

PKH CONDITIONAL CASH TRANSFER

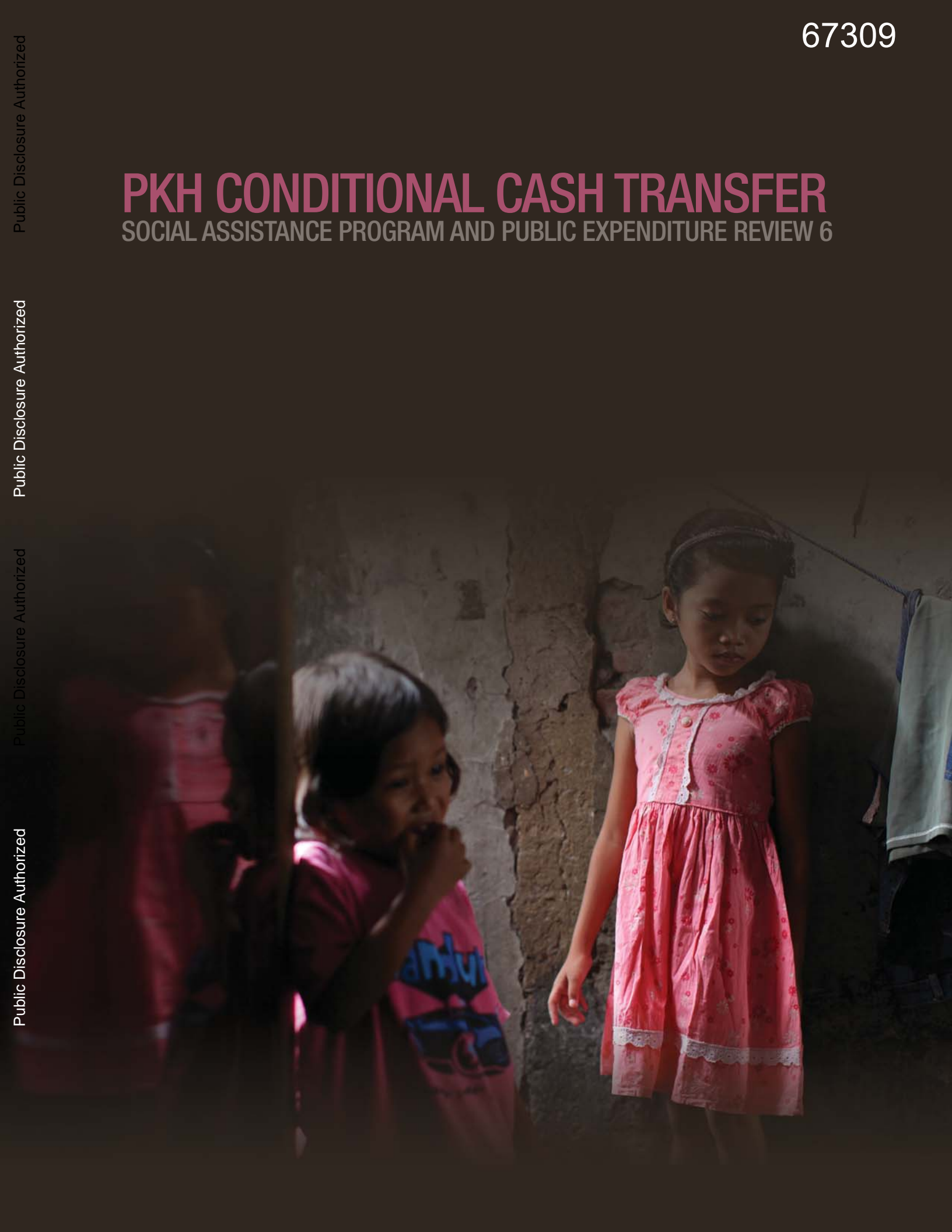
SOCIAL ASSISTANCE PROGRAM AND PUBLIC EXPENDITURE REVIEW 6

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List of Abbreviations, Acronyms and Indonesian Terms

