

**PROGRAM-FOR-RESULTS INFORMATION DOCUMENT (PID)
APPRAISAL STAGE**

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I. Country Context

1. **Indonesia is the world’s largest archipelagic state, the fourth most populous nation, and the tenth largest economy with regard to purchasing power parity.** It is a member of the Association of Southeast Asian Nations group of countries that have a combined population of 608.4 million and is also a member of the G-20. With more than 17,500 islands, of which 6,000 are inhabited, Indonesia has a population of over 250 million, with 300 distinct ethnic groups and over 700 languages and dialects. With a gross national income per capita of about US\$3,440 (2015), Indonesia is currently classified as a lower-middle-income country and will transition to an upper-middle-income country with continued economic growth.

2. **Over the past decade, Indonesia has seen strong growth and job creation, supporting poverty reduction, but the end of the commodity boom has exposed structural weaknesses.**¹ Following the recovery from the Asian financial crisis, annual growth averaged 5.6 percent over the 2001–2012 period. As the external tailwinds of commodity prices and demand and global financing conditions have turned to headwinds, growth has slowed, down to 4.8 percent in 2015 and projected at 5.1 percent in 2016. The slowdown in growth and weakening of commodity prices has increased fiscal pressures significantly in 2015 and 2016.

3. **Indonesia’s progress on poverty reduction contrasts sharply with its performance in sharing prosperity.** From 1999 to 2016, the national poverty rate more than halved to 10.8 percent, largely through sustained growth and job creation. Recently, however, the rate of poverty reduction has begun to stagnate, with a near zero decline in 2015. Lifting the ‘hard core’ poor permanently out of poverty will require greater focus and new programs. In 2016, the number of vulnerable (that is, those between the poverty line and 1.5 times the line) remains

¹ World Bank. 2015. Indonesia - Systematic Country Diagnosis: Connecting the Bottom 40 percent to the Prosperity Generation.

high, at 24 percent of the population, mainly due to a lack of productive employment and vulnerability to shocks. Together, the poor and vulnerable are 35 percent of the population. Inequality, as measured by the Gini coefficient, increased from 30 points in 2000 to 41 points by 2014, by far the fastest widening seen in the East Asia and Pacific Region.

4. **Despite progress made in human development, several challenges remain.** In education, adult literacy is at almost 95 percent; gross enrollment has reached 100 percent, 83 percent, and 32 percent in primary, secondary, and tertiary education, respectively; and the share of female enrollment exceeds that of males at each level.² But disparities in access among socioeconomic groups have persisted. About 23 percent of villages do not have any pre-primary education services. There are also severe disparities in education service provision between urban and rural areas and across provinces. Health outcomes and outputs in Indonesia have also improved in recent years. Life expectancy at birth has steadily increased to 69 years in 2014, up from 63 years in 1990. The under-five mortality rate has declined from 85 per 1,000 live births in 1990 to 27 in 2015. However, there is slow progress on maternal health and chronic malnutrition. Indonesia has one of the highest maternal mortality rates in the East Asia and Pacific Region (190 per 100,000 live births in 2013). Births attended by skilled health staff, rates of immunization, and rates of access to improved sanitation facilities also remain behind the region's developing country average. And latest data from 2013 showed that 37 percent of under-five children were stunted, while 12 percent were wasted. Stunting affected all income groups but worsened among the poorest, it increased from 41 percent in 2007 to 48 percent in 2013.

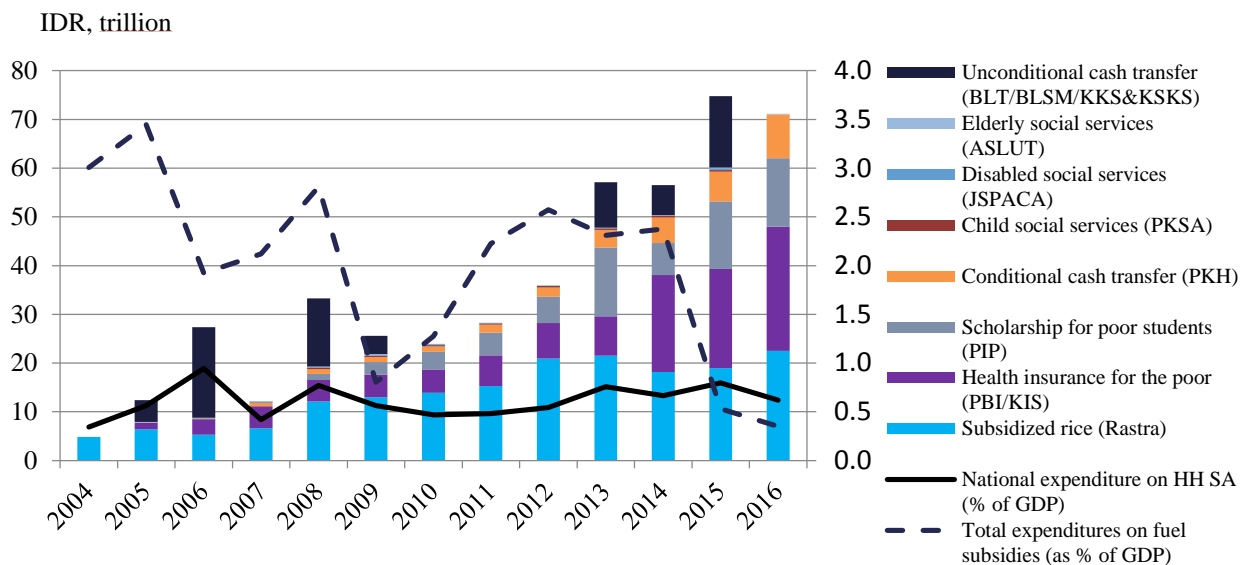
II. Sectoral (or multi-sectoral) and Institutional Context

