these dramatic improvements in health. Further studies and rigorous evaluations are needed to assess how Generasi compares with other child and maternal health interventions in attaining these targets. For education, the lack of overall impact raises questions regarding Generasi's investments in this area and whether the education targets for primary and junior secondary education were the correct ones. Indonesia already has reached high primary school enrollment levels. Over the past few years, it has increased its spending on education significantly. During the second and third years of implementation, the program increased efforts to focus more on non-users rather than those already in school. The program is also currently considering the possibility of revising education indicators in Year 4 (beginning in mid-2010) to focus more on quality and student achievement, in addition to the original enrollment and attendance targets.

This study provides strong evidence that in this context, community incentives work and are more effective for focusing impacts on the poorest quintiles and increasing providers' efforts. The policy implications are that poverty programs may wish to experiment more with embedding incentives into their designs.

The next round of evaluation in 2009–10—using both quantitative and qualitative methods—should reveal much more about the impacts of Generasi. These interim findings provide some preliminary insights into the direction this program is heading.

Introduction

1.1 Background

Over the past decades, Indonesia has made remarkable strides in key human development indicators. Primary school enrollment is close to universal for both boys and girls and the child mortality rate has declined rapidly (World Bank 2006; World Bank 2008). Nevertheless, infant mortality, child malnutrition, maternal mortality, and junior secondary school enrollment are lower in Indonesia than in other countries in the region (World Bank 2006; World Bank 2008). Furthermore, there are substantial geographical disparities in these outcomes, with poorer outcomes in rural and remote provinces and districts. Poor performance on these indicators is also strongly associated with levels of poverty, particularly in eastern Indonesia, suggesting that a program providing the poor with the means to access basic health and education services could be a key component of a poverty strategy for Indonesia.

Improving the health and education of children is considered critical to economic development and forms an important component of the Millennium Development Goals. Faced with these challenges, many developing countries have sought to stimulate demand for maternal and child health services and education through conditional cash transfer programs. For example, Mexico's Progresa program (Gertler 2004; Schultz 2004; Rawlings and Rubio 2005) links cash payments to behaviors such as immunization, growth monitoring, school enrollment, and school attendance. However, these types of demand-side interventions may be inappropriate in many developing world contexts, where beneficiaries do not have adequate access to health and education services (Schubert and Slater 2006; Lagarde, Haines, and Palmer 2007). In such environments, programs that address both the supply- and demand-side constraints directly may be more appropriate.

In 2007, the government of Indonesia launched two large-scale pilots of programs designed to tackle these issues: conditional cash transfers to households and an incentivized community block grant program. These two pilot projects are being implemented in six provinces and are designed to achieve the same objectives and goals. These goals are consistent with the Indonesian government's priorities and the

Millennium Development Goals: to reduce poverty, maternal mortality, and child mortality, as well as ensure universal coverage of basic education.

The **Household CCT**—the Keluarga Harapan Project (PKH)—applies the traditional CCT design with quarterly cash transfers to poor individual households identified through statistical means. CCT recipient households receive regular cash transfers through the post office as long as they meet the requirements of using specified health and education services.

The **Incentivized Community Block Grant Program,** known as PNPM Generasi, differs from the Household CCT in that block grants are allocated to communities rather than to individual targeted households. Under the program, over 1,600 villages received an annual block grant. Each village can use the grant for any activity that supported one of 12 indicators of health and education service delivery (such as prenatal and postnatal care, childbirth assisted by trained personnel, immunization, school enrollment, and school attendance). To give communities incentives to focus on the most effective policies, the government bases the size of the village's Generasi block grant for the subsequent year partly on the village's performance on each of the 12 targeted health and education indicators. The Generasi project thus takes the idea of performance incentives from conditional cash transfer programs and applies it in a way that allows communities the flexibility to address supply constraints, demand constraints, or some combination. To the best of our knowledge, the Generasi project is the first health and education program worldwide that combines community block grants with explicit performance bonuses for communities.

To allow for a rigorous, randomized evaluation of Generasi, the government of Indonesia incorporated random assignment into the selection of Generasi locations. Unlike evaluations of conditional cash transfer programs, which cannot separately identify the impact of the incentives from the impact of the additional cash provided (Gertler 2004), the Generasi evaluation was designed to separate out these two effects. Specifically, each Generasi location was further randomly allocated to one of two versions of the program: (1) an "incentivized" treatment with the pay-for-performance component (treatment A) described above; and (2) an otherwise identical "non-incentivized" treatment without the pay-for-performance incentives (treatment B). This study focuses on the Generasi program. It describes the findings from the interim evaluation survey conducted between October and December 2008 after 15 to 18 months of Generasi implementation in 129 treatment subdistricts.

1.2 The Generasi project

This section describes the Generasi project, the Indonesian community block grant program that is the focus of this study. PNPM Generasi—known in full as the National Community Empowerment Program–Healthy and Smart Generation (*Program National Pemberdayaan Masyarakat–Generasi Sehat dan Cerdas*)—is to the best of our knowledge the first health and education program worldwide that combines community block grants with explicit performance bonuses for communities.

The Generasi project began in mid-2007 in rural areas of five Indonesian provinces selected by the government: West Java, East Java, North Sulawesi, Gorontalo, and East Nusa Tenggara.[1] In 2007, the project covered 1,605 villages in 129 subdistricts, with a total budget of $20 million. In the project's second year, which began in mid-2008, the project expanded to cover a total of 2,120 villages in 176 subdistricts, with a total budget of $44 million. The project is currently continuing for a third project year (beginning in mid-2009) in these 176 subdistricts, with possible expansion to other provinces in 2010.

The Generasi project is focused on 12 indicators of maternal and child health behavior and educational behavior (see Box 1). These indicators were chosen by the government of Indonesia to be as similar as possible to the conditions for the individual household conditional cash transfer program being piloted at the same time as Generasi (but in different locations). They are in the same spirit as the conditions used by conditional cash transfer programs in other countries, such as Progresa in Mexico (Levy 2006). These 12 indicators respond to those seeking health and educational services that are within the direct control of villagers—such as the number of children who receive immunization, prenatal and postnatal care, and the number of children enrolled and attending school—rather than long-term outcomes, such as test scores or infant mortality.

In Generasi, all participating villages receive a block grant each year to improve maternal health, child health, and education in their villages. Block grants are usable for a wide variety of purposes, including, but not limited to, hiring extra midwives for the village, subsidizing the costs of prenatal and postnatal care, providing supplementary feeding, hiring extra teachers, opening a branch school in the village (*kelas jauh* or satellite classrooms, or *sekolah terbuka* or formal part-time junior secondary schooling), providing scholarships, providing school uniforms, providing transportation funds for health care or school attendance, improving health or school buildings, or even building a road or path through the forest to improve access to health and education facilities.

To decide on the allocation of the funds within a village, trained facilitators help each village elect an 11-member village management team, as well as select local facilitators and volunteers. Through social mapping and in-depth discussion groups, villagers identify problems and bottlenecks in reaching the 12 indicators. Inter-village meetings and consultation workshops with local health and education service providers allow community leaders to obtain information, technical assistance, and support from the local health and education offices as well as to coordinate the use of Generasi funds for multi-village projects. Following these discussions, the 11-member management team makes the final Generasi budget allocation.

1 An initial test of the Generasi concept was run in three villages in Gorontalo province from 2006 to 2008. Those villages are not included in the main Generasi project or analysis.

Box 1. Generasi Program Target Indicators

Health Indicators
1. Four prenatal care visits
2. Taking iron tablets during pregnancy
3. Delivery assisted by a trained professional
4. Two postnatal care visits
5. Complete childhood immunizations
6. Adequate monthly weight increases for infants
7. Monthly weighing for children under three and biannually for children under five
8. Vitamin A twice a year for children under five

Education Indicators
9. Primary school enrollment of children 6-to-12 years old
10. Minimum attendance rate of 85 percent for primary school-aged children
11. Junior secondary school enrollment of children 13-to-15 years old
12. Minimum attendance rate of 85 percent for junior secondary school-aged children

Performance incentives are a critical (and unique) element of the Generasi approach: the size of a village's block grant depends in part on its performance on the 12 targeted indicators. The purpose of the performance bonus is to increase the village's effort at achieving the targeted indicators (Holmstrom 1979), both by encouraging a more effective allocation of Generasi funds and by stimulating village outreach efforts to encourage mothers and children to obtain appropriate health care and increase educational enrollment and attendance.

The performance bonus is structured as a relative competition among villages within the same subdistrict (*kecamatan*). By making the performance bonuses relative to other villages in the subdistrict, the government sought to minimize the impact of unobserved differences in the capabilities of different areas on the performance bonuses (Lazear and Rosen 1981; Mookherjee 1984; Gibbons and Murphy 1990). The fixed allocation to each subdistrict also ensures that the performance bonus system would not result in an unequal geographic distribution of funds.[2]

The specific rule for allocating Generasi funds to villages within the subdistrict is as follows. The size of overall Generasi allocation for the entire subdistrict is predetermined by the subdistrict's population and poverty level.[3] Within a subdistrict, in year 1 of the project funds are divided among villages in proportion to the number of target beneficiaries in each village (that is, the number of children of varying ages and the expected number of pregnant women). Starting in year 2 of project implementation, 80 percent of the subdistrict's funds continue to be divided among villages in proportion to the number of target beneficiaries; the remaining 20 percent of the subdistrict's funds form a performance bonus pool, to be

2 As discussed by Gibbons and Murphy (1990) and others, one potential pitfall of relative performance incentives is that agents may have an incentive to either sabotage or collude with other agents. With an average of 12 villages per subdistrict, in this case villages face a much greater return from increasing their own performance than from sabotaging that of other villagers. Nevertheless, this possibility remains, and therefore makes the equilibrium implications of the incentives an important empirical question.

3 In 2007 the average block grant for each subdistrict was $112,300 per subdistrict; in 2008, the average block grant was raised to $200,000 per subdistrict. A subdistrict contains roughly between 15,000 and 50,000 individuals and 10 to 20 villages.

divided among villages based on their performance on the 12 Generasi indicators.[4]

The performance bonus pool is allocated to villages in proportion to a weighted sum of each village's performance above a predicted minimum achievement level. Specifically, each village's share of the performance bonus pool is determined by:

$$ShareOfBonus_v = P_v / (\ P_j)$$

where

$$P_v = [\ w_i\ \ (y_{vi} - m_{vi})]$$

In this formula, y_{vi} represents village v's performance on indicator i, w_i represents the weight for indicator i, m_{vi} represents the predicted minimum achievement level for village v and indicator i, and P_v is the total number of bonus "points" earned by village v.

Generasi uses performance relative to a constant predicted minimum attainment level, rather than improvements over an actual baseline, to avoid the ratchet effect (Weitzman 1980), as well as to avoid the problems inherent in collecting reliable baseline data on performance on all indicators in all villages before the program began. For each of the 12 Generasi indicators i, the project set the predicted minimum attainment level, m_{vi}, in village v to be equal to 70 percent of the average achievement level for villages with similar levels of access to health and education providers and numbers of beneficiaries. These minimum achievement levels were estimated by combining data on levels of each indicator from the 2004 SUSENAS household survey and 2003 PODES census of villages.[5] The weights for each indicator, w_i, were set by the government to be approximately proportional to the marginal cost of having an additional individual complete that indicator. The weights, along with the specific performance metric for each indicator i, are shown in Table 1.

4 Starting in year 2, for allocating the non-incentivized portion of the block grant (i.e., 80 percent of the subdistrict allocation in incentivized areas and 100 percent of the subdistrict allocation in non-incentivized areas), the number of target beneficiaries is weighted depending on a village's access to facilities. This calculation is identical in both incentivized and non-incentivized areas.

5 For all health indicators except monthly weighing, access to providers was divided into three categories: 1) having a midwife practicing in the village, 2) not having a midwife in the village but having a midwife practicing within 4km from the center of the village, or 3) not having a midwife practicing within 4km of the village center. For middle school, access was divided into three categories: 1) having a middle school located in the village or within 4km of the village center, 2) having a middle school located between 5 and 9km of the village center, or 3) having a middle school located 10km or more from the village center. For monthly weighing and primary school, all villages were assumed to have the same level of access, since weighing of children is always conducted in the village at monthly posyandu meetings and since virtually all villages in Indonesia have a primary school.

Table 1. Performance metrics and weights

Performance metric	Weight per measured achievement	Potential times per person per year	Potential points per person per year
1. Prenatal care visit	12	4	48
2. Iron tablets (30 pill packet)	7	3	21
3. Childbirth assisted by trained professional	100	1	100
4. Postnatal care visit	25	2	50
5. Immunization	4	12	48
6. Monthly weight increases	4	12	48
7. Monthly weighing	2	12	24
8. Vitamin A pill	10	2	20
9. Primary enrollment	25	1	25
10. Monthly primary attendance >= 85%	2	12	24
11. Middle school enrollment	50	1	50
12. Monthly middle school attendance >= 85%	5	12	60

Source: PNPM Generasi Sehat Operational Manual 2007

An important challenge in designing such an incentive system is monitoring achievement levels. To monitor achievement of the health indicators, all pregnant women and mothers in Generasi villages receive a serial-numbered coupon book, with one coupon for every possible service use per indicator (e.g., four coupons for prenatal care, one coupon for each immunization a child should receive, etc.). These coupon books are attached to a Buku KIA (Mother and Child Health Book), the standard Indonesian document that contains the child's immunization history and growth chart. When each service is performed, the service provider stamps the coupon in the coupon book. Coupons are collected by the project's facilitators at the monthly village mothers group. The coupons are used for official budget allocations. School enrollment and attendance data are obtained from the official school register.[6] Quarterly cross-village audits are conducted to ensure that villages keep accurate performance records and financial bookkeeping.

As noted previously, two versions of the Generasi project are being run to separate the impact of the performance bonuses from the overall impact of having additional financial resources available for health and education: the program with performance bonuses described above (referred to as "treatment A"), and an identical program without performance bonuses (referred to as "treatment B"). Treatment B is identical to treatment A except that in treatment B, there is no performance bonus pool; instead, in all years, 100 percent of funds are divided among villages in proportion to the number of target beneficiaries

6 Obtaining attendance data from the official school register is not a perfect measure, since it is possible that teachers could manipulate student attendance records to ensure they cross the 85 percent threshold (Linden and Shastry 2008). While more objective measures of monitoring attendance were considered, such as taking daily photos of students (as in Duflo, Hanna, and Ryan 2008) or installing fingerprint readers in all schools (Express India News Service 2008), Generasi decided not to adopt these more objective measures due to their cost and logistical complexity. The empirical analysis will be able to test for this type of differential manipulation by testing whether the difference between official school attendance records and data from direct observation of schools is greater in incentivized Generasi locations.

in each village. In all other respects, the two versions of the program are identical: the total amount of funds allocated to each subdistrict is the same in both treatments, the same socialization materials and indicators are used, the same procedures are used to pick village budget allocations, and the same monitoring tools and scoring system are used. Even the village's annual points score P_v is also calculated in treatment B areas; the only difference is that in treatment B villages the points are used simply as an end-of-year monitoring and evaluation tool, and have no relationship to the allocation of funds. Within a given subdistrict, all villages participate in the same treatment of the program; that is, either all villages received treatment A or all villages received treatment B.

The Generasi project design builds on the Indonesian government's existing community-driven development program, known as the National Community Empowerment Program (PNPM), which, along with its predecessor programs (Kecamatan Development Project), have funded over $1 billion in local infrastructure and microcredit programs in some 70,000 Indonesian villages over the past decade. The Generasi project is implemented by the government of Indonesia's Ministry of Home Affairs, and is funded in part with loans from the World Bank and grants from the Netherlands Embassy. Technical assistance and evaluations were supported by a multidonor trust fund with contributions from the World Bank, Netherlands Embassy, Australia, UK's Department for International Development (DFID), and the Danish Embassy.

1.3 Experimental Design

In order to evaluate the overall impact of Generasi, as well as to separately identify the impact of Generasi's performance incentives, Generasi locations were selected by lottery to form a randomized, controlled field experiment. The use of randomized evaluation techniques is considered the gold standard for impact evaluation of clinical and public health interventions (Gordis 2004), as well as development programs more generally (Duflo, Glennerster, and Kremer 2007). It has formed the basis of a number of high-profile social policy experiments in the United States (see Newhouse 1993; Kling, Liebman, and Katz 2007) and internationally (see Gertler 2004; Miguel and Kremer 2004; Schultz 2004; Skoufias 2005).

The Generasi randomization was conducted at the subdistrict (kecamatan) level, so that all villages within the subdistrict either received the same treatment of Generasi (treatment A or treatment B) or were in the control group. Randomizing at the subdistrict level is important since many health and education services, such as community health centers (Puskesmas) and junior secondary schools, provide services to multiple villages within a subdistrict. Increased demand for services from one village within a subdistrict could potentially therefore crowd out the services provided to other villages within the same subdistrict; alternatively, an effort by one village to improve service provision at the community health center could also benefit other villages in the same subdistrict. By randomizing at the subdistrict level, so that all villages in the subdistrict receive the same treatment status, the evaluation design ensures that we capture the total net effect of the program, since any within-subdistrict spillovers would also be captured in other

treatment villages.[7] This type of cluster-randomized design is common in program evaluations where there might be local spillovers from the treatment (Miguel and Kremer 2004; Olken 2007).

The Generasi locations were selected through the following procedure. First, 300 target subdistricts were identified, targeting poor, rural areas that had an existing community-driven development infrastructure.[8,9] Each subdistrict was then randomly assigned by computer into one of three equal-sized groups: treatment A, incentivized (100 subdistricts); treatment B, non-incentivized (100 subdistricts); or control (100 subdistricts). Within a subdistrict, all villages received the same treatment. The randomization was stratified by district (kabupaten), to ensure a balanced randomization across the 20 different districts in the study. The tests for balance confirm that the three groups of subdistricts appear similar on pre-period characteristics (World Bank 2008).

After the randomization was conducted, some subdistricts randomly selected for Generasi were not funded. In 2007, budget restrictions meant that out of the 200 subdistricts randomly selected to receive Generasi grants, 129 actually received them. In 2008, the budget was increased, and 176 subdistricts received grants. The reason that 24 out of the original 200 subdistricts were not funded in 2008 is that several subdistricts had been selected (prior to the randomization) for other programs, such as SPADA and PNPM-Urban, and several other subdistricts had unresolved financial and accountability problems with PNPM-rural. We have obtained lists of all of these categories of subdistricts dated prior to the randomization for both treatment and control locations. These lists are dated prior to the randomization and are exogenous with respect to the randomization, so we can use these lists in the analysis to increase our statistical power (see Section 2.1 for more details).

Although not all subdistricts were funded, the randomization was still strictly followed: no subdistricts randomly selected to be control areas ever received Generasi funding. Conditional on getting Generasi, whether a subdistrict received treatment A or treatment B always followed the randomization results. Data collection surveys are being conducted in all 300 subdistricts that were initially included in the randomization, regardless of the final allocation of funds.[10] This allowed us to use intent-to-treat analysis (Imbens and Angrist 1994) based on the original 300-subdistrict randomization to confirm that the changes described above were not materially affecting our results (for details on Generasi implementation in 2007 post-randomization, see Annex I, page 75).

7 Spillovers to other subdistricts are much less likely to be a problem, since the health service providers (Subdistrict Health Centers and midwifes), primary schools, and junior secondary schools that are the focus of this survey primarily provide services within a single subdistrict. Nevertheless, by using GIS information on the location of service providers, we will be able to test empirically for the presence of these cross-subdistrict spillovers.

8 To identify the 300 target subdistricts, we began by eliminating the wealthiest 20 percent of districts (kabupaten) within the five target provinces identified by the government, determined by the district's poverty rate, malnutrition rate, and junior secondary school transition rate. Districts where the PNPM program was not scheduled to operate in 2007 were also ineligible. Twenty districts were randomly selected from the remaining eligible districts, stratified by island group. Within the twenty selected districts, subdistricts were eligible for Generasi if they had previously received the PNPM program or were considered less than 67 percent urban by the Central Statistics Office.

9 Since Generasi is implemented through the national PNPM program, it could only be implemented in districts that were already included in the PNPM program. Prior experience with PNPM at the subdistrict level also simplified Generasi implementation, since the relevant legal structures for disbursing Generasi funds had already been established in these locations.

10 When the baseline survey was conducted, one of the 300 subdistricts could not be surveyed due to an avian flu quarantine. That subdistrict will, however, be included in all future survey rounds.

An important consideration for the analysis is the potential for differential provision of other programs in control groups (Duflo, Glennerster, and Kremer 2007). To ensure a fair allocation of funds, the Ministry of Home Affairs decided that no subdistrict would receive both the Generasi project and other PNPM programs, which typically fund local infrastructure (roads, bridges, etc.) and microcredit. In 2007, 18 (out of 100) control subdistricts received other PNPM programs, while no treatment subdistricts did. In addition, it is possible that local governments differentially targeted resources to control districts, since they did not receive Generasi. Detailed information on all programs received by the village is collected in the survey to investigate this possibility. Since regular PNPM programs tend to focus on basic infrastructure, not health and education, it is unlikely that the differential provision of other PNPM programs in control areas will have substantial impacts on the results. To the extent there are increases in other health and education performance in control areas due to regular PNPM or other programs, this would lead to an understatement of the true impacts of Generasi, but would not affect the comparison of treatment A and treatment B. By collecting detailed data on these additional programs, we can control for any differential placement (should it occur) to estimate the degree to which these programs are downwardly biasing our main results.

1.4 Survey Design and Implementation

The main data for the impact analysis is from a set of surveys of households, village officials, health service providers, and schools being conducted by the World Bank. A detailed list of the contents of each survey module, as well as the sample size for each module, can be found in Table 2.

Three waves of the survey were planned as part of the evaluation series. Wave I, the baseline round, was conducted from June to August 2007. Wave II, the first follow-up survey round, was conducted from October to December 2008. Wave III, a longer-term follow-up survey round, will be conducted from October to December 2009. These surveys were designed by the World Bank and the government of Indonesia and are being conducted by the Center for Population and Policy Studies (CPPS) of the University of Gadjah Mada, Yogyakarta, Indonesia. The interim evaluation is based on data collected through the Wave I and Wave II surveys, which were funded by the World Bank (through the Decentralization Support Facility and PNPM multidonor trust fund).

The sample for the surveys covers each of the 300 subdistricts that were included in the original Generasi randomization. In each subdistrict, eight villages were randomly selected (unless the subdistrict had fewer than eight villages, in which case all were selected). This resulted in a total of 2,313 villages that will be sampled in each of the three survey waves.

The sampling design for the household component of the Generasi surveys was chosen to ensure adequate coverage in the key Generasi demographic groups: mothers who recently were pregnant or gave birth, children under age 3, and children of school age. Within each village, one hamlet (*dusun*) was randomly selected, and a list of all households was obtained from the head of the hamlet. Five households were randomly sampled from that list to be interviewed. These households were stratified so that two selected households had at least one child under age 2, two selected households had a child under age 15 but no children under age 2, and one household had no children under age 15.

For some of the analysis (e.g., for examining how the incentives affect the differential targeting of Generasi benefits and increments in service provision), it is useful to have baseline and follow-up characteristics for the same individuals. Therefore, in the follow-up surveys, in half of the randomly selected villages (four villages out of the eight villages sampled in every subdistrict), the same households sampled in Wave I were contacted again in subsequent waves to form an individual level panel. Teams tracked and re-interviewed migrated or split households who provided information for any of the married women or children modules, as long as they were within the same subdistrict. In the other half of villages, a new cross-section of households are drawn from in each survey wave. The combination of panel households and non-panel households allows us to investigate heterogeneous treatment effects based on pre-period income levels and other characteristics, while at the same time ensuring that sufficient respondents with recent births and young children are enrolled in the survey sample in every round.

Health facilities and schools were also contacted again to form a panel. For midwives, a randomly selected 75 percent of the midwife sample will be re-contacted to form a panel, and 25 percent of the midwives will be newly sampled in each wave to ensure the sample captures potential in-migration of midwives in response to Generasi.

Data from these surveys are supplemented with detailed administrative data from the Generasi project's internal management information system. This includes detailed budget allocations for the block grants, performance data on the twelve Generasi indicators, and data on participation levels in Generasi village meetings.

Table 2. Questionnaire modules and sample size

Module	Contents	Sample Size (Wave I)	Panel/Non-Panel (Waves II/III)
Household core (Respondent: female household head or spouse of a male household head)	Household roster, deaths in previous 12 months, migration, water/sanitation, receipt of government poverty programs, participation in non-formal education, consumption, assets, economic shocks, health insurance, morbidity, outpatient care use, social capital, knowledge and participation in PNPM/KDP activities (Wave II)	11,920	50% panel, 50% non-panel
Married women age 16–49	Fertility history, use of health services during pregnancy, inspection of Generasi coupons (Wave II), family planning, health and education knowledge	10,794	
Children age 6–15 (Respondent: mother of the child)	School enrollment, attendance, grade repetition, cost of schooling, scholarships, child labor	9,491	
Children age < 3 (Respondent: mother of the child)	Growth monitoring (*posyandu*), immunization records, inspection of the Generasi coupons (Wave II), motor development (Wave III), breastfeeding and nutritional intake, weight measurement, height measurement (Waves I & III)	4,746	
Home-based tests (Respondent: children age 6–15)	Test of math and reading skills administered at home (separate test for age 6–12 and age 13–15) (Waves I & III)	4,793	

Module	Contents	Sample Size (Wave I)	Panel/Non-Panel (Waves II/III)
Village characteristics (Respondent: Village Head)	Demography of the village, hamlet information, access to health services and schools, economic shocks, access to media, community participation, daily laborer wage rate, development projects in the village (Waves II & III)	2,313	100% panel
Community health center (*Puskesmas*)	Head of facility background, coverage area, budget, staff roster, time allocation of head doctor and midwife coordinator, service hours, services provided, fee schedule, number of patients per service during the previous month, medical and vaccine stock, data on posyandu, participation in Generasi (Waves II & III), direct observation regarding cleanliness	300	100% panel
Village midwives	Personal background, location of duty and condition of facility, time allocation, income, services provided, fee schedule (public and private), experiences during past three deliveries, number of patients seen per service during the previous month, equipment and tools, medical supplies and stock, posyandu management, participation in Generasi (Waves II & III), structure of subsidies received	1,157	75% panel, 25% non-panel
Primary school (Waves II & III)	Principal background, principal time allocation, teacher roster, school facilities, teaching hours, enrollment records, attendance records, official test scores, scholarships, fees, budget, participation in Generasi (Wave II), direct observation of classrooms, including random check on classroom attendance	N/A	50% panel 50% non-panel
Junior secondary school	Same questionnaire for primary school	847	66% panel, 33% non-panel
Posyandu cadre (Waves II & III)	Respondent characteristics, posyandu characteristics, service providers, cadre roster, tools and equipment, participation in Generasi (Wave II)	N/A	50% panel 50% non-panel

Source: Terms of Reference for Baseline survey 2007 and Terms of Reference for Wave II survey 2008.

Some 35,500 household members, village heads, and school and health facility staff were respondents for this interim round (Wave II) survey.

Evaluation Methodology

2.1 Regression Specifications

Since the Generasi program was designed as a randomized experiment, the evaluation is econometrically straightforward: essentially, we compare outcomes in those subdistricts randomized to be treatments with those subdistricts randomized to be control areas, controlling for the level of the outcome at baseline.

In practice, since not all subdistricts randomized to receive Generasi funds actually received the program in year 1, comparing those subdistricts randomized to be treatments with those randomized to be controls would yield an intent-to-treat estimator, and while this estimator would be consistent, the estimated effects would be lower than the true treatment effect of the program. Fortunately, as described below, we know precisely how subdistricts were prioritized to receive Generasi grants in year 1. Since all prioritization was done based on information available before the randomization took place, we can incorporate that information into the evaluation design in order to improve the power of our estimates. (Note that we will also report the pure intent-to-treat results as a robustness check in Section 3.1.2 below; as one would expect, the intent-to-treat results are qualitatively similar to the main results, but the point estimates are smaller and the estimation is noisier). Note that all of the analysis outlined below (regression specifications, outcome variables, and aggregate effects) follows an analysis plan that was finalized on April 8, 2009, before we examined any of the Wave II data. The only variables we examine that were not in the original analysis plan are some additional variables related to exploring the negative education result: these variables are separately marked in the table as "Additional Education Indicators."

In particular, the rule the government used for year 1 of the program is as follows. First, the government first dropped all subdistricts that had previously received the Urban Poverty Project (UPP), were scheduled to receive the Support for Poor and Disadvantaged Areas Project (SPADA), or were on a "problem subdistrict" list defined by the project implementation agency of the Kecamatan Development Project (KDP). Since these lists were available prior to the randomization, they are exogenous with respect to the randomization, and so we drop the 36 subdistricts on these ex-ante lists, leaving 264 subdistricts

remaining.[11] Second, the government divided subdistricts based on their previous experience with the KDP program, with those that had previous KDP experience in the P (priority) group and those without it in the NP (non-priority) group. The government first funded all 105 subdistricts in the P group that had been randomly selected to receive Generasi grants in the original lottery, and then held an additional computerized lottery (stratified by province) to select an additional 21 subdistricts in the NP group from among the subdistricts in the NP group that had been originally randomized to receive Generasi. Whether a subdistrict received Generasi funding in year 1 is therefore randomly assigned once (a) we drop all subdistricts in the ex-ante drop list, and (b) we condition on group P interacted with province dummies, to take into account the different probability of receiving Generasi in P and NP areas and the fact that the NP lottery was stratified by province. Note that once a subdistrict was assigned to receive Generasi, whether it received treatment A or treatment B always followed the original randomization results.

In running the regressions, we take advantage of the baseline data by controlling for the average level of the outcome variable in the subdistrict in the baseline survey. Since we also have individual-specific panel data for half our sample, we include the pre-period value for those who have it, as well as a dummy variable that corresponds to having non-missing pre-period values. Since households came from one of three different samples (those with a child under age 2, those with a child age 2–15 but not in the first group, and all others), we include dummies for those three sample types, interacted with whether a household came from a panel or non-panel village. Finally, since many of the indicators for children vary naturally as the child ages, for all child-level variables we include age dummies.

To examine the overall impact of Generasi treatment, for each indicator of interest, we estimate the following regression on the 264 subdistricts that remain after we drop the ex-ante drop subdistrict list:

$$y_{pdsi1} = \alpha_d + \beta_1 GENERASI\_Y1_{pds} + \gamma_1 y_{pdsi0} + \gamma_2 1_{\{ypdsi0 \neq missing\}} + \gamma_3 \overline{y_{ds0}} + SAMPLE_{pdsi} + \alpha_p \times P_s + \varepsilon_{pdsi}$$

where p is a person, d is a district, s is a subdistrict, y_{pdsi1} is the outcome in Wave II, α_d is a district fixed effect, y_{pdsi0} is the baseline value for individual i (assuming that this is a panel household, and 0 if it is not a panel household), $1_{\{ydsi0 \neq missing\}}$ is a dummy for being a panel household, $\overline{y_{ds0}}$ is the average baseline value for the subdistrict, SAMPLE are dummies for how the household was sampled interacted with being a panel or cross-section household, and $\alpha_p \times P_s$ are province-specific dummies for being in the previous-KDP sample. Standard errors are clustered at the subdistrict level.

To examine the additional impact of the incentives (treatment A compared to treatment B), we estimate the same regression, but with an additional variable that captures the additional effect of incentives:

11 The ex-ante list is not a perfect predictor of who would be dropped, as 2 subdistricts on the ex-ante list to be dropped actually received Generasi. However, we drop all subdistricts on the ex-ante list to be dropped so that we can drop the identical subdistricts in the control group as well.

$$y_{pdsi1} = \acute{a}_d + \grave{e}_1 GENERASI\_Y1\_INCENTIVES_{pds} + \hat{a}_1 GENERASI\_Y1_{pds} + \tilde{a}_1 y_{pdsi0} + \tilde{a}_2 1_{\{ypdsi0 \neq mis\sin g\}}$$
$$+ \tilde{a}_3 \overline{y_{pds0}} + SAMPLE_{pdsi} + \acute{a}_p \times P + \mathring{a}_{pdsi} \quad (2)$$

Using the estimates from this regression we can also calculate the total impact of the treatment A program by adding the coefficients on *GENERASI_Y1_INCENTIVES* and *GENERASI_Y1*. We also examine a wide variety of additional specifications as robustness tests; these specifications are discussed in more detail in Section 3.1.2.

Since we have a large number of indicators, in order to calculate joint significance we will calculate average standardized effects for each family of indicators, following Kling, Liebman, and Katz (2007). Specifically, for each indicator *i*, define ^2_i to be the variance of *i*. We then estimate (1) for each indicator, but run the regressions jointly, clustering the standard errors by subdistrict to allow for arbitrary correlation among the errors within subdistricts both between and across indicators. We then define the average standardized effect as

$$\sum_i \frac{\hat{a}_i}{\acute{o}_i}. \quad (3)$$

As described above, note also that all variable definitions, regressions, and families of indicators reported in this document were specified by the authors before examining any of the Wave II (post-program) data. The only variables we examine not in the original analysis plan are some additional variables related to exploring the negative education result: these variables are separately marked in the table as "Additional Education Indicators." This hypothesis document was registered with the Abdul Latif Jameel Poverty Action Lab at MIT and is available on request.

2.2 Balance Tests

This section examines the balance of key child health and education indicators using data from the interviews of mothers in the baseline household surveys and the same estimation procedure shown in equation (1). We examine all of the twelve major indicators that are the focus of the program (these indicators are discussed in more detail in Section 3.1 below). The results are shown in Table 4. Column (1) shows the mean of each variable in the control group. Column (2) shows the "Generasi Effect", i.e., the difference between Generasi project areas and controls from estimating equation (1). Since this is a balance check, one would expect no significant differences between treatment and controls. Column (3) and column (4) show the coefficients from estimating equation (2), with column (4) showing the effect of Generasi in Treatment B (non-incentivized) areas and column (3) showing the additional effect of the incentives (i.e., the difference between Treatment A and Treatment B). Column (5) shows the total effect of Generasi in the incentivized areas, and is the sum of columns (3) and (4). Column (6) shows the total number of observations.

Looking across columns (2) through (5), we find that of the forty-eight coefficients estimated, five are statistically significant at the 10 percent level or higher, which is precisely what would be predicted by random chance. Similarly, three of forty-eight coefficients are statistically significant at the 5 percent level or higher, which is also what one would predict based on random chance. These results confirm that the randomization was indeed carried out properly and that the treatment and control groups are balanced.

The final rows of Table 4 consider the average standardized effects, computed via equation (3). We report average standardized effects for all twelve of the main indicators, and then separately report average standardized effects for the eight health indicators and four education indicators. One of the sixteen coefficients is statistically significant at the 10 percent level, once again consistent with what would expect based on random chance. This confirms that the sample is indeed balanced. Table 5 reports the same baseline regressions for the long-term health indicators, neonatal mortality, infant mortality, acute disease, malnourishment, and severe malnourishment. Two of the twenty coefficients are statistically significant at the 10 percent level, once again consistent with a balanced sample and random chance. None of the average standardized effects show any differences. Thus, along a wide variety of measures, the sample appears balanced at baseline.

Main Results

3.1 Impact on the Twelve Main Health and Education Indicators

This section presents the impact on the twelve main indicators after one year of full Generasi project implementation. The twelve health and education indicators reflect the target indicators treatment villages were required to work to improve as a condition for their participation in the project. Section 3.1.1 discusses the main results, Section 3.1.2 discusses the robustness to alternative evaluation methodologies, and 3.1.3 discusses how the results vary in each of the three main Generasi project regions: Java, NTT, and North Sulawesi/Gorontalo.

3.1.1 Overall effects

Table 6 presents the main results after one year of Generasi implementation, using the main specification discussed in Section 2.1. Each row reports the results for a different variable. As with the baseline tables, column (1) of Table 6 (and all subsequent tables) shows the mean level of the variable in the baseline survey, and column (2) shows the mean level of the variable in the control group in the Wave II survey. Column (3) reports the coefficient on the GENERASI variable from estimating equation (1), and is interpretable as the average impact of the Generasi on the variable.[12] Columns (4), (5), and (6) report the results from estimating equation (2), where column (4) is the coefficient on GENERASI_A (the additional effect of incentives relative to the non-incentivized treatment of Generasi), column (5) is the coefficient on GENERASI (the effect of the non-incentivized treatment of Generasi), and column (6) is the total effect of incentivized Generasi, computed by adding GENERASI_A to GENERASI. The

12 As described above, all regressions include district fixed effects, Group P interacted with province fixed effects, dummy variables for how the household was sampled, and (for child indicators) age dummies. The main regressions also include the average baseline value of the variable in the subdistrict and, for panel respondents, that individual's baseline value.

number of observations is in the final column. Average standardized effects, computed using equation (3), are shown at the bottom of the table.

Health

Looking first at the overall program effects in column (3), the results in Table 6 show generally positive effects on health variables and negative effects on education variables. Assessing the impact on health indicators one-by-one, participation in monthly growth monitoring for children under 3 was the only main health indicator to show statistically significant positive impact overall, indicating increased participation of an average child under 3 in the monthly growth monitoring by 0.1 sessions in the previous three months. Looking across all eight health indicators, Generasi resulted in a statistically significant average improvement of 0.03 standard deviations. The estimates of impact using baseline controls for all twelve primary indicators and the estimates using first differences (both shown in Table 7) both show stronger program impacts than those estimated using the baseline as a control variable (as shown in Table 6); these estimates will be discussed in more detail in the robustness section (3.1.2) below.

Education

Turning to the education indicators, Generasi resulted in no change in primary school enrollment or attendance, but appears to have resulted in reductions in junior secondary school age enrollment and attendance rates. Specifically, junior secondary school participation, which we define as the percentage of children age 13–15 enrolled in *any* school (either primary or junior secondary), was 3 percentage points lower (significant at 10 percent level), and junior secondary age gross attendance, defined as the percentage of school days in the past two weeks children age 13–15 attended in *any* school (either primary or junior secondary), was 5 percentage points lower (significant at 5 percent level). (Note that this latter variable counts unenrolled children as having zero attendance.) Due to these negative impacts seen in junior secondary education indicators, the average impact on the four main education indicators (primary and junior secondary school gross participation and attendance) was a statistically significant negative 0.07 standard deviations.

In our ex-ante specification of variables, we used gross attendance and school participation as the main education variables of interest, since they are defined based on age ranges and are thus the least sensitive to potentially endogenous changes in schooling practices, such as holding children back for additional years of primary school. However, to further clarify the results we also examined two other variables for middle school students. First, since gross attendance counts those children not enrolled in school as having zero attendance, we also compute "junior secondary school age conditional attendance," which is identical to gross attendance for children age 13–15 but is limited to those children actually enrolled in school. Junior secondary school conditional attendance was also 1 percentage point lower in Generasi areas relative to control (significant at 5 percent level). Second, since gross participation rates include older children participating in primary school as well as junior secondary school, we also examined junior secondary school net enrollment, which is the share of children age 13–15 enrolled in a junior secondary school. We find no statistically significant changes in junior secondary school net enrollment due to Generasi. This implies that the reductions in junior secondary school gross participation rates were due to declines in the share of children age 13–15 participating in primary school.

Since Generasi's junior secondary school enrollment indicator was age specific, targeted to improve "junior secondary school enrollment of children 13-to-15 years old," a possible hypothesis is that communities prioritized their support for children 13-to-15 years old who had already graduated from primary school—and thus could potentially enroll in junior secondary school—and did not support 13-to-15-year-olds who were still in primary school.