AFC	Asian Financial Crisis
APBD	<i>Anggaran Pendapatan dan Belanja Daerah</i> (Regional budget, both Provincial and District budgets)
Bappenas	<i>Badan Perencanaan dan Pembangunan Nasional</i> (National Development Planning Agency)
Bimtek	Bimbingan teknis (Technical Guidance)
BLT	<i>Bantuan Langsung Tunai</i> (Unconditional cash transfer)
BN/bn	Billion
BOK	<i>Bantuan Operasional Kesehatan</i> (Operational health assistance program)
BPS	<i>Badan Pusat Statistik</i> (Indonesian Central Statistics Agency - Statistics Indonesia)
BSM	<i>Bantuan Siswa Miskin</i> (Cash transfer for poor students)
CCT	Conditional Cash Transfer
CHR UI	Centre for Health Research – University of Indonesia
CSO	Civil Society Organization
DG	Directorate General
DIPA	<i>Daftar Isian Pelaksanaan Anggaran</i> (Budget Implementation Entry List)
EAP	East Asia and the Pacific
GOI	Government of Indonesia
HH/hh	Household
Jamkesmas	<i>Jaminan Kesehatan Masyarakat</i> (Health insurance scheme for the poor, formerly Askeskin)
Kabupaten	District/regency
Kemdikbud	<i>Kementerian Pendidikan dan Kebudayaan</i> (Ministry of Education and Culture, MOEC)
Kemenkes	<i>Kementerian Kesehatan</i> (Ministry of Health, MOH)
Kemenkeu	<i>Kementerian Keuangan</i> (Ministry of Finance, MOF)
KemenkomInfo	<i>Kementerian Komunikasi dan Informatika</i> (Ministry of Communications and Information Technology)
Kemensos	<i>Kementerian Sosial</i> (Ministry of Social Affairs, MOSA)
KPPN	<i>Kantor Pelayanan Perbendaharaan Negara</i> (State treasury service office)
LHS	Left hand side (of graph)
MDG	Millennium Development Goal(s)
MIS	Management Information System
NTT	<i>Nusa Tenggara Timur</i>
PKH	<i>Program Keluarga Harapan</i> (Conditional cash transfer)

PNPM	<i>Program Nasional Pemberdayaan Masyarakat</i> (Umbrella organization for all PNPM and community-driven development initiatives)
PNPM-Generasi	<i>PNPM Generasi Sehat dan Cerdas</i> (PNPM Healthy and Smart Generation Program)
PNPM-Mandiri	<i>Program Nasional Pemberdayaan Masyarakat Mandiri</i> (National Community Empowerment Program)
POK	<i>Petunjuk Operasi Kegiatan</i> (Operational guidelines)
Posyandu	<i>Pos Pelayanan Terpadu</i> (Integrated health service post)
PT Pos	<i>Perseroan Terbatas Pos Indonesia</i> (National post office system)
Raskin	<i>Beras Miskin</i> (program for sale of subsidized rice to the poor)
RHS	Right hand side (of graph)
Rp	Indonesian <i>Rupiah</i>
RPJM	<i>Rencana Pembangunan Jangka Menengah</i> (Medium-Term Development Plan, MTDP)
SMERU	SMERU Research Institute
SNP	<i>Standar Nasional Pendidikan</i> (National Education Standard)
SSN	Social Safety Net
Susenas	<i>Survei Sosio-Ekonomi Nasional</i> (National Socio-Economic Survey)
UPPKH	<i>Unit Pelaksana Program Keluarga Harapan</i> (PKH implementation unit)
US\$	United States Dollars

Executive Summary

Program Keluarga Harapan (PKH) is a conditional cash transfer providing direct cash benefits conditional on household participation in locally-provided health and education services. Macroeconomic growth has been steady and incomes have been rising in Indonesia since the Asian Financial Crisis (AFC), circa 1997/1998; in 2010 Indonesia had become a middle income economy. However, health and education indicators have lagged behind macroeconomic performance, especially for poorer households. The PKH program, which made its inaugural payments to pilot regions in 2007, is designed to directly affect household incentives for investing in health and education. The PKH program builds on Indonesia's success with large-scale, household-targeted cash transfers (see 'Social Assistance Program and Public Expenditure Review 2: BLT' in this collection) and PKH households will soon number in the millions.