5. **The year 2005 marked Indonesia's shift to begin investing comprehensively in social assistance (SA) programs because of the creation of fiscal space through the phasing out of a regressive fuel subsidy.** In 2010, a main development priority of the reelected Government was poverty reduction, implying a redesign of Indonesian SA programs to achieve broad-based economic growth and fiscal sustainability with the aim to improve access to and quality of basic social services. Since then, spending on SA has kept its upward trend to reach 0.7 percent of gross domestic product (GDP) in 2015 (still below the world average, at 1.6 percent of GDP).³

Figure 1. Expenditures on Targeted SA and Fuel Subsidies, 2004–2016

² World Bank. 2016. Investing in Early Years: Indonesia Report.

³ World Bank. 2015. The State of Social Safety Nets 2015.



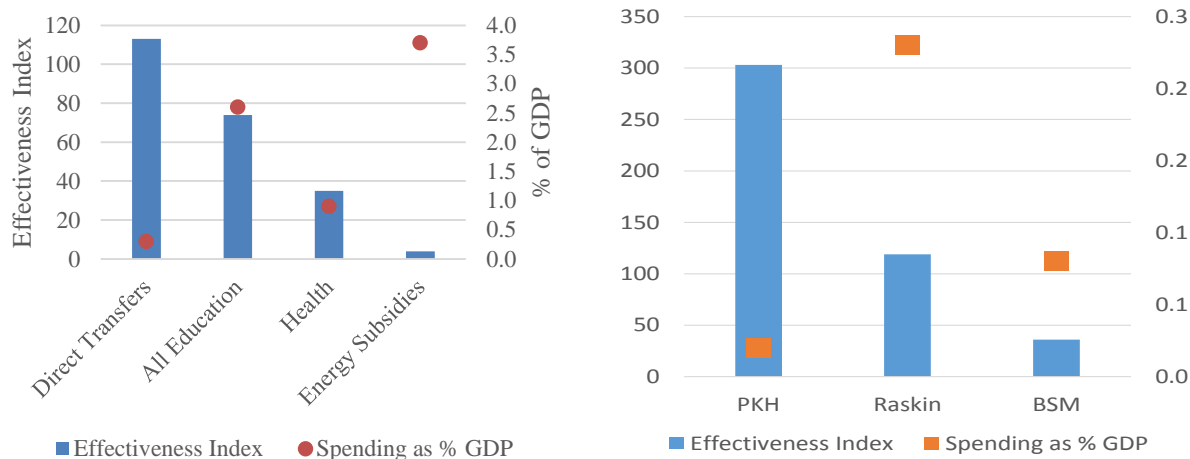
Source: World Bank. Forthcoming. Indonesia Social Assistance Public Expenditure Review.

6. **Between 2010 and 2015, the Government executed several SA reforms, including the introduction of a new conditional cash transfer (CCT) program.** For example, standardized procedures for targeting and identifying potential beneficiaries, drawing on a new national registry of nearly 26 million poor and vulnerable households, were put in place. Also over this period, the national health insurance for the poor scheme (*Penerima Bantuan Iuran, PBI*) was also expanded to reach 92.4 million people in 2016, while the rice subsidy scheme for the poor (*Subsidi Beras Sejahtera, Rastra*) reached 15.5 million households in the same year. Several reductions in poorly targeted energy subsidies were achieved while the fiscal savings were reallocated to more effective purposes, including (a) a temporary, emergency, unconditional cash transfer (called *Bantuan Langsung Sementara Masyarakat*) targeted at poor and vulnerable households; (b) a family welfare card (*Kartu Keluarga Sejahtera, KKS*) giving beneficiaries access to multiple programs; and (c) benefit and coverage increases for Indonesia’s scholarships (*Program Indonesia Pintar, PIP*) and the CCT program (*Program Keluarga Harapan, PKH*).

7. **Still, SA programs in Indonesia have limited poverty and inequality reduction impact based on current spending.** In 2012, less than one-quarter of total expenditures in the four permanent SA programs went to poor households while SA benefits eliminated only 16 percent of the poverty gap.⁴ Direct transfers are the most effective at reducing poverty and inequality, yet total spending on direct transfers is dwarfed by that of energy subsidies. Among the SA programs, PKH is the most effective one with regard to its impact on poverty and inequality reduction.

Figure 2. Effectiveness Index and Spending in Selected Categories

⁴ World Bank (2017), Social Assistance Public Expenditure Review.



Source: World Bank. 2016. “The Distributional Impact of Fiscal Policy in Indonesia”.