In interpreting these results, it is important to note that there were dramatic improvements overall in Indonesia in junior secondary age school enrollment and attendance between the baseline (column 1) and the interim evaluation (column 2) surveys, even in control areas. In particular, in control areas junior secondary gross enrollment increased from 82 percent at baseline to 91 percent in the interim survey just 18 months later. School participation rates for 13-to-15-year-olds actually increased in Generasi areas, from 82 percent at baseline to 87 percent in the interim survey; it just increased at a slower rate than in the control areas. Thus communities might have diverted resources away from junior secondary because they saw success in improving enrollment rates—they just did not know that increases in enrollments were going up everywhere in the country.[13] Nevertheless, the fact that Generasi dampened the increases in enrollment happening elsewhere in the country remains a surprise. The study team is working to understand why this may have occurred. See Section 6 discussion for several hypotheses.

Impact of incentives

The second set of results in Table 6 (columns 4-6) examines the impact separately for the two versions of Generasi: treatment A (with incentives) and treatment B (without incentives). The results show substantially higher levels of achievement on health indicators in incentivized locations: pregnant women had 0.56 more prenatal visits (significant at 5 percent level), and children had 0.1 more weight checks (significant at 10 percent level) in incentivized relative to non-incentivized areas. The average standardized health effects (averaged across all eight indicators) were a statistically significant 0.06 standard deviations higher in treatment A than treatment B locations (significant at 1 percent level).

Looking at the total effects in treatment A (column 6), the point estimates for health indicators are positive in seven of the eight indicators (all except Vitamin A capsules) with children in treatment A areas statistically significantly participating in 0.17 more growth monitoring sessions in the previous three months. The average standardized effect for all eight health indicators in treatment A was 0.07 standard deviations, statistically significant at the 1 percent level. By contrast, the average standardized effect for all eight health indicators was 0.02 (and not significant) in treatment B. Although the education indicators were not significantly different between the two treatments, the negative and statistically significant effects for junior secondary schools appear more pronounced in treatment B, with only one indicator (junior secondary school gross participation rates) showing negative impact in treatment A. All told, the evidence strongly suggests that the incentivized treatment of the program performed better than the non-incentivized treatment.

13 To assess whether local governments provided additional resources to schools in control areas to compensate for Generasi, junior secondary school budgets were compared but no differences were found (data not shown).

3.1.2 Robustness Tests

Table 7 presents the robustness of the main results for a wide variety of alternative empirical specifications. Overall, the results appear generally quite robust across the various alternative specifications, with some alternative specifications showing greater statistical significance on some indicators (particularly delivery by trained midwives and iron tablet) than the baseline specification.

To simplify comparisons across specifications, we report the results for the main twelve indicators shown in Table 6, and examine the overall impact of Generasi (i.e., the equivalent of column (3) in Table 6). For comparison, Column (1) in Table 7 presents the baseline means, column (2) presents the control means, and column (3) in Table 7 presents the main specification reported in column (3) in Table 6 above.

In Table 7, Columns (4) to (6) explore the robustness of the alternative ways of controlling for the results from the baseline survey. Column (4) begins by including in each regression the controls not only for the subdistrict average level of the indicator in that regression, but also the subdistrict average level for each of the twelve indicators. This approach controls more flexibly for differences between subdistricts, but also uses more degrees of freedom. The results with this approach are qualitatively similar to the baseline specification, although one health indicator—delivery by trained midwives (4.83 percentage point increase)—now shows statistically significant increases. In this specification, the average standardized effect for health indicates an average improvement of 0.04 standard deviations (significant at the 5 percent level).

Columns (5) and (6) examine what happens when we include fewer controls. Column (5) includes only the subdistrict average level of the indicator in the baseline, and so excludes the individual level panel data. The results from doing so look virtually identical to the main specification, which suggests that the individual level controls are not appreciably changing the results. Column (6) includes no controls whatsoever in the regression—no baseline controls, and no controls for age and how the household was sampled. Once again the results look generally similar to the main specification, although some of the point estimates attenuate and the average standardized effect for health is no longer statistically significant. Combined, these results suggest that the baseline results are not substantially driving the results, though controlling more flexibly for all twelve baseline indicators seems to strengthen the results.

Column (7) examines an alternative empirical approach: first differences. Specifically, we estimate the following regression:

$$y_{psd1} - y_{psd0} = \acute{a}_d + \hat{a}_1 GENERASI\_Y1_{pds} + \tilde{a}_2 1_{\{ypdsi0 \neq mis\sin g\}} + SAMPLE_{pdsi} + \acute{a}_p \times P_s + \mathring{a}_{pdsi}$$

where y_{pds0} is the subdistrict average baseline level or, if the individual has a person-specific baseline value from the panel, the person-specific value. As noted by Deaton (2009), in small samples controlling for baseline values can introduce bias, whereas a first-difference approach (which is equivalent to imposing a coefficient of 1 on the baseline values) does not have this problem. On the other hand, if the true coefficient on the baseline values is substantially less than 1 (as it often is), first differences can actually increase standard errors by introducing more noise into the dependent variable. The results in column (7) show that the results using first differences are somewhat stronger than the main specification, with Generasi showing statistically significant increases in deliveries by midwives (5.7 percentage points), immunization (4.9 percentage points), and weight checks (0.17 visits), and an average improvement

in health indicators of 0.061 standard deviations, which is statistically significant at the 1 percent level. The negative effects on education indicators (-5.9 percentage points for age 13–15 gross enrollment and -6.8 percentage points for age 13–15 gross attendance) are still present and statistically significant, but in this specification there is also a positive and statistically significant 4.1 percentage point increase in age 7–12 gross attendance. On balance, this specification shows stronger impacts of Generasi than the main specification.

All of the regressions so far used data at the individual level. Since the treatment is at the subdistrict level (i.e., all individuals in the same subdistrict are either treated or controls), one can repeat the analysis by first aggregating to the subdistrict level, and then running regressions with only 263 observations—one per subdistrict—estimating the following regression

$$\overline{y_{sd1}} = \acute{a}_d + \hat{a}_1 GENERASI\_Y1_{sd} + \overline{y_{sd0}} + \acute{a}_p \times P_s + \mathring{a}_{dsi}$$

where $\overline{y_{sd1}}$ denotes the subdistrict-level average value of *y*.

The results from estimating this regression at the subdistrict level are shown in column (8). The results are virtually identical to the main specification, except that the increase in deliveries assisted by trained midwives (4.8 percentage points) is now statistically significant (at the 5 percent level) in this specification.

Finally, as discussed in Section 1.3, all of the analysis so far is (a) restricted to the 264 subdistricts that were not eliminated because they were on the ex-ante lists (scheduled to receive other PNPM grants) and (b) treats subdistricts scheduled to receive Generasi in year 2 of the program as part of the control group. An alternate specification is simply to revert to the full set of 300 subdistricts originally used in the randomization (that is, not dropping any subdistricts), and compare all 200 subdistricts randomly chosen to receive Generasi against the 100 subdistricts randomly chosen to be part of the control group. This is the intent-to-treat estimate, and it will be substantially lower than the estimates above since only 129 of the 200 subdistricts identified as treatment actually received Generasi in year 1 of the program, but it is conservative in that it is based solely on the randomization we carried out by computer. The estimates using the full 300 subdistricts are in column (9). They show qualitatively similar patterns to the main specification, with statistically significant increases in iron tablets (0.10 sachets containing 30 tablets in a sachet) and weight checks (0.075 weight checks), and negative and statistically significant impacts on age 13–15 gross enrollment and 13–15 gross attendance. The only main change is that the point estimate on deliveries by trained midwives is actually negative, but it is not statistically significant.

On balance, the results presented in Table 7 show substantial robustness: the qualitative patterns in the results are quite similar across specifications; if anything, alternative specifications tend to show larger and more statistically significant results than our main, preferred specification.

3.1.3 Regional Differences

Using a regional breakdown of the findings on the impact of the twelve main indicators, we find dramatic differences among the regions. Based on the twelve key indicators, Generasi had the largest impact in North Sulawesi/Gorontalo, small positive impacts in Java, and essentially no impact in NTT.

Java

Table 8 begins by repeating the analysis shown in Table 6, but restricted to Java. The overall results in Java show a statistically significant improvement in safe deliveries by trained midwives, which improved 5.0 percentage points (significant at the 5 percent level) above and beyond the control group mean of 84.3 percent. This is despite the fact that safe deliveries generally increased during this period in Java, with the mean at baseline (Wave I, column 1) and mean of the control group in Wave II (column 2) increasing by about 7 percentage points. No other health indicators show statistically significant effects, though point estimates are positive for prenatal visits, iron tablets, growth monitoring, and Vitamin A. The point estimates suggest an average improvement in health of 0.04 standard deviations, statistically significant at the 10 percent level. On education, none of the four main education indicators show any statistically significant change in Java. The only statistically significant change (at the 10 percent level) is attendance at school for 13–15 year olds enrolled in school ("conditional attendance"), which declined by 1 percentage point. Average education effects show no statistically significant impacts.

In interpreting the small effects on Java, it is important to note that twelve indicators have generally improved during the period between Wave I (column 1) and Wave II (column 2)—except for antenatal and prenatal care visits—with control means (column 2) considerably higher in Java than in the other two regions for virtually all main indicators. The single exception is Vitamin A, which was slightly higher in Sulawesi than in Java; otherwise, control areas in Java were higher than Sulawesi in all eleven other main indicators and higher than NTT in all twelve indicators. The high baseline levels in Java may have meant that it was harder to obtain improvements.

The differences between the incentivized (treatment A) and non-incentivized (treatment B) versions were less pronounced in Java than in the national sample. Increased probability of safe delivery was only observed in treatment B areas (by 8.2 percentage points at 1 percent significance level, column 5) and an increase in children's participation in growth monitoring was observed only in treatment A areas (increased participation by 0.12 sessions in previous 3 months, significant at 10 percent level, column 6). The average impact on health indicators of 0.05 standard deviations (significant at 10 percent level) was observed only in treatment A areas but not in treatment B areas, although the difference in average standardized effects between treatment A and treatment B was not statistically significant.

NTT

Table 9 shows the results for NTT. In general, in NTT the point estimates of four of the eight health indicators suggest negative impact, with two of the eight indicators (prenatal visits and Vitamin A) negative and statistically significant and none of the indicators positive and statistically significant. In education, the point estimates point to positive primary school enrollment and attendance effects and negative effects on junior secondary school. The estimates show a positive and statistically significant improvement in primary school age attendance of 2 percentage points and a statistically significant reduction of 6.2

percentage points for junior secondary age attendance. The average effects for both education and health are negative but not statistically significant.

Although Generasi had no effect overall, the estimates suggest that the average effect was actually negative in treatment B (non-incentivized areas), while it was positive in treatment A areas. In particular, in treatment A areas pregnant women had 0.68 more prenatal visits (significant at the 10 percent level), 0.63 more postnatal visits (significant at the 5 percent level), and 0.25 more sachets of iron tablets (significant at the 5 percent level). Most impressively, treatment A reduced malnutrition by a statistically significant 0.6 percentage points (from 35 percent in the control areas). In treatment B, the average standardized effect for health was 0.077 standard deviations (statistically significant at the 10 percent level); in treatment A, the average standardized effect for health was 0.024 standard deviations (not statistically significant). The average effects for education were not statistically significant in either treatment.

One potential explanation for the difference in Generasi performance between NTT and elsewhere is that villagers may have focused more intensively on nutritional supplements. During the period between the baseline and Wave II surveys, there was a surge in the malnutrition rate of children under 3 in NTT from the baseline of 24.7 percent in 2007 to 35.3 percent in control areas in Wave II in 2008, while in the other two regions malnutrition rates were relatively stable. Given this large increase in malnutrition in NTT and considerable media attention on malnutrition in NTT during the period of evaluation,[14],[15] it is not surprising that communities focused more on nutritional intervention in NTT. The Generasi impact—in particular in treatment A areas—shows a strong preventive effect of malnutrition; nevertheless, even with the large treatment effect in treatment A areas, it could not completely negate the surge in malnutrition during this period. We will explore this issue in discussing fund allocation decisions below.

Sulawesi

Table 10 shows the results for the provinces of North Sulawesi and Gorontalo, and we find that Generasi had the largest effects in these two provinces. All but two health indicators indicated positive impacts, although all education indicators did worse in Generasi areas than control areas. Most impressively, Generasi increased the probability of delivery by trained midwives by 11.7 percentage points (significant at the 5 percent level). The average impact on health indicators for the Generasi project was 0.08 standard deviations (significant at the 10 percent level).

As for the impact on children's schooling, all main schooling indicators were negative. One indicator—13-to-15-year-old gross attendance—fell by a statistically significant 9.5 percentage points (significant at the 10 percent level). Another statistically significant change was a 2.8 percentage point reduction in junior secondary school attendance conditional being enrolled (significant at the 10 percent level). The average impact on education indicators in the North Sulawesi was a negative 0.15 standard deviations (significant at the 5 percent level).

14 "Five People die of malnutrition in NTT", March 8, 2008, Jakarta Post (http://www.thejakartapost.com/news/2008/03/07/five-people-die-malnutrition-ntt-html?1)

15 "23 *Anak Meninggal di NTT* (23 children die in NTT)", June 17, 2008, KOMPAS (http://koran.kompas.com/read/xml/2008/06/17/0144580/23.anak.meninggal.di.ntt)

The positive average impact on health indicators in Sulawesi was predominantly found in improvements of health indicators in treatment A areas (column 6): a 15.8 percentage point increase in the probability of safe delivery (significant at the 1 percent level); an 11.5 percentage point increase in childhood immunization completion (significant at the 10 percent level); and an increased children's participation in the monthly growth monitoring sessions by 0.37 sessions in the previous three months (significant at the 10 percent level). In treatment B areas (column 5), the only indicator that improved was safe delivery, which increased by 8.5 percentage points (significant at the 10 percent level). In education, treatment B areas fared worse than controls in junior secondary school gross enrollment by 13.6 percentage points and junior secondary school gross attendance by 17.0 percentage points (both significant at the 1 percent level); and junior secondary school attendance among those who were enrolled in one by 4.3 percentage points (significant at the 5 percent level). These statistically significant negative impacts in indicators related to junior secondary schooling were not observed in treatment A areas (column 6). In net terms, treatment A increased the health indicators by 0.17 standard deviations (significant at the 1 percent level). Moreover, treatment A in Sulawesi was the only area to achieve a statistically significant average increase across all twelve main indicators (0.13 standard deviations, significant at the 5 percent level.)

3.2 Impact on Long-Term Final Outcomes

In this interim survey we only studied long-term health outcomes, but not for education.[16] The health outcomes studied were neonatal (deaths within 28 days) and infant mortality (deaths within the first year), morbidity of childhood diseases (acute respiratory infection (ARI) and diarrhea) among children under 3 in the previous one month, and malnutrition (defined by < -2 SD weight-for-age) and severe malnutrition (<-3 SD weight-for-age) also among children under 3. We present the results from all provinces first and then by region. The two-year analysis will also include test scores to measure impacts on education as well as other measures of malnutrition such as height-for-age and weight-for-height.

3.2.1 All Provinces

Table 11 shows the Generasi's interim impact on final health outcomes. We observe positive impacts in all of the long-term final health outcomes studied in Wave II, with significantly lower mortality. Compared to the control areas, Generasi areas had 5.2 fewer neonatal deaths (deaths within 28 days of birth) per 1,000 live births during the 18 months prior to the survey (significant at the 10 percent level) and 7.6 fewer infant deaths per 1,000 live births (deaths within one year of birth) during the previous 24 months (significant at the 5 percent level). These effects are very large: they imply that Generasi reduced neonatal mortality by 47 percent from the level in the control group, and reduced infant mortality by 28 percent from the level in the control group.[17] Although such effects are large, other community-based

16 The reason we chose not to include long-term education outcomes is that the best way to measure long-term education outcomes is test scores. Since these indicators are costly to collect, and we did not expect an impact on test scores in the short run, we elected to collect test score data only at baseline and at the follow-up wave.

17 Given the small sample size in this province (only 531 infants), it is useful to examine the raw numbers: of 531 infants in the 0–24 month sample in this province, 10 out of 300 (3.33 percent) died in control areas, whereas only 3 out of 231 (1.3 percent) died in Generasi treatment areas. The raw data with no fixed effects or other corrections thus suggests a reduction of 20 deaths per thousand. Once one splits the data into Group P and Group NP, the differences are 5.59 percent vs. 1.56 percent (group P, fisher's exact p-value of 0.060) and 1.27 percent vs. 0 percent (group NP, fisher's exact p-value N/A).

interventions have also reduced infant mortality by similar orders of magnitude (Bjorkman and Svensson 2009).

In interpreting the infant mortality results, it is important to note that, although the baseline was balanced in general (see Section 2.2), the one variable where there may have been some pre-period differences (by pure random chance) is infant mortality, though not neonatal mortality. In particular, the baseline regressions to test the balance resulting from randomization suggest (Table 5 discussed above) that the Generasi treatment areas had lower infant mortality of 8.8 deaths per 1,000 live births at the baseline of the project implementation (significant at the 10 percent level). Neonatal mortality, on the other hand, did not have statistically significant imbalance detected between project implementation and control areas. Moreover, we found reductions in neonatal and infant mortality even in provinces where there were no differences at baseline (see Table 59 and Table 60). Of course, these regressions control for the baseline infant mortality rate in each subdistrict, and the regression results controlling for these baseline levels statistically significantly indicate that Generasi considerably reduced neonatal and infant mortality in 18 months. Nevertheless, the differences in baseline value for infant mortality suggest that some caution should be used in interpreting these results.

Point estimates for morbidity of childhood diseases and malnutrition both suggest reductions from the Generasi project, although the estimates are not statistically significant. The average impact on final health outcomes indicates an improvement in health outcomes of 0.03 standard deviations (significant at the 5 percent level). Without neonatal and infant mortality, however, the average impact on childhood diseases and malnutrition suggest an improvement of 0.02 standard deviations, but is not statistically significant. Comparing treatment A and treatment B, we found no difference between the two treatments on mortality, but we do find that treatment A with community incentives did better on morbidity and malnourishment. In particular, the average standardized effects—excluding the mortality indicators—were 0.05 standard deviations better in treatment A (significant at the 5 percent level).

Examining the mortality indicators, the reductions in infant mortality were virtually identical in both treatment A and treatment B locations (a statistically significant reduction of 8.0 deaths per thousand in treatment B and a statistically significant reduction of 7.2 deaths per thousand in treatment A). There was also a neonatal mortality reduction of 5.6 deaths per 1,000 live births in treatment A. A similar point estimate of 5.0 deaths per 1,000 live births was observed in treatment B, but it was not statistically significant. Comparing these estimates to the baseline (Table 60), while the baseline showed a statistically significant reduction in infant mortality in treatment A, it showed no such impact in treatment B. Combined, the fact that we are controlling for the baseline mortality rates and the mortality reduction appears in treatment B—where there was no difference at baseline—as well as treatment A suggests that these are real infant mortality reductions rather than mere artifacts of the data. It is also worth noting that none of the average standardized effects show statistically significant differences at baseline, whereas the differences in the post-period are statistically significant.

3.2.2 Regional Breakdown

When Generasi's impact on long-term final health outcomes is broken down into regions, Java has the smallest impacts (Table 12), with somewhat larger impacts detected in NTT (Table 13), and very large impacts in North Sulawesi/Gorontalo (Table 14). The fact that the largest impacts are found in Sulawesi is consistent with the fact that the impact on the twelve main indicators was also largest in Sulawesi, as discussed above.

In Java, no statistically significant positive impacts were found on long-term health outcome indicators (Table 12). The only statistically significant effect is a reduction in infant mortality in Java in treatment A, which fell by 5.8 deaths per 1,000 births, or a 45 percent reduction from the level observed in the control group. No impact was detected in treatment B, and none of the other indicators in Java showed statistically significant changes. The average standardized effects in Java were not statistically significant.
In NTT, all but one health outcome indicator suggests positive impacts of Generasi implementation, with a significant reduction in neonatal mortality of 14.3 deaths per 1,000 live births, a reduction of 65 percent from the mean level in the control group (significant at the 5 percent level, Table 13, column 3). The one health outcome indicator not suggesting positive impact was morbidity of childhood illnesses of diarrhea or ARI. Both treatment A and treatment B reduced neonatal mortality at statistically significant levels, with similar sized reductions in both treatments (a reduction of 14.6 deaths per 1,000 live births in treatment B areas, as shown in Table 13, column 5) and 14.1 deaths per 1,000 live births in treatment A areas (column 6). Generasi also led to increases in breastfeeding in NTT, which may be related to the improvements in neonatal mortality rates. There was some indication that a reduction in infant mortality was also observed in treatment B areas only, with 14.5 fewer deaths per 1,000 live births (significant at the 10 percent level). The average standardized effects are statistically significant (at the 10 percent level) in treatment A (0.06 standard deviations), but not in treatment B (0.02 standard deviations).

NTT also saw substantial reductions in malnourishment in treatment A areas. This occurred during a period characterized by a large surge in malnutrition, from 24.7 percent at baseline in 2007 to 35.3 percent in the control areas in 2008, as discussed above in Section 3.1.3. Generasi treatment A prevented malnutrition of children under 3 (defined as more than 2 standard deviations below the weight-for-age mean) by a statistically significant 6.2 percentage points from a control group mean of 35.3 percent, a prevention of 17.6 percent. As discussed in Section 4.3.2, supplementary feeding at village health posts increased dramatically in NTT—by about 21 percentage points. This may be related to the decline in malnutrition, although the increase in supplementary feeding occurred in both treatment A and treatment B locations.

One partial explanation for why malnutrition appears to have declined only in treatment A in NTT is that in treatment B, infant mortality also declined. Given that malnutrition is a likely cause of infant death in NTT, it is likely that the marginal children who survived in treatment B in NTT were very malnourished. Thus, precisely because of the reduction in infant mortality in treatment B, the sample of children in treatment B includes these additional very small and malnourished children who in treatment A (or control) would have died and not been in the sample. The reduction in mortality and the survivorship of these malnourished children in treatment B may be masking the actual greater reduction in malnutrition in treatment B, and suggests that in fact malnutrition was reduced in both treatment A and B in NTT.
By far the largest impacts in health outcomes were observed in North Sulawesi/Gorontalo. In particular, in North Sulawesi/Gorontalo, infant mortality declined by 42 births per 1,000 live births. Compared to control areas in North Sulawesi/Gorontalo, Generasi project areas were also found to have less severe malnutrition among children under 3 by 3.6 percentage points, a 32.8 percent reduction from the baseline level (significant at the 10 percent level, column 3). The mortality impacts were found equally in treatment A and treatment B areas; the observed malnourishment effects were slightly larger in treatment B than treatment A, but the difference between them was not statistically significant. Overall, the project improved health indicators in Sulawesi by a statistically significant 0.09 standard deviations (significant at the 10 percent level).

3.3 Impact on Non-Targeted Indicators

This section discusses Generasi's positive and negative spillovers and the program's effects beyond the targeted health and education indicators. Since the program supports community mobilization for increased use of basic health and education services and promotes provider-community collaboration, it is possible that there would be positive spillovers on non-targeted indicators. On the other hand, if Generasi diverted effort toward targeted indicators and away from non-targeted indicators, it is theoretically possible that spillover effects could have been negative. In general, spillovers were very small but positive for health and negative for education.

For health, the main spillovers we expected were increases in quality of services, a possible decline in the use of non-targeted health services, and improved parental knowledge and parenting practices. In education, spillovers were expected in reduced child labor, increased high school enrollment, reduced school dropout rates, higher primary to junior secondary school transition rates, and an increased number of school hours attended by those enrolled in school. We examine these impacts in detail in the following sections.

3.3.1 All Provinces

We did not find changes in the quality of prenatal care services measured by the completeness of services mothers received during their first antenatal care visit (column 3, Table 15) but the quality of village integrated health posts seems to have improved measured by the content of services mothers received during the village health post sessions. Facility-based (versus home) deliveries increased by 4 percentage points in the incentivized (Group A) areas; however, we did not find changes in the use of non-targeted health services or changes in health behaviors, such as use of modern family planning devices, use of curative outpatient care, timing of initiation of breastfeeding, or lengths of exclusive breastfeeding. Nor did we find changes in the mothers' knowledge of good parenting practices, measured as a combined indicator of mothers' knowledge on breastfeeding practices and management of diarrhea. The fertility rate also was not affected by the project. During this first year of Generasi, spillovers on health were observed indicators that were not targeted by the project, but communities invested in them as the means to reach the target indicators. Many Generasi communities invested their community block grants on improving village health post equipment, furniture, and incentives for the cadres. Spillovers to other indicators that require changes in behaviors—such as use of non-targeted health services, or better parenting and feeding practices—may take longer than 15–18 months, the period of time currently being studied.

As for non-targeted indicators in education, we found increases in hours spent by school-age children on work for wages and non-waged household work. School-aged children in Generasi treatment areas worked 12 minutes more for wages and 39 minutes more on household chores (both significant at the 1 percent level). This is consistent with the finding reported earlier that enrollment rates for the 13–15 age range grew more slowly in Generasi areas than in controls. Children enrolled in school actually spent less time (about half an hour less) in Generasi areas compared to control areas, consistent with the lower attendance. We did not find impacts in high school enrollment, primary and junior secondary school dropout rates, or primary school to junior secondary school transition rates.

Reflecting the positive changes in non-targeted health indicators, the average improvement across all nine health indicators was estimated to be 0.03 standard deviations (significant at the 5 percent level). Average change in the nine non-targeted education indicators, on the other hand, was a negative 0.07 standard deviations (significant at the 5 percent level).

The negative spillover effects were all found to be most strongly present in treatment B areas, where communities were not given financial incentives (column 5, Table 15). Only one additional non-targeted indicator was found significant in treatment A: a 4 percentage point increase in institutional deliveries (i.e., childbirth in a facility, rather than at home) in treatment A areas compared to controls (significant at the 10 percent level), although the same effect was not found in treatment B areas. On average, a negative change in non-targeted education (-0.08 standard deviation, significant at the 5 percent level) was found in Generasi treatment areas, although the negative impact was more pronounced in treatment B areas (-0.09 standard deviation, significant at the 5 percent level) than in treatment A areas (-0.06 standard deviations, significant at the 10 percent level). In contrast, non-targeted health indicators showed improvement in treatment A only (a 0.04 standard deviation, significant at the 5 percent level).

3.3.2 Regional Breakdown

Mirroring the findings on the main indicators, spillover effects were strongest in Sulawesi, and only a few were detected in Java and NTT. The spillovers on educational indicators were varying, with impacts observed in different directions. This did not allow us to draw a consistent picture across the regions.

We found improvements in village health post quality in Java (Table 16) and Sulawesi (Table 18) by 6 and 13.3 percent respectively. These are areas where communities invested their efforts as the means to improve the target indicators. We did not find other effects on quality of services. Changes in parenting behaviors were mixed: the time period when mothers exclusively breastfed their children increased on average by about 2.5 days in NTT (only seen in treatment A areas, column 6, Table 17, significant at the 10 percent level), but decreased by 3.8 days in Sulawesi (in both treatment A and B areas, significant at the 1 percent level). There is also a slight indication that the use of outpatient curative care increased in NTT, but only in treatment B areas (an increase of 0.05 percentage points, significant at the 10 percent level). There was also an increase in institutional deliveries in Sulawesi, but only in treatment A areas (by 0.06 percentage points, significant at the 10 percent level). We observed reductions in fertility rates in treatment A areas in Sulawesi by 0.047 percentage points (significant at the 10 percent level). In general, although not statistically significant, the point estimates indicate a decline in fertility rates in NTT and Sulawesi, and no change in Java. This is very encouraging given the potential perverse incentives for communities to increase the number of pregnancies and deliveries, particularly in treatment A areas.

In both NTT and Sulawesi, school-age children spent on average 90 more minutes on household chores in the previous one week in both regions compared to children in control areas (significant at the 1 percent level in NTT and 5 percent level in Sulawesi). In addition, in Sulawesi school-age children worked 68 more minutes for waged labor in the past one week (significant at the 5 percent level), which was predominantly observed in treatment B areas. This contrasts with Java, where school-age children spent on average 11 minutes less on waged labor (significant at the 5 percent level), although only in treatment

A areas. In sum, average standard effects in health indicate that improvements were observed in Java (Table 16), in NTT (Table 17), and in treatment A areas in Sulawesi (Table 18), although only reaching statistical significance in Java. In contrast, statistically significantly negative impacts in the average non-targeted education indicators were observed only in treatment A and treatment B areas in NTT and treatment B areas in Sulawesi.

Where Were Generasi Effects Largest?

4.1 Areas

In this section we examine the type of environments in which Generasi is most effective. As an indicator of project effectiveness in areas with different levels of pre-existing service delivery systems, an interaction term with baseline levels of service coverage was included in the models. Column 3 of Table 19 shows the changes of the coefficients found in Column 3 of Table 6 with a one-unit increase in the subdistricts' average baseline levels. A positive coefficient in column 3 of Table 19 implies larger effect sizes in areas with higher baseline levels, whereas a negative coefficient implies larger project effect in areas with lower baseline levels. To help interpret the magnitude of the interactions, column 4 shows the effect of one year of Generasi implementation on subdistricts at the 10th percentile in terms of baseline performance on the specific outcome variable at the baseline period.

4.1.1 All Provinces

In general, Column 3 in Table 19 shows negative changes in coefficients with increased average baseline levels, suggesting that Generasi had a larger impact in those subdistricts with lower baseline performance. There were two indicators with statistically significant differential impact: complete childhood immunization and malnutrition. In subdistricts with a lower baseline average coverage of childhood immunization, we found greater project impact on immunization. Likewise, in subdistricts with a higher baseline malnutrition rate, we observed greater reduction of malnutrition as a result of Generasi treatment. The fact that Generasi's impact on health was greater in areas with lower pre-period coverage is intuitive, given that these areas had greater room for improvement.

Subdistricts at the lowest 10th percentile at baseline levels had larger project impact (column 4, Table 19) than for average subdistricts (column 3, Table 6). Looking at the 10th percentile at baseline, we observed statistically significant improvements in three health indicators when compared to controls at the 10th percentile: (1) pregnant mothers received 0.19 more sachets of iron pills (significant at the 10 percent level); (2) one-year-olds were 6 percent more likely to have received complete childhood immunization;

and (3) children under 3 attended 0.17 more growth monitoring sessions in the preceding three months (both significant at the 5 percent level). There were no statistically significant differences in the average effects for health or education indicators among the different poverty groups. The average impact on health was larger among those in subdistricts at the lowest 10th percentile at baseline by 0.07 standard deviations (significant at the 5 percent level).

Table 20 shows the difference in Generasi impacts by treatment A and treatment B. Columns 4 and 5 in Table 20 suggest that in general larger treatment effects were observed in both in treatment A and treatment B subdistricts with lower baseline levels. We only found two statistically significant differences in treatment A areas: (1) greater project impact on immunization coverage in subdistricts with lower baseline immunization coverage, and (2) larger reduction in malnutrition in subdistricts with higher baseline levels of malnutrition. Reflecting insignificant differences between treatment A and treatment B, no difference was observed in the average effects of health and education indicators by the baseline wealth levels in treatment A or treatment B areas.

4.1.2 Regional Breakdown

There are important regional differences in the impact when considering the baseline level of outcomes. Larger impacts were observed in subdistricts in Java with lower baseline outcome levels, while project impacts do not seem to be affected by baseline levels of outcome in NTT and Sulawesi. This likely reflects the fact that baseline levels of service provision were low enough in NTT and Sulawesi for the program to have an effect throughout the province, whereas in Java, there were some subdistricts where service provision was high enough that the program was unlikely to have an additional impact.

In Java, four of the eight main health indicators showed a statistically significant difference in the levels of Generasi impact according to the subdistrict's level of outcome indicator at baseline (Table 21). Project impacts were larger in subdistricts with lower baseline levels of safe delivery by trained professionals (significant at the 10 percent level), receipt of iron tablets, and childhood immunization coverage (both significant at the 5 percent level) than those presented in Column 3 of Table 8. Subdistricts with higher malnutrition rates at baseline levels in Java were found to have larger Generasi impact than the average. All the education indicators suggest that project impacts were smaller in subdistricts with higher outcome level at baseline, although none of them were statistically significant. The results show that, for the 10th percentile subdistrict in Java, the Generasi program increased all eight health indicators by a statistically significant 0.14 standard deviations and increased all twelve program indicators by a statistically significant 0.09 standard deviations.

We found that the differential impact on health indicators was more prominent in treatment B areas (Table 22), with only one (immunization) of the four indicators' differential impacts found in treatment A areas. On average, however, there was no significant difference between treatment A and treatment B in Java in terms of standardized effects on health or on education by baseline service coverage level.

In NTT (Table 23) and Sulawesi (Table 25), Generasi impacts seem not to be affected by the levels of outcome indicators at baseline. Although small differences are observed between treatment A and treatment B areas in NTT (Table 24) and Sulawesi (Table 26), they cancel out. Perhaps the only noteworthy differentials between treatment A and B in Sulawesi is the positive differential (larger impact in subdistricts

with higher baseline level) in treatment B areas and negative differential (smaller impact in subdistricts with higher baseline level) in primary school enrollment and attendance. Although these differences in impact between treatment A and treatment B are highly statistically significant, they too cancel out for Generasi impact as a whole in Sulawesi for these indicators. The interaction between treatment and baseline coverage levels on the average standardized effects across education indicators revealed opposite effects in the two regions of NTT and Sulawesi. In treatment B areas in NTT, subdistricts with higher baseline levels had smaller average impact on education indicators (by -0.87 standard deviation, significant at the 5 percent level). In contrast, in treatment B areas in Sulawesi, larger impacts were observed on average for education indicators in subdistricts with higher baseline levels (by 0.93 standard deviations, significant at the 5 percent level), while in treatment A areas smaller average impacts were observed in subdistricts with higher baseline levels (by -1.88 standard deviations, significant at the 1 percent level). This suggests that in Sulawesi, at least for education, community incentives made Generasi work better for subdistricts whose indicators for education were lagging behind at baseline. In NTT, however, treatment B was more effective in improving education indicators in trailing subdistricts at baseline.

4.2 Individuals

One of the unique features of Generasi is that communities conduct their own needs assessment and targeting of beneficiaries. As part of the government's poverty alleviation program, it is important to understand whether Generasi communities are able to appropriately target the poor and the vulnerable. In this section we explore whether the Generasi project is effective on the poor relative to the better-off, and how different community incentives affect the two groups. To investigate the heterogeneity in project impacts by the individual's baseline level of per capita consumption, interaction terms were included to split the project effects for the poor (defined as being in the bottom two quintiles according to the baseline household consumption per capita) and the relatively better-off (defined as being in the top three quintiles).

For the program as a whole, on average there were no statistically significant differences between the bottom two quintiles and the top three quintiles. However, this average masks important differences between the two versions of the programs: treatment A (the incentivized version of the program) had larger impacts for the bottom two quintiles, whereas treatment B (the non-incentivized version of the program) had larger impacts for the top three quintiles. The incentives in the program therefore played an important role in encouraging communities to focus their efforts on the poor.

4.2.1 All Provinces

Columns 3 and 5 of Table 27—which show the project's impact on the twelve main indicators for poor individuals (column 3) and for the relatively better-off (column 5)—suggest small heterogeneities in Generasi's impact on individuals in different wealth groups, with no striking differences in the project's impact on the two groups. Increased participation in growth monitoring was equally observed in both wealth groups; the poor attended 0.18 more sessions, while the relatively better-off attended 0.15 more sessions in the previous three months compared to those in the control areas. A statistically significant reduction in school attendance by 13–15 year olds (by 5 percentage points) was observed among the

poor (significant at the 10 percent level). Although a similar level of reduction was observed among the better-off group, it was not statistically significant. On average, the point estimates suggest larger impacts among the better-off than among the poor for health indicators, though these differences are not statistically significant; in education, the better-off were met with larger negative effects of the project than the poor.

The community incentives seem to have moved the locus of treatment effects from the better off to the poor. For example, column 4 of Table 28 shows that the poor did 14 percentage points worse on delivery than the rich; by contrast, the poor did 16 percentage points better than the rich on safe delivery in treatment A. Likewise, treatment B reduced malnutrition rates by 7.2 percentage points more for the rich than the poor, whereas treatment A reduced malnutrition rates by 13 percentage points more for the poor than for the rich. On average, treatment A improved health indicators among the poor (0.12 standard deviations, significant at the 5 percent level) while treatment B improved health indicators of the better-off (0.08 standard deviations, significant at the 5 percent level). As for education indicators, although none of the groups had a significant effect, the impact on both wealth groups in treatment A was positive, while the impact on both wealth groups in treatment B was negative.

4.2.2 Regional Breakdown

Although there were few indicators that show different impacts on the poor and the better-off, in general both the poor and relatively better-off fared equally in Java and Sulawesi. In NTT, the poor fared better in treatment A, whereas the better-off fared better in treatment B.

No notable differences in impact for the poor and the relatively better-off were observed in Java (Table 29) or in Sulawesi (Table 33). Both treatment A and B seem to have worked equally in Java for the poor as well as the better-off (Table 30). In Sulawesi, treatment A resulted in more pro-poor impacts for the health indicators and the education indicators (Table 34). Among the poor, treatment A in Sulawesi resulted in positive impacts only in antenatal care, malnutrition, and junior secondary school gross enrollment and attendance. In treatment B areas in Sulawesi, although primary school enrollment increased by 4 percentage points among the poor, both junior secondary school enrollment and attendance worsened for the poor. The poor in treatment A areas of Sulawesi were the only ones who statistically significantly benefited both for the average across main health indicators (by 0.38 standard deviations, significant at the 5 percent level) and for the average across main education indicators (by 0.30 standard deviations, significant at the 5 percent level). In contrast, in treatment B areas in Sulawesi, the poor were impacted negatively by Generasi, resulting in a negative 0.27 standard deviation in education (significant at the 5 percent level).

In NTT, Generasi seems to have favored those in the relatively better-off group than the poor, with immunization coverage improving only for the better-off (Table 31). Looking at the impacts in treatment A and treatment B separately, we found large differences in how the two treatments worked in NTT (Table 32). In general, treatment B only affected the poor negatively, with specific negative impacts on antenatal care, safe delivery, and postnatal care visits (significant at the 10 percent level, 1 percent level, and 5 percent level respectively). On average, the poor in treatment B areas were 0.25 standard deviations worse off in the standardized effects for health compared to controls. On the other hand, the poor in treatment A areas benefited more than the better-off with receiving more postnatal care and iron tablets.

The average improvement of the main health indicators for the poor in treatment A in NTT was 0.16 standard deviations (statistically significant at the 10 percent level), much larger than the benefits the better-off saw in their average of the health indicators (0.04 standard deviations).

4.3 Direct Benefits of Generasi Funds

In addition to the communities' ability to target individuals, communities must also be able to design appropriate village-level projects that will address common and shared hurdles in accessing target health and education services. This section explores the types and quantities of direct benefits received by children under 3, school-aged children, and pregnant mothers.

In general, Generasi hugely increased provision of school uniforms, school supplies, supplementary feeding, cash subsidies for schooling, and antenatal/postnatal care and fees for delivery assistance. Cash subsidies for schooling were mostly found in Java and treatment A areas in Sulawesi, while intensive supplementary feeding was only found in treatment B areas in NTT.

4.3.1 All Provinces

Generasi substantially increased the probability that pregnant mothers, children under 3, and school-age children received materials and cash subsidies related to health and education (Table 35). In general, statistically significantly more 6-to-15-year-old children in Generasi areas received scholarships (by 1.1 percentage points, a 46 percent increase); school uniforms (by 9 percentage points, an eleven-fold increase, or 1,173 percent); school supplies (by 5.7 percentage points, a six-fold increase, or 632 percent); transportation subsidies (by 1 percentage point); and supplementary feeding at school (by 0.4 percentage points). More children under 3 in Generasi areas received supplementary feeding (by 15.5 percentage points, a 32 percent increase) and intensive supplementary feeding (by 1.7 percentage points, a 59 percent increase). Similarly, statistically significantly more mothers received financial subsidies to receive antenatal care and postnatal care (by 3 percentage points, a seven-fold increase, or 758 percent) and for childbirth (by 11.6 percentage points, a four-fold increase, or 385 percent).