PKH has an immediate impact on household vulnerability while encouraging investment in long-term household productivity that may disrupt the intergenerational cycle of poverty. The quarterly cash transfer component ranges from a minimum of Rp 600,000 to a maximum of Rp 2.2 million per year. Like conditional cash transfers (CCTs) the world over, disbursements are made only after a mother's verified attendance at pre- and post-natal checkups, a professionally-attended birth, newborn and toddler weighings and health checks; or after verification that a PKH household's school-aged children have good attendance records at their schools (whichever applies to a household). PKH gives cash, which can be used to defray the cost of attending conditioned services while it promotes early investments in health and education that have long-lasting implications for welfare and productivity. PKH benefits also include facilitation for beneficiary households, including ongoing exposure to health and education service providers and ongoing encouragement of healthy and smart behaviors which can spread to peer households in the community.



Impact evaluation architecture – a randomized controlled trial - was built into PKH, allowing an experimental evaluation of PKH's effectiveness for households and communities. This is a first for Indonesia: PKH is the only household-targeted social assistance initiative to have designed randomized impact evaluation into the initial allocation of the program. This brings three major benefits for policymakers: 1) The evidence available for evaluating the impacts of the PKH program on household welfare is extensive and sound; 2) the program design and the impact analysis design have generated additional excitement, both nationally and internationally, about the program, its goals and social assistance initiatives in general; and 3) the results and underlying data will be made publicly available, which has already spurred interest in additional evaluations that will stock the shelves of social assistance policy research libraries.

PKH's cash transfers directly increased income for very poor households while promoting healthy behaviors. Expenditure on health services saw especially large increases, and PKH households also increased their share of food expenditure on protein-rich foods. Nearly all of the cash transfers were spent by households on basic necessities like food, clothes, and health care. PKH households were able to increase expenditure on all major budget categories (except education) and the increase in health care expenditure alone meant that after the PKH program, beneficiaries had increased their shares of overall expenditure on health.

PKH brought very poor households to health care facilities more often. PKH households acquired pre- and post-natal care, assisted birth, weight check-ups, and immunizations at greater rates. They increased overall health care visits at both public and private providers. For "spillover households" – poor and eligible households in PKH areas who were not chosen to receive PKH transfers – some of these health behaviors as well as spending on health also increased, but at smaller rates. Over the two-year study period, PKH households did not register noticeable changes in health outcomes (like frequency of illness or malnutrition) save for an increase in reporting of, and seeking treatment for, diarrhea.

PKH children stayed in school longer, but PKH did not lead to increased enrollment rates for very poor households or significant reductions in child wage labor.

PKH was successful in increasing the number of hours spent in school of those enrolled in either primary or junior secondary school. PKH did not change already high enrollment rates in basic or junior secondary education, nor did it reduce already low drop-out rates. The lack of effect on enrollment is likely due to very high initial rates of enrollment combined with a benefit size that is much less than the average cost of a year in the public schooling system and an initial schedule of payments that did not synchronize with the school fee cycle.

Oversight, verification, and conditionality-monitoring processes, which together with the Management Information System (MIS) provide verification and incentives for healthy behaviors, have only recently become available everywhere.

For a CCT, monitoring beneficiary behavior to ensure they meet conditionalities and change their rates of investment in health and education is crucial for longer-term outcomes. In PKH, there were early difficulties with the verification of beneficiaries (incorrect data); printing, distribution, and responsibility for filling out forms for recording attendance as well as confusion over the content of the forms; frequent backlogs in beneficiary profile updates (e.g., number of children and age) and conditionality monitoring updates; and unfamiliarity and steep learning curves with the computerized MIS system. These process bottlenecks translated into a lack of enforcement of conditionality, incorrect payments, payments that arrived outside of schedule, and lingering confusion over which agency and which actor was responsible for parts of the PKH process.

Facilitators have proven crucial for PKH success, but they are not delivering similar levels of quality facilitation everywhere.