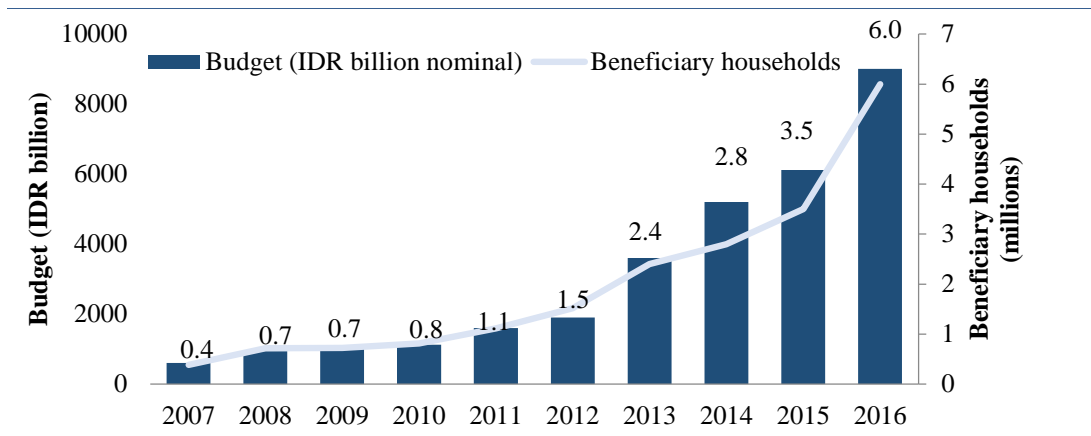
Note: Effectiveness here is defined as how much a program reduces inequality, and therewith poverty, divided by the total budget spent. Direct transfers include the PKH, Rastra, and PIP

8. **The administration that took office in 2015 added a focus on reducing inequality and has identified SA, in particular the PKH program, as a means of reducing inequality in income and in opportunity.** The PKH program, implemented by the Ministry of Social Affairs (MoSA), was initiated in 2007 in seven Indonesian provinces covering just under half a million families. Since then it has been expanding its coverage as part of a larger effort to build up a comprehensive social protection system to improve poor and vulnerable families' welfare and opportunity. PKH aims not only to help increase the beneficiaries' current consumption so as to alleviate poverty in the short run, but also to ensure their investment in human capital of their children through education and health conditionalities. As PKH would encourage the beneficiary families to access and use basic health, nutrition, and education services, it is expected to promote the future generation's opportunity and productivity in the long run.

9. **After reviewing the design, process, and systems of the PKH program, the Government had decided to expand its coverage to an impressive 6 million families, making it the third largest CCT in the world.** In the context of Indonesia's main SA programs, PKH has the highest effectiveness in terms of poverty and inequality reduction impact per IDR spent, but the lowest budget allocation.⁵ Due to the potential highly effective impact of PKH with regard to poverty and inequality reduction per rupiah spent, the new administration had decided an impressive national scale-up in coverage, from 3.5 million families in 2015 to 6 million families (about nine percent of the population) by the end of 2016. With the expansion, all except a few districts in Indonesia, including those of Papua, with the highest poverty rates in the country but previously not covered by PKH, are now covered. The ultimate goal of MoSA is to further expand the program by up to 15 million families by 2019 and reduce exclusion errors (poor families with children not covered; highly marginalized and remote regions with high presence of indigenous populations excluded). The program would come a long way from when it was first introduced in 2007 in seven Indonesian provinces covering just 382,000 very poor households.

⁵ World Bank. 2017 (forthcoming). Social Assistance Public Expenditure Review.

Figure 3. PKH Coverage, Budgetary Support, 2007–2016



Source: MoSA (2014, 2015, 2016) and Ministry of Finance (MoF) (2008–2013).

Note: 2011–2013 data are realized budget; 2014, 2015, and 2016 data are budgeted totals.

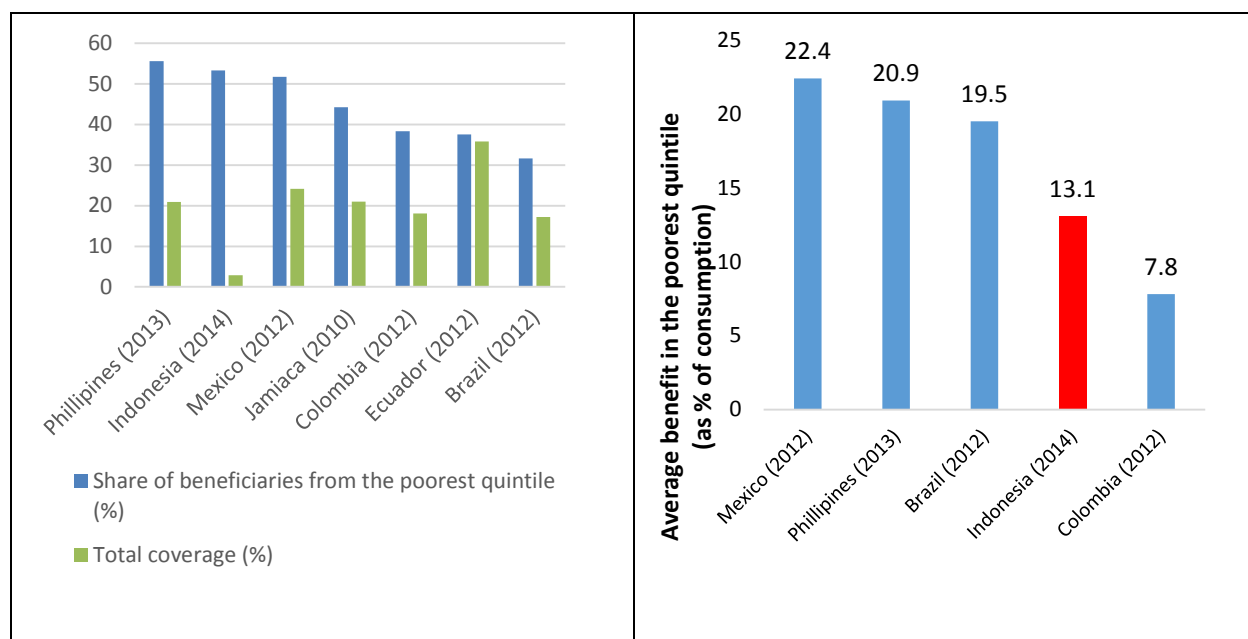
10. **PKH’s potential contribution to poverty and inequality reduction could be even higher when compared to other large CCT programs in the world.** With the expansion, all provinces in Indonesia, including Papua and West Papua, with the highest poverty rates in the country, are now covered. However, both its coverage and benefit level are still relatively low when compared to other large CCT programs. For example, the CCT programs in Mexico, Brazil, and the Philippines cover between 20 percent and 30 percent of the population and provide cash transfer benefits at 20 percent of consumption. Further coverage expansion will reduce exclusion errors, particularly among the vulnerable population who may easily fall below the poverty line due to various shocks, and focus on the disadvantaged and remote regions with a high presence of indigenous populations.