In comparing treatment A and treatment B (Table 35, column 5 and 6), particularly in education more financial subsidies such as scholarships and transport subsidies were provided in treatment A than in treatment B. In terms of support for use of health services, more children in treatment B areas received intensive supplementary feeding than in treatment A.

Given all the positive impacts Generasi has had in the provision of financial and material support for children under 3 and school-age children, large average impacts were observed for direct benefits received in health and education: an improvement of 0.19 standard deviations for health benefits and 0.23 standard deviations for education benefits (both statistically significant at the 1 percent level). On average, however, treatment A areas seem to have favored education benefits compared to treatment B (0.28 standard deviations and 0.18 standard deviation respectively, both significant at the 1 percent level).

4.3.2 Regional Breakdown

A few notable differences were found in the three regions. Scholarships increased only in Java (Table 36, column 3) and in treatment A areas in Sulawesi (Table 38, column 6), but not in NTT (Table 37, column 3). Supplementary feeding at village health post sessions was observed in all three regions. These monthly supplementary feeding activities at village health posts are popular among village health post cadres, and provide incentives for mothers and children to participate in village health posts. Villages also conducted more intensive supplementary feeding activities targeted specifically at malnourished children. NTT was the only region where a statistically significant increase in intensive supplementary feeding was observed (3.9 percentage points increase, significant at the 5 percent level), most of which happened in treatment B areas (6.3 percentage points increase, significant at the 5 percent level), which also experienced the largest reductions in infant mortality. The average impact across health benefits and education benefits in the two treatment areas differed by region. In treatment A areas in Java and Sulawesi, both saw a larger impact on education direct benefits than health benefits. In treatment B areas on the other hand, in Java health benefits and education benefits were about the same, health benefits were larger than education in NTT, and education benefits were larger than health in Sulawesi.

How and Why did the Generasi Project Work?

This section explores the mechanisms through which Generasi—as a whole and the incentives in particular—altered the changes in coverage of basic health and education services. We first examined changes on the provider supply side: the quantity of providers (Section 5.1), the inputs used by providers (Section 5.2), and the effort put in by providers (5.3). We found some increases in access to education, with the particular type of indicator affected varying by province (e.g., more junior secondary schools in Java, more primary schools in NTT, more junior secondary school teachers overall). However, by far the most pronounced change was in provider effort—in particular, we found that midwives in treatment A locations were spending substantially more time providing services, particularly outreach activities and public services. We then examined effort on the part of the community in Section 5.4. We found substantial increases in community effort: Generasi increased the number of cadre (volunteers) at village health posts and increased the number of school committee members for primary schools. We also found greater participation in monitoring meetings, and—perhaps surprisingly—greater participation in community groups in the village more generally and in semi-volunteer public labor service (*gotong royong*) activities.

Finally, in Section 5.5, we examine quantities of services using data from providers. The main finding was a dramatic increase in all types of health services provided at village health posts. We found statistically significant increases in the quantity of children weighed, nutritional supplements, immunization, ANC visits, iron pills, and Vitamin A. The provider data also confirmed the small declines in junior secondary school enrollment in Generasi treatment B areas, with the declines larger (and only statistically significant) in the 2007–08 school year.

Taken together, the results in this section tell a consistent story: Generasi increased health performance in large part through increased community engagement, particularly through service provision at the village health posts.

5.1 Changes in Provider Quantities

The first question in examining the impact of Generasi on supply is the quantity of providers. We examined changes in six types of providers at the village level: for health, we examined the presence of midwives and the number of active village health posts; for education, we examined the presence of primary school and junior secondary school in the village and the number of teachers at primary school and junior secondary school.

5.1.1 All Provinces

Overall, the estimates show that Generasi had no impact on the quantity of health providers, but may have had various impacts on access to education that varied by region. Looking across all provinces, we found increases in the number of junior secondary school teachers (by about one teacher in every two schools), but only in treatment B (non-incentivized) areas (Table 39). Although none of the other individual effects are statistically significant, the point estimates for all four education indicators are positive, resulting in an average improvement of 0.04 standard deviations (significant at the 10 percent level).

5.1.2 Regional Breakdown

Examined province by province, the estimates reveal that Generasi did affect the presence of schools in the village—but because the type of school affected varied by province, the average effect across the entire program is not large enough to be detectable. Specifically, in Java, Generasi increased the probability that a village had a junior secondary school by 3.6 percentage points (an increase of 7 percent of the control mean level, significant at the 10 percent level) (Table 40). In NTT, where not all villages had primary schools, the program increased by 2 percentage points the probability that a village had a primary school (significant at the 10 percent level, Table 41). Since 96 percent of villages in NTT had primary schools in the control group, this implies that Generasi created primary schools in half of the villages that did not previously have one. The fact that primary schools increased in NTT—the only area where they were not likely to be universal before the program—confirms that the flexibility of the Generasi block grants allowed a very different use of funds in NTT, commensurate with local needs. Moreover, the point estimates for the effect on junior secondary school presence in NTT, at 3.6 percentage points, were virtually identical to the impact in Java, although the effect was not statistically significant. Neither of these effects was present in Sulawesi, which is why we find no effect on average in the program as a whole (Table 42). Java was the only region with a statistically significant average impact on education (0.09 standard deviations; columns 3 and 6, Table 40 , significant at the 5 percent level), while we did not find significant average impact in the other two regions.

5.2 Changes in Provider Inputs

This section describes Generasi's impact on the inputs providers use. Specifically, we examine the quality of the midwife's facility (water and electricity), the midwife's availability of medical supplies and tools, the number of school classrooms, the condition of the school building, and the presence of latrines at school.

Overall, we found no clear impact of Generasi on these variables.

5.2.1 All Provinces

Specifically, column 3 of Table 43 shows Generasi's impact on the quality of infrastructure. The project did not significantly improve the infrastructure for midwives or at schools, with none of the variables showing statistically significant effects. When comparing the impact of treatment A (column 6) and treatment B (column 5), the only indicator with a statistically significant change was the improved midwives' access to clean water in treatment B areas (an improvement of 0.05 percentage points, significant at the 5 percent level). There were no such improvements observed in treatment A areas.

5.2.2 Regional Breakdown

Looking region by region, in Java (Table 44), the only statistically significant effect of Generasi detected was the improved midwives' access to clean water (an improvement of 5 percentage points, significant at the 5 percent level), which came from treatment B locations. The effects on other indicators were not statistically significant, and the effect sizes were also very small (column 3). In NTT (Table 45), no significant overall impact was observed in provider infrastructures (column 3). When treatment A and treatment B effects are assessed separately, one significant improvement was observed in midwives' access to electricity, a 10.4 percentage point improvement in treatment A areas (significant at the 10 percent level, column 6). No such improvement was found in treatment B areas (column 5). In Sulawesi (Table 46), the only significant effect observed was on the availability of student latrines at junior secondary schools (an increase of 9.1 percentage points, significant at the 10 percent level). Declines were observed in midwives' access to water and number of junior secondary school classrooms in treatment B, and in the condition of junior secondary school buildings in treatment A. In net terms, however, these effects show no clear pattern and little overall significance, as evidenced by the minimal changes on the standardized average effects.

5.3 Changes in Provider Effort

This section examines the third component of supply: provider effort. Specifically, we examine midwife labor supply, midwife participation in village health post activities, teacher absence, and teacher teaching behavior. We found that Generasi was associated with midwives spending more time working, with more total time spent in outreach observed in treatment A areas and more time spent per village health post overall. We found no impact on teacher attendance or teaching behavior.

5.3.1 All Provinces

The overall results are shown in Table 47. According to midwives' self-reports, midwives in Generasi areas spent more time at each village health post session providing various health services for mothers and their children (Table 47, column 3). An average midwife in Generasi areas reported spending 0.19 hours (about 11 minutes) more per village health post session compared to control areas (significant at the 10 percent level). This may be a reflection of the very large increase in the number of mothers and children receiving services at village health posts in Generasi areas, as seen below in section 5.5. We did not find other midwife indicators to be statistically significant for the program as a whole. As for teacher efforts, we did not find statistically significant effects either in the proportions present or engaged in teaching at the time of the survey teams' visits.

In treatment A areas (column 6), midwives reported spending 0.79 more hours (about 47 minutes) providing outreach services during the previous three working days (significant at the 10 percent level). Although no other midwife indicator reflecting their efforts was statistically significant, all of the point estimates suggest midwives spent increased amounts of time providing services in treatment A areas than in control areas. For example, midwives spent 0.89 more hours in the previous three days providing outreach in treatment A than in treatment B, 1.7 hours more in the previous three days providing all public services in treatment A than in treatment B, and 3.1 more hours working in treatment A than in treatment B (column 4). These results are consistent with the main results showing that the increase in weight checks at village health posts, prenatal visits, and postnatal visits was higher in incentivized areas than in non-incentivized areas. This suggests that the increase in midwife hours is driven by the increased demand for their services, which in turn is spurred on by the incentives. The standardized average effect for health was only statistically significant in treatment A areas, with an improvement of 0.09 standard deviations (Column 6, significant at the 10 percent level), but was not significant for Generasi treatment as a whole (Column 3). We did not find positive or negative impacts on school teacher's efforts either in treatment A or treatment B areas.

5.3.2 Regional Breakdown

Examining the results regionally, we found generally positive effects in the provision of midwives' services in Java and Sulawesi, but not in NTT. Teachers, particularly in NTT, seem to have responded negatively, but were generally more positive in Sulawesi, and mixed in Java. In general, we found more positive effects on provider quantity in treatment A areas and more negative effects in treatment B areas, except in NTT, where we found no positive effects on provider efforts.

Specifically, column 3 in Table 48 shows changes in provider efforts in Generasi areas in Java. Midwives in Java reported spending 0.87 more hours (about 52 minutes) on outreach services (significant at the 1 percent level), which was observed predominantly in treatment A areas. Midwives in Java generally increased the amount of time spent working as a result of Generasi, but may have reduced the amount of time working in their public capacity. The only positive finding regarding school teachers as a result of Generasi was found in Java: primary school teachers were 2.4 percentage points more likely to be present (at the 10 percent significance level) at the time of the survey, which generally was unannounced.

In treatment B areas in Java (Table 48, column 5), midwives spent on average 36 minutes more on outreach services but about 74 minutes less on public services at the health facility in the previous three days as a result of Generasi (both significant at the 10 percent level). Midwives in treatment A areas in Java (column 6), on the other hand, in general (although also not statistically significant) spent more time working, on average 68 minutes more on outreach services during the previous three days (significant at the 1 percent level). The point estimates of all other midwife effort indicators in treatment A areas suggest an increased amount of time spent providing services overall. As a result, the standardized average impact in Java was statistically significant for health in treatment A areas, with an improvement of 0.10 standard deviations (column 6, Table 48).

The effect of Generasi on midwives and teachers in NTT was largely more negative than positive (Table 49, column 3). Although none of the midwife effort indicators were statistically significant, the point estimates suggest that midwives spent less time working overall. Primary and junior secondary school

teachers were 7 percentage points less likely to be present at school and 17.5 percentage points less likely to be engaged in teaching at the time of the observation (both significant at the 10 percent level). These negative effects found on midwives and teachers were more pronounced in treatment B (columns 5) areas in NTT than in treatment A areas (columns 6). The standardized average effects in NTT were highly statistically significantly negative, particularly for education, with negative 0.32 standard deviations in Generasi locations overall in NTT (significant at the 1 percent level). Although average effects on health indicators were not statistically significant, average standardized effects combined for health and education indicators were negative at -0.17 standard deviations in NTT (significant at the 1 percent level).

In Sulawesi, midwives spent about 53 more minutes per village health post session in Generasi areas (significant at the 5 percent level, Table 50, column 3). No other midwife effort indicators were statistically significant. As for school teachers, although none of the indicators were statistically significant, the point estimates suggest a more positive impact on teachers' attendance and time spent teaching than in the other two regions.

Midwives in treatment B areas in Sulawesi (Table 50, column 5) reported spending more time per village health post session, although in general—according to the point estimates—they seem to have spent less time working in the previous three days as a result of Generasi. In contrast, in treatment A areas (column 6), midwives not only spent more time per village health post session by about 48 minutes, but also on average reported spending 4.59 more hours working in the previous three days (significant at the 10 percent level). Point estimates of all other midwife effort indicators suggest positive effects of treatment A on midwives; the average standardized effect in treatment A areas showed a highly significantly positive effect of 0.26 standard deviations (column 6, significant at the 1 percent level). Teachers, on the other hand, seem to have responded better to treatment B than to treatment A, although none of the indicators were statistically significant, nor were the average standardized effects for education in Sulawesi.

5.4 Changes in Community Effort

The analysis above explored the impact of Generasi on providers, primarily midwives and schools. This section explores the impact of Generasi on the community's effort. In this section, we examine three types of community effort: (1) community effort at direct service provision, such as the number of active village health post sessions and the number of cadres at the village health post; (2) community effort at outreach, such as health sweepings and school committee meetings with parents; and (3) community effort at monitoring, such as the number of school committee meetings. We also examine spillovers of Generasi to other types of community activities, such as the semi-volunteer public labor service (*gotong royong)*, government service, and other community groups.

Overall, we find scattered bits of evidence that Generasi increased community effort, particularly on the number of cadres at village health post meetings, the number of junior secondary school students, and the number of parents participating in health education meetings. On average, Generasi had positive impacts on community efforts, mostly due to its effects on community efforts related to health activities.

5.4.1 All Provinces

Table 51 shows the results for all provinces. We found that Generasi did not change the number of active village health posts or the frequency with which they met; it did, however, increase the number of village health post cadres by 0.24 people, or about 5 percent of the control group mean. The effects on the number of cadres were equally present in treatment A and treatment B locations. The increase in the number of cadres is consistent with the very large increase in the number of services delivered at village health posts; see Section 5.5 below. Consistent with the increased number of participants receiving services at village health posts, in both treatments A and B areas, the number of times mothers participated in health education sessions increased by 0.1 times in the past 15 months.

Turning to community outreach, we found no effects of Generasi—either treatment A or treatment B—on any of our metrics of community outreach. Specifically, we found no impact on the number of village health post sweepings, where the village health post cadres go door-to-door to make sure all households are receiving services, and we found no impact on the number of school committee meetings with parents for either primary or junior secondary schools.

We did, however, find an impact on one metric of community effort at monitoring: in treatment A locations, the number of primary school committee members increased by 0.75. We found no impact in treatment B, nor on any of the other community monitoring effort variables.

Perhaps the most striking result is that we saw positive spillovers from Generasi to other types of community activities—in Generasi communities, the average household spent 3.2 more hours over the past three months doing semi-volunteer public labor service, a 11 percent increase..

Generasi's overall average impact on community efforts was a positive change of 0.1 standard deviation, most of which was due to the impact on community efforts related to health, with a standardized average positive impact of 0.19 standard deviations (both statistically significant at the 1 percent level). No average impact was observed on community efforts related to education.

5.4.2 Regional Breakdown

We found some regional differences on community efforts as a result of the Generasi program. Village health post cadres' efforts on outreach seem to have increased only in Sulawesi, while they remained the same in Java and decreased in NTT, which we predominantly observe in treatment B areas.

Improvements in community efforts in monitoring schools through school committees were only observed in Java, where the number of primary school committee members increased by about one member per school in treatment A areas. In NTT and in Sulawesi although the numbers of school committee members may have not changes, a small increase in the number of meetings were observed: an average number of junior secondary school committee meetings in the previous school year increased by 1.3 times in Generasi areas in Sulawesi, and 1.5 times in treatment B areas in NTT (significant at 5 percent and 10 percent levels, respectively).

Household members' participation in other community activities increased only in Java and in treatment B areas in NTT, but not in Sulawesi. The baseline mean (column 1) and control mean (column 2) suggest the community members in NTT already spent considerably more time on semi-voluntary public labor activities than in the other two regions.

Overall, Generasi had positive impacts on community efforts in all three regions, with all three regions indicating positive standardized average impacts on health activities but no impact on community efforts associated with education.

5.5 Quantities from Provider Data

This section explores the changes in quantities and prices from the provider data. First, the quantities of services reported by services providers (midwives, health centers, village health post, and primary and junior secondary schools) are discussed. This is followed by the analysis of the impact on fees charged for maternal health services by health facilities, midwives, and cost of education. By analyzing prices and quantities together, we can begin to understand the incidence of Generasi benefits, as well as the degree to which Generasi shifted demand curves, supply curves, or both.

5.5.1 All Provinces

The results for all provinces are shown in Table 55. The table shows quantities and fees for a variety of services provided by midwives (childbirths at private and government practice, ante-natal care, post-natal care, family planning), childbirth at Puskesmas, school enrollment and school fees, and village health post services and fees.

Several results are worth noting. First, the results show a dramatic increase in all maternal and child health services offered at village health posts: the quantity of children weighed increased by 8.3 (20 percent increase); the quantity of children receiving nutritional supplements increased by 13.9 (40 percent increase); the quantity of children immunized increased by 3.1 (27 percent increase); the quantity of pregnant mothers receiving ante-natal care increased by 1.9 (42 percent increase); the quantity of pregnant mothers receiving iron pills increased by 2.3 (48 percent increase); and the quantity of children receiving Vitamin A increased by 8.8 (20 percent increase). These substantial increases do not appear to be due to record keeping—family planning services at village health post, for example, remained unchanged. The results were similar in treatments A and B. These results suggest that a major contribution of Generasi was a revitalization of the village health post system, bringing more mothers and children into the health care net. The fact that so many more mothers and children were being brought into the modern health care net may be a major reason why the Generasi program succeeded in reducing infant mortality—with such regular contact with health professionals, many at-risk children might have been saved.

Second, the data from midwives suggest that there were increases in fees charged for delivery services, even though the total number of services delivered did not change substantially. Fees charged by midwives increased by Rp. 15,500 in private practice (4.6 percent), and fees charged for government delivery

increased by Rp. 22,000 (12.9 percent). This suggests that Generasi led to an outward shift in the demand for childbirths, and that the incidence of this shift in demand took the form of higher payments received by midwives.

Third, the data show that Generasi led to lower junior secondary school enrollments in the 2007–08 school year. Enrollments from school-based data were 15 students lower (5 percent), which is consistent with the findings shown in the household survey.

The average standardized effects confirm that there were increases in health quantities—an increase of 0.11 standard deviations. These were driven largely by the increases at village health posts, which increased by 0.27 standard deviations. The average standardized effects for fees were not statistically significant.

5.5.2 Regional Breakdown

There is relatively little regional heterogeneity in the effects in this section. The price impacts for childbirth are virtually identical for the three provinces considered, with the exception that in Sulawesi the fee increase is disproportionately for private deliveries. The quantity increases at village health posts are felt everywhere, though they are weaker in NTT than in the other provinces. The junior secondary school enrollment declines are equally seen in NTT and Java, but do not appear in Sulawesi. Sulawesi is the only province to show reductions in fees paid by mothers for births at the health center, with commensurate increases in the quantity that take place at the health center (thus evidence of a supply increase).

06

Discussion

This interim report describes the impact these Generasi subdistricts had against the project's target indicators after 15–18 months of project implementation. At the time this follow-up survey was conducted in late 2008, all 129 Generasi subdistricts had successfully completed the first project cycle.

The interim survey showed that the program improved health. The eight main health indicators showed improvements, but the most striking impact was on final health outcome indicators, particularly the very large reductions in neonatal and infant mortality.

We found stark regional differences that correspond with different local conditions. Sulawesi demonstrated the largest overall average improvements in the eight main health indicators as well as health outcome indicators, with infant mortality declining by as much as 71 percent. In NTT, there was only improvement in one of the twelve main indicators—malnourishment—and only in treatment A locations. However, NTT had the largest reduction in neonatal mortality (an estimated 65 percent reduction) and the largest reduction in malnutrition (an estimated 18 percent reduction, although limited to treatment A areas). The focus on reducing malnutrition in NTT is consistent with the fact that NTT had the largest malnutrition problem to start with, and suggests that communities may have adjusted the focus of the program to match local needs. In contrast, Java was able to demonstrate small improvements in the average of the eight health indicators, although no drastic improvements in health outcome indicators were observed as in the other two regions. With relatively high levels of service coverage and low levels of mortality and malnutrition observed at the baseline, communities in Java had a harder time improving their indicators. But even within Java, Generasi substantially improved health indicators in those communities with low pre-period levels of service provision. Thus, the project is seeing some of the strongest health effects in those areas with the lowest pre-period levels of service. Also, in the next survey round, the project will explore further the extent to which communities respond in a more targeted way to specific issues and gaps.

The large improvements in neonatal mortality and infant mortality observed in Generasi project areas are comparable to those achieved by other community-based programs (Bjorkman and Svensson 2009). All health services promoted by Generasi are services included in Indonesia's Ministry of Health protocols for maternal, neonatal, and child health, and are services regularly provided throughout the country. Therefore, Generasi suggests that large improvements in health outcomes are possible through community

mobilization toward improved coverage of regular health programs. Although biological causality of how Generasi's project inputs lead to improvements in child health cannot be proved through this study, the study demonstrates that increasing community mobilization toward targeted results does lead to improved child health. As seen in this study, Generasi has been most effective in increasing service delivery at village health posts. These are village-level (or often hamlet-level) monthly health posts managed by volunteers, the village health post cadres. All maternal and child health services targeted by Generasi other than delivery and antenatal care (depending on whether privacy can be ensured at the village health post) are provided at the village health post, usually a midwife. Generasi increased community collective efforts in the provision of services through increasing the number of village health post cadres and increasing participation in health education. Generasi also changed health provider behaviors, increasing their time spent on public services and on the provision of outreach services in particular, which most likely resulted in a pro-poor shift in their service provision. So far, Generasi's effects are limited to service provision at the village-level and behaviors of individual service providers assigned to village-level service delivery. No impact has been found yet on services provided beyond the village level, such as services provided at subdistrict health facilities.

The differences in the degree of success in mobilizing communities and providers may provide some clues to understand the reasons behind the differences in the findings in the three regions. Generasi in Sulawesi has been considerably more effective in mobilizing community efforts than in NTT. In addition, health providers in Sulawesi responded positively, increasing their work hours and providing more outreach services. In contrast, the impacts on health providers in NTT were very small and mostly negative. Interestingly, in NTT only child health services—such as growth monitoring and vitamin A— increased through village health posts, while none of the maternal health service provision increased through village health posts, even though in other regions service provision of both maternal health services and child health services increased. Other social and cultural factors affecting the use of maternal health services in NTT may be at play, such as the practice of seclusion of the mother and her infant child during the first 40 days after birth (*Se'i*) found in North Central Timor (TTU) district in NTT (Rahayu, Toyamah, Hutagalung, Rosfadhila, and Syukri 2008).

In contrast, the first 15 to 18 months of Generasi led to no improvements in education, and in fact the program shows negative impacts on enrollment and attendance of 13–15 year olds who would have otherwise been completing primary school. Consistent with lower enrollment in this cohort, there were also signs of increased child labor, particularly in NTT and Sulawesi. There may be several reasons for this. First, it is noteworthy that junior secondary gross enrollment increased overall in both treatment and control areas. In control areas, junior secondary gross enrollment increased from 83 percent at baseline to 91 percent in the interim survey just 18 months later. School participation for 13–15 year olds actually increased in Generasi areas, from 83 percent at baseline to 87 percent in the interim survey; it just increased at a slower rate than in the control areas. The period between 2007 and 2009 has seen major increases in overall government expenditures for education. Over the past few years, the government has significantly increased overall public spending on education, from 17.2 percent of total national budget in 2007 (World Bank 2007) to an estimated 20 percent in 2009. [18] At both the national and district levels, the government was spending much more on free schooling and school-based management, thus

18 The Constitutional Court obliges the government to meet the "20 percent rule," whereby at least 20 percent of the national budget (both central and subnational) allocation is expected to be allocated for education.

it was a period of great flux. Given the secular improvements in enrollment that were taking place during this period, many Generasi communities may have thought they were having an impact on enrollments, not realizing that enrollments also were increasing in communities without Generasi. Second, there may be issues regarding the Generasi's targeting only 13–15 year olds and not other age groups. The specific Generasi target indicator called for improvements in junior secondary school enrollment of children 13 to 15 years old. Field reports indicate that communities and facilitators may have interpreted this age conditionality strictly while allocating funds. Third, the program missed the registration period for the school year and Generasi funds were available for communities to fund activities only halfway through the school year, making new enrollments for the ongoing school year extremely difficult. Lastly, in the first year of implementation, field and supervision reports were finding that communities were favoring more assistance toward children already in school, rather than focusing on out-of-school children.

It is not just the lack of positive impact on the four target indicators observed for education, but Generasi did not have effects on community mobilization for education or change teacher behaviors. According to the Generasi project's management systems information data, communities on average spent 56 percent of their block grant allocation for activities related to education, demonstrating that it is not that communities placed lower priority to education than health. Unlike for the health sector, at least in the first 15–18 months, Generasi was unable to increase community participation in school committees. Nor did the project have any impact on teacher behavior, at least in terms of their presence and involvement in pedagogical activities at the time of the impact evaluation survey teams' visits. Since community mobilization seems to have been critical to improving health, the lack of community mobilization in education might help explain the stark differences in the findings.

This study provides strong evidence that with clear and measurable target indicators, community incentives work and communities with incentives consistently outperform those without community incentives. Overall, community incentives had the following effects: they made Generasi more effective for the poor, and increased provider efforts. Surprisingly, community incentives did not have effects on the level of community efforts. Throughout the evaluation, we found consistently that the incentives improved performance, and little evidence that they made performance worse.

07

Policy Implications and Conclusion

It would be premature to draw any definitive conclusions from a new pilot program that has only been in operation for 15 to 18 months. This interim evaluation provides some initial insights into the program's direction thus far, but much more will be revealed during the follow-up impact survey round scheduled for 2009–10. Additional cost comparisons and cost-benefit analyses will also be conducted next year. However, some preliminary reflections are warranted at this juncture.

Generasi piggybacked on KDP/PNPM-Rural, a community-driven development program that was already in place in Indonesia since 1998. When the government of Indonesia decided in 2007 to move from an unconditional cash transfer scheme to a conditional transfer scheme, they opted to try two different approaches, one the traditional individual household approach as proven successful in many countries of Latin America, and the other, an incentivized community block grant program, taking into consideration the success and architecture already in place under KDP. Unlike in Mexico and other countries, it was not clear that Indonesia had the administrative capacity and supply-side services to make an individual CCT program work in certain areas of the country. Thus, Generasi provides one unique example of how an established government program can be adapted to address certain education and health targets using a community approach. Building upon an already existing national program, which covered most of the poorest areas of the country, also facilitated a much faster start-up of the pilot.

Building the evaluation into the design of the program from the outset has been critical to learn lessons from the program for possible expansion in the future. To allow for a rigorous, randomized evaluation of Generasi, the government incorporated random assignment into the selection of the locations. Each location was further randomly allocated to an incentivized versus non-incentivized treatment allowing for comparison of effects. As this is a pilot program, it was important that the evaluation prove robust and provide empirical evidence as to whether the intervention was having its desired impact. Discussions from the earliest stages included evaluation in the design.

Preliminary results from the interim evaluation point to significant impacts in health. The main eight health indicators showed some improvements, but the most marked impact is on final health outcome indicators, particularly the very large reductions in neonatal and infant mortality. The evidence from this

interim survey points to community mobilization as potentially a significant factor in explaining these dramatic improvements. These activities include increasing the number of village health post cadres and enhancing participation in health education, along with shifts in health provider behaviors. Further studies and rigorous evaluations are needed to assess how Generasi compares with other child and maternal health interventions in attaining these targets.

For education, the lack of overall impact raises questions regarding Generasi's investments in this area. Several hypotheses were proposed earlier in the paper to explain the dynamics. In light of the fact that enrollment in primary education has already reached 95 percent nationally and Indonesia is experiencing significant gains on the junior secondary enrollment front (7 to 8 percent increases in both treatment and control areas), there is a risk that Generasi will be "crowded out" by other larger education expenditures. In fact, field supervision and monitoring reports were already questioning the efficacy of the targets at the primary school level. The program is currently considering the possibility of revising education indicators in Year 3 to focus more upon quality and student achievement rather than the enrollment and attendance targets as originally designed.

Community incentives have proven to be more effective for focusing impacts on the poorest quintiles and increasing providers' efforts. This finding was surprising given field reports that there was a wide range of understanding by facilitators and villagers about the scoring and incentives system during the first year. The policy implications are that poverty programs may wish to experiment more with embedding incentives into the designs. However, these findings will need to be monitored and evaluated over time. One possibility is that the conditionalities may work less well over time, as there may be more "gaming" of the system as the program progresses and the rules become more familiar. Alternatively, the program may work better over time as it continues to incentivize communities to work harder toward the specified targets.

The next round of evaluation in 2009–10—using both quantitative and qualitative methods—should reveal much more about the efficacy and effectiveness of Generasi. These interim findings provide some preliminary insight into the direction this program is heading.

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Annex

Annex I: Randomization and Implementation of Generasi in 2007

The primary reason that some (not all) 200 subdistricts received Generasi was that the 2007 supplemental budget allocation for Generasi was cut by the national parliament, so that in 2007, funding was only available for 129 Generasi subdistricts.[19] In choosing which 129 of the 200 randomly selected subdistricts should be funded, the Ministry of Home Affairs prioritized those locations that had already participated in the PNPM program, since those locations already had the legal infrastructure for distributing PNPM program funds and it was easier to re-budget other monies to fund Generasi in those areas.

The final allocation of Generasi is shown in Table 3. The 300 Generasi sample subdistricts are subdivided into two groups: the 170 subdistricts that had received the PNPM program in previous years (denoted group P, the prioritized group), and the 130 subdistricts that had not previously received the PNPM program in previous years (denoted group NP, the non-prioritized group).[20] In Group P, Generasi was funded according to the randomization results in a total of 106 subdistricts in 2007, or 92 percent of the Group P subdistricts that had been chosen according to the randomization.[21] The 2008 allocation for Group P was similar.[22] In Group NP, Generasi was funded in 23 subdistricts, or 27 percent of the Group

19 Funding for 108 subdistricts came from World Bank loans; funding for the remaining 21 subdistricts came from a grant from the Dutch government. Both funding sources were channeled through the government budget, and were implemented identically in the field.

20 The randomization results are statistically unrelated to whether a subdistrict is in Group P or Group NP. Specifically, the p-value from a Fisher exact test of the two-way relationship between the three randomization categories (incentivized, non-incentivized, control) and a group P dummy is 0.739.

21 Four categories of subdistricts were deemed ineligible for Generasi in 2007: (1) they had been identified as "problematic" PNPM subdistricts, i.e., there were allegations of improper use of PNPM funds; (2) they had been identified as eligible for the urban version of PNPM; (3) they had been identified as eligible for the SPADA (conflict areas) version of PNPM; or (4) they were the one subdistrict where a three-village Generasi pilot was being run from 2006 to 2008. Which subdistricts fell into which categories were determined based on information obtained prior to the date of the randomization, and is available for all subdistricts regardless of the results of the randomization.

22 The only difference between 2007 and 2008 in Group P is that two Group P subdistricts funded in 2007 were identified as "problematic" and were dropped from 2008, and one subdistrict that had previously been identified as "problematic" resolved its financial problems and was allowed to resume.

NP subdistricts that had been chosen according to the randomization. Of these 23 subdistricts, 21 were chosen randomly by computer, stratified by province, in a second lottery among Group NP locations; the remaining 2 subdistricts were chosen by the ministry. In 2008, additional funding became available, and a total of 71 (84 percent) of the 85 Group NP subdistricts randomly selected for Generasi received the program.

Table 3. Generasi implementation and randomization results

	Randomization results						Total
	Incentivized *Generasi*		Non-incentivized *Generasi*		Control		
	P	NP	P	NP	P	NP	
Total subdistricts	60	40	55	45	55	45	300
Received *Generasi* in:							
2007	57	11	49	12	0	0	129
2008	55	35	50	36	0	0	176

Since the share of subdistricts randomly selected to Generasi that were subsequently funded is much higher in Group P, and since Group P/NP status is predetermined with respect to the randomization (it depends only on whether a subdistrict had received the PNPM program in previous years), we can improve the statistical power beyond intent-to-treat estimates by incorporating this information into the analysis.

Table 4. Baseline regressions, 12 main indicators *

		Model 1		Model 2		
Indicator	Control mean	Total Generasi Year 1 Effect	Versi A additional effect	Total Versi B impact	Total Versi A impact	Number observations
	(1)	(2)	(3)	(4)	(5)	(6)
Number prenatal visits	7.808	-0.255	-0.198	-0.159	-0.356	3708
	(0.130)	(0.229)	(0.257)	(0.262)	(0.262)	
Delivery by trained midwife	0.691	-0.020	0.003	-0.022	-0.018	2810
	(0.016)	(0.025)	(0.031)	(0.030)	(0.029)	
Number of postnatal visits	3.012	0.073	-0.189	0.166	-0.023	2810
	(0.111)	(0.176)	(0.198)	(0.209)	(0.195)	
Iron tablet sachets	1.591	-0.048	-0.051	-0.023	-0.074	3676
	(0.038)	(0.064)	(0.072)	(0.076)	(0.070)	
Percent of immunization	0.680	-0.0378**	-0.002	-0.0369*	-0.0387*	3316
	(0.011)	(0.019)	(0.023)	(0.022)	(0.021)	
Number of weight checks	2.140	-0.066	-0.046	-0.042	-0.089	4045
	(0.033)	(0.056)	(0.064)	(0.068)	(0.060)	
Number Vitamin A supplements	1.521	0.028	0.1303**	-0.036	0.094	2284
	(0.044)	(0.053)	(0.065)	(0.062)	(0.061)	
Percent malnourished	0.173	0.015	0.015	0.007	0.022	3977
	(0.011)	(0.013)	(0.016)	(0.015)	(0.016)	
SD age gross enrollment	0.950	0.000	0.012	-0.006	0.006	5137
	(0.005)	(0.007)	(0.008)	(0.008)	(0.009)	
SMP age gross enrollment	0.825	0.009	0.017	0.001	0.017	1754
	(0.016)	(0.023)	(0.027)	(0.027)	(0.027)	
SD age gross attendance	0.910	-0.016	0.022	-0.0280**	-0.006	4397
	(0.007)	(0.012)	(0.016)	(0.014)	(0.014)	
SMP age gross attendance	0.752	0.020	0.032	0.004	0.037	1511
	(0.019)	(0.027)	(0.033)	(0.032)	(0.031)	
Average standardized effect		-0.023	0.013	-0.030	-0.016	
		(0.020)	(0.023)	(0.024)	(0.023)	
Average standardized effect health		-0.036	-0.013	-0.030	-0.0426*	
		(0.023)	(0.026)	(0.028)	(0.024)	
Average standardized effect education		0.004	0.065	-0.029	0.036	
		(0.042)	(0.048)	(0.049)	(0.047)	

*Note that these are in the baseline, so we predict no effect.

Table 5. Baseline regressions, long-term final outcomes

		Model 1		Model 2		
Indicator	Control mean	Total Generasi Year 1 Effect	Versi A additional effect	Total Versi B impact	Total Versi A impact	Number observations
	(1)	(2)	(3)	(4)	(5)	(6)
Mortality 0-28 days	0.014	-0.003	-0.008	0.001	-0.007	2847
(births in past 18 months)	(0.004)	(0.005)	(0.006)	(0.005)	(0.006)	
Mortality 0-11 months	0.024	-0.0088*	-0.010	-0.004	-0.0137**	3508
(of births in past 24 months)	(0.005)	(0.005)	(0.006)	(0.006)	(0.006)	
Diarrhea or ARI	0.348	-0.013	-0.025	0.000	-0.025	4083
	(0.013)	(0.017)	(0.022)	(0.021)	(0.019)	
Malnourished	0.173	0.015	0.015	0.007	0.022	3977
(< -2 SD deviations)	(0.011)	(0.013)	(0.016)	(0.015)	(0.016)	
Severe malnourished	0.046	0.009	-0.009	0.014	0.004	3977
(< -3 SD deviations)	(0.006)	(0.009)	(0.010)	(0.011)	(0.010)	
Average standardized effect health		0.007	0.039	-0.012	0.027	
		(0.021)	(0.027)	(0.026)	(0.025)	
Average standardized effect health excluding mortality		-0.018	0.019	-0.027	-0.005	
		(0.027)	(0.033)	(0.033)	(0.019)	

Note: average standardized effect rows are always defined so that positive is an improvement (i.e., lower mortality, lower malnourishment)

Table 6. Results for main indicators, all provinces (baseline as control variable)

			Model 1		Model 2		
Indicator	Baseline mean	Control mean	Total Generasi Year 1 Effect	Versi A additional effect	Total Versi B impact	Total Versi A impact	Number observations
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Main 12 indicators							
Number prenatal visits	7.647	7.510	-0.006	0.6080***	-0.311	0.297	3837
	(0.072)	(0.141)	(0.189)	(0.224)	(0.201)	(0.236)	
Delivery by trained midwife	0.670	0.755	0.035	-0.004	0.037	0.033	2761
	(0.009)	(0.017)	(0.023)	(0.025)	(0.026)	(0.026)	
Number of postnatal visits	3.036	2.831	-0.047	0.3807*	-0.248	0.133	2761
	(0.064)	(0.129)	(0.148)	(0.214)	(0.170)	(0.193)	
Iron tablet sachets	1.588	1.977	0.091	0.080	0.051	0.131	3788
	(0.021)	(0.049)	(0.071)	(0.081)	(0.080)	(0.084)	
Percent of immunization	0.653	0.693	0.016	0.017	0.008	0.024	3521
	(0.006)	(0.013)	(0.015)	(0.018)	(0.017)	(0.018)	
Number of weight checks	2.126	2.192	0.1109***	0.0992*	0.062	0.1607***	4804
	(0.019)	(0.040)	(0.043)	(0.053)	(0.049)	(0.052)	
Number Vitamin A supplements	1.529	1.560	-0.002	-0.012	0.004	-0.008	2758
	(0.024)	(0.044)	(0.044)	(0.058)	(0.053)	(0.052)	
Percent malnourished	0.168	0.199	-0.004	-0.026	0.009	-0.016	4749
	(0.006)	(0.014)	(0.013)	(0.016)	(0.015)	(0.016)	
Age 7–12 gross enrollment	0.948	0.982	0.002	-0.004	0.003	0.000	4962
	(0.003)	(0.005)	(0.005)	(0.006)	(0.006)	(0.005)	
Age 13–15 gross enrollment	0.822	0.906	-0.0408**	0.015	-0.0479**	-0.0333*	1856
	(0.009)	(0.019)	(0.018)	(0.024)	(0.022)	(0.020)	
Age 7–12 gross attendance	0.904	0.956	0.001	0.000	0.001	0.001	4952
	(0.004)	(0.006)	(0.005)	(0.006)	(0.005)	(0.005)	
Age 13–15 gross attendance	0.768	0.884	-0.0516***	0.023	-0.0629***	-0.0396*	1853
Additional Education Indicators	(0.011)	(0.019)	(0.018)	(0.025)	(0.023)	(0.021)	
Age 13–15 conditional attendance	0.958	0.976	-0.0122**	0.005	-0.0149**	-0.010	1624
	(0.005)	(0.007)	(0.005)	(0.007)	(0.006)	(0.006)	
Age 13–15 enrolled in SMP	0.593	0.672	-0.013	0.040	-0.033	0.007	1856
	(0.012)	(0.030)	(0.027)	(0.031)	(0.034)	(0.029)	
Age 7–12 enrolled in SD	0.886	0.905	0.001	-0.004	0.003	-0.001	4962

			Model 1		Model 2		
Indicator	Baseline mean	Control mean	Total Generasi Year 1 Effect	Versi A additional effect	Total Versi B impact	Total Versi A impact	Number observations
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
	(0.004)	(0.011)	(0.008)	(0.010)	(0.010)	(0.010)	
Age 13–15 enrolled other than SMP	0.229	0.234	-0.029	-0.026	-0.016	-0.043	1856
	(0.010)	(0.027)	(0.025)	(0.029)	(0.029)	(0.030)	
Kecamatan SD gross enrollment	0.934	0.943	-0.006	-0.012	0.000	-0.012	263
	(0.007)	(0.017)	(0.014)	(0.016)	(0.016)	(0.017)	
Kecamatan SMP gross enrollment	0.861	0.997	-0.064	0.072	-0.0994*	-0.028	262
	(0.029)	(0.077)	(0.055)	(0.062)	(0.059)	(0.067)	
Average standardized effect			-0.002	0.0493**	-0.027	0.023	
			(0.018)	(0.022)	(0.021)	(0.021)	
Average standardized effect health			0.0344*	0.0614***	0.003	0.0646***	
			(0.019)	(0.022)	(0.022)	(0.022)	
Average standardized effect education			-0.0742**	0.025	-0.0863**	-0.061	
			(0.035)	(0.045)	(0.044)	(0.039)	

Table 7. Results for main indicators, all provinces (robustness to alternative specifications)

Indicator	Baseline mean	Control mean	Main specification	Baseline controls for all 12 indicators	Baseline controls for kecamatan averages only (no individual panel)	No controls	First differences	Kecamatan level regression, with baseline control	Full Intent-to-treat on 300 kecamatan, controlling for kecamatan avg
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
Number prenatal visits	7.647	7.510	-0.006	0.038	-0.007	-0.064	0.158	0.026	-0.057
	(0.072)	(0.141)	(0.189)	(0.192)	(0.190)	(0.203)	(0.247)	(0.207)	(0.166)
Delivery by trained midwife	0.670	0.755	0.035	0.0483**	0.037	0.019	0.0573**	0.048**	-0.015
	(0.009)	(0.017)	(0.023)	(0.021)	(0.023)	(0.024)	(0.028)	(0.024)	(0.020)
Number of postnatal visits	3.036	2.831	-0.047	-0.035	-0.040	-0.032	-0.155	-0.074	0.136
	(0.064)	(0.129)	(0.148)	(0.158)	(0.148)	(0.147)	(0.224)	(0.158)	(0.137)
Iron tablet sachets	1.588	1.977	0.091	0.113	0.092	0.079	0.131	0.090	0.102*
	(0.021)	(0.049)	(0.071)	(0.071)	(0.071)	(0.070)	(0.089)	(0.072)	(0.056)
Percent of immunization	0.653	0.693	0.016	0.016	0.016	0.006	0.0488**	0.021	0.021
	(0.006)	(0.013)	(0.015)	(0.015)	(0.015)	(0.017)	(0.021)	(0.017)	(0.013)
Number of weight checks	2.126	2.192	0.1109***	0.1127**	0.1094**	0.0899**	0.1719***	0.111**	0.075*
	(0.019)	(0.040)	(0.043)	(0.045)	(0.043)	(0.044)	(0.060)	(0.048)	(0.041)
Number Vitamin A supplements	1.529	1.560	-0.002	0.008	-0.001	0.015	-0.019	0.019	0.012
	(0.024)	(0.044)	(0.044)	(0.041)	(0.045)	(0.048)	(0.065)	(0.051)	(0.042)
Percent malnourished	0.168	0.199	-0.004	-0.006	-0.006	-0.004	-0.010	-0.005	0.000
	(0.006)	(0.014)	(0.013)	(0.013)	(0.013)	(0.013)	(0.020)	(0.014)	(0.012)
SD age gross enrollment	0.948	0.982	0.002	0.002	0.002	0.002	0.000	0.001	0.000
	(0.003)	(0.005)	(0.005)	(0.005)	(0.005)	(0.005)	(0.008)	(0.004)	(0.004)
SMP age gross enrollment	0.822	0.906	-0.0408**	-0.0332*	-0.0452**	-0.0485**	-0.0594**	-0.050***	-0.046***
	(0.009)	(0.019)	(0.018)	(0.018)	(0.019)	(0.019)	(0.027)	(0.019)	(0.014)
SD age gross attendance	0.904	0.956	0.001	0.002	0.002	0.000	0.0402**	0.001	-0.004
	(0.004)	(0.006)	(0.005)	(0.005)	(0.005)	(0.005)	(0.017)	(0.005)	(0.004)
SMP age gross attendance	0.768	0.884	-0.0516***	-0.0467**	-0.0535***	-0.0573***	-0.0687**	-0.059***	-0.048***
	(0.011)	(0.019)	(0.018)	(0.019)	(0.019)	(0.019)	(0.033)	(0.019)	(0.015)
Average standardized effect			-0.002	0.007	-0.002	-0.013	0.024		
			(0.018)	(0.018)	(0.019)	(0.020)	(0.023)		
Average standardized effect health			0.0344*	0.0448**	0.0357*	0.024	0.0614***		
			(0.019)	(0.020)	(0.019)	(0.022)	(0.021)		
Average standardized effect education			-0.0742**	-0.0677*	-0.0777**	-0.0861**	-0.051		
			(0.035)	(0.039)	(0.037)	(0.038)	(0.055)		

Table 8. Results for main indicators, Java (baseline as control variable)

			Model 1		Model 2		
Indicator	Baseline mean	Control mean	Total Generasi Year 1 Effect	Versi A additional effect	Total Versi B impact	Total Versi A impact	Number observations
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Main 12 indicators							
Number prenatal visits	8.080	7.982	0.221	0.381	0.025	0.406	2534
	(0.081)	(0.171)	(0.225)	(0.250)	(0.241)	(0.269)	
Delivery by trained midwife	0.764	0.843	0.0504**	-0.0588**	0.0821***	0.023	1787
	(0.010)	(0.019)	(0.025)	(0.029)	(0.030)	(0.028)	
Number of postnatal visits	3.605	3.587	-0.059	0.275	-0.207	0.068	1787
	(0.081)	(0.172)	(0.207)	(0.308)	(0.241)	(0.272)	
Iron tablet sachets	1.639	2.071	0.131	-0.057	0.161	0.104	2504
	(0.025)	(0.061)	(0.100)	(0.107)	(0.110)	(0.115)	
Percent of immunization	0.701	0.736	-0.006	0.012	-0.012	-0.001	2280
	(0.007)	(0.014)	(0.016)	(0.023)	(0.022)	(0.018)	
Number of weight checks	2.213	2.377	0.074	0.092	0.027	0.1189*	3062
	(0.023)	(0.047)	(0.055)	(0.065)	(0.067)	(0.061)	
Number Vitamin A supplements	1.488	1.444	0.046	0.060	0.014	0.074	1809
	(0.028)	(0.053)	(0.054)	(0.071)	(0.070)	(0.059)	
Percent malnourished	0.126	0.118	0.008	0.000	0.008	0.007	3027
	(0.007)	(0.015)	(0.015)	(0.018)	(0.017)	(0.018)	
Age 7–12 gross enrollment	0.959	0.993	-0.001	-0.005	0.002	-0.003	2991
	(0.004)	(0.004)	(0.004)	(0.006)	(0.005)	(0.005)	
Age 13–15 gross enrollment	0.833	0.943	-0.024	-0.019	-0.014	-0.033	1173
	(0.011)	(0.020)	(0.023)	(0.031)	(0.030)	(0.026)	
Age 7–12 gross attendance	0.914	0.969	0.001	-0.006	0.004	-0.002	2983
	(0.005)	(0.006)	(0.005)	(0.006)	(0.006)	(0.006)	
Age 13–15 gross attendance	0.783	0.926	-0.032	-0.017	-0.023	-0.040	1170
Additional Education Indicators	(0.013)	(0.021)	(0.023)	(0.033)	(0.030)	(0.027)	
Age 13–15 conditional attendance	0.960	0.982	-0.0105*	-0.003	-0.009	-0.012	1037
	(0.006)	(0.008)	(0.006)	(0.010)	(0.008)	(0.007)	
Age 13–15 enrolled in SMP	0.666	0.743	-0.013	-0.008	-0.009	-0.017	1173
	(0.014)	(0.037)	(0.035)	(0.042)	(0.048)	(0.033)	

			Model 1		Model 2		
Indicator	Baseline mean	Control mean	Total Generasi Year 1 Effect	Versi A additional effect	Total Versi B impact	Total Versi A impact	Number observations
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Age 7–12 enrolled in SD	0.882	0.894	-0.005	-0.003	-0.004	-0.007	2991
	(0.006)	(0.015)	(0.010)	(0.012)	(0.013)	(0.011)	
Age 13–15 enrolled other than SMP	0.167	0.200	-0.013	-0.012	-0.007	-0.018	1173
	(0.011)	(0.034)	(0.032)	(0.041)	(0.037)	(0.040)	
Kecamatan SD gross enrollment	0.913	0.920	-0.002	-0.011	0.004	-0.008	178
	(0.008)	(0.019)	(0.017)	(0.019)	(0.021)	(0.019)	
Kecamatan SMP gross enrollment	0.982	1.115	-0.069	-0.013	-0.062	-0.075	177
	(0.035)	(0.107)	(0.070)	(0.081)	(0.074)	(0.087)	
Average standardized effect			0.010	-0.007	0.013	0.006	
			(0.024)	(0.032)	(0.030)	(0.027)	
Average standardized effect health			0.0421*	0.021	0.031	0.0523*	
			(0.024)	(0.027)	(0.029)	(0.027)	
Average standardized effect education			-0.056	-0.063	-0.023	-0.086	
			(0.052)	(0.071)	(0.066)	(0.060)	

Table 9. Results for main indicators, East Nusa Tenggara (baseline as control variable)

			Model 1		Model 2		
Indicator	Baseline mean	Control mean	Total Generasi Year 1 Effect	Versi A additional effect	Total Versi B impact	Total Versi A impact	Number observations
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Main 12 indicators							
Number prenatal visits	6.822	7.012	-0.7708*	0.6762*	-1.1168**	-0.441	810
	(0.170)	(0.323)	(0.410)	(0.389)	(0.459)	(0.452)	
Delivery by trained midwife	0.427	0.659	-0.054	0.084	-0.100	-0.016	600
	(0.021)	(0.042)	(0.061)	(0.059)	(0.067)	(0.069)	
Number of postnatal visits	1.444	1.357	-0.074	0.6271**	-0.388	0.239	600
	(0.092)	(0.196)	(0.251)	(0.300)	(0.252)	(0.346)	
Iron tablet sachets	1.589	1.976	0.039	0.2489*	-0.090	0.159	798
	(0.048)	(0.117)	(0.115)	(0.134)	(0.137)	(0.128)	
Percent of immunization	0.549	0.586	0.044	-0.009	0.049	0.040	763
	(0.015)	(0.033)	(0.030)	(0.036)	(0.029)	(0.040)	
Number of weight checks	2.237	2.347	0.109	0.068	0.077	0.145	1091
	(0.037)	(0.082)	(0.080)	(0.100)	(0.098)	(0.090)	
Number Vitamin A supplements	1.586	1.736	-0.1735*	-0.138	-0.103	-0.2407**	571
	(0.053)	(0.084)	(0.093)	(0.090)	(0.102)	(0.108)	
Percent malnourished	0.247	0.353	-0.028	-0.0708**	0.008	-0.0623*	1077
	(0.014)	(0.035)	(0.032)	(0.031)	(0.033)	(0.035)	
Age 7–12 gross enrollment	0.929	0.952	0.015	0.004	0.013	0.018	1291
	(0.007)	(0.017)	(0.011)	(0.012)	(0.013)	(0.012)	
Age 13–15 gross enrollment	0.810	0.893	-0.053	-0.019	-0.044	-0.063	410
	(0.020)	(0.042)	(0.033)	(0.036)	(0.035)	(0.040)	
Age 7–12 gross attendance	0.892	0.931	0.0165*	0.013	0.010	0.0230**	1290
	(0.009)	(0.018)	(0.010)	(0.011)	(0.012)	(0.011)	
Age 13–15 gross attendance	0.746	0.860	-0.0618*	-0.012	-0.057	-0.0683*	410
Additional Education Indicators	(0.024)	(0.044)	(0.032)	(0.038)	(0.037)	(0.037)	
Age 13–15 conditional attendance	0.949	0.963	-0.006	-0.001	-0.006	-0.006	358
	(0.013)	(0.020)	(0.011)	(0.014)	(0.010)	(0.015)	
Age 13–15 enrolled in SMP	0.431	0.589	0.023	0.064	-0.007	0.057	410
	(0.026)	(0.066)	(0.057)	(0.050)	(0.061)	(0.063)	
Age 7–12 enrolled in SD	0.907	0.917	0.023	0.003	0.022	0.024	1291

			Model 1		Model 2		
Indicator	Baseline mean	Control mean	Total Generasi Year 1 Effect	Versi A additional effect	Total Versi B impact	Total Versi A impact	Number observations
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
	(0.008)	(0.021)	(0.015)	(0.019)	(0.017)	(0.019)	
Age 13–15 enrolled other than SMP	0.380	0.304	-0.0838*	-0.065	-0.050	-0.1146**	410
	(0.025)	(0.062)	(0.045)	(0.048)	(0.054)	(0.048)	
Kecamatan SD gross enrollment	1.007	1.008	-0.018	0.005	-0.021	-0.016	51
	(0.015)	(0.052)	(0.037)	(0.035)	(0.038)	(0.046)	
Kecamatan SMP gross enrollment	0.549	0.761	-0.004	0.141	-0.070	0.070	51
	(0.039)	(0.116)	(0.116)	(0.111)	(0.118)	(0.136)	
Average standardized effect			-0.033	0.0665*	-0.0673*	-0.001	
			(0.035)	(0.039)	(0.037)	(0.045)	
Average standardized effect health			-0.025	0.1011**	-0.0770*	0.024	
			(0.040)	(0.042)	(0.045)	(0.046)	
Average standardized effect education			-0.048	-0.003	-0.048	-0.050	
			(0.054)	(0.063)	(0.058)	(0.067)	

Table 10. Results for main indicators, Sulawesi /Gorontalo (baseline as control variable)

			Model 1		Model 2		
Indicator	Baseline mean	Control mean	Total Generasi Year 1 Effect	Versi A additional effect	Total Versi B impact	Total Versi A impact	Number observations
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Main 12 indicators							
Number prenatal visits	6.607	6.288	0.161	1.390	-0.456	0.934	493
	(0.242)	(0.360)	(0.535)	(0.927)	(0.531)	(0.864)	
Delivery by trained midwife	0.559	0.585	0.1174**	0.073	0.0849*	0.1577***	374
	(0.027)	(0.046)	(0.048)	(0.047)	(0.050)	(0.056)	
Number of postnatal visits	2.586	2.076	0.163	0.652	-0.109	0.543	374
	(0.188)	(0.288)	(0.432)	(0.610)	(0.493)	(0.533)	
Iron tablet sachets	1.317	1.621	-0.037	0.3744*	-0.206	0.169	486
	(0.054)	(0.115)	(0.151)	(0.193)	(0.146)	(0.202)	
Percent of immunization	0.577	0.674	0.073	0.080	0.035	0.1148*	478
	(0.018)	(0.031)	(0.053)	(0.058)	(0.051)	(0.066)	
Number of weight checks	1.534	1.451	0.224	0.261	0.108	0.3687*	651
	(0.056)	(0.099)	(0.133)	(0.190)	(0.094)	(0.205)	
Number Vitamin A supplements	1.635	1.723	-0.016	-0.151	0.041	-0.110	378
	(0.073)	(0.118)	(0.100)	(0.202)	(0.113)	(0.167)	
Percent malnourished	0.234	0.268	-0.008	-0.055	0.017	-0.038	645
	(0.019)	(0.035)	(0.034)	(0.059)	(0.034)	(0.054)	
Age 7–12 gross enrollment	0.935	0.986	-0.008	-0.007	-0.005	-0.012	680
	(0.010)	(0.010)	(0.013)	(0.022)	(0.014)	(0.020)	
Age 13–15 gross enrollment	0.793	0.813	-0.071	0.1975***	-0.1358***	0.062	273
	(0.024)	(0.057)	(0.044)	(0.055)	(0.042)	(0.047)	
Age 7–12 gross attendance	0.882	0.949	-0.022	-0.006	-0.019	-0.025	679
	(0.012)	(0.012)	(0.013)	(0.024)	(0.015)	(0.021)	
Age 13–15 gross attendance	0.741	0.788	-0.0950*	0.2237***	-0.1698***	0.054	273
Additional Education Indicators	(0.027)	(0.057)	(0.048)	(0.055)	(0.045)	(0.047)	
Age 13–15 conditional attendance	0.958	0.970	-0.0284*	0.035	-0.0425**	-0.008	229
	(0.012)	(0.016)	(0.015)	(0.024)	(0.018)	(0.018)	
Age 13–15 enrolled in SMP	0.524	0.563	-0.061	0.2113**	-0.1337**	0.078	273
	(0.030)	(0.072)	(0.069)	(0.079)	(0.063)	(0.097)	

			Model 1		Model 2		
Indicator	Baseline mean	Control mean	Total Generasi Year 1 Effect	Versi A additional effect	Total Versi B impact	Total Versi A impact	Number observations
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Age 7–12 enrolled in SD	0.861	0.924	-0.024	-0.022	-0.014	-0.036	680
	(0.013)	(0.022)	(0.024)	(0.033)	(0.026)	(0.034)	
Age 13–15 enrolled other than SMP	0.269	0.250	-0.008	-0.010	-0.005	-0.015	273
	(0.026)	(0.063)	(0.074)	(0.063)	(0.083)	(0.074)	
Kecamatan SD gross enrollment	0.904	0.961	-0.003	-0.050	0.020	-0.031	34
	(0.022)	(0.028)	(0.036)	(0.043)	(0.041)	(0.041)	
Kecamatan SMP gross enrollment	0.819	0.855	-0.099	0.3916**	-0.2982*	0.093	34
	(0.068)	(0.149)	(0.155)	(0.161)	(0.173)	(0.164)	
Average standardized effect			0.005	0.2012***	-0.0746*	0.1266**	
			(0.045)	(0.059)	(0.042)	(0.054)	
Average standardized effect health			0.0838*	0.1665**	0.008	0.1746***	
			(0.048)	(0.067)	(0.047)	(0.061)	
Average standardized effect education			-0.1528**	0.2708***	-0.2402***	0.031	
			(0.072)	(0.091)	(0.080)	(0.062)	

Table 11. Results for final outcomes, all provinces (baseline as control variable)

			Model 1		Model 2		
Indicator	Baseline mean	Control mean	Total Generasi Year 1 Effect	Versi A additional effect	Total Versi B impact	Total Versi A impact	Number observations
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Mortality 0–28 days	0.013	0.011	-0.0052*	-0.001	-0.005	-0.0056*	2765
(births in past 18 months)	(0.002)	(0.004)	(0.003)	(0.003)	(0.003)	(0.003)	
Mortality 0–12 months	0.024	0.027	-0.0076**	0.001	-0.0080*	-0.0072*	3788
(births in past 24 months)	(0.003)	(0.006)	(0.004)	(0.004)	(0.004)	(0.004)	
Mortality 0–12 months	0.028	0.041	-0.0099*	-0.005	-0.008	-0.0121**	2002
(births in past 12-24 months)	(0.004)	(0.011)	(0.005)	(0.007)	(0.007)	(0.006)	
Diarrhea or ARI	0.355	0.327	-0.009	-0.036	0.009	-0.028	4804
	(0.008)	(0.016)	(0.018)	(0.024)	(0.020)	(0.023)	
Malnourished	0.168	0.199	-0.004	-0.026	0.009	-0.016	4749
(< -2 SD deviations)	(0.006)	(0.014)	(0.013)	(0.016)	(0.015)	(0.016)	
Severe malnourished	0.047	0.057	-0.006	-0.002	-0.005	-0.008	4749
(< -3 SD deviations)	(0.003)	(0.008)	(0.007)	(0.009)	(0.008)	(0.009)	
Average standardized effect health			0.0342**	0.030	0.019	0.0494**	
			(0.017)	(0.021)	(0.019)	(0.021)	
Average standardized effect health excluding mortality			0.019	0.0496*	-0.006	0.043	
			(0.023)	(0.029)	(0.025)	(0.029)	

Note: average standardized effect rows are always defined so that positive is an improvement (i.e., lower mortality, lower malnourishment)

Table 12. Results for final outcomes, Java (baseline as control variable)

			Model 1		Model 2		
Indicator	Baseline mean	Control mean	Total Generasi Year 1 Effect	Versi A additional effect	Total Versi B impact	Total Versi A impact	Number observations
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Mortality 0–28 days	0.012	0.008	-0.001	-0.003	0.000	-0.003	1775
(births in past 18 months)	(0.003)	(0.005)	(0.003)	(0.004)	(0.004)	(0.004)	
Mortality 0–12 months	0.019	0.013	-0.002	-0.0079*	0.002	-0.0058*	2431
(births in past 24 months)	(0.003)	(0.005)	(0.004)	(0.004)	(0.005)	(0.003)	
Mortality 0–12 months	0.023	0.019	-0.003	-0.0129*	0.004	-0.0092**	1321
(births in past 12–24 months)	(0.005)	(0.010)	(0.005)	(0.007)	(0.008)	(0.005)	
Diarrhea or ARI	0.330	0.307	-0.015	-0.043	0.007	-0.036	3063
	(0.009)	(0.021)	(0.024)	(0.032)	(0.026)	(0.032)	
Malnourished	0.126	0.118	0.008	0.000	0.008	0.007	3027
(< -2 SD deviations)	(0.007)	(0.015)	(0.015)	(0.018)	(0.017)	(0.018)	
Severe malnourished	0.029	0.026	0.003	0.000	0.003	0.003	3027
(< -3 SD deviations)	(0.003)	(0.007)	(0.007)	(0.009)	(0.009)	(0.008)	
Average standardized effect health			0.007	0.045	-0.017	0.028	
			(0.024)	(0.030)	(0.030)	(0.028)	
Average standardized effect health excluding mortality			-0.003	0.031	-0.019	0.013	
			(0.034)	(0.040)	(0.039)	(0.040)	

Note: average standardized effect rows are always defined so that positive is an improvement (i.e., lower mortality, lower malnourishment)

Table 13. Results for final outcomes, East Nusa Tenggara (baseline as control variable)

			Model 1		Model 2		
Indicator	Baseline mean	Control mean	Total Generasi Year 1 Effect	Versi A additional effect	Total Versi B impact	Total Versi A impact	Number observations
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Mortality 0–28 days	0.016	0.022	-0.0143**	0.001	-0.0146**	-0.0141**	607
(births in past 18 months)	(0.005)	(0.013)	(0.007)	(0.003)	(0.007)	(0.007)	
Mortality 0–12 months	0.029	0.035	-0.006	0.0165*	-0.0145*	0.002	826
(births in past 24 months)	(0.006)	(0.014)	(0.009)	(0.009)	(0.008)	(0.011)	
Mortality 0–12 months	0.027	0.069	-0.018	0.011	-0.023	-0.013	390
(births in past 12-24 months)	(0.009)	(0.030)	(0.015)	(0.016)	(0.017)	(0.018)	
Diarrhea or ARI	0.357	0.258	0.014	-0.058	0.039	-0.018	1090
	(0.016)	(0.032)	(0.038)	(0.046)	(0.044)	(0.044)	
Malnourished	0.247	0.353	-0.028	-0.0708**	0.008	-0.0623*	1077
(< -2 SD deviations)	(0.014)	(0.035)	(0.032)	(0.031)	(0.033)	(0.035)	
Severe malnourished	0.086	0.091	-0.005	-0.013	0.002	-0.011	1077
(< -3 SD deviations)	(0.009)	(0.021)	(0.018)	(0.023)	(0.021)	(0.021)	
Average standardized effect health			0.038	0.041	0.019	0.0607*	
			(0.029)	(0.032)	(0.029)	(0.035)	
Average standardized effect health excluding mortality			0.013	0.1065**	-0.038	0.069	
			(0.038)	(0.052)	(0.039)	(0.046)	

Note: average standardized effect rows are always defined so that positive is an improvement (i.e., lower mortality, lower malnourishment)

Table 14. Results for final outcomes, Sulawesi /Gorontalo (baseline as control variable)

			Model 1		Model 2		
Indicator	Baseline mean	Control mean	Total Generasi Year 1 Effect	Versi A additional effect	Total Versi B impact	Total Versi A impact	Number observations
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Mortality 0–28 days	0.010	0.008	-0.004	0.008	-0.007	0.001	383
(births in past 18 months)	(0.005)	(0.008)	(0.007)	(0.012)	(0.006)	(0.013)	
Mortality 0–12 months	0.039	0.059	-0.0417***	-0.007	-0.0391***	-0.0458***	531
(births in past 24 months)	(0.009)	(0.018)	(0.009)	(0.017)	(0.010)	(0.015)	
Mortality 0–12 months	0.048	0.071	-0.0470***	-0.016	-0.0396**	-0.0551**	291
(births in past 12–24 months)	(0.014)	(0.028)	(0.014)	(0.024)	(0.016)	(0.021)	
Diarrhea or ARI	0.474	0.470	-0.036	0.023	-0.046	-0.023	651
	(0.021)	(0.039)	(0.040)	(0.066)	(0.036)	(0.066)	
Malnourished	0.234	0.268	-0.008	-0.055	0.017	-0.038	645
(< -2 SD deviations)	(0.019)	(0.035)	(0.034)	(0.059)	(0.034)	(0.054)	
Severe malnourished	0.064	0.110	-0.0361*	0.012	-0.0413**	-0.030	645
(< -3 SD deviations)	(0.011)	(0.025)	(0.021)	(0.031)	(0.020)	(0.033)	
Average standardized effect health			0.0933*	-0.007	0.0964**	0.090	
			(0.046)	(0.076)	(0.038)	(0.078)	
Average standardized effect health excluding mortality			0.068	0.013	0.061	0.075	
			(0.055)	(0.098)	(0.045)	(0.098)	

Note: average standardized effect rows are always defined so that positive is an improvement (i.e., lower mortality, lower malnourishment)

Table 15. Results for non-targeted outcomes, all provinces (baseline as control variable)

			Model 1		Model 2		
Indicator	Baseline mean	Control mean	Total Generasi Year 1 Effect	Versi A additional effect	Total Versi B impact	Total Versi A impact	Number observations
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Quality of prenatal care services	0.546	0.577	0.010	0.017	0.002	0.019	3836
	(0.004)	(0.008)	(0.010)	(0.013)	(0.013)	(0.012)	
Facility-based vs. home deliveries	0.397	0.441	0.031	0.022	0.019	0.0415*	2761
	(0.009)	(0.020)	(0.020)	(0.026)	(0.023)	(0.025)	
Use of family planning	0.528	0.532	-0.001	0.017	-0.010	0.007	8305
	(0.006)	(0.014)	(0.014)	(0.014)	(0.014)	(0.016)	
Use of health services curative care	.	0.587	-0.004	-0.008	0.000	-0.009	7521
	(.)	(0.013)	(0.016)	(0.018)	(0.019)	(0.018)	
Quality of posyandu	.	0.330	0.0595***	-0.019	0.0694***	0.0500*	4112
	(.)	(0.018)	(0.022)	(0.027)	(0.025)	(0.026)	
Age 7–15 hours wage work	0.431	0.156	0.2053**	-0.3841***	0.3959***	0.012	6810
	(0.047)	(0.048)	(0.099)	(0.125)	(0.141)	(0.078)	
Age 7–15 hours household work	3.915	3.287	0.6525***	-0.4941*	0.8975***	0.4034*	6809
	(0.081)	(0.181)	(0.220)	(0.286)	(0.285)	(0.226)	
Age 7–15 wage work dummy	0.031	0.021	0.007	-0.0144**	0.0145**	0.000	6810
	(0.002)	(0.005)	(0.005)	(0.006)	(0.007)	(0.005)	
Age 7–15 household work dummy	0.728	0.673	0.008	0.010	0.004	0.013	6809
	(0.005)	(0.015)	(0.013)	(0.018)	(0.016)	(0.016)	
Gross high school enrollment	.	0.383	-0.027	-0.011	-0.022	-0.032	1479
	(.)	(0.033)	(0.037)	(0.045)	(0.043)	(0.044)	
Dropout rates	0.026	0.011	0.0066*	-0.001	0.007	0.006	6630
	(0.002)	(0.003)	(0.004)	(0.005)	(0.005)	(0.004)	
SD to SMP transition	0.885	0.976	-0.005	-0.008	0.000	-0.009	641
	(0.013)	(0.017)	(0.011)	(0.013)	(0.010)	(0.014)	
SD to SMP transition alt. def.	0.869	0.954	0.003	0.013	-0.004	0.009	645
	(0.014)	(0.023)	(0.014)	(0.018)	(0.016)	(0.017)	
Number of hours attended school	17.112	25.882	-0.6629**	0.146	-0.7355*	-0.5900*	6795
	(0.166)	(0.257)	(0.308)	(0.439)	(0.411)	(0.342)	
Initiation of breastfeeding	0.575	0.632	0.013	0.018	0.004	0.022	4798
	(0.008)	(0.017)	(0.019)	(0.023)	(0.022)	(0.023)	

			Model 1		Model 2		
Indicator	Baseline mean	Control mean	Total Generasi Year 1 Effect	Versi A additional effect	Total Versi B impact	Total Versi A impact	Number observations
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Exclusive breastfeeding	0.472	0.401	0.016	-0.007	0.020	0.012	4806
	(0.008)	(0.017)	(0.021)	(0.026)	(0.025)	(0.024)	
Mother's knowledge	.	0.602	0.006	-0.005	0.008	0.004	4558
	(.)	(0.007)	(0.007)	(0.010)	(0.009)	(0.009)	
Fertility rate	0.344	0.326	-0.010	0.017	-0.018	-0.002	8325
	(0.005)	(0.013)	(0.010)	(0.012)	(0.011)	(0.012)	
Numbers hrs. school (enroll only)	18.401	26.776	-0.5215**	0.208	-0.6260**	-0.418	6493
	(0.167)	(0.212)	(0.235)	(0.336)	(0.308)	(0.269)	
Average standardized effect			-0.011	0.021	-0.022	-0.001	
			(0.016)	(0.021)	(0.020)	(0.019)	
Average standardized effect health			0.0317**	0.014	0.025	0.0385**	
			(0.015)	(0.020)	(0.018)	(0.018)	
Average standardized effect education			-0.0760**	0.032	-0.0916**	-0.0594*	
			(0.031)	(0.038)	(0.038)	(0.035)	

Table 16. Results for non-targeted outcomes, Java (baseline as control variable)

			Model 1		Model 2		
Indicator	Baseline mean	Control mean	Total Generasi Year 1 Effect	Versi A additional effect	Total Versi B impact	Total Versi A impact	Number observations
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Quality of prenatal care services	0.575	0.604	0.012	0.018	0.003	0.021	2534
	-0.005	(0.010)	(0.014)	(0.015)	(0.016)	(0.015)	
Facility-based vs. home deliveries	0.496	0.546	0.038	-0.002	0.039	0.037	1787
	-0.012	(0.026)	(0.027)	(0.037)	(0.029)	(0.035)	
Use of family planning	0.584	0.572	-0.009	0.007	-0.013	-0.006	5609
	-0.007	(0.017)	(0.017)	(0.016)	(0.018)	(0.019)	
Use of health services curative care	.	0.608	-0.010	0.019	-0.020	-0.001	5096
	(.)	(0.016)	(0.020)	(0.020)	(0.023)	(0.021)	
Quality of posyandu	.	0.274	0.0568**	-0.029	0.0719**	0.043	2664
	(.)	(0.021)	(0.024)	(0.035)	(0.031)	(0.030)	
Age 7–15 hours wage work	0.231	0.062	-0.042	-0.1876**	0.056	-0.1321**	4159
	-0.041	(0.031)	(0.068)	(0.088)	(0.094)	(0.066)	
Age 7–15 hours household work	3.381	2.678	0.022	-0.288	0.171	-0.117	4160
	-0.094	(0.183)	(0.208)	(0.251)	(0.250)	(0.232)	
Age 7–15 wage work dummy	0.019	0.009	0.003	-0.002	0.004	0.002	4159
	-0.002	(0.004)	(0.005)	(0.006)	(0.005)	(0.006)	
Age 7–15 household work dummy	0.680	0.613	-0.012	0.029	-0.027	0.002	4160
	-0.007	(0.021)	(0.019)	(0.025)	(0.023)	(0.022)	
Gross high school enrollment	.	0.397	0.011	0.038	-0.008	0.030	960
	(.)	(0.044)	(0.040)	(0.050)	(0.045)	(0.049)	
Dropout rates	0.025	0.007	0.007	0.009	0.002	0.0118**	4078
	-0.002	(0.004)	(0.005)	(0.006)	(0.006)	(0.005)	
SD to SMP transition	0.880	0.963	-0.003	-0.021	0.009	-0.012	393
	-0.016	(0.026)	(0.017)	(0.014)	(0.014)	(0.021)	
SD to SMP transition alt. def.	0.860	0.963	0.000	-0.019	0.011	-0.008	393
	-0.017	(0.026)	(0.016)	(0.015)	(0.013)	(0.021)	
Number of hours attended school	16.927	25.578	-0.546	-0.418	-0.331	-0.7487*	4148
	-0.202	(0.312)	(0.338)	(0.503)	(0.437)	(0.408)	
Initiation of breastfeeding	0.579	0.665	0.007	0.011	0.002	0.013	3057
	-0.010	(0.021)	(0.020)	(0.029)	(0.023)	(0.026)	

			Model 1		Model 2		
Indicator	Baseline mean	Control mean	Total Generasi Year 1 Effect	Versi A additional effect	Total Versi B impact	Total Versi A impact	Number observations
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Exclusive breastfeeding	0.440	0.381	0.022	-0.040	0.042	0.002	3065
	-0.010	(0.022)	(0.027)	(0.035)	(0.033)	(0.031)	
Mother's knowledge	.	0.651	0.005	-0.012	0.011	-0.001	2973
	(.)	(0.007)	(0.009)	(0.012)	(0.011)	(0.011)	
Fertility rate	0.345	0.303	0.002	0.0280*	-0.013	0.016	5620
	-0.007	(0.016)	(0.013)	(0.015)	(0.015)	(0.015)	
Numbers hrs. school (enroll only)	17.952	25.961	-0.332	0.092	-0.380	-0.288	3993
	-0.203	(0.286)	(0.287)	(0.417)	(0.349)	(0.360)	
Average standardized effect			0.013	-0.001	0.014	0.013	
			(0.022)	(0.025)	(0.025)	(0.025)	
Average standardized effect health			0.0339*	0.001	0.033	0.035	
			(0.020)	(0.026)	(0.024)	(0.024)	
Average standardized effect education			-0.018	-0.004	-0.015	-0.019	
			(0.040)	(0.041)	(0.044)	(0.045)	

Table 17. Results for non-targeted outcomes, East Nusa Tenggara (baseline as control variable)

			Model 1		Model 2		
Indicator	Baseline mean	Control mean	Total Generasi Year 1 Effect	Versi A additional effect	Total Versi B impact	Total Versi A impact	Number observations
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Quality of prenatal care services	0.486	0.556	-0.020	-0.005	-0.018	-0.022	809
	(0.010)	(0.022)	(0.018)	(0.025)	(0.023)	(0.021)	
Facility-based vs. home deliveries	0.191	0.326	0.011	0.0780*	-0.032	0.046	600
	(0.016)	(0.041)	(0.051)	(0.044)	(0.060)	(0.052)	
Use of family planning	0.285	0.277	0.041	0.0698*	0.008	0.0775*	1567
	(0.012)	(0.030)	(0.037)	(0.036)	(0.036)	(0.045)	
Use of health services curative care	.	0.600	0.014	-0.0750**	0.0490*	-0.026	1326
	(.)	(0.030)	(0.027)	(0.037)	(0.025)	(0.037)	
Quality of posyandu	.	0.518	0.029	-0.070	0.064	-0.006	984
	(.)	(0.039)	(0.053)	(0.045)	(0.053)	(0.057)	
Age 7–15 hours wage work	0.519	0.085	0.153	-0.259	0.2802*	0.021	1699
	(0.111)	(0.064)	(0.140)	(0.158)	(0.166)	(0.150)	
Age 7–15 hours household work	5.077	4.103	1.5252***	-0.621	1.8304***	1.2096**	1698
	(0.196)	(0.373)	(0.512)	(0.639)	(0.622)	(0.550)	
Age 7–15 wage work dummy	0.032	0.018	-0.003	-0.016	0.005	-0.011	1699
	(0.004)	(0.009)	(0.008)	(0.011)	(0.010)	(0.010)	
Age 7–15 household work dummy	0.815	0.786	0.026	-0.011	0.031	0.020	1698
	(0.009)	(0.028)	(0.019)	(0.029)	(0.022)	(0.027)	
Gross high school enrollment	.	0.383	-0.107	-0.079	-0.061	-0.141	309
	(.)	(0.072)	(0.097)	(0.118)	(0.121)	(0.106)	
Dropout rates	0.027	0.009	0.002	-0.011	0.007	-0.004	1642
	(0.004)	(0.007)	(0.008)	(0.008)	(0.008)	(0.009)	
SD to SMP transition	0.846	1.000	0.000	0.000	0.000	0.000	140
	(0.040)	0.000	0.000	0.000	0.000	0.000	
SD to SMP transition alt. def.	0.835	0.938	0.016	0.039	-0.002	0.037	142
	(0.041)	(0.063)	(0.035)	(0.029)	(0.038)	(0.034)	
Number of hours attended school	17.695	26.614	-0.649	0.343	-0.834	-0.491	1696
	(0.354)	(0.607)	(0.643)	(0.950)	(0.870)	(0.735)	
Initiation of breastfeeding	0.666	0.679	0.030	0.054	0.003	0.057	1090
	(0.016)	(0.034)	(0.043)	(0.042)	(0.048)	(0.045)	

			Model 1		Model 2		
Indicator	Baseline mean	Control mean	Total Generasi Year 1 Effect	Versi A additional effect	Total Versi B impact	Total Versi A impact	Number observations
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Exclusive breastfeeding	0.652	0.553	0.0849*	0.034	0.067	0.1006**	1091
	(0.016)	(0.036)	(0.045)	(0.046)	(0.053)	(0.049)	
Mother's knowledge	.	0.545	0.009	0.004	0.007	0.011	970
	(.)	(0.016)	(0.018)	(0.021)	(0.018)	(0.022)	
Fertility rate	0.373	0.427	-0.026	-0.016	-0.018	-0.033	1574
	(0.013)	(0.033)	(0.023)	(0.023)	(0.022)	(0.028)	
Numbers hrs school (enroll only)	19.340	28.388	-1.1893**	0.428	-1.4226*	-0.9943*	1615
	(0.360)	(0.422)	(0.515)	(0.750)	(0.762)	(0.509)	
Average standardized effect			-0.019	0.023	-0.030	-0.007	
			(0.027)	(0.035)	(0.032)	(0.033)	
Average standardized effect health			0.040	0.018	0.029	0.047	
			(0.031)	(0.036)	(0.035)	(0.036)	
Average standardized effect education			-0.1232**	0.033	-0.1369**	-0.1037*	
			(0.054)	(0.065)	(0.065)	(0.060)	

Table 18. Results for non-targeted outcomes, Sulawesi /Gorontalo (baseline as control variable)