11. **PKH’s eligibility depends on both family resources and demographic composition.** To be eligible, a family must be included in the country’s social registry (formerly called the Unified Database or UDB, now called Siskada) and ranked below a certain poverty cutoff point. They must meet at least one of the following conditions: a family member is pregnant or lactating; the family has one or more children below 6 years of age; the family has children ages 7 years to 21 years attending primary or secondary school; or the family has children ages 16 years to 21 years who have not yet completed basic education. Furthermore, PKH beneficiary families must be in compliance with the relevant health and education conditionalities to receive the cash transfers, which are made only after verification of the compliance of the conditionality. Mothers are the main recipient in the majority of cases. Since November 2016, eligible families that have a severely disabled or an elderly person (70 years and older) living with them also receive additional transfers as long as they have not yet been covered by other SA programs (such as the old age assistance program).

12. **Robust impact evaluations have already shown positive impacts of PKH in increasing food expenditures, health-seeking behavior, and education for poor families and**

the communities in which they live.⁶ Two rounds of impact evaluation, using randomized-control trial techniques, have shown increases in participation in elementary and secondary schools, transition from primary to junior secondary schools, prenatal visits, and complete immunization for children. Similarly, a recent study showed that both worldwide and in Indonesia, CCTs do not increase recipients' purchasing of alcohol or cigarettes. Furthermore, another presumption was disproven, the notion that cash transfers discourage work.⁷

Figure 4. PKH Targeting Performance and Coverage (left panel) and Benefit Level (right panel)



Source: World Bank calculations based on Susenas 2014 and World Bank Atlas of Social Protection Indicators of Resilience and Equity (www.worldbank.org/aspire). Both targeting performance (beneficiary incidence) and coverage are pre-transfer estimates, where data is available.

13. PKH also has the potential to play a bigger role in Indonesia's fight against malnutrition. The impact evaluations have shown that PKH is associated with important reduction in child severe stunting of 3 percentage points, a significant milestone in a country with levels of malnutrition among the highest in the world. Indeed, in 2013, one-third of (almost 9 million) children in the country under age five were stunted and the prevalence of stunting among children from the poorest 20 percent is also highest. The Government has pledged to take a multisectoral approach to address various binding constraints and bottlenecks in both the supply side (for example, service provisions of health, nutrition, water, and sanitation) and demand side (for example, awareness and knowledge in nutrition, and positive behavior changes). PKH could address the demand-side issues effectively by not only incentivizing beneficiary families to use existing health and nutrition services, but also promoting positive

⁶ See World Bank. 2011. *Program Keluarga Harapan: Main Findings from the Impact Evaluation of Indonesia's Pilot Household Conditional Cash Transfer Program*. Washington, DC: World Bank
TNP2K (National Team for the Acceleration of Poverty Reduction). 2015. *Evaluation Longer-Term Impact of Indonesia's CCT Program: Evidence from a Randomized Control Trial*. Jakarta: World Bank.

⁷ Banerjee, Hanna, Kreindler, and Olken. 2015. "Debunking the Stereotype of the Lazy Welfare Recipient: Evidence from Cash Transfer Programs Worldwide." Working Paper No. 308.

behavior changes (for example, exclusive breastfeeding) through monthly group-based learning meetings, called Family Development Sessions (FDSs). FDSs were originally designed as an instrument of graduation strategy to support PKH beneficiary families who are at the end of their six-year cycle. MoSA has decided to roll out FDSs to PKH beneficiary families regardless of their status in the six-year cycle. The FDS' structured learning modules are also to be upgraded incorporating the new findings from behavior research.

14. **Still, several reforms lie ahead to improve PKH implementation.** For instance, MoSA needs to establish a clear road map for identification and progressive inclusion of PKH beneficiaries, including in remote underserved areas (for example, Papua) and to new beneficiary groups (elderly, disabled). PKH's scale-up also requires a review of the program management information system (PMIS) to verify how it can effectively cope with expansion, including a potential review of its business processes, to ensure its capability and reliability to support expanded operational needs. MoSA also intends to pursue a rapid rollout of bank account based card payment options (including savings accounts) for a more diversified financial inclusion strategy. Changes in program rules and scale-up will require an overhaul of the grievance redress system (GRS). A massive scale-up and other potential program changes will require a thorough strategy on how to effectively communicate such innovations to the beneficiaries and the general public (including media). PKH's expansion will also demand a thorough strengthening of the institutional architecture of the program, which will be much harder to administer from the central level, and revise the current human resource (HR) strategy, in particular with relation to the role and functions of the program facilitators. All these key reforms will require appropriate funding that is yet to be guaranteed.