Indicator	Baseline mean	Control mean	Model 1 Total Generasi Year 1 Effect	Versi A additional effect	Model 2 Total Versi B impact	Total Versi A impact	Number observations
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Quality of prenatal care services	0.479	0.495	0.046	0.0641*	0.019	0.0826**	493
	(0.012)	(0.021)	(0.028)	(0.036)	(0.033)	(0.036)	
Facility-based vs home deliveries	0.200	0.237	0.0489**	0.024	0.038	0.0620*	374
	(0.022)	(0.039)	(0.024)	(0.037)	(0.030)	(0.031)	
Use of family planning	0.582	0.627	-0.027	-0.007	-0.024	-0.030	1129
	(0.015)	(0.031)	(0.027)	(0.040)	(0.030)	(0.038)	
Use of health services curative care	.	0.507	-0.006	-0.023	0.004	-0.018	1099
	(.)	(0.030)	(0.046)	(0.068)	(0.063)	(0.051)	
Quality of posyandu	.	0.276	0.1330**	0.1930**	0.046	0.2394***	464
	(.)	(0.042)	(0.056)	(0.088)	(0.059)	(0.077)	
Age 7–15 hours wage work	1.153	0.505	1.1440**	-1.3750**	1.7478***	0.373	952
	(0.197)	(0.206)	(0.434)	(0.660)	(0.592)	(0.349)	
Age 7–15 hours household work	4.118	4.065	1.5291**	-0.705	1.8275**	1.1226*	951
	(0.207)	(0.592)	(0.610)	(0.830)	(0.803)	(0.572)	
Age 7–15 wage work dummy	0.087	0.057	0.0381*	-0.0641**	0.0656**	0.002	952
	(0.009)	(0.017)	(0.021)	(0.027)	(0.024)	(0.018)	
Age 7–15 household work dummy	0.776	0.714	0.049	-0.019	0.057	0.038	951
	(0.014)	(0.033)	(0.035)	(0.048)	(0.042)	(0.042)	
Gross high school enrollment	.	0.342	-0.072	-0.112	-0.016	-0.127	210
	(.)	(0.075)	(0.088)	(0.087)	(0.079)	(0.113)	
Dropout rates	0.030	0.021	0.005	-0.024	0.016	-0.008	910
	(0.006)	(0.011)	(0.009)	(0.016)	(0.012)	(0.013)	
SD to SMP transition	0.960	1.000	0.001	0.055	-0.023	0.033	108
	(0.022)	0.000	(0.010)	(0.049)	(0.021)	(0.035)	
SD to SMP transition alt. def.	0.960	0.938	0.009	0.120	-0.040	0.080	110
	(0.022)	(0.063)	(0.040)	(0.078)	(0.055)	(0.053)	
Number of hours attended school	16.834	25.886	-1.108	2.4140*	-1.943	0.471	951
	(0.469)	(0.604)	(1.056)	(1.338)	(1.232)	(1.104)	
Initiation of breastfeeding	0.402	0.476	-0.010	-0.052	0.014	-0.039	651
	(0.021)	(0.039)	(0.060)	(0.079)	(0.069)	(0.075)	
Exclusive breastfeeding	0.320	0.287	-0.1271***	0.009	-0.1306***	-0.1216***	650

Indicator	Baseline mean	Control mean	Model 1 Total Generasi Year 1 Effect	Versi A additional effect	Model 2 Total Versi B impact	Total Versi A impact	Number observations
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
	(0.020)	(0.035)	(0.033)	(0.050)	(0.039)	(0.044)	
Mother's knowledge	.	0.509	0.006	0.016	-0.001	0.016	615
	(.)	(0.016)	(0.015)	(0.025)	(0.017)	(0.022)	
Fertility rate	0.299	0.314	-0.033	-0.027	-0.020	-0.0470*	1131
	(0.014)	(0.029)	(0.020)	(0.026)	(0.023)	(0.024)	
Numbers hrs. school (enroll only)	18.689	27.308	-0.228	0.581	-0.435	0.146	885
	(0.479)	(0.437)	(0.566)	(1.015)	(0.749)	(0.772)	
Average standardized effect			-0.037	0.1104*	-0.0819**	0.029	
			(0.027)	(0.062)	(0.038)	(0.043)	
Average standardized effect health			0.015	0.065	-0.013	0.051	
			(0.031)	(0.049)	(0.031)	(0.046)	
Average standardized effect education			-0.1144***	0.179	-0.1848**	-0.006	
			(0.044)	(0.115)	(0.074)	(0.071)	

Table 19. Results for main indicators, all provinces (interaction with pre-period level of outcome variable, model 1)

			Model 1		
Indicator	Baseline mean	Control mean	Generasi Year 1 * Pre Period Level	Generasi Year 1 evaluated at 10th pctile	Number observations
	(1)	(2)	(3)	(4)	(5)
Main 12 indicators					
Number prenatal visits	7.647	7.510	0.144	-0.392	3837
	(0.072)	(0.141)	(0.112)	(0.342)	
Delivery by trained midwife	0.670	0.755	-0.031	0.049	2761
	(0.009)	(0.017)	(0.062)	(0.043)	
Number of postnatal visits	3.036	2.831	-0.055	0.066	2761
	(0.064)	(0.129)	(0.081)	(0.215)	
Iron tablet sachets	1.588	1.977	-0.170	0.1888*	3788
	(0.021)	(0.049)	(0.103)	(0.098)	
Percent of immunization	0.653	0.693	-0.1443**	0.0558**	3521
	(0.006)	(0.013)	(0.070)	(0.027)	
Number of weight checks	2.126	2.192	-0.077	0.1666**	4804
	(0.019)	(0.040)	(0.083)	(0.082)	
Number Vitamin A supplements	1.529	1.560	-0.027	0.011	2758
	(0.024)	(0.044)	(0.093)	(0.061)	
Percent malnourished	0.168	0.199	-0.1780*	-0.030	4749
	(0.006)	(0.014)	(0.097)	(0.021)	
Age 7–12 gross enrollment	0.948	0.982	-0.066	0.006	4962
	(0.003)	(0.005)	(0.075)	(0.009)	
Age 13–15 gross enrollment	0.822	0.906	-0.060	-0.027	1856
	(0.009)	(0.019)	(0.095)	(0.028)	
Age 7–12 gross attendance	0.904	0.956	-0.049	0.007	4952
	(0.004)	(0.006)	(0.035)	(0.006)	
Age 13–15 gross attendance	0.768	0.884	-0.024	-0.045	1853
	(0.011)	(0.019)	(0.087)	(0.031)	
Average standardized effect			-0.107	0.033	
			(0.084)	(0.030)	
Average standardized effect health			-0.030	0.0696**	
			(0.048)	(0.031)	
Average standardized effect education			-0.260	-0.039	
			(0.224)	(0.056)	

Table 20. Results for main indicators, all provinces (interaction with pre-period level of outcome variable, model 2)

Indicator	Baseline mean	Control mean	Versi A additional effect * pre-period level	Generasi Versi B total effect * pre-period level	Generasi Versi A total effect * pre-period level	Versi A additional effect at 10th pctile of pre-period	Number observations
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Main 12 indicators							
Number prenatal visits	7.647	7.510	0.010	0.143	0.153	0.590	3837
	(0.072)	(0.141)	(0.135)	(0.118)	(0.138)	(0.367)	
Delivery by trained midwife	0.670	0.755	-0.1255*	0.036	-0.090	0.050	2761
	(0.009)	(0.017)	(0.071)	(0.070)	(0.074)	(0.046)	
Number of postnatal visits	3.036	2.831	-0.057	-0.022	-0.080	0.4813*	2761
	(0.064)	(0.129)	(0.110)	(0.106)	(0.087)	(0.255)	
Iron tablet sachets	1.588	1.977	0.063	-0.207	-0.144	0.047	3788
	(0.021)	(0.049)	(0.151)	(0.130)	(0.125)	(0.110)	
Percent of immunization	0.653	0.693	-0.101	-0.088	-0.1892**	0.041	3521
	(0.006)	(0.013)	(0.087)	(0.078)	(0.085)	(0.029)	
Number of weight checks	2.126	2.192	0.012	-0.081	-0.069	0.090	4804
	(0.019)	(0.040)	(0.106)	(0.098)	(0.098)	(0.107)	
Number Vitamin A supplements	1.529	1.560	-0.007	-0.023	-0.030	-0.008	2758
	(0.024)	(0.044)	(0.154)	(0.115)	(0.128)	(0.095)	
Percent malnourished	0.168	0.199	-0.158	-0.097	-0.2554**	-0.0473*	4749
	(0.006)	(0.014)	(0.138)	(0.113)	(0.129)	(0.027)	
Age 7–12 gross enrollment	0.948	0.982	0.043	-0.084	-0.041	-0.007	4962
	(0.003)	(0.005)	(0.127)	(0.105)	(0.090)	(0.012)	
Age 13–15 gross enrollment	0.822	0.906	0.006	-0.066	-0.060	0.014	1856
	(0.009)	(0.019)	(0.148)	(0.119)	(0.119)	(0.044)	
Age 7–12 gross attendance	0.904	0.956	-0.005	-0.046	-0.051	0.000	4952
	(0.004)	(0.006)	(0.033)	(0.039)	(0.039)	(0.006)	
Age 13–15 gross attendance	0.768	0.884	-0.027	-0.023	-0.050	0.032	1853
	(0.011)	(0.019)	(0.132)	(0.106)	(0.111)	(0.048)	
Average standardized effect			0.003	-0.109	-0.105	0.0709*	
			(0.136)	(0.113)	(0.100)	(0.041)	
Average standardized effect health			-0.020	-0.017	-0.037	0.0926**	
			(0.065)	(0.054)	(0.062)	(0.036)	
Average standardized effect education			0.050	-0.291	-0.242	0.028	
			(0.369)	(0.310)	(0.254)	(0.086)	

Table 21. Results for main indicators, Java (interaction with pre-period level of outcome variable, model 1)

			Model 1		
Indicator	Baseline mean	Control mean	Generasi Year 1 * Pre Period Level	Generasi Year 1 evaluated at 10th pctile	Number observations
	(1)	(2)	(3)	(4)	(5)
Main 12 indicators					
Number prenatal visits	8.080	7.982	0.091	-0.011	2534
	(0.081)	(0.171)	(0.134)	(0.392)	
Delivery by trained midwife	0.764	0.843	-0.1394*	0.1128**	1787
	(0.010)	(0.019)	(0.076)	(0.050)	
Number of postnatal visits	3.605	3.587	-0.152	0.277	1787
	(0.081)	(0.172)	(0.115)	(0.337)	
Iron tablet sachets	1.639	2.071	-0.3138**	0.3324**	2504
	(0.025)	(0.061)	(0.138)	(0.144)	
Percent of immunization	0.701	0.736	-0.1907**	0.044	2280
	(0.007)	(0.014)	(0.082)	(0.028)	
Number of weight checks	2.213	2.377	0.029	0.055	3062
	(0.023)	(0.047)	(0.114)	(0.101)	
Number Vitamin A supplements	1.488	1.444	-0.080	0.083	1809
	(0.028)	(0.053)	(0.113)	(0.070)	
Percent malnourished	0.126	0.118	-0.2549*	-0.031	3027
	(0.007)	(0.015)	(0.151)	(0.029)	
Age 7–12 gross enrollment	0.959	0.993	-0.103	0.008	2991
	(0.004)	(0.004)	(0.076)	(0.008)	
Age 13–15 gross enrollment	0.833	0.943	-0.063	-0.010	1173
	(0.011)	(0.020)	(0.124)	(0.034)	
Age 7–12 gross attendance	0.914	0.969	-0.049	0.009	2983
	(0.005)	(0.006)	(0.050)	(0.010)	
Age 13–15 gross attendance	0.783	0.926	-0.022	-0.025	1170
	(0.013)	(0.021)	(0.117)	(0.041)	
Average standardized effect			-0.202	0.0938**	
			(0.125)	(0.039)	
Average standardized effect health			-0.065	0.1370***	
			(0.070)	(0.042)	
Average standardized effect education			-0.477	0.008	
			(0.349)	(0.084)	

Table 22. Results for main indicators, Java (interaction with pre-period level of outcome variable, model 2)

Indicator	Baseline mean	Control mean	Versi A additional effect * pre-period level	Generasi Versi B total effect * pre-period level	Generasi Versi A total effect * pre-period level	Versi A additional effect at 10th pctile of pre-period	Number observations
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Main 12 indicators							
Number prenatal visits	8.080	7.982	-0.131	0.175	0.044	0.752	2534
	(0.081)	(0.171)	(0.190)	(0.174)	(0.155)	(0.500)	
Delivery by trained midwife	0.764	0.843	0.1791*	-0.2120***	-0.033	-0.1384**	1787
	(0.010)	(0.019)	(0.099)	(0.076)	(0.096)	(0.067)	
Number of postnatal visits	3.605	3.587	-0.038	-0.131	-0.169	0.337	1787
	(0.081)	(0.172)	(0.160)	(0.145)	(0.128)	(0.424)	
Iron tablet sachets	1.639	2.071	0.235	-0.4452**	-0.210	-0.200	2504
	(0.025)	(0.061)	(0.212)	(0.173)	(0.174)	(0.158)	
Percent of immunization	0.701	0.736	-0.109	-0.127	-0.2360**	0.041	2280
	(0.007)	(0.014)	(0.123)	(0.101)	(0.102)	(0.038)	
Number of weight checks	2.213	2.377	0.050	0.000	0.050	0.058	3062
	(0.023)	(0.047)	(0.180)	(0.165)	(0.128)	(0.154)	
Number Vitamin A supplements	1.488	1.444	-0.010	-0.077	-0.087	0.065	1809
	(0.028)	(0.053)	(0.173)	(0.162)	(0.119)	(0.104)	
Percent malnourished	0.126	0.118	0.066	-0.2882*	-0.222	0.010	3027
	(0.007)	(0.015)	(0.229)	(0.166)	(0.207)	(0.040)	
Age 7–12 gross enrollment	0.959	0.993	0.191	-0.1539*	0.037	-0.020	2991
	(0.004)	(0.004)	(0.124)	(0.081)	(0.117)	(0.013)	
Age 13–15 gross enrollment	0.833	0.943	0.120	-0.097	0.022	-0.044	1173
	(0.011)	(0.020)	(0.194)	(0.145)	(0.170)	(0.053)	
Age 7–12 gross attendance	0.914	0.969	0.007	-0.056	-0.049	-0.007	2983
	(0.005)	(0.006)	(0.054)	(0.068)	(0.050)	(0.010)	
Age 13–15 gross attendance	0.783	0.926	-0.067	0.005	-0.062	0.005	1170
	(0.013)	(0.021)	(0.172)	(0.138)	(0.150)	(0.064)	
Average standardized effect			0.211	-0.2557*	-0.045	-0.040	
			(0.176)	(0.145)	(0.153)	(0.057)	
Average standardized effect health			0.011	-0.062	-0.051	-0.001	
			(0.104)	(0.084)	(0.090)	(0.055)	
Average standardized effect education			0.612	-0.644	-0.032	-0.120	
			(0.489)	(0.416)	(0.425)	(0.123)	

Table 23. Results for main indicators, East Nusa Tenggara (interaction with pre-period level of outcome variable, model 1)

			Model 1		
Indicator	Baseline mean	Control mean	Generasi Year 1 * Pre Period Level	Generasi Year 1 evaluated at 10th pctile	Number observations
	(1)	(2)	(3)	(4)	(5)
Main 12 indicators					
Number prenatal visits	6.822	7.012	-0.078	-0.553	810
	(0.170)	(0.323)	(0.192)	(0.731)	
Delivery by trained midwife	0.427	0.659	0.141	-0.102	600
	(0.021)	(0.042)	(0.228)	(0.093)	
Number of postnatal visits	1.444	1.357	0.329	-0.484	600
	(0.092)	(0.196)	(0.252)	(0.422)	
Iron tablet sachets	1.589	1.976	0.099	-0.026	798
	(0.048)	(0.117)	(0.167)	(0.168)	
Percent of immunization	0.549	0.586	0.139	0.003	763
	(0.015)	(0.033)	(0.143)	(0.061)	
Number of weight checks	2.237	2.347	-0.479	0.3658*	1091
	(0.037)	(0.082)	(0.301)	(0.194)	
Number Vitamin A supplements	1.586	1.736	-0.135	-0.117	571
	(0.053)	(0.084)	(0.168)	(0.117)	
Percent malnourished	0.247	0.353	0.024	-0.024	1077
	(0.014)	(0.035)	(0.219)	(0.045)	
Age 7–12 gross enrollment	0.929	0.952	-0.136	0.025	1291
	(0.007)	(0.017)	(0.176)	(0.019)	
Age 13–15 gross enrollment	0.810	0.893	-0.052	-0.042	410
	(0.020)	(0.042)	(0.144)	(0.039)	
Age 7–12 gross attendance	0.892	0.931	0.055	0.013	1290
	(0.009)	(0.018)	(0.072)	(0.009)	
Age 13–15 gross attendance	0.746	0.860	-0.104	-0.027	410
	(0.024)	(0.044)	(0.142)	(0.062)	
Average standardized effect			-0.061	-0.004	
			(0.129)	(0.048)	
Average standardized effect health			0.022	0.007	
			(0.096)	(0.062)	
Average standardized effect education			-0.226	-0.025	
			(0.320)	(0.063)	

Table 24. Results for main indicators, East Nusa Tenggara (interaction with pre-period level of outcome variable, model 2)

Indicator	Baseline mean	Control mean	Versi A additional effect * pre-period level	Generasi Versi B total effect * pre-period level	Generasi Versi A total effect * pre-period level	Versi A additional effect at 10th pctile of pre-period	Number observations
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Main 12 indicators							
Number prenatal visits	6.822	7.012	0.190	-0.143	0.047	0.230	810
	(0.170)	(0.323)	(0.139)	(0.194)	(0.216)	(0.507)	
Delivery by trained midwife	0.427	0.659	-0.3265*	0.328	0.002	0.1768**	600
	(0.021)	(0.042)	(0.170)	(0.251)	(0.246)	(0.070)	
Number of postnatal visits	1.444	1.357	0.529	0.291	0.8203**	0.237	600
	(0.092)	(0.196)	(0.336)	(0.245)	(0.388)	(0.329)	
Iron tablet sachets	1.589	1.976	0.082	0.051	0.133	0.196	798
	(0.048)	(0.117)	(0.208)	(0.200)	(0.207)	(0.181)	
Percent of immunization	0.549	0.586	-0.059	0.165	0.106	0.007	763
	(0.015)	(0.033)	(0.101)	(0.143)	(0.161)	(0.040)	
Number of weight checks	2.237	2.347	0.163	-0.5905*	-0.428	-0.011	1091
	(0.037)	(0.082)	(0.252)	(0.343)	(0.312)	(0.171)	
Number Vitamin A supplements	1.586	1.736	0.161	-0.190	-0.028	-0.213	571
	(0.053)	(0.084)	(0.247)	(0.166)	(0.258)	(0.142)	
Percent malnourished	0.247	0.353	-0.024	0.001	-0.023	-0.074	1077
	(0.014)	(0.035)	(0.308)	(0.219)	(0.334)	(0.051)	
Age 7–12 gross enrollment	0.929	0.952	0.4060*	-0.415	-0.009	-0.029	1291
	(0.007)	(0.017)	(0.228)	(0.253)	(0.168)	(0.020)	
Age 13–15 gross enrollment	0.810	0.893	0.3288*	-0.171	0.158	-0.1160*	410
	(0.020)	(0.042)	(0.189)	(0.157)	(0.180)	(0.065)	
Age 7–12 gross attendance	0.892	0.931	0.066	0.022	0.088	0.006	1290
	(0.009)	(0.018)	(0.094)	(0.077)	(0.096)	(0.014)	
Age 13–15 gross attendance	0.746	0.860	0.5118***	-0.3188*	0.193	-0.2296***	410
	(0.024)	(0.044)	(0.161)	(0.173)	(0.169)	(0.076)	
Average standardized effect			0.3992**	-0.253	0.146	-0.019	
			(0.175)	(0.153)	(0.168)	(0.050)	
Average standardized effect health			-0.017	0.056	0.040	0.0789*	
			(0.115)	(0.103)	(0.138)	(0.046)	
Average standardized effect education			1.2312***	-0.8719**	0.359	-0.2133**	
			(0.444)	(0.424)	(0.381)	(0.092)	

Table 25. Results for main indicators, Sulawesi (interaction with pre-period level of outcome variable, model 1)

			Model 1		
Indicator	Baseline mean	Control mean	Generasi Year 1 * Pre Period Level	Generasi Year 1 evaluated at 10th pctile	Number observations
	(1)	(2)	(3)	(4)	(5)
Main 12 indicators					
Number prenatal visits	6.607	6.288	0.410	-0.951	493
	(0.242)	(0.360)	(0.324)	(0.863)	
Delivery by trained midwife	0.559	0.585	0.012	0.113	374
	(0.027)	(0.046)	(0.192)	(0.087)	
Number of postnatal visits	2.586	2.076	0.364	-0.374	374
	(0.188)	(0.288)	(0.272)	(0.663)	
Iron tablet sachets	1.317	1.621	-0.136	0.020	486
	(0.054)	(0.115)	(0.504)	(0.254)	
Percent of immunization	0.577	0.674	-0.080	0.091	478
	(0.018)	(0.031)	(0.284)	(0.100)	
Number of weight checks	1.534	1.451	-0.085	0.285	651
	(0.056)	(0.099)	(0.209)	(0.196)	
Number Vitamin A supplements	1.635	1.723	0.164	-0.132	378
	(0.073)	(0.118)	(0.241)	(0.183)	
Percent malnourished	0.234	0.268	-0.311	-0.051	645
	(0.019)	(0.035)	(0.266)	(0.055)	
Age 7–12 gross enrollment	0.935	0.986	-0.050	-0.004	680
	(0.010)	(0.010)	(0.217)	(0.023)	
Age 13–15 gross enrollment	0.793	0.813	-0.075	-0.056	273
	(0.024)	(0.057)	(0.239)	(0.072)	
Age 7–12 gross attendance	0.882	0.949	-0.131	-0.006	679
	(0.012)	(0.012)	(0.095)	(0.016)	
Age 13–15 gross attendance	0.741	0.788	0.020	-0.100	273
	(0.027)	(0.057)	(0.254)	(0.087)	
Average standardized effect			-0.034	-0.007	
			(0.221)	(0.072)	
Average standardized effect health			0.086	0.050	
			(0.158)	(0.068)	
Average standardized effect education			-0.272	-0.120	
			(0.563)	(0.135)	

Table 26. Results for main indicators, Sulawesi (interaction with pre-period level of outcome variable, model 2)

Indicator	Baseline mean	Control mean	Versi A additional effect * pre-period level	Generasi Versi B total effect * pre-period level	Generasi Versi A total effect * pre-period level	Versi A additional effect at 10th pctile of pre-period	Number observations
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Main 12 indicators							
Number prenatal visits	6.592	6.288	0.068	0.344	0.412	1.134	493
	(0.242)	(0.360)	(0.445)	(0.228)	(0.418)	(1.228)	
Delivery by trained midwife	0.560	0.585	0.066	-0.008	0.059	0.054	374
	(0.027)	(0.046)	(0.252)	(0.199)	(0.253)	(0.095)	
Number of postnatal visits	2.581	2.076	-0.465	0.4534*	-0.012	1.585	374
	(0.188)	(0.288)	(0.454)	(0.239)	(0.468)	(1.373)	
Iron tablet sachets	1.313	1.621	-0.191	0.038	-0.153	0.4437*	486
	(0.054)	(0.115)	(0.801)	(0.524)	(0.615)	(0.256)	
Percent of immunization	0.579	0.674	-0.482	0.072	-0.410	0.155	478
	(0.018)	(0.031)	(0.498)	(0.226)	(0.527)	(0.114)	
Number of weight checks	1.517	1.451	0.228	-0.124	0.104	0.116	651
	(0.056)	(0.099)	(0.329)	(0.189)	(0.341)	(0.181)	
Number Vitamin A supplements	1.641	1.723	0.756	0.199	0.955	-1.006	378
	(0.073)	(0.118)	(0.722)	(0.208)	(0.691)	(0.673)	
Percent malnourished	0.248	0.268	-0.384	-0.018	-0.402	-0.094	645
	(0.019)	(0.035)	(0.398)	(0.328)	(0.300)	(0.066)	
Age 7–12 gross enrollment	0.941	0.986	-1.3832***	0.3893***	-0.9939***	0.0902***	680
	(0.009)	(0.010)	(0.226)	(0.114)	(0.216)	(0.015)	
Age 13–15 gross enrollment	0.809	0.813	-0.146	0.314	0.168	0.2433***	273
	(0.024)	(0.057)	(0.367)	(0.198)	(0.351)	(0.066)	
Age 7–12 gross attendance	0.895	0.949	-0.6429***	-0.054	-0.6970***	0.0593***	679
	(0.012)	(0.012)	(0.180)	(0.085)	(0.195)	(0.020)	
Age 13–15 gross attendance	0.750	0.788	-0.039	0.3844**	0.345	0.2640***	273
	(0.026)	(0.057)	(0.340)	(0.176)	(0.345)	(0.069)	
Average standardized effect			-0.9122***	0.3548**	-0.5575**	0.2642**	
			(0.250)	(0.156)	(0.242)	(0.101)	
Average standardized effect health			0.035	0.067	0.102	0.138	
			(0.231)	(0.155)	(0.228)	(0.131)	
Average standardized effect education			-2.8072***	0.9310**	-1.8762***	0.5177***	
			(0.526)	(0.360)	(0.564)	(0.091)	

Table 27. Results for main indicators, all provinces (split by per-capita consumption quintile, model 1)

			Model 1			
Indicator	Baseline mean	Control mean	Generasi Year 1 for Bottom 2 Quintiles	Generasi Year 1 Top 3 Quintile Additional Effect	Generasi Year 1 Total Effect for Top 3 Quintiles	Number observations
	(1)	(2)	(3)	(4)	(5)	(6)
Main 12 indicators						
Number prenatal visits	7.700	7.671	0.363	-0.306	0.057	1020
	(0.106)	(0.239)	(0.440)	(0.543)	(0.392)	
Delivery by trained midwife	0.665	0.742	-0.078	0.075	-0.003	812
	(0.013)	(0.028)	(0.048)	(0.060)	(0.044)	
Number of postnatal visits	2.989	2.972	-0.447	0.7770*	0.330	812
	(0.092)	(0.212)	(0.344)	(0.451)	(0.326)	
Iron tablet sachets	1.606	1.939	0.144	-0.008	0.136	1002
	(0.030)	(0.082)	(0.162)	(0.170)	(0.138)	
Percent of immunization	0.651	0.699	0.022	0.024	0.045	1190
	(0.009)	(0.019)	(0.031)	(0.038)	(0.028)	
Number of weight checks	2.128	2.189	0.1760**	-0.028	0.1481*	2084
	(0.028)	(0.046)	(0.080)	(0.103)	(0.083)	
Number Vitamin A supplements	1.522	1.745	-0.018	0.092	0.074	1079
	(0.036)	(0.054)	(0.096)	(0.113)	(0.085)	
Percent malnourished	0.166	0.222	0.000	-0.006	-0.006	2049
	(0.009)	(0.017)	(0.027)	(0.037)	(0.025)	
Age 7–12 gross enrollment	0.951	0.976	0.010	-0.015	-0.005	2689
	(0.004)	(0.005)	(0.008)	(0.010)	(0.007)	
Age 13–15 gross enrollment	0.814	0.908	-0.040	0.020	-0.020	1104
	(0.014)	(0.016)	(0.029)	(0.037)	(0.026)	
Age 7–12 gross attendance	0.901	0.953	0.007	-0.014	-0.008	2682
	(0.006)	(0.006)	(0.008)	(0.011)	(0.008)	
Age 13–15 gross attendance	0.758	0.887	-0.0546*	0.011	-0.044	1101
	(0.016)	(0.016)	(0.031)	(0.038)	(0.027)	
Average standardized effect			-0.013	0.034	0.021	
			(0.039)	(0.044)	(0.029)	
Average standardized effect health			0.008	0.060	0.0679**	
			(0.046)	(0.052)	(0.034)	
Average standardized effect educ.			-0.056	-0.018	-0.074	
			(0.058)	(0.068)	(0.049)	

Table 28. Results for main indicators, all provinces (split by per-capita consumption quintile, model 2)

Indicator		Control mean	Generasi Versi B bottom 2 quintiles	Generasi Versi B top 3 quintiles additional effect	Generasi Versi B top 3 quintiles total	Generasi Versi A bottom 2 quintiles	Generasi Versi A top 3 quintiles additional effect	Generasi Versi A top 3 quintiles total	Number observations
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
Main 12 indicators									
Number prenatal visits	7.700	7.671	-0.262	0.299	0.038	1.1495*	-1.086	0.063	1020
	(0.106)	(0.239)	(0.531)	(0.726)	(0.469)	(0.622)	(0.839)	(0.511)	
Delivery by midwife	0.665	0.742	-0.1026*	0.1604**	0.058	0.041	-0.1631**	-0.1220**	812
	(0.013)	(0.028)	(0.056)	(0.071)	(0.051)	(0.061)	(0.078)	(0.053)	
Number of postnatal visits	2.989	2.972	-0.603	0.603	0.000	0.300	0.365	0.666	812
	(0.092)	(0.212)	(0.415)	(0.552)	(0.387)	(0.440)	(0.578)	(0.423)	
Iron tablet sachets	1.606	1.939	0.019	0.185	0.204	0.225	-0.3555*	-0.131	1002
	(0.030)	(0.082)	(0.180)	(0.201)	(0.150)	(0.170)	(0.215)	(0.166)	
Percent of immunization	0.651	0.699	-0.005	0.049	0.045	0.047	-0.044	0.003	1190
	(0.009)	(0.019)	(0.039)	(0.048)	(0.034)	(0.043)	(0.053)	(0.035)	
Number of weight checks	2.128	2.189	0.136	-0.063	0.073	0.082	0.083	0.1648*	2084
	(0.028)	(0.046)	(0.100)	(0.133)	(0.097)	(0.112)	(0.144)	(0.099)	
Number Vitamin A supplements	1.522	1.745	-0.014	0.065	0.051	-0.005	0.051	0.046	1079
	(0.036)	(0.054)	(0.117)	(0.161)	(0.111)	(0.128)	(0.182)	(0.128)	
Percent malnourished	0.166	0.222	0.038	-0.072	-0.034	-0.0683*	0.1269**	0.0586*	2049
	(0.009)	(0.017)	(0.033)	(0.044)	(0.025)	(0.036)	(0.051)	(0.034)	
Age 7–12 gross enrollment	0.951	0.976	0.009	-0.014	-0.005	0.003	-0.002	0.001	2689
	(0.004)	(0.005)	(0.010)	(0.011)	(0.009)	(0.009)	(0.013)	(0.011)	
Age 13–15 gross enrollment	0.814	0.908	-0.065	0.035	-0.029	0.048	-0.025	0.023	1104
	(0.014)	(0.016)	(0.042)	(0.057)	(0.035)	(0.045)	(0.061)	(0.033)	
Age 7–12 gross attendance	0.901	0.953	0.002	-0.012	-0.009	0.008	-0.004	0.004	2682
	(0.006)	(0.006)	(0.010)	(0.014)	(0.011)	(0.011)	(0.016)	(0.012)	
Age 13–15 gross attendance	0.758	0.887	-0.0840*	0.030	-0.054	0.058	-0.032	0.025	1101
	(0.016)	(0.016)	(0.044)	(0.057)	(0.034)	(0.046)	(0.060)	(0.036)	
Average standardized effect			-0.076	0.0948*	0.019	0.1162**	-0.1087*	0.008	
			(0.046)	(0.057)	(0.034)	(0.051)	(0.063)	(0.037)	
Average standardized Health			-0.058	0.1337**	0.0754**	0.1211**	-0.1337*	-0.013	
			(0.053)	(0.064)	(0.038)	(0.059)	(0.071)	(0.039)	
Average standardized effect education			-0.111	0.017	-0.094	0.107	-0.059	0.048	
			(0.080)	(0.099)	(0.061)	(0.083)	(0.107)	(0.067)	

Table 29. Results for main indicators, Java (split by per-capita consumption quintile, model 1)

			Model 1			
Indicator	Baseline mean	Control mean	Generasi Year 1 for Bottom 2 Quintiles	Generasi Year 1 Top 3 Quintile Additional Effect	Generasi Year 1 Total Effect for Top 3 Quintiles	Number observations
	(1)	(2)	(3)	(4)	(5)	(6)
Main 12 indicators						
Number prenatal visits	8.100	7.919	0.878	-0.308	0.510	648
	(0.119)	(0.281)	(0.610)	(0.649)	(0.383)	
Delivery by trained midwife	0.764	0.813	-0.002	0.015	0.024	523
	(0.014)	(0.033)	(0.061)	(0.069)	(0.048)	
Number of postnatal visits	3.626	3.446	-0.352	0.766	0.336	523
	(0.118)	(0.286)	(0.558)	(0.653)	(0.374)	
Iron tablet sachets	1.630	2.144	0.367	-0.286	0.146	638
	(0.036)	(0.109)	(0.250)	(0.234)	(0.165)	
Percent of immunization	0.704	0.731	0.044	-0.051	-0.014	771
	(0.011)	(0.023)	(0.039)	(0.046)	(0.029)	
Number of weight checks	2.228	2.265	0.2364**	-0.060	0.2026**	1357
	(0.034)	(0.057)	(0.107)	(0.124)	(0.091)	
Number Vitamin A supplements	1.466	1.752	-0.036	0.054	0.022	729
	(0.043)	(0.065)	(0.115)	(0.139)	(0.097)	
Percent malnourished	0.117	0.148	0.018	-0.012	0.011	1336
	(0.010)	(0.018)	(0.033)	(0.044)	(0.023)	
Age 7–12 gross enrollment	0.958	0.992	0.006	-0.007	0.001	1621
	(0.005)	(0.004)	(0.006)	(0.010)	(0.007)	
Age 13–15 gross enrollment	0.824	0.930	-0.013	0.011	0.008	714
	(0.017)	(0.018)	(0.049)	(0.053)	(0.030)	
Age 7–12 gross attendance	0.905	0.970	0.003	-0.005	0.000	1616
	(0.008)	(0.006)	(0.008)	(0.012)	(0.009)	
Age 13–15 gross attendance	0.760	0.906	-0.028	0.007	-0.008	711
	(0.020)	(0.018)	(0.049)	(0.053)	(0.030)	
Average standardized effect			0.046	-0.014	0.044	
			(0.060)	(0.064)	(0.036)	
Average standardized effect health			0.078	-0.016	0.066	
			(0.068)	(0.071)	(0.040)	
Average standardized effect education			-0.017	-0.012	0.002	
			(0.102)	(0.110)	(0.067)	

Table 30. Results for main indicators, Java (split by per-capita consumption quintile, model 2)

Indicator		Control mean	Generasi Versi B bottom 2 quintiles	Generasi Versi B top 3 quintiles additional effect	Generasi Versi B top 3 quintiles total	Generasi Versi A bottom 2 quintiles	Generasi Versi A top 3 quintiles additional effect	Generasi Versi A top 3 quintiles total	Number observations
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
Main 12 indicators									
Number prenatal visits	8.100	7.919	0.450	0.117	0.566	0.818	-0.802	0.016	648
	(0.119)	(0.281)	(0.648)	(0.807)	(0.488)	(0.719)	(0.874)	(0.583)	
Delivery by trained midwife	0.764	0.813	0.027	0.052	0.079	-0.062	-0.058	-0.1204*	523
	(0.014)	(0.033)	(0.062)	(0.082)	(0.067)	(0.081)	(0.105)	(0.065)	
Number of postnatal visits	3.626	3.446	-0.240	0.355	0.114	-0.175	0.716	0.541	523
	(0.118)	(0.286)	(0.701)	(0.854)	(0.467)	(0.830)	(0.923)	(0.511)	
Iron tablet sachets	1.630	2.144	0.415	-0.272	0.143	-0.098	-0.017	-0.115	638
	(0.036)	(0.109)	(0.271)	(0.288)	(0.186)	(0.302)	(0.330)	(0.194)	
Percent of immunization	0.704	0.731	0.048	-0.049	-0.001	-0.008	-0.004	-0.012	771
	(0.011)	(0.023)	(0.053)	(0.065)	(0.040)	(0.058)	(0.069)	(0.042)	
Number of weight checks	2.228	2.265	0.213	-0.150	0.064	0.052	0.174	0.2263*	1357
	(0.034)	(0.057)	(0.134)	(0.161)	(0.119)	(0.142)	(0.175)	(0.116)	
Number Vitamin A supplements	1.466	1.752	-0.080	0.023	-0.057	0.081	0.054	0.135	729
	(0.043)	(0.065)	(0.142)	(0.204)	(0.135)	(0.166)	(0.228)	(0.154)	
Percent malnourished	0.117	0.148	0.060	-0.0978*	-0.038	-0.071	0.1570**	0.0863**	1336
	(0.010)	(0.018)	(0.045)	(0.055)	(0.025)	(0.049)	(0.064)	(0.036)	
Age 7–12 gross enrollment	0.958	0.992	0.004	-0.006	-0.001	0.003	-0.003	0.000	1621
	(0.005)	(0.004)	(0.008)	(0.011)	(0.011)	(0.009)	(0.012)	(0.012)	
Age 13–15 gross enrollment	0.824	0.930	-0.028	0.028	-0.001	0.032	-0.033	-0.001	714
	(0.017)	(0.018)	(0.071)	(0.082)	(0.041)	(0.076)	(0.090)	(0.038)	
Age 7–12 gross attendance	0.905	0.970	0.006	-0.008	-0.003	-0.005	0.007	0.002	1616
	(0.008)	(0.006)	(0.011)	(0.014)	(0.012)	(0.012)	(0.016)	(0.013)	
Age 13–15 gross attendance	0.760	0.906	-0.039	0.016	-0.022	0.022	-0.018	0.004	711
	(0.020)	(0.018)	(0.070)	(0.079)	(0.040)	(0.075)	(0.086)	(0.041)	
Average standardized effect			0.026	0.012	0.038	0.037	-0.048	-0.011	
			(0.070)	(0.081)	(0.043)	(0.084)	(0.093)	(0.050)	
Average standardized effect health			0.060	0.013	0.073	0.031	-0.050	-0.019	
			(0.072)	(0.085)	(0.044)	(0.090)	(0.100)	(0.047)	
Average standardized effect education			-0.041	0.010	-0.031	0.050	-0.043	0.007	
			(0.148)	(0.162)	(0.085)	(0.156)	(0.177)	(0.093)	

Table 31. Results for main indicators, East Nusa Tenggara (split by per-capita consumption quintile, model 1)

			Model 1			
Indicator	Baseline mean	Control mean	Generasi Year 1 for Bottom 2 Quintiles	Generasi Year 1 Top 3 Quintile Additional Effect	Generasi Year 1 Total Effect for Top 3 Quintiles	Number observations
	(1)	(2)	(3)	(4)	(5)	(6)
Main 12 indicators						
Number prenatal visits	6.783	7.529	-1.1008*	-1.108	-2.209	234
	(0.256)	(0.551)	(0.644)	(1.470)	(1.354)	
Delivery by trained midwife	0.423	0.618	-0.1923*	0.232	0.039	178
	(0.030)	(0.066)	(0.098)	(0.190)	(0.153)	
Number of postnatal visits	1.425	1.891	-0.470	0.231	-0.239	178
	(0.129)	(0.369)	(0.477)	(0.670)	(0.657)	
Iron tablet sachets	1.663	1.754	-0.153	0.301	0.149	228
	(0.074)	(0.180)	(0.244)	(0.409)	(0.387)	
Percent of immunization	0.546	0.687	-0.045	0.2976***	0.2528***	263
	(0.021)	(0.040)	(0.055)	(0.087)	(0.076)	
Number of weight checks	2.236	2.623	-0.064	0.207	0.142	455
	(0.053)	(0.072)	(0.133)	(0.275)	(0.240)	
Number Vitamin A supplements	1.594	1.797	-0.296	0.4952**	0.200	218
	(0.073)	(0.147)	(0.190)	(0.227)	(0.200)	
Percent malnourished	0.257	0.395	-0.018	-0.098	-0.116	447
	(0.021)	(0.043)	(0.054)	(0.098)	(0.085)	
Age 7–12 gross enrollment	0.930	0.965	0.016	-0.011	0.005	707
	(0.010)	(0.012)	(0.015)	(0.020)	(0.014)	
Age 13–15 gross enrollment	0.816	0.874	-0.053	-0.049	-0.102	241
	(0.030)	(0.036)	(0.041)	(0.081)	(0.074)	
Age 7–12 gross attendance	0.893	0.942	0.017	0.002	0.019	706
	(0.013)	(0.013)	(0.015)	(0.029)	(0.023)	
Age 13–15 gross attendance	0.774	0.853	-0.052	-0.119	-0.1714**	241
	(0.036)	(0.036)	(0.046)	(0.088)	(0.075)	
Average standardized effect			-0.1236**	0.143	0.019	
			(0.050)	(0.089)	(0.085)	
Average standardized effect health			-0.1678***	0.2827**	0.115	
			(0.062)	(0.122)	(0.112)	
Average standardized effect education			-0.035	-0.137	-0.173	
			(0.071)	(0.132)	(0.108)	