15. **As PKH is a key pillar of the comprehensive SA system, the efforts to strengthen the program will actually contribute to the development of the whole SA system.** While the Government has in place a collection of SA programs to achieve its poverty reduction goals, these programs reach only portions of all intended beneficiaries and are highly fragmented both internally and in relation to the rest of the system. In recognition of the great potential of better coordination between its suite of SA programs and implementation units, the MoSA leadership is also undertaking a review of its organizational structure, management models, and HR base, starting with a ministry wide information management and information technology (IT) strategic plan. It has also started to pilot a payment integration model between PKH and the subsidized rice scheme Rastrea (given current coverage gaps of Rastrea among PKH families). And, MoSA is undertaking technology and HR upgrading to be able to manage the UDB, currently hosted by the National Team for the Acceleration of Poverty Reduction (TNP2K) under the Vice President's Office until MoSA's capacity is strengthened, and eventually transform it into a dynamic social registry information system for SA interventions. An additional challenge is how central and local governments coordinate implementation of SA programs. In 2014, less than 30 percent of the CCT families in the poorest decile received PIP, PBI, and Rastrea even though they were eligible for all three programs. Efforts at integration have been made; however, very little progress has been made regarding common standards and processes among programs. More recently, MoSA, in coordination with the National Development Planning Agency (*Badan Perencanaan Pembangunan Nasional*, BAPPENAS) is piloting an Integrated Service and Referral System (SLRT) in 50 districts to promote better coordination, referral, and update of beneficiary information. Similarly, MoSA is piloting and aiming to scale up coverage for a new concept (called 'e-Warong') to integrate digital payments of benefits at the local level, including

PKH, Rastra, and Cooperative Business Groups (*Kelompok Usaha Bersama*, KUBE)-PKH (for PKH beneficiaries) in several localities.

III. Program Scope

16. **The integrations of family-based SA schemes for poor and vulnerable families through CCTs is one of the key strategies in the National Medium-term Development Plan (RPJMN) 2015–2019.**⁸ The RPJMN recognizes the need to perfect the social protection system comprehensively for all citizens and to support special programs for the poor by improving targeting accuracy.⁹ In it, under the section on ‘Policy Directions and Development Strategies’ (page 1–71), in the ‘Organization of Comprehensive Social Protection’ subsection, and ‘Structuring of Regular and Temporary SA Based on Families and the Life Cycle through Productive and Prosperous Families’ theme, the Government has determined the need to establish a comprehensive social protection system for all citizens and improve targeting accuracy of the SA programs for the poor. Its policy direction, in particular, discusses the need to “integrate several family-based SA schemes for poor and vulnerable families that have children, disabled, and elderly in the form of CCTs and/or through in-kind assistance to support nutrition.”

17. **In turn, MoSA’s Strategic Plan (Renstra)¹⁰ for the period 2015–2019 also put the focus on PKH as a key instrument for poverty alleviation.** PKH’s legal framework is supported by several subsequent ministerial decrees.¹¹ In synchronization with the RPJMN, MoSA’s Renstra 2015–2019 has established the following strategic objectives: (a) to contribute to reducing the number of poor people and vulnerable groups by at least one percentage point and support them in meeting their basic needs and improving their abilities and (b) to improve the HR capacity of the institution by increasing the quality of its social welfare activities and its facilitators. The first objective is expected to be partially achieved by increasing PKH coverage to at least 6,000,000 in 2016 (already achieved) and up to 15,000,000 poor families by 2019, covering all 34 provinces, 426 districts, and 98 cities, as well as by expanding and integrating other SA interventions (see Table 1).

Table 1. Selected MoSA Minimum Strategic Targets by 2019

Beneficiaries of CCT (PKH)	6 million (minimum) to 15 million (maximum) Families
PKH participants who are beneficiaries of PBI	452,500 families
Poor and vulnerable people who are beneficiaries of welfare family saving program	16,030,897 people

⁸ This RPJMN was published by the Presidential Decree No. 2 of 2015.

⁹ The mandate of the Government of Indonesia in the area of social protection is stated in Law No. 11 of 2009 on Social Welfare, and Law No. 13 on 2011 on Management of Poor People. Those laws are then strengthened with the Government Regulation No. 39 of 2012 on Social Welfare Implementation and Government Regulation No. 63 of 2013 on the Implementation of Poor People Management through Area Approach, and Law No. 23 of 2014 on Local Government, and Government Regulation No. 38 of 2007 on Government Affairs Distribution between the Government, provincial government and city/district government.

¹⁰ MoSA. 2015. “Rencana Strategis (Renstra) Kementerian Sosial RI, Tahun 2015–2019”.

¹¹ The most recent one is number 12/LJS/09/2016.

Persons with severe disability who are beneficiaries of SA	24,500 people
Abandoned elderly who are beneficiaries of SA	33,000 people
Poor and vulnerable families that are beneficiary of sustainable business activity group (KUBE-PKH).	70,000 (rural), 326,411 (urban), and 135,000 (coastal, outer islands, and border areas) families

Source: Renstra 2015–2019.