Table 32. Results for main indicators, East Nusa Tenggara (split by per-capita consumption quintile, model 2)

Indicator		Control mean	Generasi Versi B bottom 2 quintiles	Generasi Versi B top 3 quintiles additional effect	Generasi Versi B top 3 quintiles total	Generasi Versi A bottom 2 quintiles	Generasi Versi A top 3 quintiles additional effect	Generasi Versi A top 3 quintiles total	Number observations
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
Main 12 indicators									
Number prenatal visits	6.783	7.529	-1.4765*	-0.741	-2.217	0.656	-0.581	0.075	234
	(0.256)	(0.551)	(0.876)	(1.819)	(1.553)	(0.883)	(1.737)	(1.249)	
Delivery by trained midwife	0.423	0.618	-0.2869***	0.4061**	0.119	0.157	-0.3714*	-0.215	178
	(0.030)	(0.066)	(0.104)	(0.182)	(0.146)	(0.097)	(0.200)	(0.186)	
Number of postnatal visits	1.425	1.891	-1.1159**	0.568	-0.548	1.1966**	-0.206	0.991	178
	(0.129)	(0.369)	(0.503)	(0.755)	(0.791)	(0.490)	(0.976)	(0.865)	
Iron tablet sachets	1.663	1.754	-0.404	0.637	0.233	0.4194**	-0.612	-0.192	228
	(0.074)	(0.180)	(0.269)	(0.459)	(0.393)	(0.199)	(0.469)	(0.432)	
Percent of immunization	0.546	0.687	-0.082	0.2862***	0.2039***	0.079	0.057	0.1362**	263
	(0.021)	(0.040)	(0.061)	(0.090)	(0.075)	(0.069)	(0.103)	(0.068)	
Number of weight checks	2.236	2.623	-0.042	0.180	0.137	-0.044	0.053	0.009	455
	(0.053)	(0.072)	(0.183)	(0.335)	(0.266)	(0.193)	(0.298)	(0.232)	
Number Vitamin A supplements	1.594	1.797	-0.188	0.388	0.201	-0.189	0.180	-0.010	218
	(0.073)	(0.147)	(0.242)	(0.349)	(0.231)	(0.189)	(0.380)	(0.269)	
Percent malnourished	0.257	0.395	-0.005	-0.095	-0.101	-0.026	-0.014	-0.040	447
	(0.021)	(0.043)	(0.060)	(0.110)	(0.087)	(0.051)	(0.094)	(0.083)	
Age 7–12 gross enrollment	0.930	0.965	0.005	-0.001	0.004	0.020	-0.013	0.008	707
	(0.010)	(0.012)	(0.019)	(0.027)	(0.018)	(0.018)	(0.023)	(0.017)	
Age 13–15 gross enrollment	0.816	0.874	-0.040	-0.174	-0.2140*	-0.002	0.230	0.228	241
	(0.030)	(0.036)	(0.049)	(0.147)	(0.123)	(0.053)	(0.155)	(0.138)	
Age 7–12 gross attendance	0.893	0.942	0.001	0.020	0.020	0.029	-0.029	0.000	706
	(0.013)	(0.013)	(0.020)	(0.036)	(0.026)	(0.019)	(0.030)	(0.022)	
Age 13–15 gross attendance	0.774	0.853	-0.057	-0.199	-0.2563*	0.026	0.148	0.174	241
	(0.036)	(0.036)	(0.063)	(0.169)	(0.133)	(0.066)	(0.179)	(0.156)	
Average standardized effect	6.783		-0.1916***	0.156	-0.036	0.1313**	-0.005	0.127	
			(0.063)	(0.132)	(0.107)	(0.065)	(0.140)	(0.106)	
Average standardized effect health			-0.2549***	0.3610**	0.106	0.1558*	-0.121	0.035	
			(0.079)	(0.152)	(0.124)	(0.086)	(0.156)	(0.107)	
Average standardized effect education			-0.065	-0.255	-0.3197*	0.082	0.228	0.310	
			(0.084)	(0.220)	(0.177)	(0.091)	(0.231)	(0.211)	

Table 33. Results for main indicators, Sulawesi (split by per-capita consumption quintile, model 1)

			Model 1			
Indicator	Baseline mean	Control mean	Generasi Year 1 for Bottom 2 Quintiles	Generasi Year 1 Top 3 Quintile Additional Effect	Generasi Year 1 Total Effect for Top 3 Quintiles	Number observations
	(1)	(2)	(3)	(4)	(5)	(6)
Main 12 indicators						
Number prenatal visits	6.863	7.134	1.994	-2.740	-0.746	138
	(0.361)	(0.620)	(1.222)	(1.763)	(1.133)	
Delivery by trained midwife	0.529	0.685	-0.047	-0.051	-0.098	111
	(0.040)	(0.064)	(0.114)	(0.157)	(0.091)	
Number of postnatal visits	2.103	2.852	0.099	0.347	0.446	111
	(0.249)	(0.483)	(0.856)	(1.065)	(0.987)	
Iron tablet sachets	1.378	1.561	-0.056	0.428	0.372	136
	(0.081)	(0.163)	(0.410)	(0.413)	(0.330)	
Percent of immunization	0.550	0.609	0.033	0.071	0.104	156
	(0.027)	(0.048)	(0.095)	(0.101)	(0.074)	
Number of weight checks	1.481	1.435	0.363	-0.346	0.017	272
	(0.083)	(0.122)	(0.226)	(0.267)	(0.238)	
Number Vitamin A supplements	1.682	1.667	0.372	-0.066	0.307	132
	(0.116)	(0.126)	(0.283)	(0.327)	(0.254)	
Percent malnourished	0.236	0.283	-0.070	0.168	0.0984*	266
	(0.028)	(0.043)	(0.097)	(0.122)	(0.051)	
Age 7–12 gross enrollment	0.967	0.944	0.022	-0.049	-0.027	361
	(0.010)	(0.018)	(0.025)	(0.037)	(0.025)	
Age 13–15 gross enrollment	0.762	0.872	-0.101	0.076	-0.025	149
	(0.040)	(0.049)	(0.070)	(0.090)	(0.052)	
Age 7–12 gross attendance	0.895	0.917	-0.003	-0.070	-0.0731**	360
	(0.017)	(0.018)	(0.029)	(0.042)	(0.028)	
Age 13–15 gross attendance	0.724	0.860	-0.115	0.072	-0.043	149
	(0.044)	(0.049)	(0.078)	(0.088)	(0.053)	
Average standardized effect			0.052	-0.069	-0.017	
			(0.098)	(0.112)	(0.044)	
Average standardized effect health			0.148	-0.094	0.054	
			(0.117)	(0.134)	(0.055)	
Average standardized effect education			-0.140	-0.019	-0.158	
			(0.124)	(0.143)	(0.094)	

Table 34. Results for main indicators, Sulawesi (split by per-capita consumption quintile, model 2)

Indicator	Baseline	Control mean	Generasi Versi B bottom 2 quintiles	Generasi Versi B top 3 quintiles additional effect	Generasi Versi B top 3 quintiles total	Generasi Versi A bottom 2 quintiles	Generasi Versi A top 3 quintiles additional effect	Generasi Versi A top 3 quintiles total	Number observations
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
Main 12 indicators									
Number prenatal	6.863	7.134	0.059	-0.175	-0.116	3.8472*	-5.4552*	-1.608	138
	(0.361)	(0.620)	(1.205)	(1.884)	(1.350)	(1.997)	(2.915)	(1.803)	
Delivery by trained midwife	0.529	0.685	-0.134	0.033	-0.102	0.164	-0.150	0.014	111
	(0.040)	(0.064)	(0.139)	(0.181)	(0.113)	(0.148)	(0.167)	(0.133)	
Number of postnatal visits	2.103	2.852	0.186	-0.071	0.115	-0.200	1.157	0.957	111
	(0.249)	(0.483)	(0.950)	(1.265)	(1.229)	(0.865)	(1.435)	(1.180)	
Iron tablet sachets	1.378	1.561	-0.371	0.7997**	0.429	0.599	-0.757	-0.158	136
	(0.081)	(0.163)	(0.413)	(0.391)	(0.394)	(0.506)	(0.571)	(0.496)	
Percent of immunization	0.550	0.609	-0.067	0.139	0.073	0.173	-0.084	0.088	156
	(0.027)	(0.048)	(0.137)	(0.123)	(0.085)	(0.150)	(0.133)	(0.083)	
Number of weight	1.481	1.435	0.128	-0.080	0.048	0.471	-0.557	-0.087	272
	(0.083)	(0.122)	(0.240)	(0.326)	(0.213)	(0.311)	(0.414)	(0.412)	
Number Vitamin A	1.682	1.667	0.175	0.307	0.4810*	0.263	-0.816	-0.554	132
	(0.116)	(0.126)	(0.396)	(0.467)	(0.279)	(0.508)	(0.541)	(0.353)	
Percent	0.236	0.283	0.045	0.029	0.074	-0.2200**	0.287	0.067	266
	(0.028)	(0.043)	(0.092)	(0.139)	(0.078)	(0.104)	(0.170)	(0.117)	
Age 7–12 gross	0.967	0.944	0.0380*	-0.0692**	-0.031	-0.034	0.041	0.007	361
	(0.010)	(0.018)	(0.021)	(0.026)	(0.021)	(0.039)	(0.052)	(0.040)	
Age 13–15 gross enrollment	0.762	0.872	-0.1925**	0.169	-0.023	0.2129***	-0.144	0.069	149
	(0.040)	(0.049)	(0.077)	(0.124)	(0.066)	(0.072)	(0.127)	(0.074)	
Age 7–12 gross	0.895	0.917	0.004	-0.0843*	-0.0801**	-0.014	0.028	0.014	360
	(0.017)	(0.018)	(0.030)	(0.046)	(0.033)	(0.045)	(0.064)	(0.045)	
Age 13–15 gross attendance	0.724	0.860	-0.2257***	0.164	-0.062	0.2619***	-0.128	0.1337*	149
	(0.044)	(0.049)	(0.076)	(0.111)	(0.062)	(0.068)	(0.110)	(0.072)	
Average standardized			-0.129	0.125	-0.005	0.3554***	-0.3569**	-0.002	
			(0.111)	(0.129)	(0.055)	(0.123)	(0.148)	(0.082)	
Average standardized effect health			-0.061	0.146	0.085	0.3824**	-0.4714***	-0.089	
			(0.142)	(0.141)	(0.069)	(0.158)	(0.164)	(0.098)	
Average standardized effect education			-0.2654**	0.082	-0.183	0.3013**	-0.128	0.174	
			(0.124)	(0.191)	(0.112)	(0.137)	(0.231)	(0.169)	

Table 35. Direct benefits, all provinces (baseline as control variable)

Indicator	Baseline mean	Control mean	Model 1 Total Generasi Year 1 Effect	Versi A additional effect	Model 2 Total Versi B impact	Total Versi A impact	Number observations
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Received scholarship		0.025	0.0110**	0.011	0.006	0.0163**	7421
		(0.005)	(0.005)	(0.008)	(0.006)	(0.007)	
Received uniform		0.013	0.0938***	0.028		0.1080***	7319
		(0.004)	(0.013)	(0.018)	(0.012)	(0.019)	
Received other school supplies		0.008	0.0569***	0.011		0.0625***	7403
		(0.003)	(0.009)	(0.012)	(0.009)	(0.012)	
Received transport subsidy		0.000	0.0093***	0.010	0.0046*	0.0141***	7432
		0.000	(0.003)	(0.006)	(0.003)	(0.005)	
Received other school support		0.000	0.000	0.001	0.000	0.000	7421
		0.000	0.000	0.000	0.000	0.000	
Received supplementary feeding at school		0.000	0.0044**	0.001	0.0040**	0.005	7423
		0.000	(0.002)	(0.004)	(0.002)	(0.003)	
Received supplementary feeding at village health post		0.469	0.1551***	-0.003		0.1534***	5392
		(0.017)	(0.024)	(0.028)	(0.028)	(0.028)	
Received intensive supplementary feeding at village health		0.027	0.0170**	-0.0182*	0.0261**	0.008	5392
		(0.006)	(0.007)	(0.011)	(0.010)	(0.007)	
Received health subsidy for prenatal/postnatal care		0.005	0.0303***	0.008		0.0340***	4553
		(0.002)	(0.006)	(0.009)	(0.007)	(0.008)	
Received health subsidy for childbirth		0.039	0.1156***	-0.028		0.1021***	2701
		(0.008)	(0.014)	(0.019)	(0.017)	(0.017)	
Average standardized effect			0.2043***	0.029		0.2191***	
			(0.019)	(0.028)	(0.019)	(0.027)	
Average standardized effect health			0.1869***	-0.015		0.1796***	
			(0.017)	(0.025)	(0.019)	(0.022)	
Average standardized effect education			0.2305***	0.0948**		0.2783***	
			(0.032)	(0.045)	(0.029)	(0.046)	

Note: All outcomes are dummy variables

Table 36. Direct benefits, Java (baseline as control variable)

			Model 1		Model 2		
Indicator	Baseline mean	Control mean	Total Generasi Year 1 Effect	Versi A additional effect	Total Versi B impact	Total Versi A impact	Number observations
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Received scholarship		0.010	0.0139**	-0.002	0.0151*	0.0128*	4557
		(0.004)	(0.006)	(0.010)	(0.008)	(0.007)	
Received uniform		0.012	0.0695***	0.0381*	0.0498***	0.0879***	4522
		(0.004)	(0.016)	(0.022)	(0.013)	(0.024)	
Received other school supplies		0.010	0.0391***	0.016	0.0306***	0.0470***	4553
		(0.004)	(0.011)	(0.015)	(0.010)	(0.015)	
Received transport subsidy		0.000	0.0046*	0.001	0.004	0.005	4566
		0.000	(0.003)	(0.004)	(0.003)	(0.004)	
Received other school support		0.000	0.000	0.001	0.000	0.001	4557
		0.000	0.000	(0.001)	0.000	(0.001)	
Received supplementary feeding at school		0.000	0.001	0.000	0.001	0.001	4565
		0.000	(0.001)	(0.001)	(0.001)	(0.001)	
Received supplementary feeding at village health post		0.604	0.1076***	0.002	0.1064***	0.1088***	3385
		(0.022)	(0.029)	(0.033)	(0.035)	(0.033)	
Received intensive supplementary feeding at village health post		0.026	0.012	-0.006	0.015	0.010	3385
		(0.007)	(0.009)	(0.013)	(0.012)	(0.010)	
Received health subsidy for prenatal/postnatal care		0.007	0.0208**	0.001	0.0202**	0.0214**	3023
		(0.003)	(0.008)	(0.009)	(0.009)	(0.010)	
Received health subsidy for childbirth		0.060	0.1296***	-0.027	0.1441***	0.1167***	1738
		(0.013)	(0.019)	(0.026)	(0.022)	(0.024)	
Average standardized effect			0.1757***	0.028	0.1616***	0.1891***	
			(0.026)	(0.035)	(0.024)	(0.036)	
Average standardized effect health			0.1521***	-0.009	0.1571***	0.1478***	
			(0.019)	(0.024)	(0.021)	(0.025)	
Average standardized effect education			0.2111***	0.083	0.1684***	0.2512***	
			(0.053)	(0.071)	(0.045)	(0.074)	

Table 37. Direct benefits, East Nusa Tenggara (baseline as control variable)

Indicator	Baseline mean	Control mean	Model 1 Total Generasi Year 1 Effect	Versi A additional effect	Model 2 Total Versi B impact	Total Versi A impact	Number observations
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Received scholarship		0.070	0.002	0.022	-0.009	0.014	1857
		(0.016)	(0.013)	(0.015)	(0.012)	(0.017)	
Received uniform		0.021	0.1329***	0.014	0.1260***	0.1404***	1803
		(0.009)	(0.027)	(0.038)	(0.025)	(0.039)	
Received other school supplies		0.004	0.0766***	0.006	0.0736***	0.0799***	1848
		(0.004)	(0.016)	(0.020)	(0.016)	(0.022)	
Received transport subsidy		0.000	0.0124*	0.017	0.005	0.021	1857
		0.000	(0.007)	(0.017)	(0.006)	(0.014)	
Received other school support		0.000	0.000	0.000	0.000	0.000	1857
		0.000	0.000	0.000	0.000	0.000	
Received supplementary feeding at school		0.000	0.0148***	0.004	0.0131**	0.017	1850
		0.000	(0.006)	(0.013)	(0.006)	(0.011)	
Received supplementary feeding at village health post		0.349	0.2085***	-0.059	0.2388***	0.1801***	1250
		(0.035)	(0.047)	(0.057)	(0.058)	(0.052)	
Received intensive supplementary feeding at village		0.026	0.0386**	-0.0480**	0.0634**	0.015	1250
		(0.012)	(0.018)	(0.022)	(0.025)	(0.013)	
Received health subsidy for prenatal/postnatal care		0.006	0.0462***	0.037	0.0279*	0.0647***	931
		(0.006)	(0.014)	(0.024)	(0.014)	(0.022)	
Received health subsidy for childbirth		0.000	0.0633***	0.025	0.0499*	0.0746***	594
		0.000	(0.020)	(0.025)	(0.026)	(0.021)	
Average standardized effect			0.2514***	0.039	0.2327***	0.2721***	
			(0.036)	(0.058)	(0.037)	(0.054)	
Average standardized effect health			0.2701***	0.004	0.2687***	0.2722***	
			(0.041)	(0.062)	(0.047)	(0.056)	
Average standardized effect education			0.2280***	0.084	0.1878***	0.2719***	
			(0.047)	(0.070)	(0.043)	(0.070)	

Table 38. Direct benefits, Sulawesi /Gorontalo (baseline as control variable)

			Model 1		Model 2		
Indicator	Baseline mean	Control mean	Total Generasi Year 1 Effect	Versi A additional effect	Total Versi B impact	Total Versi A impact	Number observations
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Received scholarship		0.015	0.015	0.0428**	-0.004	0.0388**	1007
		(0.008)	(0.012)	(0.020)	(0.009)	(0.018)	
Received uniform		0.010	0.1180***	0.023	0.1079***	0.1305***	994
		(0.007)	(0.029)	(0.043)	(0.030)	(0.041)	
Received other school supplies		0.005	0.0908***	0.011	0.0857***	0.0971**	1002
		(0.005)	(0.029)	(0.041)	(0.026)	(0.044)	
Received transport subsidy		0.000	0.0213**	0.0358**	0.005	0.0410***	1009
		0.000	(0.009)	(0.015)	(0.005)	(0.014)	
Received other school support		0.000	0.000	0.000	0.000	0.000	1007
		0.000	0.000	0.000	0.000	0.000	
Received supplementary feeding at school		0.000	0.000	0.000	0.000	0.000	1008
		0.000	0.000	0.000	0.000	0.000	
Received supplementary feeding at village health post		0.204	0.2385***	0.123	0.1820***	0.3053***	757
		(0.031)	(0.062)	(0.081)	(0.064)	(0.078)	
Received intensive supplementary feeding at village health		0.030	0.000	-0.003	0.001	-0.002	757
		(0.013)	(0.009)	(0.012)	(0.012)	(0.009)	
Received health subsidy for prenatal/postnatal care		0.000	0.0461***	-0.021	0.0556***	0.0349***	599
		0.000	(0.012)	(0.020)	(0.017)	(0.012)	
Received health subsidy for childbirth		0.017	0.1463***	-0.1483***	0.2108***	0.0625***	369
		(0.012)	(0.034)	(0.043)	(0.039)	(0.022)	
Average standardized effect			0.3295***	0.032	0.3138***	0.3460***	
			(0.050)	(0.071)	(0.060)	(0.062)	
Average standardized effect health			0.3516***	-0.126	0.4056***	0.2802***	
			(0.057)	(0.084)	(0.082)	(0.044)	
Average standardized effect education			0.3073***	0.1897**	0.2221***	0.4118***	
			(0.073)	(0.094)	(0.063)	(0.095)	

Table 39. Results for service provider quantities, all provinces (baseline as control variable)

			Model 1		Model 2		
Indicator	Baseline mean	Control mean	Total Generasi Year 1 Effect	Versi A additional effect	Total Versi B impact	Total Versi A impact	Number observations
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Midwife/Polindes in village	0.783	0.806	-0.010	0.021	-0.021	0.000	2026
	(0.009)	(0.016)	(0.019)	(0.023)	(0.023)	(0.021)	
Number of active village health posts in village	4.516	4.222	-0.043	-0.098	0.006	-0.092	2027
	(0.078)	(0.106)	(0.119)	(0.125)	(0.144)	(0.124)	
SD located in village	0.991	0.992	0.003	-0.001	0.004	0.002	2027
	(0.002)	(0.004)	(0.003)	(0.004)	(0.004)	(0.003)	
SMP located in village	0.457	0.465	0.023	-0.006	0.026	0.019	2027
	(0.011)	(0.020)	(0.016)	(0.019)	(0.019)	(0.018)	
Number of teachers at SD (includes guru honor)	.	10.445	0.177	0.263	0.047	0.310	1056
	(.)	(0.172)	(0.250)	(0.346)	(0.281)	(0.325)	
Number of teachers at SMP (includes guru honor)	22.568	21.949	0.304	-0.4420*	0.5208**	0.079	745
	(0.430)	(0.704)	(0.213)	(0.254)	(0.248)	(0.250)	
Average standardized effect			0.020	0.005	0.017	0.023	
			(0.020)	(0.025)	(0.024)	(0.023)	
Average standardized effect health			-0.021	0.008	-0.025	-0.017	
			(0.032)	(0.035)	(0.038)	(0.035)	
Average standardized effect education			0.0404*	0.004	0.039	0.042	
			(0.023)	(0.030)	(0.028)	(0.028)	

Table 40. Results for service provider quantities, Java (baseline as control variable)

			Model 1		Model 2		
Indicator	Baseline mean	Control mean	Total Generasi Year 1 Effect	Versi A additional effect	Total Versi B impact	Total Versi A impact	Number observations
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Midwife/Polindes in village	0.870	0.894	0.011	-0.030	0.026	-0.003	1359
	(0.009)	(0.015)	(0.019)	(0.024)	(0.024)	(0.020)	
Number of active village health posts in village	5.405	5.198	-0.094	-0.108	-0.039	-0.147	1360
	(0.103)	(0.136)	(0.181)	(0.190)	(0.223)	(0.183)	
SD located in village	0.999	1.000	-0.002	0.003	-0.004	0.000	1360
	(0.001)	0.000	(0.002)	(0.003)	(0.003)	(0.001)	
SMP located in village	0.513	0.499	0.0359*	-0.015	0.0439*	0.029	1360
	(0.014)	(0.025)	(0.020)	(0.023)	(0.024)	(0.022)	
Number of teachers at SD (includes guru honor)	.	10.481	0.495	0.319	0.334	0.653	716
	(.)	(0.204)	(0.307)	(0.394)	(0.307)	(0.412)	
Number of teachers at SMP (includes guru honor)	25.031	24.510	0.331	-0.461	0.5645*	0.103	519
	(0.533)	(0.898)	(0.259)	(0.334)	(0.318)	(0.300)	
Average standardized effect			0.0540*	-0.020	0.0645**	0.045	
			(0.029)	(0.033)	(0.031)	(0.035)	
Average standardized effect health			0.001	-0.068	0.035	-0.032	
			(0.044)	(0.050)	(0.054)	(0.047)	
Average standardized effect education			0.0896**	0.012	0.0840**	0.0957**	
			(0.036)	(0.044)	(0.037)	(0.046)	

Table 41. Results for service provider quantities, East Nusa Tenggara (baseline as control variable)

			Model 1		Model 2		
Indicator	Baseline mean	Control mean	Total Generasi Year 1 Effect	Versi A additional effect	Total Versi B impact	Total Versi A impact	Number observations
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Midwife/Polindes in village	0.582	0.658	-0.068	0.054	-0.0951**	-0.041	402
	(0.025)	(0.044)	(0.043)	(0.045)	(0.045)	(0.051)	
Number of active village health posts in village	3.020	2.958	0.091	-0.005	0.093	0.088	402
	(0.083)	(0.134)	(0.109)	(0.091)	(0.113)	(0.123)	
SD located in village	0.973	0.958	0.0215*	-0.016	0.0291*	0.013	402
	(0.008)	(0.018)	(0.013)	(0.011)	(0.015)	(0.012)	
SMP located in village	0.221	0.233	0.036	0.022	0.026	0.048	402
	(0.021)	(0.039)	(0.029)	(0.043)	(0.040)	(0.032)	
Number of teachers at SD (includes guru honor)	.	10.850	-0.906	0.000	-0.906	-0.906	204
	(.)	(0.524)	(0.581)	(0.824)	(0.776)	(0.643)	
Number of teachers at SMP (includes guru honor)	17.508	18.868	0.003	-0.473	0.227	-0.246	125
	(0.739)	(1.195)	(0.460)	(0.453)	(0.514)	(0.498)	
Average standardized effect			-0.018	0.003	-0.021	-0.018	
			(0.043)	(0.053)	(0.056)	(0.044)	
Average standardized effect health			-0.040	0.055	-0.068	-0.013	
			(0.058)	(0.054)	(0.059)	(0.068)	
Average standardized effect education			-0.008	-0.024	0.003	-0.020	
			(0.051)	(0.065)	(0.069)	(0.049)	

Table 42. Results for service provider quantities, Sulawesi /Gorontalo (baseline as control variable)

			Model 1		Model 2		
Indicator	Baseline mean	Control mean	Total Generasi Year 1 Effect	Versi A additional effect	Total Versi B impact	Total Versi A impact	Number observations
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Midwife/Polindes in village	0.642	0.649	0.011	0.1677*	-0.063	0.105	265
	(0.030)	(0.046)	(0.071)	(0.096)	(0.078)	(0.092)	
Number of active village health posts in village	2.249	2.027	0.011	-0.262	0.127	-0.135	265
	(0.106)	(0.124)	(0.149)	(0.233)	(0.179)	(0.202)	
SD located in village	0.974	1.000	-0.006	0.003	-0.008	-0.005	265
	(0.010)	0.000	(0.010)	(0.014)	(0.010)	(0.015)	
SMP located in village	0.528	0.595	-0.051	-0.026	-0.039	-0.065	265
	(0.031)	(0.047)	(0.043)	(0.050)	(0.035)	(0.063)	
Number of teachers at SD (includes guru honor)	.	9.875	0.303	0.502	0.077	0.579	136
	(.)	(0.317)	(0.608)	(1.003)	(0.727)	(0.855)	
Number of teachers at SMP (includes guru honor)	16.230	15.405	0.616	0.319	0.475	0.794	101
	(0.849)	(1.295)	(0.525)	(0.750)	(0.594)	(0.680)	
Average standardized effect			0.026	0.069	-0.005	0.064	
			(0.075)	(0.123)	(0.092)	(0.101)	
Average standardized effect health			0.016	0.075	-0.017	0.058	
			(0.091)	(0.137)	(0.107)	(0.122)	
Average standardized effect education			0.033	0.065	0.003	0.069	
			(0.093)	(0.142)	(0.106)	(0.128)	

Table 43. Results for service provider inputs, all provinces (baseline as control variable)

Indicator	Baseline mean	Control mean	Model 1 Total Generasi Year 1 Effect	Model 1 Versi A additional effect	Model 2 Total Versi B impact	Model 2 Total Versi A impact	Number observations
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Midwives							
Has access to water	0.714	0.785	0.026	-0.051	0.0505**	0.000	936
	(0.018)	(0.030)	(0.021)	(0.031)	(0.024)	(0.028)	
Has access to electricity	0.956	0.995	0.002	0.011	-0.004	0.007	936
	(0.008)	(0.005)	(0.012)	(0.019)	(0.015)	(0.017)	
Percentage of drugs in stock	0.610	0.791	-0.017	-0.029	-0.003	-0.031	1043
	(0.010)	(0.015)	(0.017)	(0.023)	(0.021)	(0.020)	
Percentage of tools available	0.625	0.665	0.005	0.014	-0.002	0.012	1042
Schools	(0.010)	(0.015)	(0.013)	(0.017)	(0.016)	(0.015)	
Number of classrooms (SD)	.	5.872	-0.089	0.199	-0.188	0.012	1056
	(.)	(0.072)	(0.127)	(0.164)	(0.138)	(0.162)	
Number of classrooms (SMP)	8.644	8.931	0.117	0.209	0.014	0.224	746
	(0.217)	(0.389)	(0.230)	(0.241)	(0.272)	(0.245)	
Condition of school building (SD, scale 0-1)	.	0.869	-0.005	-0.029	0.010	-0.019	1051
	(.)	(0.011)	(0.014)	(0.018)	(0.015)	(0.017)	
Condition of school building (SMP, scale 0-1)	0.903	0.916	-0.002	0.002	-0.003	-0.001	742
	(0.006)	(0.009)	(0.013)	(0.015)	(0.017)	(0.012)	
Has student latrine (SD)	.	0.799	0.011	0.018	0.002	0.020	1056
	(.)	(0.022)	(0.028)	(0.037)	(0.034)	(0.033)	
Has student latrine (SMP)	0.928	0.923	0.019	0.015	0.012	0.027	746
	(0.010)	(0.018)	(0.020)	(0.028)	(0.025)	(0.023)	
Has student latrine with water (SD)	.	0.553	0.032	-0.028	0.046	0.018	1032
	(.)	(0.028)	(0.036)	(0.047)	(0.043)	(0.043)	
Has student latrine with water (SMP)	0.662	0.717	-0.053	0.006	-0.056	-0.050	741
	(0.018)	(0.030)	(0.035)	(0.048)	(0.044)	(0.041)	
Average standardized effect			-0.002	-0.002	-0.001	-0.003	
			(0.027)	(0.036)	(0.034)	(0.031)	
Average standardized effect health			0.004	-0.032	0.019	-0.013	
			(0.033)	(0.053)	(0.043)	(0.041)	
Average standardized effect education			-0.005	0.013	-0.012	0.002	
			(0.035)	(0.045)	(0.043)	(0.040)	

Table 44. Results for service provider inputs, Java (baseline as control variable)

			Model 1		Model 2		
Indicator	Baseline mean	Control mean	Total Generasi Year 1 Effect	Versi A additional effect	Total Versi B impact	Total Versi A impact	Number observations
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Midwives							
Has access to water	0.788	0.826	0.0483**	-0.044	0.0700***	0.027	697
	(0.019)	(0.032)	(0.023)	(0.033)	(0.025)	(0.031)	
Has access to electricity	0.998	1.000	-0.006	-0.003	-0.005	-0.008	697
	(0.002)	0.000	(0.011)	(0.019)	(0.013)	(0.016)	
Percentage of drugs in stock	0.618	0.822	-0.004	-0.017	0.004	-0.013	713
	(0.011)	(0.017)	(0.016)	(0.022)	(0.020)	(0.018)	
Percentage of tools available	0.677	0.707	0.017	0.015	0.010	0.025	712
Schools	(0.010)	(0.014)	(0.013)	(0.016)	(0.016)	(0.015)	
Number of classrooms (SD)	.	5.764	0.009	0.265	-0.124	0.140	716
	(.)	(0.079)	(0.155)	(0.176)	(0.139)	(0.208)	
Number of classrooms (SMP)	9.332	9.543	-0.065	0.270	-0.202	0.068	520
	(0.268)	(0.517)	(0.182)	(0.312)	(0.270)	(0.206)	
Condition of school building (SD, scale 0-1)	.	0.873	-0.008	-0.028	0.006	-0.022	714
	(.)	(0.013)	(0.017)	(0.022)	(0.020)	(0.021)	
Condition of school building (SMP, scale 0-1)	0.903	0.906	0.012	0.007	0.008	0.015	517
	(0.007)	(0.012)	(0.015)	(0.019)	(0.020)	(0.014)	
Has student latrine (SD)	.	0.793	0.026	-0.002	0.027	0.026	716
	(.)	(0.028)	(0.034)	(0.043)	(0.039)	(0.041)	
Has student latrine (SMP)	0.932	0.935	0.009	0.012	0.003	0.015	520
	(0.011)	(0.020)	(0.024)	(0.037)	(0.033)	(0.028)	
Has student latrine with water (SD)	.	0.611	0.051	-0.023	0.062	0.039	702
	(.)	(0.034)	(0.042)	(0.052)	(0.049)	(0.051)	
Has student latrine with water (SMP)	0.743	0.787	-0.051	0.025	-0.063	-0.038	516
	(0.020)	(0.034)	(0.042)	(0.057)	(0.052)	(0.049)	
Average standardized effect			0.020	0.007	0.017	0.023	
			(0.033)	(0.041)	(0.039)	(0.038)	
Average standardized effect health			0.032	-0.037	0.051	0.013	
			(0.039)	(0.061)	(0.049)	(0.049)	
Average standardized effect education			0.014	0.029	0.000	0.029	
			(0.048)	(0.056)	(0.055)	(0.056)	

Table 45. Results for service provider inputs, East Nusa Tenggara (baseline as control variable)

Indicator	Baseline mean	Control mean	Model 1 Total Generasi Year 1 Effect	Model 1 Versi A additional effect	Model 2 Total Versi B impact	Model 2 Total Versi A impact	Number observations
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Midwives							
Has access to water	0.354	0.455	-0.023	-0.039	-0.007	-0.046	126
	(0.045)	(0.109)	(0.073)	(0.137)	(0.093)	(0.107)	
Has access to electricity	0.788	0.955	0.018	0.1582*	-0.054	0.1040*	126
	(0.039)	(0.046)	(0.048)	(0.081)	(0.064)	(0.057)	
Percentage of drugs in stock	0.571	0.661	-0.050	-0.105	0.000	-0.106	204
	(0.034)	(0.052)	(0.058)	(0.071)	(0.066)	(0.070)	
Percentage of tools available	0.424	0.455	-0.025	0.005	-0.027	-0.022	204
Schools	(0.030)	(0.049)	(0.038)	(0.049)	(0.047)	(0.043)	
Number of classrooms (SD)	.	6.450	-0.292	-0.298	-0.144	-0.442	204
	(.)	(0.216)	(0.328)	(0.451)	(0.438)	(0.353)	
Number of classrooms (SMP)	7.597	8.842	0.054	-0.058	0.080	0.022	125
	(0.498)	(0.743)	(0.458)	(0.558)	(0.589)	(0.459)	
Condition of school building (SD, scale 0-1)	.	0.795	0.027	-0.031	0.042	0.012	202
	(.)	(0.028)	(0.036)	(0.044)	(0.035)	(0.047)	
Condition of school building (SMP, scale 0-1)	0.871	0.901	-0.031	-0.004	-0.029	-0.033	124
	(0.016)	(0.027)	(0.038)	(0.035)	(0.046)	(0.036)	
Has student latrine (SD)	.	0.817	0.014	0.102	-0.036	0.066	204
	(.)	(0.050)	(0.068)	(0.087)	(0.083)	(0.074)	
Has student latrine (SMP)	0.952	0.974	-0.004	0.078	-0.040	0.038	125
	(0.019)	(0.026)	(0.033)	(0.050)	(0.048)	(0.030)	
Has student latrine with water (SD)	.	0.362	0.079	-0.011	0.084	0.074	199
	(.)	(0.064)	(0.096)	(0.121)	(0.109)	(0.118)	
Has student latrine with water (SMP)	0.483	0.579	-0.084	-0.022	-0.074	-0.096	124
	(0.046)	(0.081)	(0.093)	(0.103)	(0.097)	(0.119)	
Average standardized effect			-0.040	0.029	-0.053	-0.024	
			(0.075)	(0.102)	(0.099)	(0.080)	
Average standardized effect health			-0.064	0.007	-0.068	-0.060	
			(0.094)	(0.162)	(0.129)	(0.120)	
Average standardized effect education			-0.027	0.040	-0.046	-0.006	
			(0.081)	(0.115)	(0.111)	(0.086)	

Table 46. Results for service provider inputs, Sulawesi /Gorontalo (baseline as control variable)

Indicator	Baseline mean	Control mean	Model 1 Total Generasi Year 1 Effect	Versi A additional effect	Model 2 Total Versi B impact	Total Versi A impact	Number observations
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Midwives							
Has access to water	0.798	0.829	-0.045	0.012	-0.0504*	-0.039	113
	(0.046)	(0.065)	(0.033)	(0.050)	(0.028)	(0.053)	
Has access to electricity	0.949	1.000	0.028	-0.078	0.0622*	-0.016	113
	(0.025)	0.000	(0.029)	(0.055)	(0.036)	(0.043)	
Percentage of drugs in stock	0.620	0.781	-0.025	0.071	-0.055	0.017	126
	(0.026)	(0.032)	(0.042)	(0.063)	(0.048)	(0.055)	
Percentage of tools available	0.608	0.678	-0.022	0.018	-0.031	-0.012	126
Schools	(0.029)	(0.039)	(0.044)	(0.065)	(0.059)	(0.049)	
Number of classrooms (SD)	.	5.661	-0.231	0.8653***	-0.6218**	0.244	136
	(.)	(0.173)	(0.261)	(0.293)	(0.273)	(0.269)	
Number of classrooms (SMP)	6.420	6.786	-0.029	0.569	-0.269	0.300	101
	(0.442)	(0.737)	(0.358)	(0.350)	(0.356)	(0.436)	
Condition of school building (SD, scale 0-1)	.	0.930	-0.033	-0.032	-0.018	-0.0500**	135
	(.)	(0.017)	(0.020)	(0.034)	(0.028)	(0.024)	
Condition of school building (SMP, scale 0-1)	0.943	0.967	0.000	-0.003	0.001	-0.002	101
	(0.013)	(0.012)	(0.016)	(0.019)	(0.014)	(0.024)	
Has student latrine (SD)	.	0.804	-0.058	-0.057	-0.032	-0.089	136
	(.)	(0.054)	(0.069)	(0.113)	(0.098)	(0.076)	
Has student latrine (SMP)	0.880	0.833	0.0906*	-0.038	0.1061**	0.068	101
	(0.033)	(0.058)	(0.048)	(0.046)	(0.047)	(0.060)	
Has student latrine with water (SD)	.	0.527	-0.112	-0.102	-0.065	-0.1670*	131
	(.)	(0.068)	(0.093)	(0.120)	(0.125)	(0.085)	
Has student latrine with water (SMP)	0.469	0.595	0.001	-0.005	0.004	-0.002	101
	(0.051)	(0.077)	(0.087)	(0.164)	(0.130)	(0.104)	
Average standardized effect			-0.065	0.007	-0.068	-0.060	
			(0.047)	(0.072)	(0.063)	(0.053)	
Average standardized effect health			-0.051	0.016	-0.057	-0.041	
			(0.074)	(0.094)	(0.086)	(0.089)	
Average standardized effect education			-0.072	0.003	-0.073	-0.070	
			(0.064)	(0.102)	(0.094)	(0.065)	

Table 47. Results for service provider efforts, all provinces (baseline as control variable)