18. **MoSA’s Renstra and PKH’s updated Operational Guidelines also highlight several areas of reform at both the ministerial and the program levels, to achieve the stated objectives of improved performance and impact of PKH.** For PKH to be a ‘center of excellence’ in poverty alleviation and foster ‘social empowerment’, MoSA’s Renstra discusses the need for “integration, focus, program/activity segmentation, service targets, program/activity implementation supervision, synergy and synchronization, service and supervision standards, social welfare implementation human resource quality and quantity, institutional quantity and quality, output-oriented service system mechanism, and the lack of integrated data base and service system” as key challenges to overcome during 2015-2019. It also recognizes that “parallel with the increase of budget target and PKH coverage from initially 3,000,000 to 6,000,000, and even up to 15,000,000 poor families in 2019, a new institution is needed to improve PKH implementation performance by putting into consideration a vast coverage area that consists of 34 provinces, 426 districts and 98 cities as well as 6.982 sub-districts.” This last reference accounts for extending PKH coverage to provinces previously not served and despite having the highest poverty incidence (for example, Papua), now becoming a truly national program. The strengthening of PKH business processes, improving target accuracy, broadening target, and strengthening inter-program complementarity, as well as the inclusion of components (benefits) for people with severe disabilities and elderly, are also highlighted as critical agendas beyond 2016, in the recently updated (August 2016) program Operational Guidelines.¹²

19. **While multiyear budget planning is not the norm in Indonesia, to achieve these targets and results, MoSA undertook expenditure framework exercises that anticipated budgetary needs between IDR 61.7 trillion (RPJM) and IDR 86.8 trillion (Renstra) for 2015–2019.** More detailed budget figures for PKH alone are presented in Table 2. With a total of IDR 8.7 trillion (US\$653 million) in 2016 second revised budget, PKH represents almost 70 percent of MoSA’s budget. For 2017 its budget is expected to increase by 42 percent over the actual 2016 program spending to reach US\$958 million (0.12 percent of Indonesia’s GDP), in light of the planned expansion. A more detailed disaggregation of the planned 2017 budget shows that 88 percent of the expenditures are related to cash transfers to beneficiaries, with administrative costs around 12 percent, of which 64 percent correspond to salaries of facilitators and other contracted staff (around 25,000) (Table 3). The ambitious system-strengthening agenda that lies ahead to successfully cope with the program expansion will likely require an increase in the administrative cost share allocation.

Table 2: PKH Expenditure Framework, 2016-2017

PKH Budget (IDR billion)	2015 Planned	2015 Realised	2016 Planned	2016 Revised	2016 Realised	2017 Planned
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¹² MoSA. 2016. “Pedoman Pelaksanaan Program Keluarga Harapan”, updated September 2016.

				(2 nd phase)		
Total	6,385	6,266	9,998	8,683	8,964	12,748
Benefit Transfer	5,580	5,580	8,708	7,621	7,965	11,340
<i>as % of Total</i>	87%	89%	87%	88%	89%	88%
Administration Cost	805	686	1,290	1,011	999	1,408
<i>as % of Total</i>	13%	11%	13%	12%	11%	12%

Source: MoSA (2016-2017) & MoF Financial Note

Table 3. PKH by Budget Category, 2017

Administration Cost by Activity Type	2016 Realised	2017 Planned
Compensation for staff (contracted)	66%	64%
Fee for payment services (PT Pos)	15%	14%
FDS Training	0%	10%
Field implementation (IT, M&E, basic trainings, other operation cost)	19%	12%

Source: Renstra of the MoSA 2015–2019.

Note: PT Pos is the Indonesian Post Company.

IV. Program Development Objective(s)

20. **The PDO is to support the conditional cash transfer (CCT) program coverage expansion, strengthen its delivery system, and improve its coordination with other complementary social programs.**

21. **The progress toward achieving the PDO will be measured through six key results indicators:**

- (a) Share of sub-districts with PKH beneficiary families having switched to cashless payment methods
- (b) Share of PKH beneficiaries receiving other SA program benefits
- (c) Share of children ages 7–18 years in PKH beneficiary families attending primary, junior, and senior secondary school at least 85 percent of the time
- (d) Share of children ages 0–6 years in PKH beneficiary families who received basic health and nutrition services in accordance with protocol
- (e) Total number of PKH beneficiary families

22. **These indicators reflect the three Results Areas that the proposed World Bank lending operation is expected to support:**

- **Results Area 1:** Strengthening the program delivery system to improve efficiency, transparency, and accountability

- **Results Area 2:** Improving access to basic social services and complementary SA programs by the CCT beneficiaries
- **Results Area 3:** Expanding coverage and improving inclusivity of the CCT program

23. The first and second indicators reflect the enhanced operational efficiency and transparency of PKH delivery system with regard to payments made to the program beneficiaries through modern electronic payment modalities, and complaints redressed on time (Results Area 1). The third to fifth indicators reflect the improved coordination between PKH and other complementary social programs, ensuring that PKH beneficiaries are also prioritized to receive other SA benefits and services, particularly PIP, Rastra, and PBI, as well as the effective use of health and education services through compliance with Program conditionality (Results Area 2). Finally, the sixth indicator reflects the progressive expansion of PKH program among the poor and vulnerable population, including previously excluded areas (Results Area 3).

V. Environmental and Social Effects

24. **There are no infrastructure and other physical activities that are supported and/or financed through PKH.** Therefore, it is expected that the program will not generate potential environmental impacts that may result in the loss, degradation, or conversion of natural habitats, pollution, and/or changes in land or resource use.

25. **The program supports the demand for health and education services, but not the supply side, which is not under MoSA's purview.** However, the program could have social risks associated with exclusion from the program and low understanding of the aim and scope of the program due to inadequate outreach and socialization, which could foster perceptions of unfairness and suspicion particularly among households that do not receive PKH benefits.

26. **These issues were approached in the Environmental and Social Systems Assessment (ESSA) by focusing attention on how the poor and marginalized communities are identified, surveyed, and eventually enrolled in the program.** Specifically, the ESSA took into account issues around targeting, gender, timing and means of cash transfers, power dynamics at the community level, the role of facilitators, cadres, and service providers with regard to access to the program, and, lastly, existing complaint handling mechanisms. The assessment was done both at the national and subnational levels, covering several districts (Medan, Serang, Lebak, and Serdang Bedagai) that have been participating in PKH and also new districts that were recently included for the program expansion. The assessment also draws on key findings from the GIZ's scoping study, covering nine districts¹³ in Papua and West Papua which were selected based on accessibility and the existence of similar programs.

27. **The social risks for PKH are Moderate.** The program fosters inclusion by expanding to mostly cover the most disadvantaged population groups (for example, the disabled and indigenous populations). Social risks are mainly associated with the program's capacity to correctly target poor beneficiaries, engage with communities and make use of appropriate

¹³ Raja Ampat, Nabire, Kaimana, Dogiyai, Deiyai, Paniai, Tolikara, Jayawijaya, and Pegunungan Bintang.

communication channels, roll out a responsive GRS and create enabling environments to help PKH households use cash transfers to improve their overall welfare, health, and education outcomes.

28. **Among the main social risks are the lack of a fully functional GRS, as well as the limited capacity to resolve complaints at the local level given the highly centralized implementation approach.** To date, the majority of complaints received is related to exclusion issues and there is no functioning GRS that the district and provincial governments can use to manage grievances or inform complainants about the status of their complaints. Theoretically, PKH households and community members can submit their complaints to facilitators who are responsible for recording complaints received by filling standardized forms and relaying the complaints to the related departments in MoSA for further resolution. An operational manual for grievance reporting and redress is available, but was reported not operational or effective. In addition, the current system does not provide a space for the communities to voice their complaints in an anonymous manner. Complaints are only recorded in the local social agencies and no follow-up actions can be effectively mobilized. Such complaints are often left stalled as the local governments seem reluctant to take full responsibility or be held accountable for programs where they have limited involvement.

29. **Supply-side readiness is a critical factor that affects the extent to which social inclusion within PKH can be sustained.** The assessment suggests that enforcing stringent conditionalities for households to stay eligible can be challenging in areas where there are serious supply-side issues and, therefore, attempts to make conditionalities and verification protocols more contextual become critical to promote social inclusion for communities in underserved areas. In some remote locations, such as small islands, forests, or highland areas, verification of compliance to conditionalities can be very much compromised by the lack of basic services and previous assessments on the supply-side readiness, such constraints often stem from uneven distribution of personnel, such as teachers and midwives, rather than the absence of facilities or infrastructure. Issues around supply-side readiness are likely to increase as PKH is beginning to include remote, unserved areas and is looking toward greater inclusion of the elderly and people with severe disabilities.

30. **Lack of legal documentation was acknowledged to be an emerging issue as PKH is moving toward an electronic payment system and seeking complementarity with other SA programs where ownership of a Single Identity Number (*Nomor Induk Kependudukan*, NIK) is a technical requirement.** Such an issue may disproportionately affect people who are not formally registered and transient populations, including nomadic, seafaring, and farming communities and temporary and migrant workers. Unregistered individuals may not be formally recognized by their villages or wards as residents and therefore are often not proposed for SA programs. Secondly, these individuals might be registered in their original place of residence and therefore may miss out on censuses and surveys. Furthermore, there are limits to the BPS' capacity to cover communities or groups living in very remote areas. Such constraints may potentially get worse in the new PKH areas, particularly in Eastern Indonesia where access is limited and logistical costs for surveys are high.

31. **No systematic differences were found on school enrollment and immunization by gender.** Data from Susenas 2014 shows that for primary school enrollment, 4 percent more male

children in PKH families were enrolled than female children. However, for junior secondary school level, 80 percent of females and 75 percent of males were enrolled in 2014. The national rates for non-PKH families were similar with 1 percentage point additional enrollment among males in primary and 2.5 percentage points more for females in junior secondary. For senior secondary education, males tend to have higher enrollment rates among PKH families, 49 percent versus 46 percent (among non-PKH families, the difference in favor of males is 1 percentage point). With regard to immunizations, female under-six received full immunization coverage by 5 percentage points more than males in the same age group; at the same time, the difference is almost absent for non-PKH children (64 percent to 63.5 percent). While no systematic differences are found across gender indicators, there are important differences in outcomes in favor of PKH beneficiaries versus non-PKH counterparts, suggesting that PKH is making a difference in raising enrollment and health behaviors across gender, as espoused by the program's goals and conditionalities.

Table 4. Differences in Enrollment and Immunization Indicators by Gender

Indicator	PKH Beneficiaries		Non-PKH Beneficiaries	
	Females (%)	Males (%)	Females (%)	Males (%)
Primary school (ages 7–12)	90	94	85	86
Junior secondary school (ages 13–15)	80	75	78.5	76
Senior secondary school (ages 16–18)	46	49	54	55
Immunization (ages 0–5)	71	66	64	63.5

Source: Susenas, 2014.