			Model 1		Model 2		
Indicator	Baseline mean	Control mean	Total Generasi Year 1 Effect	Versi A additional effect	Total Versi B impact	Total Versi A impact	Number observations
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Midwives							
Hours spent in outreach over past 3 days	3.200	2.498	0.339	0.8838**	-0.098	0.7858*	1043
	(0.175)	(0.273)	(0.308)	(0.423)	(0.331)	(0.409)	
Hours spent providing public services over past 3 days	13.635	12.389	-0.370	1.7021**	-1.2107**	0.491	1043
	(0.389)	(0.535)	(0.486)	(0.721)	(0.596)	(0.610)	
Hours spent providing private services over past 3 days	10.693	9.995	0.012	0.562	-0.266	0.296	1043
	(0.482)	(0.769)	(0.707)	(0.893)	(0.830)	(0.842)	
Total hours spent working over past 3 days	27.573	24.882	-0.102	3.1132***	-1.635	1.478	1043
	(0.607)	(0.915)	(0.868)	(1.156)	(1.026)	(1.050)	
Number of village health posts attended in past month	4.151	3.754	0.100	0.027	0.087	0.114	1043
	(0.132)	(0.216)	(0.218)	(0.340)	(0.242)	(0.308)	
Number of hours midwife spends per village health post	3.034	2.722	0.1878*	-0.073	0.2237*	0.151	1042
Teachers	(0.067)	(0.115)	(0.110)	(0.126)	(0.124)	(0.129)	
Percent present at time of interview (SD)	.	0.863	0.012	-0.007	0.016	0.008	1078
	(.)	(0.009)	(0.013)	(0.017)	(0.015)	(0.016)	
Percent present at time of interview (SMP)	.	0.881	-0.008	0.008	-0.012	-0.004	723
	(.)	(0.010)	(0.012)	(0.014)	(0.014)	(0.014)	
Percent teaching at time of class observation (SD)	.	0.667	-0.029	0.029	-0.043	-0.014	1077
	(.)	(0.026)	(0.034)	(0.043)	(0.042)	(0.038)	
Percent teaching at time of class observation (SMP)	.	0.603	-0.056	-0.002	-0.056	-0.057	723
	(.)	(0.032)	(0.039)	(0.048)	(0.047)	(0.044)	
Average standardized effect			0.001	0.0760**	-0.036	0.040	
			(0.025)	(0.035)	(0.030)	(0.032)	
Average standardized effect health			0.028	0.1158**	-0.029	0.0864*	
			(0.034)	(0.048)	(0.038)	(0.044)	
Average standardized effect education			-0.039	0.016	-0.047	-0.031	
			(0.040)	(0.053)	(0.048)	(0.048)	

Table 48. Results for service provider efforts, Java (baseline as control variable)

			Model 1		Model 2		
Indicator	Baseline mean	Control mean	Total Generasi Year 1 Effect	Versi A additional effect	Total Versi B impact	Total Versi A impact	Number observations
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Midwives							
Hours spent in outreach over past 3 days	3.132	2.035	0.8749***	0.540	0.6022*	1.1426***	713
	(0.187)	(0.283)	(0.332)	(0.423)	(0.346)	(0.432)	
Hours spent providing public services over past 3 days	12.868	12.359	-0.430	1.6039*	-1.2402*	0.364	713
	(0.380)	(0.570)	(0.555)	(0.898)	(0.681)	(0.752)	
Hours spent providing private services over past 3 days	13.502	12.521	0.041	0.923	-0.425	0.498	713
	(0.586)	(0.992)	(0.982)	(1.299)	(1.171)	(1.184)	
Total hours spent working over past 3 days	29.507	26.916	0.438	3.1032**	-1.126	1.977	713
	(0.684)	(1.157)	(1.109)	(1.452)	(1.313)	(1.336)	
Number of village health posts attended in past month	4.535	4.021	0.035	0.175	-0.053	0.122	713
	(0.146)	(0.266)	(0.296)	(0.495)	(0.337)	(0.431)	
Number of hours midwife spends per village health post	2.755	2.488	0.048	-0.109	0.104	-0.006	712
Teachers	(0.068)	(0.120)	(0.104)	(0.132)	(0.114)	(0.132)	
Percent present at time of interview (SD)	.	0.880	0.0240*	0.009	0.019	0.0287*	725
	(.)	(0.011)	(0.015)	(0.017)	(0.018)	(0.016)	
Percent present at time of interview (SMP)	.	0.905	0.005	0.019	-0.005	0.014	510
	(.)	(0.011)	(0.013)	(0.014)	(0.015)	(0.015)	
Percent teaching at time of class observation (SD)	.	0.688	-0.032	0.028	-0.047	-0.018	725
	(.)	(0.032)	(0.040)	(0.049)	(0.048)	(0.046)	
Percent teaching at time of class observation (SMP)	.	0.623	-0.043	0.032	-0.059	-0.027	510
	(.)	(0.040)	(0.049)	(0.059)	(0.060)	(0.054)	
Average standardized effect			0.030	0.1013**	-0.021	0.0799**	
			(0.031)	(0.043)	(0.038)	(0.039)	
Average standardized effect health			0.045	0.1148*	-0.013	0.1018*	
			(0.043)	(0.062)	(0.049)	(0.057)	
Average standardized effect education			0.007	0.081	-0.034	0.047	
			(0.045)	(0.059)	(0.056)	(0.053)	

Table 49. Results for service provider efforts, East Nusa Tenggara (baseline as control variable)

			Model 1		Model 2		
Indicator	Baseline mean	Control mean	Total Generasi Year 1 Effect	Versi A additional effect	Total Versi B impact	Total Versi A impact	Number observations
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Midwives							
Hours spent in outreach over past 3 days	3.254	3.968	-0.854	1.216	-1.445	-0.229	204
	(0.548)	(1.084)	(0.886)	(1.229)	(0.896)	(1.230)	
Hours spent providing public services over past 3 days	15.640	11.807	-0.154	0.832	-0.555	0.277	204
	(1.227)	(1.461)	(1.308)	(1.337)	(1.506)	(1.396)	
Hours spent providing private services over past 3 days	1.360	1.613	-1.214	0.274	-1.3457*	-1.072	204
	(0.385)	(0.709)	(0.812)	(0.653)	(0.752)	(1.002)	
Total hours spent working over past 3 days	20.434	17.387	-2.458	1.977	-3.4062*	-1.429	204
	(1.399)	(1.323)	(1.744)	(2.118)	(1.786)	(2.257)	
Number of village health posts attended in past month	2.885	3.161	0.028	0.010	0.024	0.033	204
	(0.179)	(0.315)	(0.191)	(0.219)	(0.194)	(0.246)	
Number of hours midwife spends per village health post	3.969	3.871	0.239	-0.079	0.277	0.199	204
Teachers	(0.191)	(0.297)	(0.279)	(0.298)	(0.297)	(0.336)	
Percent present at time of interview (SD)	.	0.847	-0.028	-0.026	-0.015	-0.041	210
	(.)	(0.018)	(0.029)	(0.043)	(0.036)	(0.035)	
Percent present at time of interview (SMP)	.	0.887	-0.0662*	0.005	-0.0682*	-0.064	119
	(.)	(0.020)	(0.033)	(0.041)	(0.035)	(0.043)	
Percent teaching at time of class observation (SD)	.	0.590	-0.077	0.069	-0.111	-0.042	209
	(.)	(0.064)	(0.081)	(0.088)	(0.101)	(0.086)	
Percent teaching at time of class observation (SMP)	.	0.676	-0.1746*	-0.102	-0.127	-0.2296*	119
	(.)	(0.078)	(0.088)	(0.118)	(0.096)	(0.118)	
Average standardized effect			-0.1703***	0.028	-0.1842***	-0.1562**	
			(0.060)	(0.076)	(0.067)	(0.074)	
Average standardized effect health			-0.074	0.084	-0.114	-0.030	
			(0.081)	(0.102)	(0.082)	(0.108)	
Average standardized effect education			-0.3155***	-0.055	-0.2896**	-0.3449**	
			(0.110)	(0.142)	(0.131)	(0.131)	

Table 50. Results for service provider efforts, Sulawesi /Gorontalo (baseline as control variable)

			Model 1		Model 2		
Indicator	Baseline mean	Control mean	Total Generasi Year 1 Effect	Versi A additional effect	Total Versi B impact	Total Versi A impact	Number observations
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Midwives							
Hours spent in outreach over past 3 days	3.519	3.026	-0.289	1.7670*	-1.078	0.689	126
	(0.543)	(0.596)	(0.817)	(0.992)	(0.946)	(0.969)	
Hours spent providing public services over past 3 days	15.228	12.974	-0.681	4.070	-2.492	1.577	126
	(1.496)	(1.721)	(1.467)	(2.540)	(2.053)	(1.907)	
Hours spent providing private services over past 3 days	7.734	7.395	2.234	0.134	2.174	2.307	126
	(1.267)	(1.377)	(1.675)	(2.382)	(2.366)	(1.591)	
Total hours spent working over past 3 days	26.481	23.395	1.259	6.036	-1.448	4.5878*	126
	(2.020)	(2.112)	(2.247)	(3.660)	(3.193)	(2.512)	
Number of village health posts attended in past month	3.722	3.237	0.900	-0.424	1.086	0.663	126
	(0.597)	(0.605)	(0.563)	(0.699)	(0.703)	(0.589)	
Number of hours midwife spends per village health post	3.324	2.658	0.8887**	-0.024	0.8994*	0.8753**	126
Teachers	(0.232)	(0.338)	(0.390)	(0.444)	(0.468)	(0.424)	
Percent present at time of interview (SD)	.	0.816	0.008	-0.050	0.031	-0.019	143
	(.)	(0.026)	(0.038)	(0.063)	(0.035)	(0.064)	
Percent present at time of interview (SMP)	.	0.789	0.009	-0.047	0.031	-0.016	94
	(.)	(0.028)	(0.038)	(0.053)	(0.042)	(0.052)	
Percent teaching at time of class observation (SD)	.	0.667	0.058	-0.054	0.082	0.028	143
	(.)	(0.063)	(0.100)	(0.150)	(0.132)	(0.119)	
Percent teaching at time of class observation (SMP)	.	0.463	0.009	-0.061	0.037	-0.024	94
	(.)	(0.079)	(0.088)	(0.124)	(0.110)	(0.103)	
Average standardized effect			0.1113*	0.051	0.089	0.1399*	
			(0.055)	(0.084)	(0.066)	(0.074)	
Average standardized effect health			0.1471*	0.2093*	0.053	0.2627***	
			(0.078)	(0.118)	(0.108)	(0.089)	
Average standardized effect educ.			0.058	-0.187	0.143	-0.044	
			(0.099)	(0.154)	(0.109)	(0.141)	

Table 51. Community effort, all provinces (baseline as control variable)

Indicator	Baseline mean	Control mean	Model 1 Total Generasi Year 1 Effect	Model 1 Versi A additional effect	Model 2 Total Versi B impact	Model 2 Total Versi A impact	Number observations
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Community effort at direct service provision							
Number of village health posts in village	4.519	4.222	-0.041	-0.098	0.008	-0.090	2027
	(0.078)	(0.106)	(0.118)	(0.125)	(0.143)	(0.123)	
Number of village health post meetings in past year at selected village	.	11.800	0.040	-0.085	0.082	-0.003	2103
health post	(.)	(0.059)	(0.092)	(0.102)	(0.109)	(0.101)	
Number of cadres at selected village health posts	.	4.750	0.2420*	-0.066	0.2748*	0.2084*	2103
Community effort at outreach	(.)	(0.073)	(0.124)	(0.142)	(0.164)	(0.116)	
Number of sweepings at selected village health posts in last year	.	5.965	-0.174	-0.299	-0.026	-0.325	2102
	(.)	(0.233)	(0.329)	(0.388)	(0.372)	(0.392)	
Number of SD school committee meetings with parents in past year	.	2.217	-0.027	0.154	-0.102	0.052	1048
	(.)	(0.141)	(0.120)	(0.122)	(0.134)	(0.134)	
Number of SMP school committee meetings with parents in past	2.309	2.178	-0.059	-0.141	0.011	-0.130	734
Community effort at monitoring	(0.073)	(0.101)	(0.096)	(0.125)	(0.117)	(0.113)	
Number of SD school committee members	.	9.049	0.104	1.2784***	-0.529	0.7498*	1052
	(.)	(0.261)	(0.324)	(0.475)	(0.402)	(0.391)	
Number of SMP school committee members	8.268	8.944	-1.100	0.546	-1.369	-0.822	745
	(0.176)	(0.904)	(0.911)	(0.538)	(0.914)	(0.986)	
Number of SD school committee meetings with teachers in past year	.	4.112	-0.227	0.228	-0.339	-0.111	1038
	(.)	(0.295)	(0.307)	(0.352)	(0.350)	(0.357)	
Number of SMP school committee meetings with teachers in year	4.484	3.860	0.290	0.354	0.117	0.470	732
Participation in health / education programs	(0.203)	(0.303)	(0.334)	(0.453)	(0.385)	(0.422)	
Participation in meetings about health education	.	0.281	0.1108***	-0.009	0.1150***	0.1058***	3293
	(.)	(0.015)	(0.034)	(0.025)	(0.034)	(0.039)	
Proportion of kids under 3 who own buku kupon	.	0.167	0.1172***	0.028	0.1052***	0.1327***	2818
	(.)	(0.112)	(0.022)	(0.018)	(0.022)	(0.025)	
Proportion of moms who own buku kupon	.	0.455	0.1665***	0.035	0.1505***	0.1859***	2204
	(.)	(0.158)	(0.036)	(0.021)	(0.038)	(0.038)	
Proportion of kids under 3 who use buku kupon	.	0.083	0.0643***	0.0232*	0.0543***	0.0775***	2730
	(.)	(0.083)	(0.016)	(0.013)	(0.017)	(0.019)	
Proportion of moms who use buku kupon	.	0.200	0.0840***	0.005	0.0817***	0.0866***	2147

Indicator	Baseline mean	Control mean	Model 1 Total Generasi Year 1 Effect	Model 2 Versi A additional effect	Total Versi B impact	Total Versi A impact	Number observations
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
	(.)	(0.133)	(0.020)	(0.014)	(0.022)	(0.021)	
Proportion of kids under 3 with KIA	0.573	0.474	-0.024	0.0454*	-0.0467*	-0.001	4802
	(0.008)	(0.017)	(0.022)	(0.026)	(0.026)	(0.026)	
Proportion of kids under 3 with KMS	0.385	0.522	0.1254***	-0.004	0.1275***	0.1233***	4799
Spillovers to other types of community activities	(0.008)	(0.017)	(0.018)	(0.024)	(0.023)	(0.020)	
Participation in gotong royong (hours worked per household)	37.679	28.489	3.245	-8.8331**	7.6379**	-1.195	10631
	(1.024)	(1.881)	(2.144)	(3.471)	(3.167)	(2.288)	
Women's participation in government groups (RT etc)	0.021	0.020	0.001	0.005	-0.002	0.003	6980
	(0.002)	(0.004)	(0.004)	(0.006)	(0.006)	(0.005)	
Number of groups household participates in	2.050	1.644	0.080	0.1202*	0.021	0.1407**	10642
	(0.014)	(0.037)	(0.049)	(0.064)	(0.052)	(0.063)	
Average standardized effect			0.1007***	0.0309*	0.0862***	0.1172***	
			(0.019)	(0.018)	(0.021)	(0.020)	
Average standardized effect health			0.1884***	0.019	0.1805***	0.1992***	
			(0.029)	(0.025)	(0.032)	(0.033)	
Average standardized effect education			-0.026	0.0700*	-0.060	0.010	
			(0.035)	(0.039)	(0.040)	(0.040)	

Table 52. Community effort, Java (baseline as control variable)

			Model 1		Model 2		
Indicator	Baseline mean	Control mean	Total Generasi Year 1 Effect	Versi A additional effect	Total Versi B impact	Total Versi A impact	Number observations
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Community effort at direct service provision							
Number of village health posts in village	5.408	5.198	-0.091	-0.108	-0.036	-0.144	1360
	(0.103)	(0.136)	(0.180)	(0.190)	(0.222)	(0.182)	
Number of village health post meetings in past year at selected village	.	11.870	-0.126	-0.025	-0.113	-0.138	1427
	(.)	(0.061)	(0.100)	(0.111)	(0.124)	(0.104)	
Number of cadres at selected village health posts	.	4.631	0.2359*	-0.066	0.269	0.203	1427
Community effort at outreach	(.)	(0.074)	(0.140)	(0.177)	(0.187)	(0.140)	
Number of sweepings at selected village health post in last year	.	5.336	-0.008	-0.506	0.248	-0.258	1426
	(.)	(0.263)	(0.414)	(0.491)	(0.462)	(0.501)	
Number of SD school committee meetings with parents in past	.	2.127	0.131	0.157	0.053	0.210	710
	(.)	(0.108)	(0.134)	(0.147)	(0.153)	(0.150)	
Number of SMP school committee meetings with parents in past	2.337	2.318	-0.137	-0.240	-0.015	-0.2550*	512
Community effort at monitoring	(0.090)	(0.138)	(0.119)	(0.155)	(0.141)	(0.143)	
Number of SD school committee members	.	8.745	0.168	1.6052***	-0.6412*	0.9639**	715
	(.)	(0.275)	(0.318)	(0.378)	(0.354)	(0.371)	
Number of SMP school committee members	7.918	7.719	0.118	0.8879*	-0.333	0.555	519
	(0.204)	(0.304)	(0.346)	(0.463)	(0.370)	(0.453)	
Number of SD school committee meetings with teachers in past	.	4.641	-0.512	-0.016	-0.504	-0.520	705
	(.)	(0.372)	(0.393)	(0.402)	(0.477)	(0.405)	
Number of SMP school committee meetings with teachers in year	4.768	4.583	0.016	0.928	-0.460	0.468	510
Participation in health / education programs	(0.243)	(0.433)	(0.447)	(0.596)	(0.478)	(0.586)	
Participation in meetings about health education	.	0.244	0.1101***	-0.014	0.1170***	0.1026***	2150
	(.)	(0.019)	(0.033)	(0.032)	(0.035)	(0.038)	
Proportion of kids under 3 who own buku kupon	.	0.167	0.1056***	0.0546**	0.0801***	0.1347***	1697
	(.)	(0.112)	(0.029)	(0.022)	(0.031)	(0.033)	
Proportion of moms who own buku kupon	.	0.455	0.1356***	0.0732**	0.1011**	0.1743***	1395
	(.)	(0.158)	(0.045)	(0.029)	(0.049)	(0.049)	
Proportion of kids under 3 who use buku kupon	.	0.083	0.0606***	0.0310*	0.0465**	0.0774***	1651
	(.)	(0.083)	(0.022)	(0.018)	(0.023)	(0.026)	
Proportion of moms who own buku kupon	.	0.200	0.0745***	0.016	0.0667**	0.0831***	1357

Indicator	Baseline mean	Control mean	Model 1 Total Generasi Year 1 Effect	Versi A additional effect	Model 2 Total Versi B impact	Total Versi A impact	Number observations
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
	(.)	(0.133)	(0.024)	(0.019)	(0.028)	(0.026)	
Proportion of kids under 3 with KIA	0.620	0.504	0.011	0.044	-0.012	0.033	3065
	(0.010)	(0.023)	(0.028)	(0.035)	(0.035)	(0.031)	
Proportion of kids under 3 with KMS	0.415	0.572	0.1161***	-0.017	0.1246***	0.1081***	3064
Spillovers to other types of community activities	(0.010)	(0.022)	(0.024)	(0.033)	(0.033)	(0.026)	
Participation in gotong royong (hours worked per household)	36.055	21.779	2.350	-4.002	4.359	0.358	7184
	(1.224)	(1.838)	(1.985)	(3.089)	(2.745)	(2.297)	
Women's participation in government groups (RT, etc)	0.012	0.013	-0.001	-0.005	0.002	-0.003	5062
	(0.002)	(0.004)	(0.004)	(0.007)	(0.006)	(0.005)	
	2.071	1.729	0.044	0.2014**	-0.057	0.1447*	7191
Number of groups household participates in	(0.016)	(0.046)	(0.066)	(0.090)	(0.072)	(0.085)	
Average standardized effect			0.0971***	0.0652***	0.0653**	0.1305***	
			(0.025)	(0.025)	(0.029)	(0.027)	
Average standardized effect health			0.1742***	0.042	0.1548***	0.1972***	
			(0.038)	(0.034)	(0.043)	(0.043)	
Average standardized effect education			-0.006	0.1354**	-0.075	0.061	
			(0.044)	(0.053)	(0.048)	(0.053)	

Table 53. Community effort, East Nusa Tenggara (baseline as control variable)

			Model 1		Model 2		
Indicator	Baseline mean	Control mean	Total Generasi Year 1 Effect	Versi A additional effect	Total Versi B impact	Total Versi A impact	Number observations
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Community effort at direct service provision							
Number of village health posts in village	3.020	2.958	0.091	-0.005	0.093	0.088	402
	(0.083)	(0.134)	(0.109)	(0.091)	(0.113)	(0.123)	
Number of village health post meetings in past year at selected village	.	11.725	0.308	-0.254	0.4334*	0.180	408
	(.)	(0.156)	(0.227)	(0.240)	(0.242)	(0.265)	
Number of cadres at selected village health posts	.	4.967	0.215	-0.3835*	0.4055*	0.022	408
Community effort at outreach	(.)	(0.150)	(0.189)	(0.226)	(0.225)	(0.208)	
Number of sweepings at selected village health post in last year	.	6.900	-1.4290*	0.790	-1.8209**	-1.031	408
	(.)	(0.731)	(0.724)	(0.722)	(0.789)	(0.814)	
Number of SD school committee meetings with parents in past year	.	2.200	-0.365	0.086	-0.406	-0.321	203
	(.)	(0.190)	(0.263)	(0.252)	(0.300)	(0.283)	
Number of SMP school committee meetings with parents in past	2.274	1.895	-0.040	0.018	-0.048	-0.030	125
Community effort at monitoring	(0.186)	(0.168)	(0.247)	(0.288)	(0.288)	(0.284)	
Number of SD school committee members	.	9.763	0.038	1.2577*	-0.580	0.677	202
	(.)	(0.603)	(0.665)	(0.648)	(0.630)	(0.820)	
Number of SMP school committee members	10.000	10.105	-0.711	-0.606	-0.432	-1.038	125
	(0.441)	(0.815)	(0.781)	(0.858)	(0.937)	(0.843)	
Number of SD school committee meetings with teachers in past	.	2.729	0.907	1.072	0.387	1.459	201
	(.)	(0.370)	(0.698)	(0.920)	(0.655)	(0.994)	
Number of SMP school committee meetings with teachers in year	3.082	2.763	0.977	-1.1504*	1.5030*	0.353	125
Participation in health / education programs	(0.232)	(0.334)	(0.658)	(0.640)	(0.839)	(0.525)	
Participation in meetings about health education	.	0.447	-0.028	-0.070	0.005	-0.064	771
	(.)	(0.036)	(0.154)	(0.045)	(0.137)	(0.135)	
Proportion of kids under 3 who own buku kupon	.	.	0.1652***	-0.019	0.1741***	0.1553***	772
	(.)	(.)	(0.036)	(0.038)	(0.046)	(0.047)	
Proportion of moms who own buku kupon	.	.	0.3173***	-0.031	0.3313***	0.3006***	552
	(.)	(.)	(0.028)	(0.040)	(0.038)	(0.040)	
Proportion of kids under 3 who use buku kupon	.	.	0.0686***	0.004	0.0666***	0.0709***	740
	(.)	(.)	(0.015)	(0.022)	(0.018)	(0.021)	
Proportion of moms who own buku kupon	.	.	0.1043*	-0.021	0.1136**	0.0930*	537

Indicator	Baseline mean	Control mean	Model 1 Total Generasi Year 1 Effect	Model 2 Versi A additional effect	Model 2 Total Versi B impact	Model 2 Total Versi A impact	Number observations
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
	(.)	(.)	(0.054)	(0.030)	(0.049)	(0.050)	
Proportion of kids under 3 with KIA	0.559	0.626	-0.1310***	0.046	-0.1541***	-0.1083**	1086
	(0.016)	(0.036)	(0.041)	(0.044)	(0.044)	(0.047)	
Proportion of kids under 3 with KMS	0.189	0.316	0.1572***	0.010	0.1518***	0.1617***	1084
Spillovers to other types of community activities	(0.013)	(0.034)	(0.029)	(0.043)	(0.038)	(0.035)	
Participation in gotong royong (hours worked per household)	48.412	54.500	8.139	-25.0601**	20.4610*	-4.599	2067
	(2.665)	(7.268)	(8.233)	(11.230)	(11.465)	(7.654)	
Women's participation in government groups (RT etc)	0.057	0.024	0.010	0.027	-0.005	0.023	1057
	(0.008)	(0.012)	(0.015)	(0.019)	(0.013)	(0.020)	
Number of groups household participates in	1.992	1.428	0.156	-0.092	0.2052**	0.113	2070
	(0.032)	(0.074)	(0.097)	(0.097)	(0.102)	(0.113)	
Average standardized effect			0.1154***	-0.025	0.1264***	0.1013**	
			(0.039)	(0.041)	(0.043)	(0.042)	
Average standardized effect health			0.1841***	-0.042	0.2041***	0.1617***	
			(0.049)	(0.047)	(0.048)	(0.048)	
Average standardized effect education			0.010	0.014	0.001	0.015	
			(0.097)	(0.103)	(0.110)	(0.108)	

Table 54. Community effort, North Sulawesi/Gorontalo (baseline as control variable)

			Model 1		Model 2		
Indicator	Baseline mean	Control mean	Total Generasi Year 1 Effect	Versi A additional effect	Total Versi B impact	Total Versi A impact	Number observations
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Community effort at direct service provision							
Number of village health posts in village	2.249	2.027	0.011	-0.262	0.127	-0.135	265
	(0.106)	(0.124)	(0.149)	(0.233)	(0.179)	(0.202)	
Number of village health post meetings in past year at selected	.	11.616	0.386	-0.003	0.388	0.384	268
	(.)	(0.197)	(0.273)	(0.322)	(0.305)	(0.331)	
Number of cadres at selected village health posts	.	4.964	0.305	0.615	0.028	0.6431*	268
Community effort at outreach	(.)	(0.284)	(0.516)	(0.509)	(0.723)	(0.332)	
Number of sweepings at selected village health post in last year	.	7.339	0.852	-1.430	1.496	0.066	268
	(.)	(0.476)	(0.772)	(1.078)	(0.893)	(0.982)	
Number of SD school committee meetings with parents in past	.	2.571	-0.241	0.245	-0.350	-0.105	135
	(.)	(0.693)	(0.390)	(0.392)	(0.413)	(0.457)	
Number of SMP school committee meetings with parents in past	2.204	1.927	0.201	0.083	0.163	0.247	97
Community effort at monitoring	(0.144)	(0.189)	(0.212)	(0.353)	(0.316)	(0.218)	
Number of SD school committee members	.	9.446	-0.082	-0.434	0.117	-0.317	135
	(.)	(0.915)	(1.436)	(3.108)	(2.213)	(2.010)	
Number of SMP school committee members	7.910	12.357	-6.704	-1.634	-5.980	-7.614	101
	(0.490)	(4.840)	(5.578)	(3.230)	(5.236)	(6.485)	
Number of SD school committee meetings with teachers in past	.	3.582	-0.550	-0.205	-0.459	-0.664	132
	(.)	(0.894)	(0.599)	(0.568)	(0.650)	(0.684)	
Number of SMP school committee meetings with teachers in year	4.755	2.175	1.2980**	-0.004	1.300	1.2957*	97
Participation in health / education programs	(0.759)	(0.324)	(0.539)	(1.010)	(0.783)	(0.664)	
Participation in meetings about health education	.	0.200	0.2375**	0.1938***	0.1804***	0.3742***	372
	(.)	(0.031)	(0.094)	(0.054)	(0.055)	(0.074)	
Proportion of kids under 3 who own buku kupon	.	.	0.1291***	0.002	0.1287***	0.1303***	349
	(.)	(.)	(0.010)	(0.017)	(0.012)	(0.015)	
Proportion of moms who own buku kupon	.	.	0.1953***	-0.010	0.1986***	0.1883***	257
	(.)	(.)	(0.041)	(0.018)	(0.040)	(0.041)	
Proportion of kids under 3 who use buku kupon	.	.	0.0881***	0.0305*	0.0801***	0.1106***	339

Indicator	Baseline mean	Control mean	Model 1 Total Generasi Year 1 Effect	Versi A additional effect	Model 2 Total Versi B impact	Total Versi A impact	Number observations
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
	(.)	(.)	(0.012)	(0.015)	(0.018)	(0.021)	
Proportion of moms who own buku kupon	.	.	0.1270***	0.002	0.1265***	0.1280***	253
	(.)	(.)	(0.035)	(0.011)	(0.035)	(0.036)	
Proportion of kids under 3 with KIA	0.374	0.212	0.021	0.036	0.004	0.040	651
	(0.021)	(0.032)	(0.044)	(0.054)	(0.042)	(0.060)	
Proportion of kids under 3 with KMS	0.573	0.606	0.1215**	0.000	0.1216**	0.1214**	651
Spillovers to other types of community activities	(0.021)	(0.038)	(0.045)	(0.054)	(0.054)	(0.051)	
Participation in gotong royong (hours worked per household)	29.934	25.672	-1.246	-6.427	1.670	-4.756	1380
	(2.339)	(2.979)	(3.218)	(4.136)	(4.223)	(3.104)	
Women's participation in government groups (RT etc)	0.032	0.041	-0.003	0.0280*	-0.014	0.014	861
	(0.007)	(0.016)	(0.016)	(0.016)	(0.019)	(0.013)	
Number of groups household participates in	2.029	1.561	0.109	0.086	0.070	0.156	1381
	(0.044)	(0.101)	(0.078)	(0.134)	(0.080)	(0.125)	
Average standardized effect			0.1979***	0.023	0.1923***	0.2157***	
			(0.031)	(0.032)	(0.034)	(0.039)	
Average standardized effect health			0.3496***	0.043	0.3386***	0.3817***	
			(0.053)	(0.043)	(0.058)	(0.064)	
Average standardized effect education			0.014	-0.004	0.016	0.012	
			(0.069)	(0.106)	(0.093)	(0.080)	

Table 55. Results for service-provider-based quantities, all provinces (baseline as control variable)

			Model 1		*Model 2*		
Indicator	Baseline mean	Control mean	Total Generasi Year 1 Effect	Versi A additional effect	Total Versi B impact	Total Versi A impact	Number observations
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Midwife							
Fee charged for child birth at private practice	293800.000 (5678.006)	340500.000 (9927.995)	15510.4268** (6216.398)	-5315.251 (8358.456)	18120.8105** (7076.409)	12805.560 (7843.922)	928
Number of child births at private practice in last month	2.953 (0.156)	2.591 (0.222)	-0.144 (0.215)	0.126 (0.222)	-0.207 (0.221)	-0.080 (0.262)	1042
Fee charged for child birth at gov't practice	138200.000 (6265.318)	186500.000 (13568.787)	22181.3184* (12522.959)	7503.837 (15676.978)	18537.275 (14722.440)	26041.1133* (14810.508)	761
Number of child births at gov't practice in last month	6.989 (1.215)	3.123 (0.603)	0.202 (0.800)	-1.166 (1.293)	0.773 (1.133)	-0.393 (0.907)	1043
Fee charged for child birth (avg. of private & gov't)	249700.000 (6200.277)	307800.000 (11603.178)	16918.8184** (8478.320)	12542.710 (10417.096)	10604.603 (10584.039)	23147.3125** (9216.406)	888
Total number of child births in last month	9.942 (1.232)	5.701 (0.640)	0.031 (0.836)	-1.035 (1.308)	0.537 (1.168)	-0.497 (0.936)	1043
Fee paid by mother for normal childbirth	1121000.000 (105900.000)	1284000.000 (226100.000)	2311000.000 (2412000.000)	9189000.000 (7380000.000)	-2353000.000 (2294000.000)	6836000.000 (5813000.000)	326
Fee charged for ANC at private practice	12314.425 (326.196)	14642.106 (536.801)	86.396 (478.455)	-986.103 (617.815)	567.516 (568.279)	-418.587 (564.900)	922
Number of ANC visits at private practice in last month	3.283 (0.328)	4.128 (0.576)	-0.7535** (0.369)	-0.161 (0.348)	-0.6743* (0.408)	-0.8356** (0.409)	1043
Fee charged for ANC at gov't practice	2619.440 (244.963)	2715.972 (345.466)	44.274 (329.965)	-365.377 (399.444)	214.721 (428.815)	-150.656 (330.414)	771
Number of ANC visit at gov't practice in last month	12.641 (1.450)	6.967 (0.910)	0.471 (1.366)	0.463 (1.519)	0.244 (1.424)	0.706 (1.694)	1043
Fee charged for ANC visit (avg. of private & gov't)	6123.070 (303.025)	8927.499 (556.459)	-649.444 (513.564)	-151.425 (565.194)	-575.475 (582.405)	-726.900 (589.940)	963
Total number of ANC visits in last month	15.924 (1.545)	11.095 (1.065)	-0.325 (1.470)	0.362 (1.647)	-0.502 (1.544)	-0.141 (1.819)	1043
Fee paid by mother for ANC visit	17338.510 (756.967)	19562.107 (1714.741)	735.403 (1745.379)	-672.743 (3067.317)	1077.310 (2420.070)	404.567 (2221.658)	1330

Indicator	Baseline mean	Control mean	*Model 1* Total Generasi Year 1 Effect	Versi A additional effect	*Model 2* Total Versi B impact	Total Versi A impact	Number observations
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fee charged for family planning visit at private practice	.	14292.106	370.282	161.293	291.500	452.793	915
	(.)	(640.344)	(293.546)	(448.026)	(424.638)	(303.004)	
Number of family planning visits at private practice	.	34.320	0.505	-4.242	2.568	-1.673	869
	(.)	(2.845)	(3.200)	(4.558)	(3.907)	(3.990)	
Fee charged for family planning visit at gov't practice	.	8073.427	-301.688	671.959	-612.436	59.523	732
	(.)	(1144.910)	(639.935)	(780.387)	(835.214)	(638.801)	
Number of family planning visits at gov't practice	.	15.958	1.772	-11.506	7.360	-4.146	745
	(.)	(2.649)	(4.679)	(11.636)	(8.433)	(6.363)	
Fee charged for family planning visit (avg. private & gov't)							
	.	12658.750	-126.335	381.866	-313.033	68.833	975
	(.)	(668.079)	(344.771)	(453.066)	(480.457)	(328.442)	
Total number of family planning visits in last month	.	41.764	0.148	-10.890	5.498	-5.392	1015
	(.)	(3.011)	(4.455)	(8.932)	(7.066)	(5.516)	
Fee paid by mother for family planning visit	13734.921	15526.718	-29.472	-166.460	53.280	-113.180	590
	(159.661)	(400.210)	(324.364)	(527.520)	(416.411)	(420.518)	
Puskesmas							
Normal childbirth at Puskesmas - fee charged by midwife	140000.000	183900.000	17226.805	-14250.000	24633.846	10381.356	193
	(9815.070)	(21105.691)	(21378.611)	(23969.926)	(23783.584)	(25297.057)	
Normal childbirth at Puskesmas – quantity by	45.023	43.808	-11.812	-10.342	-6.833	-17.175	256
	(3.901)	(9.534)	(14.703)	(11.664)	(15.803)	(15.832)	
Normal childbirth at Puskesmas - fee paid by mother	322600.000	328400.000	-72760.000	98196.836	-119900.000	-21710.000	52
	(25713.873)	(60268.711)	(84704.578)	(73169.375)	(95717.438)	(83997.180)	
Schools							
SD - Annual cost of school for TA 07/08	.	33958.297	-10160.000	8708.418	-14480.000	-5767.267	1055
	(.)	(8392.981)	(12897.368)	(13183.061)	(13192.259)	(15677.502)	

Indicator	Baseline mean	Control mean	*Model 1* Total Generasi Year 1 Effect	Versi A additional effect	*Model 2* Total Versi B impact	Total Versi A impact	Number observations
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
SD – Number of students enrolled at TA 07/08	. (.)	153.551 (3.667)	-6.902 (6.352)	1.995 (8.387)	-7.889 (7.378)	-5.894 (7.851)	1055
SD – Number of students enrolled in TA 08/09	. (.)	153.973 (3.668)	-5.325 (6.241)	0.840 (8.174)	-5.740 (7.230)	-4.901 (7.694)	1055
SD - Cost of school from parents for previous semester	16713.465 (1359.935)	28026.555 (5219.804)	1982.565 (3709.511)	5514.204 (5372.202)	-730.740 (3454.610)	4783.464 (5510.832)	4663
SMP - annual cost of school for TA 07/08	66658.625 (9174.676)	774300.000 (379000.000)	-330400.000 (321100.000)	104100.000 (176900.000)	-381700.000 (341700.000)	-277600.000 (324500.000)	744
SMP – Number of students enrolled at TA 07/08	282.986 (9.095)	301.457 (15.465)	-15.3413* (7.874)	15.421 (9.488)	-22.9328** (10.741)	-7.512 (7.097)	743
SMP – Number of students enrolled in TA 08/09	303.921 (9.166)	311.362 (15.998)	-7.961 (7.759)	7.292 (8.742)	-11.550 (10.247)	-4.258 (7.215)	743
SMP - Cost of school from parents for previous semester	69681.758 (10624.378)	111200.000 (15254.492)	-5472.915 (10194.533)	8516.227 (13554.396)	-9846.517 (12379.746)	-1330.290 (12122.701)	1616
Village health post							
Village health post - Fee for visit	. (.)	213.692 (36.203)	-41.428 (41.651)	-0.449 (34.386)	-41.206 (42.242)	-41.654 (47.778)	2088
Village health post – quantity of kids weighed at last meeting where service was offered	. (.)	41.055 (1.048)	8.3562*** (1.580)	0.667 (2.498)	8.0238*** (2.092)	8.6906*** (1.932)	2062
Village health post – quantity of kids with nutritional at last meeting where service	. (.)	34.831 (1.143)	13.9169*** (1.692)	-0.547 (2.520)	14.1880*** (2.061)	13.6405*** (2.158)	2023
Village health post – quantity of kids immunized at last	.	11.874	3.1471***	1.837	2.2474*	4.0848***	1957

			Model 1		*Model 2*		
Indicator	Baseline mean	Control mean	Total Generasi Year 1 Effect	Versi A additional effect	Total Versi B impact	Total Versi A impact	Number observations
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
where service was offered	(.)	(0.651)	(0.957)	(1.459)	(1.206)	(1.176)	
Village health post – quantity of moms receiving ANC visits at last meeting where service	.	4.546	1.9144***	0.810	1.5150*	2.3245***	2049
	(.)	(0.359)	(0.574)	(0.896)	(0.822)	(0.603)	
Village health post – quantity of moms receiving iron pills at last meeting where service was offered	.	4.804	2.3030***	1.031	1.7937*	2.8241***	2011
	(.)	(0.417)	(0.655)	(1.068)	(0.918)	(0.754)	
Village health post – quantity of kids receiving Vitamin A at last meeting where service was offered	.	44.068	8.8103***	4.454	6.5828**	11.0373***	1958
	(.)	(1.565)	(2.448)	(3.292)	(2.849)	(3.029)	
Village health post – quantity of moms receiving family planning pills at last meeting where service was offered	.	2.829	4.282	9.019	-0.163	8.856	1998
	(.)	(0.320)	(3.279)	(7.226)	(1.303)	(6.802)	
Village health post – quantity injections at last meeting where service was offered	.	2.807	-0.083	0.536	-0.347	0.189	1998
	(.)	(0.381)	(0.533)	(0.787)	(0.670)	(0.650)	
Average standardized effect fees			-0.048	-0.222	0.064	-0.158	
			(0.057)	(0.159)	(0.055)	(0.127)	
Average standardized effect health fees			-0.070	-0.270	0.066	-0.203	
			(0.071)	(0.202)	(0.068)	(0.160)	
Average standardized effect education fees			0.034	-0.044	0.0559*	0.012	
			(0.033)	(0.036)	(0.033)	(0.042)	

Indicator	Baseline mean	Control mean	*Model 1* Total Generasi Year 1 Effect	Versi A additional effect	*Model 2* Total Versi B impact	Total Versi A impact	Number observations
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Average standardized effect midwife fees			-0.107	-0.312	0.052	-0.260	
			(0.086)	(0.251)	(0.083)	(0.198)	
Average standardized effect puskesmas fees			0.094	-0.153	0.166	0.012	
			(0.125)	(0.121)	(0.140)	(0.129)	
Average standardized effect school fees			0.034	-0.044	0.0559*	0.012	
			(0.033)	(0.036)	(0.033)	(0.042)	
Average standardized effect village health post fees			0.045	0.001	0.045	0.045	
			(0.045)	(0.037)	(0.046)	(0.052)	
Average standardized effect quantities			0.0768**	0.053	0.051	0.0990**	
			(0.032)	(0.058)	(0.035)	(0.047)	
Average standardized effect health quantities			0.1092***	0.057	0.0808**	0.1380**	
			(0.036)	(0.066)	(0.038)	(0.057)	
Average standardized effect			-0.069	0.034	-0.086	-0.052	
			(0.050)	(0.064)	(0.058)	(0.061)	
Average standardized effect midwife quantities			-0.009	-0.051	0.016	-0.035	
			(0.040)	(0.056)	(0.051)	(0.046)	
Average standardized effect puskesmas quantities			-0.141	-0.124	-0.082	-0.205	
			(0.166)	(0.131)	(0.178)	(0.178)	
Average standardized effect school quantities			-0.069	0.034	-0.086	-0.052	
			(0.050)	(0.064)	(0.058)	(0.061)	
Average standardized effect village health post quantities			0.2738***	0.202	0.1743***	0.3760***	
			(0.064)	(0.127)	(0.055)	(0.115)	

Table 56. Results for service-provider-based quantities, Java (baseline as control variable)

Indicator	Baseline mean	Control mean	Model 1 Total Generasi Year 1 Effect	Versi A additional effect	Model 2 Total Versi B impact	Total Versi A impact	Number observations
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Midwife							
Fee charged for childbirth at private practice	351900.000	403500.000	11478.9863*	499.417	11220.440	11719.857	690
	(4159.818)	(6863.081)	(5939.805)	(8850.000)	(7118.613)	(7680.305)	
Number of childbirths at private practice in last month	3.786	3.184	-0.207	0.441	-0.429	0.012	712
	(0.198)	(0.279)	(0.319)	(0.322)	(0.324)	(0.389)	
Fee charged for childbirth at gov't practice	156900.000	257900.000	27318.123	22027.215	16353.078	38380.2930*	450
	(8349.875)	(17925.639)	(18564.885)	(23253.984)	(22020.680)	(21691.897)	
Number of childbirths at gov't practice in last month	7.448	3.606	-0.616	-1.555	0.163	-1.392	713
	(1.673)	(0.879)	(1.019)	(1.347)	(1.366)	(1.059)	
Fee charged for childbirth (avg. of private & gov't)	301200.000	375000.000	17644.8730*	22191.6621*	6166.756	28358.4180***	635
	(6263.445)	(9997.459)	(9317.905)	(12252.356)	(11923.325)	(10293.046)	
Total number of childbirths in last month	11.234	6.768	-0.723	-1.206	-0.118	-1.325	713
	(1.693)	(0.917)	(1.064)	(1.367)	(1.412)	(1.099)	
Fee paid by mother for normal childbirth	1194000.000	1137000.000	2811000.000	10800000.000	-2992000.000	7810000.000	263
	(119900.000)	(221000.000)	(2816000.000)	(8646000.000)	(3008000.000)	(6560000.000)	
Fee charged for ANC at private practice	14651.315	16318.841	48.496	-1245.0643*	687.756	-557.309	698
	(317.840)	(486.894)	(522.209)	(659.195)	(616.411)	(597.064)	
Number of ANC visits at private practice in last month	4.268	5.366	-1.0010*	0.167	-1.0845**	-0.918	713
	(0.451)	(0.798)	(0.508)	(0.479)	(0.548)	(0.574)	
Fee charged for ANC at gov't practice	2649.289	2902.326	288.240	-833.281	672.802	-160.479	466
	(120.252)	(471.650)	(449.804)	(544.940)	(619.199)	(392.765)	

Indicator	Baseline mean	Control mean	Model 1 Total Generasi Year 1 Effect	Versi A additional effect	Model 2 Total Versi B impact	Total Versi A impact	Number observations
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Number of ANC visit at gov't practice in last month	13.710	7.028	-0.198	1.515	-0.954	0.561	713
	(1.998)	(1.259)	(1.669)	(1.590)	(1.416)	(2.174)	
Fee charged for ANC visit (avg. of private & gov't)	7143.160	10590.042	-235.962	-433.444	-15.801	-449.244	674
	(262.631)	(659.126)	(664.926)	(787.974)	(777.804)	(765.630)	
Total number of ANC visits in last month	17.978	12.394	-1.216	1.790	-2.105	-0.316	713
	(2.130)	(1.478)	(1.828)	(1.810)	(1.561)	(2.400)	
Fee paid by mother for ANC visit	18087.273	19642.734	544.141	-6.752	547.664	540.913	1204
	(817.291)	(1574.498)	(1668.177)	(2857.894)	(2110.406)	(2271.800)	
Fee charged for family planning visit at private practice	.	14684.782	65.875	-413.395	278.403	-134.992	699
	(.)	(158.596)	(260.349)	(392.705)	(375.437)	(259.565)	
Number of family planning visits at private practice in last month	.	42.095	0.426	-5.432	3.204	-2.229	684
	(.)	(3.431)	(4.201)	(5.835)	(5.283)	(5.023)	
Fee charged for family planning visit at gov't practice	.	7945.122	548.400	461.349	336.797	798.146	427
	(.)	(743.992)	(726.618)	(1005.656)	(984.657)	(754.501)	
Number of family planning visits at gov't practice in last month	.	17.963	-3.536	-3.470	-1.803	-5.273	445
	(.)	(4.250)	(5.016)	(6.516)	(6.578)	(5.360)	
Fee charged for family planning visit (avg. private & gov't)	.	13852.502	192.500	37.705	173.398	211.104	686
	(.)	(245.172)	(320.501)	(429.356)	(442.365)	(322.336)	
Total number of family planning visits in last month	.	51.714	-4.249	-6.230	-1.078	-7.308	703
	(.)	(3.916)	(5.137)	(6.611)	(6.688)	(5.589)	
Fee paid by mother for family planning visit	14200.355	15808.695	-200.704	-42.054	-179.760	-221.814	529
	(137.559)	(400.352)	(316.603)	(571.903)	(427.784)	(425.877)	

Indicator	Baseline mean	Control mean	Model 1 Total Generasi Year 1 Effect	Versi A additional effect	Model 2 Total Versi B impact	Total Versi A impact	Number observations
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Puskesmas							
Normal childbirth at Puskesmas—fee charged by midwife	175500.000	244500.000	6140.040	-44290.000	30625.551	-13670.000	119
	(13823.153)	(29725.004)	(31992.010)	(35966.238)	(35452.707)	(38218.539)	
Normal childbirth at Puskesmas—quantity by midwife	53.712	53.412	-17.563	-14.867	-10.223	-25.091	174
	(5.466)	(13.800)	(22.091)	(17.597)	(24.075)	(23.491)	
Normal childbirth at Puskesmas—fee paid by mother	415500.000	468200.000	-1355.631	17206.916	-10020.000	7188.965	29
	(32305.658)	(69174.594)	(109200.000)	(100100.000)	(129500.000)	(117800.000)	
Schools							
SD—Annual cost of school for TA 07/08	.	34801.102	-18890.000	6757.504	-22300.000	-15540.000	716
	(.)	(11836.044)	(18136.898)	(18696.635)	(18344.443)	(22228.951)	
SD—Number of students enrolled at TA 07/08	.	150.099	-0.240	5.409	-2.968	2.441	716
	(.)	(4.543)	(7.971)	(9.475)	(8.669)	(9.861)	
SD—Number of students enrolled in TA 08/09	.	149.576	-0.060	5.620	-2.894	2.726	716
	(.)	(4.462)	(7.805)	(9.530)	(8.531)	(9.738)	
SD—Cost of school from parents for previous semester	22237.020	28224.160	483.165	5096.276	-2111.263	2985.013	2737
	(2248.002)	(8621.638)	(5368.060)	(8965.915)	(4990.001)	(8518.420)	
SMP—annual cost of school for TA 07/08	57393.641	1001000.000	-86010.000	97367.961	-135500.000	-38120.000	519
	(8539.093)	(577200.000)	(161900.000)	(206200.000)	(185100.000)	(199300.000)	
SMP—Number of students enrolled at TA 07/08	321.951	339.993	-19.7770*	20.6643*	-30.2590**	-9.595	518
	(11.708)	(20.808)	(10.440)	(11.890)	(14.291)	(9.002)	
SMP—Number of students enrolled in TA 08/09	344.049	344.112	-4.999	10.816	-10.483	0.333	518

Indicator	Baseline mean	Control mean	Model 1 Total Generasi Year 1 Effect	Versi A additional effect	Model 2 Total Versi B impact	Total Versi A impact	Number observations
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
	(11.821)	(21.580)	(10.235)	(12.600)	(14.654)	(8.655)	
SMP—Cost of school from parents for previous semester	66247.039	102100.000	-7738.818	11974.637	-14000.000	-2024.986	1096
	(6854.382)	(14912.148)	(10139.580)	(15739.694)	(12369.708)	(13375.269)	
Village health post							
Village health post—Fee for visit	.	180.285	-67.443	-26.311	-54.122	-80.433	1419
	(.)	(49.337)	(58.927)	(42.099)	(58.831)	(65.800)	
Village health post—quantity of kids weighed at last meeting where service was offered	.	41.427	8.6760***	0.245	8.5516***	8.7964***	1404
	(.)	(1.265)	(2.048)	(3.237)	(2.659)	(2.564)	
Village health post—quantity of kids with nutritional supplement at last meeting where service was offered	.	37.852	12.2008***	-0.265	12.3353***	12.0706***	1386
	(.)	(1.439)	(2.214)	(3.290)	(2.801)	(2.717)	
Village health post—quantity of kids immunized at last meeting where service was offered	.	10.221	3.0567**	-0.040	3.0763*	3.0368**	1329
	(.)	(0.739)	(1.257)	(1.974)	(1.705)	(1.484)	
Village health post—quantity of moms receiving ANC visits at last meeting where service was offered	.	3.940	1.9180**	-0.156	1.9967*	1.8404**	1391
	(.)	(0.427)	(0.740)	(1.257)	(1.147)	(0.761)	
Village health post—quantity of moms receiving iron pills at last meeting where service was offered	.	3.826	2.7232***	0.744	2.3487**	3.0925***	1365
	(.)	(0.454)	(0.783)	(1.363)	(1.167)	(0.882)	
Village health post— quantity of kids receiving Vitamin A at last meeting where service was offered	.	46.841	6.3287**	3.474	4.549	8.0227**	1339
	(.)	(1.874)	(3.071)	(4.362)	(3.729)	(3.765)	
Village health post—quantity of moms receiving family planning pills	.	1.883	6.298	12.684	-0.057	12.627	1365

Indicator	Baseline mean	Control mean	Model 1 Total Generasi Year 1 Effect	Versi A additional effect	Model 2 Total Versi B impact	Total Versi A impact	Number observations
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
at last meeting where service was offered	(.)	(0.259)	(4.997)	(11.163)	(1.941)	(10.370)	
Village health post—quantity of moms receiving family planning injections at last meeting where service was offered	.	1.528	0.261	0.352	0.085	0.437	1370
	(.)	(0.271)	(0.657)	(0.973)	(0.844)	(0.785)	
Average standardized effect fees			-0.106	-0.296	0.054	-0.243	
			(0.088)	(0.253)	(0.093)	(0.194)	
Average standardized effect health fees			-0.145	-0.364	0.051	-0.313	
			(0.111)	(0.321)	(0.118)	(0.245)	
Average standardized effect education fees			0.042	-0.043	0.0643*	0.021	
			(0.037)	(0.049)	(0.037)	(0.052)	
Average standardized effect midwife fees			-0.185	-0.471	0.069	-0.402	
			(0.136)	(0.399)	(0.146)	(0.304)	
Average standardized effect puskesmas fees			-0.014	0.087	-0.064	0.023	
			(0.168)	(0.170)	(0.191)	(0.187)	
Average standardized effect school fees			0.042	-0.043	0.0643*	0.021	
			(0.037)	(0.049)	(0.037)	(0.052)	
Average standardized effect village health post fees			0.067	0.026	0.054	0.080	
			(0.059)	(0.042)	(0.058)	(0.065)	
Average standardized effect quantities			0.1003*	0.121	0.040	0.154	
			(0.055)	(0.108)	(0.044)	(0.095)	
Average standardized effect health quantities			0.1283**	0.132	0.062	0.1942*	
			(0.065)	(0.128)	(0.049)	(0.118)	

Indicator	Baseline mean	Control mean	Model 1 Total Generasi Year 1 Effect	Versi A additional effect	Model 2 Total Versi B impact	Total Versi A impact	Number observations
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Average standardized effect education quantities			-0.025	0.070	-0.061	0.010	
			(0.063)	(0.076)	(0.072)	(0.075)	
Average standardized effect midwife quantities			-0.048	-0.014	-0.041	-0.054	
			(0.047)	(0.056)	(0.054)	(0.056)	
Average standardized effect puskesmas quantities			-0.180	-0.152	-0.105	-0.257	
			(0.216)	(0.172)	(0.235)	(0.229)	
Average standardized effect school quantities			-0.025	0.070	-0.061	0.010	
			(0.063)	(0.076)	(0.072)	(0.075)	
Average standardized effect village health post quantities			0.3646***	0.332	0.1983**	0.5298**	
			(0.133)	(0.282)	(0.089)	(0.257)	

Table 57. Results for service-provider-based quantities, East Nusa Tenggara (baseline as control variable)

Indicator	Baseline mean	Control mean	Model 1 Total Generasi Year 1 Effect	Versi A additional effect	Model 2 Total Versi B impact	Total Versi A impact	Number observations
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Midwife							
Fee charged for childbirth at private practice	34712.645	92000.000	14128.060	-33540.000	28379.760	-5163.729	125
	(6747.714)	(22900.147)	(22027.369)	(24412.715)	(25893.920)	(22921.141)	
Number of childbirths at private practice in last month	0.310	0.419	-0.026	-0.173	0.057	-0.117	204
	(0.091)	(0.190)	(0.198)	(0.214)	(0.232)	(0.216)	
Fee charged for childbirth at gov't practice	54288.992	47535.715	20679.451	-16860.000	28740.152	11881.313	194
	(6589.469)	(12634.094)	(16032.868)	(23383.537)	(20269.494)	(18910.484)	
Number of childbirths at gov't practice in last month	8.177	2.194	1.458	-2.349	2.553	0.205	204
	(1.575)	(0.528)	(1.434)	(3.176)	(2.243)	(2.059)	
Fee charged for childbirth (avg. of private & gov't)	56224.164	64500.000	19966.176	-22170.000	31222.982	9053.095	150
	(7054.939)	(20718.969)	(19557.359)	(22133.408)	(23549.863)	(21097.463)	
Total number of childbirths in last month	8.487	2.613	1.466	-2.590	2.672	0.082	204
	(1.592)	(0.526)	(1.439)	(3.256)	(2.293)	(2.073)	
Fee paid by mother for normal childbirth	525200.000	265100.000	161700.000	245800.000	11598.646	257400.000	30
		(56110.191)	(241200.000)	(359900.000)	(347100.000)	(280900.000)	
Fee charged for ANC at private practice	922.619	4250.000	-1388.814	-100.331	-1348.036	-1448.367	114
	(279.267)	(1507.656)	(1149.954)	(1459.866)	(1174.559)	(1594.058)	
Number of ANC visits at private practice in last month	0.221	0.355	-0.295	-0.331	-0.137	-0.4674*	204
	(0.077)	(0.171)	(0.279)	(0.307)	(0.373)	(0.250)	
Fee charged for ANC at gov't practice	2616.823	1423.077	-368.377	-313.255	-218.799	-532.054	189
	(1281.327)	(360.227)	(538.416)	(554.967)	(714.799)	(463.864)	
Number of ANC visit at gov't practice in last month	11.407	6.194	3.563	-2.060	4.542	2.482	204
	(1.687)	(1.601)	(3.454)	(3.990)	(4.109)	(3.786)	
Fee charged for ANC visit (avg. of private & gov't)	2768.937	2351.429	-899.717	-230.100	-797.204	-1027.3043*	177

Indicator	Baseline mean	Control mean	Model 1 Total Generasi Year 1 Effect	Versi A additional effect	Model 2 Total Versi B impact	Total Versi A impact	Number observations
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
	(1383.104)	(692.964)	(676.302)	(605.334)	(834.387)	(606.322)	
Total number of ANC visits in last month	11.628	6.548	3.130	-2.425	4.282	1.857	204
	(1.700)	(1.588)	(3.507)	(4.064)	(4.255)	(3.740)	
Fee paid by mother for ANC visit	6044.484	6187.500	16978.414	-22250.000	27577.830	5329.674	70
	(1674.315)	(4749.753)	(17794.207)	(30463.793)	(28863.107)	(15392.864)	
Fee charged for family planning visit at private practice	.	2611.111	111.374	551.201	-109.316	441.885	104
	(.)	(983.986)	(808.159)	(1296.153)	(886.210)	(1219.587)	
Number of family planning visits at private practice in last month	.	1.133	-1.042	0.976	-1.442	-0.466	81
	(.)	(0.506)	(1.204)	(1.587)	(1.182)	(1.724)	
Fee charged for family planning visit at gov't practice	.	1592.593	-161.075	99.277	-207.138	-107.861	189
	(.)	(336.562)	(355.054)	(453.024)	(383.556)	(462.269)	
Number of family planning visits at gov't practice in last month	.	12.071	11.142	-31.557	25.991	-5.566	189
	(.)	(2.107)	(12.163)	(34.789)	(24.052)	(18.513)	
Fee charged for family planning visit (avg. private & gov't)	.	1987.654	-525.809	233.201	-632.852	-399.651	176
	(.)	(454.648)	(408.852)	(482.714)	(433.034)	(525.614)	
Total number of family planning visits in last month	.	12.679	10.038	-31.206	24.704	-6.502	191
	(.)	(2.029)	(12.181)	(34.049)	(23.744)	(18.209)	
Fee paid by mother for family planning visit	3125.000	9000.000	5000.000	-1842.105	5789.4736**	3947.3684***	19
	(579.423)	(5567.764)	0.000	(1792.710)	(2227.797)	(823.881)	
Puskesmas							
Normal childbirth at Puskesmas—fee charged by midwife	42795.453	94857.141	-10760.000	10446.594	-15670.000	-5222.366	47
	(9528.392)	(29567.738)	(23502.625)	(25136.674)	(27751.059)	(26035.744)	
Normal childbirth at Puskesmas—quantity by midwife	24.451	31.154	-10.626	6.977	-13.833	-6.856	48
	(2.854)	(16.350)	(16.363)	(12.515)	(16.829)	(18.737)	
Normal childbirth at Puskesmas—fee paid by mother	174900.000	118000.000	-1.500e+04***	360000.000	-375000.000	-15000.000	12
	(25373.746)	(41521.078)	(0.009)	0.000	0.000	0.000	

Indicator	Baseline mean	Control mean	Model 1 Total Generasi Year 1 Effect	Versi A additional effect	Model 2 Total Versi B impact	Total Versi A impact	Number observations
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Schools							
SD—Annual cost of school for TA 07/08	.	21991.525	23116.350	18527.055	13886.041	32413.094	203
	(.)	(10511.231)	(22428.061)	(21269.490)	(25172.986)	(24586.082)	
SD—Number of students enrolled at TA 07/08	.	166.915	-40.6978***	-25.328	-28.079	-53.4070***	203
	(.)	(8.573)	(12.838)	(20.392)	(18.014)	(14.092)	
SD—Number of students enrolled in TA 08/09	.	171.356	-35.8940***	-29.515	-21.190	-50.7043***	203
	(.)	(9.211)	(12.970)	(18.894)	(17.598)	(13.698)	
SD—Cost of school from parents for previous semester	9034.550	32325.000	-755.862	4664.353	-3059.726	1604.627	1302
	(968.681)	(7752.840)	(5286.648)	(7318.863)	(5522.470)	(7155.377)	
SMP—annual cost of school for TA 07/08	130500.000	312300.000	66177.969	2.685e+05*	-57120.000	211400.000	125
	(40537.965)	(99505.328)	(95044.609)	(152600.000)	(102500.000)	(128300.000)	
SMP—Number of students enrolled at TA 07/08	222.379	294.342	-24.818	4.398	-26.817	-22.419	125
	(15.730)	(26.766)	(18.399)	(22.206)	(25.814)	(14.651)	
SMP—Number of students enrolled in TA 08/09	241.024	320.368	-22.9598*	-9.406	-18.706	-28.1125*	125
	(15.658)	(29.601)	(13.455)	(9.662)	(13.381)	(15.197)	
SMP—Cost of school from parents for previous semester	124200.000	116300.000	-11090.000	-15970.000	-2985.496	-18950.000	299
	(66527.031)	(47143.902)	(27736.481)	(34934.363)	(34407.852)	(30730.357)	
Village health post							
Village health post—Fee for visit	.	420.168	13.964	63.241	-17.264	45.977	403
	(.)	(83.750)	(72.025)	(76.263)	(77.919)	(82.924)	
Village health post—quantity of kids weighed at last meeting where service was offered	.	44.556	4.904	5.285	2.279	7.5638**	398
	(.)	(2.169)	(3.167)	(4.578)	(4.178)	(3.442)	
Village health post—quantity of kids with nutritional supplement at last meeting where service was offered	.	28.531	16.1121***	-0.065	16.1436***	16.0789***	386
	(.)	(2.618)	(2.548)	(4.075)	(3.215)	(3.318)	

Indicator	Baseline mean	Control mean	Model 1 Total Generasi Year 1 Effect	Versi A additional effect	Model 2 Total Versi B impact	Total Versi A impact	Number observations
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Village health post—quantity of kids immunized at last meeting where service was offered	.	12.127	1.182	2.907	-0.232	2.675	375
	(.)	(1.514)	(1.571)	(1.919)	(1.751)	(1.860)	
Village health post—quantity of moms receiving ANC visits at last meeting where service was offered	.	6.470	1.282	1.803	0.400	2.202	396
	(.)	(1.127)	(1.362)	(1.484)	(1.595)	(1.452)	
Village health post—quantity of moms receiving iron pills at last meeting where service was offered	.	7.974	0.816	0.441	0.598	1.039	388
	(.)	(1.457)	(1.853)	(2.438)	(2.330)	(2.099)	
Village health post—quantity of kids receiving Vitamin A at last meeting where service was offered	.	30.900	10.5310***	7.229	6.9975**	14.2260***	375
	(.)	(2.532)	(2.862)	(4.633)	(3.193)	(4.160)	
Village health post—quantity of moms receiving family planning pills at last meeting where service	.	4.087	-0.058	1.272	-0.680	0.592	382
was offered	(.)	(0.880)	(0.989)	(1.310)	(1.349)	(0.961)	
Village health post—quantity of moms receiving family planning injections at last meeting	.	4.910	-0.032	-0.086	0.011	-0.075	381
where service was offered	(.)	(0.938)	(1.188)	(1.529)	(1.497)	(1.328)	
Average standardized effect fees			-0.087	-0.146	0.087	-0.059	
			(0.079)	0.000	0.000	0.000	
Average standardized effect health fees			-0.089	-0.142	0.112	-0.030	
			(0.098)	0.000	0.000	0.000	
Average standardized effect education fees			-0.083	-0.163	-0.006	-0.169	
			(0.096)	0.000	0.000	0.000	
Average standardized effect midwife fees			-0.130	0.143	-0.192	-0.049	

Indicator	Baseline mean	Control mean	Model 1 Total Generasi Year 1 Effect	Versi A additional effect	Model 2 Total Versi B impact	Total Versi A impact	Number observations
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
			(0.115)	0.000	0.000	0.000	
Average standardized effect puskesmas fees			0.125	-1.882	1.982	0.100	
			(0.096)	0.000	0.000	0.000	
Average standardized effect school fees			-0.083	-0.163	-0.006	-0.169	
			(0.096)	0.000	0.000	0.000	
Average standardized effect village health post fees			-0.015	-0.069	0.019	-0.050	
			(0.080)	0.000	0.000	0.000	
Average standardized effect quantities			0.027	-0.081	0.066	-0.014	
			(0.066)	0.000	0.000	0.000	
Average standardized effect health quantities			0.111	-0.053	0.135	0.083	
			(0.076)	0.000	0.000	0.000	
Average standardized effect education quantities			-0.3504***	-0.207	-0.248	-0.454	
			(0.090)	0.000	0.000	0.000	
Average standardized effect midwife quantities			0.086	-0.228	0.194	-0.034	
			(0.123)	0.000	0.000	0.000	
Average standardized effect puskesmas quantities			-0.180	0.118	-0.235	-0.116	
			(0.259)	0.000	0.000	0.000	
Average standardized effect school quantities			-0.3504***	-0.207	-0.248	-0.454	
			(0.090)	0.000	0.000	0.000	
Average standardized effect village health post quantities			0.1761**	0.123	0.116	0.239	
			(0.071)	0.000	0.000	0.000	

Table 58. Results for service-provider-based quantities, Sulawesi /Gorontalo (baseline as control variable)

Indicator	Baseline mean	Control mean	Model 1 Total Generasi Year 1 Effect	Versi A additional effect	Model 2 Total Versi B impact	Total Versi A impact	Number observations
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Midwife							
Fee charged for childbirth at private practice	244500.000	265200.000	40161.512	12750.211	34117.648	46867.859	113
	(11682.638)	(16353.814)	(24124.014)	(35225.879)	(23493.813)	(35370.520)	
Number of childbirths at private practice in last month	1.861	2.158	0.035	-0.775	0.393	-0.381	126
	(0.332)	(0.534)	(0.487)	(0.524)	(0.624)	(0.442)	
Fee charged for childbirth at gov't practice	163400.000	120100.000	8569.106	3581.273	6856.678	10437.951	117
	(13117.015)	(19471.467)	(32902.152)	(42805.020)	(33838.055)	(44626.434)	
Number of childbirths at gov't practice in last month	2.608	2.079	0.806	2.454	-0.284	2.169	126
	(0.531)	(0.463)	(1.287)	(2.614)	(1.799)	(2.033)	
Fee charged for childbirth (avg. of private & gov't)	203000.000	218000.000	33052.590	12459.971	27447.809	39907.781	103
	(12482.780)	(20228.647)	(26669.908)	(32104.518)	(30678.482)	(31518.588)	
Total number of childbirths in last month	4.468	4.237	1.405	1.233	0.883	2.116	126
	(0.571)	(0.610)	(1.825)	(2.403)	(2.086)	(2.386)	
Fee paid by mother for normal childbirth	812400.000	2535000.000	-1557000.000	1454000.000	-1917000.000	-462900.000	33
			(1296000.000)	(1288000.000)	(1286000.000)	(1532000.000)	
Fee charged for ANC at private practice	10902.598	13906.250	1765.725	515.579	1561.918	2077.497	110
	(959.939)	(1567.281)	(1894.182)	(2736.516)	(2113.804)	(2601.164)	
Number of ANC visits at private practice in last month	1.899	2.579	-0.357	-1.877	0.492	-1.385	126
	(0.369)	(0.923)	(1.009)	(1.314)	(1.157)	(1.154)	
Fee charged for ANC at gov't practice	2461.539	3265.625	-35.203	1813.280	-808.292	1004.988	116
	(382.863)	(834.605)	(758.426)	(1300.276)	(768.042)	(1250.195)	
Number of ANC visit at gov't practice in last month	8.152	7.368	-0.706	1.896	-1.521	0.375	126
	(1.198)	(1.356)	(2.287)	(3.214)	(3.182)	(2.226)	
Fee charged for ANC visit (avg. of private & gov't)	4402.783	7051.199	-2010.545	2187.235	-2908.7263**	-721.491	112

Indicator	Baseline mean	Control mean	Model 1 Total Generasi Year 1 Effect	Versi A additional effect	Model 2 Total Versi B impact	Total Versi A impact	Number observations
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
	(519.826)	(1286.246)	(1258.373)	(1582.211)	(1099.843)	(1934.357)	
Total number of ANC visits in last month	10.051	9.947	-0.991	1.847	-1.785	0.062	126
	(1.291)	(1.525)	(2.542)	(3.773)	(3.780)	(2.193)	
Fee paid by mother for ANC visit	18856.250	34230.770	-10730.000	14023.046	-13910.000	115.055	56
	(3583.908)	(22502.465)	(8228.656)	(9461.528)	(9369.263)	(8883.446)	
Fee charged for family planning visit at private practice	.	18882.354	2271.507	2838.536	1033.745	3872.2805**	112
	(.)	(3096.636)	(1439.429)	(2757.257)	(2204.959)	(1592.276)	
Number of family planning visits at private practice in last month	.	14.759	1.811	-2.299	2.780	0.481	104
	(.)	(3.222)	(3.465)	(4.432)	(3.716)	(4.482)	
Fee charged for family planning visit at gov't practice	.	13529.412	-2728.809	2565.491	-3902.131	-1336.641	116
	(.)	(4296.702)	(2461.513)	(3911.430)	(3431.418)	(2787.646)	
Number of family planning visits at gov't practice in last month	.	14.219	0.574	-2.847	1.825	-1.022	111
	(.)	(4.058)	(5.865)	(7.170)	(6.055)	(7.649)	
Fee charged for family planning visit (avg. private & gov't)	.	16357.848	-789.884	2628.240	-1937.883	690.358	113
	(.)	(3304.422)	(1821.906)	(3431.964)	(2771.517)	(1970.541)	
Total number of family planning visits in last month	.	25.229	2.498	-3.259	3.884	0.626	121
	(.)	(4.419)	(6.463)	(8.870)	(6.853)	(8.824)	
Fee paid by mother for family planning visit	14644.737	14538.462	2629.969	224.971	2535.160	2760.131	42
	(622.283)	(1365.159)	(2105.814)	(1456.916)	(2140.703)	(2391.587)	
Puskesmas							
Normal childbirth at Puskesmas—fee charged by midwife	162700.000	100800.000	75012.977	55695.719	50975.461	106700.000	27
	-15155.492	-23691.781	-63503.504	-73173.781	-70788.250	-80263.781	
Normal childbirth at Puskesmas—quantity by midwife	30.647	20.571	10.7653**	(9.628)	15.0919**	5.464	34
	-6.464	-4.799	-5.139	-6.887	-6.028	-6.110	
Normal childbirth at Puskesmas—fee paid by mother	289100.000	166700.000	-2.505e+05***	0.000	-2.505e+05***	-2.505e+05***	11
	-65093.703	-166700.000	-58925.566	0.000	-58925.566	-58925.566	
Schools							
SD—Annual cost of school for TA 07/08	.	43375.531	(18130.000)	(1545.538)	(17430.000)	(18980.000)	136
	(.)	(16622.525)	(16086.063)	(12988.986)	(15259.040)	(19671.299)	

Indicator	Baseline mean	Control mean	Model 1 Total Generasi Year 1 Effect	Versi A additional effect	Model 2 Total Versi B impact	Total Versi A impact	Number observations
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
SD—Number of students enrolled at TA 07/08	.	152.536	10.606	41.6978**	-8.212	33.4857**	136
	(.)	(8.931)	(14.103)	(17.073)	(17.108)	(14.318)	
SD—Number of students enrolled in TA 08/09	.	152.304	13.768	39.8429**	-4.213	35.6301**	136
	(.)	(8.661)	(14.212)	(17.131)	(17.088)	(14.892)	
SD—Cost of school from parents for previous semester	8484.099	22381.117	10195.796	4494.404	8186.159	12680.564	624
	(950.011)	(6000.406)	(6028.360)	(10062.902)	(5021.040)	(10306.193)	
SMP—annual cost of school for TA 07/08	34513.637	371100.000	-120900.000	-191900.000	-33590.000	-225400.000	100
	(7661.827)	(96011.320)	(165800.000)	(169500.000)	(198400.000)	(153200.000)	
SMP—Number of students enrolled at TA 07/08	157.778	168.429	0.647	10.308	-3.927	6.381	100
	(15.136)	(22.881)	(11.632)	(14.218)	(14.596)	(11.684)	
SMP—Number of students enrolled in TA 08/09	175.576	184.691	-0.275	24.5988*	-11.086	13.512	100
	(14.713)	(23.561)	(10.835)	(14.377)	(8.661)	(15.461)	
SMP—Cost of school from parents for previous semester	32191.949	141600.000	4806.616	22386.598	-5532.533	16854.065	221
	(7125.014)	(50021.711)	(32753.647)	(37927.246)	(39922.688)	(34111.481)	
Village health post							
Village health post—Fee for visit	.	118.182	-5.237	11.182	-10.249	0.933	266
	(.)	(38.164)	(47.270)	(81.177)	(66.413)	(56.068)	
Village health post—quantity of kids weighed at last meeting where service was offered	.	35.881	11.7880***	(6.766)	14.8856**	8.120	260
	(.)	-3.016	-3.830	-6.955	-5.526	-4.884	
Village health post—quantity of kids with nutritional supplement at last meeting where service was offered	.	29.864	18.5684***	(2.506)	19.6899***	17.1842**	251
	(.)	-2.521	-4.779	-8.784	-5.267	-7.750	

Indicator	Baseline mean	Control mean	Model 1 Total Generasi Year 1 Effect	Versi A additional effect	Model 2 Total Versi B impact	Total Versi A impact	Number observations
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Village health post—quantity of kids immunized at last meeting where service was offered	.	17.733	6.1466**	9.8687**	1.579	11.4481***	253
	(.)	-1.911	-2.545	-4.337	-2.284	-3.911	
Village health post—quantity of moms receiving ANC visits at last meeting where service was offered	.	4.817	2.7639**	4.0087***	0.939	4.9480***	262
	(.)	-0.574	-1.063	-1.293	-1.065	-1.167	
Village health post—quantity of moms receiving iron pills at last meeting where service was offered	.	5.085	2.5073**	3.7763**	0.790	4.5658***	258
	(.)	-0.671	-1.107	-1.491	-1.281	-1.272	
Village health post—quantity of kids receiving Vitamin A at last meeting where service was	.	47.637	17.4946*	4.994	15.191	20.1847*	244
offered	(.)	-4.957	-8.843	-11.864	-9.472	-11.925	
Village health post—quantity of moms receiving family planning pills at last meeting where	.	5.173	1.329	4.697	(0.839)	3.858	251
service was offered	(.)	-1.293	-2.020	-3.284	-2.151	-3.006	
Village health post—quantity of moms receiving family planning injections at last meeting where	.	5.543	(1.731)	2.795	-3.0149**	(0.220)	247
service was offered	(.)	-1.693	-1.383	-2.512	-1.456	-2.283	
Average standardized effect fees			-0.029	-0.139	0.027	-0.112	
			(0.072)	0.000	0.000	0.000	
Average standardized effect health fees			-0.048	-0.188	0.028	-0.160	
			(0.093)	0.000	0.000	0.000	
Average standardized effect education fees			0.043	0.041	0.024	0.065	
			(0.069)	0.000	0.000	0.000	

Indicator	Baseline mean	Control mean	Model 1 Total Generasi Year 1 Effect	Versi A additional effect	Model 2 Total Versi B impact	Total Versi A impact	Number observations
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Average standardized effect midwife fees			-0.057	-0.179	0.012	-0.167	
			(0.096)	0.000	0.000	0.000	
Average standardized effect puskesmas fees			-0.023	-0.318	0.123	-0.194	
			(0.329)	0.000	0.000	0.000	
Average standardized effect school fees			0.043	0.041	0.024	0.065	
			(0.069)	0.000	0.000	0.000	
Average standardized effect village health post fees			0.013	-0.028	0.026	-0.002	
			(0.121)	0.000	0.000	0.000	
Average standardized effect quantities			0.1792**	0.148	0.112	0.249	
			(0.068)	0.000	0.000	0.000	
Average standardized effect health quantities			0.1982**	0.100	0.153	0.253	
			(0.082)	0.000	0.000	0.000	
Average standardized effect education quantities			0.093	0.367	-0.072	0.296	
			(0.117)	0.000	0.000	0.000	
Average standardized effect midwife quantities			0.042	0.034	0.029	0.063	
			(0.158)	0.000	0.000	0.000	
Average standardized effect puskesmas quantities			0.5995**	-0.536	0.841	0.304	
			(0.263)	0.000	0.000	0.000	
Average standardized effect school quantities			0.093	0.367	-0.072	0.296	
			(0.117)	0.000	0.000	0.000	
Average standardized effect village health post quantities			0.3236***	0.253	0.208	0.461	
			(0.098)	0.000	0.000	0.000	

Table 59. Detail of mortality vis-à-vis baseline (neonatal mortality)

		Model 1		Model 2		
Indicator	Control mean	Total Generasi Year 1 Effect	Versi A additional effect	Total Versi B impact	Total Versi A impact	Number observations
	(1)	(2)	(3)	(4)	(5)	(6)
Mortality 0-28 days						
All provinces						
Treatment	0.008	-0.0052*	-0.001	-0.005	-0.0056*	2765
	(0.003)	(0.003)	(0.003)	(0.003)	(0.003)	
Baseline	0.014	-0.003	-0.008	0.001	-0.007	2847
	(0.004)	(0.005)	(0.006)	(0.005)	(0.006)	
Java						
Treatment	0.006	-0.001	-0.003	0.000	-0.003	1775
	(0.003)	(0.003)	(0.004)	(0.004)	(0.004)	
Baseline	0.011	-0.008	-0.004	-0.006	-0.010	1904
	(0.004)	(0.005)	(0.007)	(0.006)	(0.007)	
NTT						
Treatment	0.016	-0.0143**	0.001	-0.0146**	-0.0140**	607
	(0.009)	(0.007)	(0.003)	(0.007)	(0.007)	
Baseline	0.027	0.006	-0.011	0.012	0.001	596
	(0.012)	(0.013)	(0.011)	(0.014)	(0.013)	
Sulawesi						
Treatment	0.006	-0.004	0.008	-0.007	0.001	383
	(0.006)	(0.007)	(0.013)	(0.006)	(0.013)	
Baseline	0.014	0.006	-0.023	0.016	-0.007	347
	(0.010)	(0.011)	(0.014)	(0.015)	(0.009)	

Table 60. Detail of mortality vis-à-vis baseline (infant mortality)

Indicator	Control mean	Model 1 Total Generasi Year 1 Effect	Versi A additional effect	Model 2 Total Versi B impact	Total Versi A impact	Number observations
	(1)	(2)	(3)	(4)	(5)	(6)
Mortality 0-11 Months						
All provinces						
Treatment	0.018	-0.0081**	0.000	-0.0083**	-0.0079*	3788
	(0.004)	(0.004)	(0.004)	(0.004)	(0.004)	
Baseline	0.024	-0.0088*	-0.010	-0.004	-0.0137**	3508
	(0.005)	(0.005)	(0.006)	(0.006)	(0.006)	
Java						
Treatment	0.008	-0.002	-0.0082*	0.002	-0.0062*	2431
	(0.003)	(0.004)	(0.004)	(0.005)	(0.004)	
Baseline	0.013	-0.006	-0.008	-0.002	-0.010	2297
	(0.004)	(0.006)	(0.008)	(0.008)	(0.007)	
NTT						
Treatment	0.024	-0.006	0.0181*	-0.0152*	0.003	826
	(0.010)	(0.009)	(0.009)	(0.009)	(0.011)	
Baseline	0.044	-0.009	-0.011	-0.003	-0.015	758
	(0.014)	(0.011)	(0.011)	(0.013)	(0.012)	
Sulawesi						
Treatment	0.040	-0.0386***	-0.006	-0.0363***		531
	(0.012)	(0.009)	(0.016)	(0.009)	(0.014)	
Baseline	0.038	-0.015	-0.0287*	-0.001	-0.0300**	453
	(0.014)	(0.013)	(0.014)	(0.016)	(0.013)	