32. **Gender equality and female empowerment are considered as key elements within PKH toward the achievement of poverty reduction goals.** Payments are directly transferred to mothers or adult female members who act as caregivers for PKH families with the premise to empower women as decision makers and ensure that cash transfers are better managed. Over the long term, PKH is envisioned to empower women by enabling more girls to attend school and improve their health status. PKH is designed to reduce current biases toward boys in accessing basic health and education services by requiring that all children from beneficiary households, regardless of their gender, meet certain health and education requirements.

33. **Although previous studies indicate that PKH has positive impacts on education and health behaviors among women, there is little empirical evidence to date that PKH has impacts on women empowerment in intra-household bargaining power, social status, and labor-force participation.** Anecdotal evidence from the ESSA suggests that PKH female beneficiaries were already in charge of managing household expenditures and therefore receipt of cash transfers may not significantly change anything in the current household structures.

34. **The ESSA identifies several avenues that could have the potential to empower women, including**

- (a) Tailoring outreach and socialization materials by taking into account literacy levels, prevalent languages/dialects, frequency, timing, and so on to ensure that they are

inclusive, accessible, and socially and culturally appropriate;

- (b) Accommodating practical lessons in the FDS contents, particularly for women across age groups and backgrounds. The FDS needs to strengthen its function to support mother groups;
- (c) Incorporating more explicit gender perspective and gender equality guidelines in the manual for facilitators; and
- (d) Strengthening partnership with nongovernmental organizations, civil society organizations, and other organizations that are concerned with gender issues.

35. **Communities and individuals who believe that they are adversely affected as a result of a Bank supported PforR operation, as defined by the applicable policy and procedures, may submit complaints to the existing program grievance redress mechanism or the WB's GRS.** The GRS ensures that complaints received are promptly reviewed in order to address pertinent concerns. Affected communities and individuals may submit their complaint to the WB's independent Inspection Panel which determines whether harm occurred, or could occur, as a result of WB noncompliance with its policies and procedures. Complaints may be submitted at any time after concerns have been brought directly to the World Bank's attention, and Bank Management has been given an opportunity to respond. For information on how to submit complaints to the World Bank's corporate GRS, please visit <http://www.worldbank.org/GRS>. For information on how to submit complaints to the World Bank Inspection Panel, please visit www.inspectionpanel.org.

VI. Financing

Table 5: Program Financing, FY2017-FY2020 (\$ Million)

Source	Amount	% of Total
Government	5228	96.3
IBRD/IDA	200.00	3.7
Total Program Financing	5428	100.0

VII. Program Institutional and Implementation Arrangements

36. **The Program is implemented by MoSA in collaboration with other line ministries (LMs) and local governments.** The policy decision body is the National Coordination Team which is chaired by the Minister of Social Affairs and consists of echelon 1 level (top rank civil servant) officers from the following ministries/agencies: MoSA, BAPPENAS, Ministry of Health, Ministry of Education and Culture, MoF, Ministry of Religious Affairs, Ministry of Communication and Information, Ministry of Manpower, Ministry of Home Affairs, Ministry of Villages, Disadvantaged Areas, and Transmigration (MoV), Ministry of Women Empowerment

and Child Protection, and Central Bureau of Statistics (*Badan Pusat Statistik*, BPS). The policies are operationalized by a Technical Coordination Team which consists of director-level officers from those ministries/agencies. There is an equivalent PKH Technical Coordination Team at the provincial, district/city, and subdistrict levels and these local teams are responsible for implementation coordination.

37. **Within MoSA, the Directorate of Social Assurance for Family (JSK) under the Directorate General (DG) of Social Security and Protection, is responsible for implementing PKH.** PKH program management structure has been reformed recently. In October 2015, MoSA issued a ministerial decree¹⁴ to reorganize the entire directorate of JSK with the central PKH's implementation unit (*Unit Pelaksana Program Keluarga Harapan*, UPPKH). The reorganized JSK has four subdirectorates (subdit) and all are involved in PKH implementation. Both the civil servants and contracted 'experts' are re-mapped to various teams under the four subdirectorates.

38. **The institutional arrangement for PKH implementation at the subnational level has mirrored the original organizational arrangement at the central level of UPPKH.** At each subnational level, a local UPPKH consisting of contracted personnel carries out virtually all the program implementation functions, while formally being supervised by the Social Affairs Department (*Dinas Sosial*) of each subnational government.

39. **Since its inception, thousands of PKH facilitators have been at the forefront of delivering cash transfer and monitoring beneficiaries' compliance to PKH conditionality.** PKH facilitators are recruited nation-wide through a competitive selection. Their minimum educational background is three years of tertiary education, preferably with experience in social work. The ratio of facilitators to PKH families is usually 1:200–250, but this ratio is lower for islands or areas that are difficult to reach.

40. **As a CCT program, PKH depends critically on availability of health and education services.** Although the availability of standard health and education services in Indonesia is considered quite reasonable, it is likely that certain services that PKH families require to meet program conditionality might not be available. Service gaps are more likely in certain geographic (mostly rural and remote) areas. The Coordinating Ministry for Human Development and Cultural Affairs is a key institution in supporting coordination and availability of essential human development services at the local level. The district PKH Technical Coordination Teams can address supply-side constraints as they emerge.

VIII. Contact point

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¹⁴ Ministerial Decree, October 2015.

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