Socialization of the PKH program was deliberately kept to a minimum in order to avoid social jealousy and redistribution of benefits. As a consequence, most beneficiaries rely on PKH facilitators for information on program goals, objectives, conditions, and in general support and encouragement in complying with responsibilities. Interviews with beneficiaries and communities note that where the program was successful in changing behavior, facilitators were the main reason. Facilitators also encouraged local authorities and community groups to publicize the benefits of PKH behaviors. However, the same sources note that facilitators were not active to the same degree everywhere and did not always pursue households who missed appointments or children who withdrew themselves from school.

PKH's success in delivering real benefits to the very poor and in changing behaviors deserves further support and encouragement.

PKH's initial weaknesses in implementation and delivery deserve continuing attention and thoughtful solutions for greater effectiveness. PKH has submitted both its implementation and final outcomes to detailed scrutiny by national and international stakeholders and experts. The positive behavioral changes that have been documented are significant achievements for any social assistance program and especially for one that focuses on the very poorest households. The Government of Indonesia (GOI) plans on expanding the PKH program to as many as 3 million households; while it is doing so, it should continue to refine implementation, coordinate and collaborate with affiliated service providers in health, education, and local government services, and continue developing a corps of organized, enthusiastic, and skilled facilitators who can assist very poor households in achieving healthier behaviors.

1. Background

Despite gradual general improvement in most social sector indicators, poor households in Indonesia are at risk of perpetuating their low-income status through low investment in the human capital of younger members. PKH targets these investments and household incomes by transferring cash to households only after their younger members successfully obtain education and health services.

Continuous improvements in education and health outcomes for all citizens have long been a focus of Government of Indonesia social policy. Indonesia's constitution of 1945 establishes the right of Indonesian citizens to quality education and health services. In the post-Independence and Suharto eras, economic development strategies focused on financing capital investment in, and general provision of, education, health, and related social services. During the Asian Financial Crisis in the late 1990s, when the poverty rate doubled and real economic activity contracted by over 13 percent, the GOI gave priority to maintaining prior levels of spending on health and education. A year-2000 amendment to the constitution reaffirmed rights for all citizens to education and medical care and legislation in 2003 further obligated the GOI to provide education for all children 7 to 15 years of age.

Sustained macroeconomic growth since the AFC notwithstanding, Indonesia remains behind its peers and neighbors in both consumption of, and outcomes from, health and education services... For example, while maternal mortality has fallen to 240 per 100,000 live births in 2008 (from 350 in 2000), this rate is far above the average of 89 for all developing countries in the East Asia and Pacific (EAP). Likewise, while under-5 and infant mortality rates have



fallen to 39 and 30 per 1000 births in 2009, those figures remain far above the average for all EAP developing countries of 26 and 21, respectively. Rates of immunization, of births attended by skilled health staff, and of access to improved sanitation facilities also remain behind the EAP developing country average while the under-5 malnutrition rate remains higher than the EAP developing country average.¹ Poor households in Indonesia utilize health facilities far less frequently than rich households.² In education, overall primary school enrollment is near 100 percent for boys and girls of all income levels, but 'Social Assistance Program and Public Expenditure Review 5: BSM' (this collection) notes that enrollment rates in the first year of senior secondary school are more than two-thirds smaller in poor households (22 percent) than in rich households (72 percent).

....while the ongoing decentralization of social sector service funding and provision has led to increased central-level emphasis on the "pro poor" nature of social services spending. Indonesia's decentralization reforms (*circa* 2000) made district governments explicitly responsible for planning, providing, and financing local education and health services, leaving the central government with less influence over the size and orientation of district-level spending for social service provision.³ Partly as a consequence, the same early-2000s legislation mentioned above contained references to social security and education scholarships specifically for poor households. As central government influence

1 World Development Indicators (World Bank, 2010). EAP developing countries include Malaysia, Philippines, Sri Lanka, Thailand, and Vietnam.

2 See "Social Assistance Program and Public Expenditure Review 4: Jamkesmas" in this collection, which summarizes data from (among others) "Basic Health Research", (Government of Indonesia, 2007). Based on demographic characteristics alone poor households would be expected to consume health services at a far greater rate, indicating that poor households cannot afford as much health care as their household demographics require.

3 General block grants or revenue sharing from the central government is intended to cover most social service provision expenses. See 'Social Assistance Program and Public Expenditure Review 1: Public Expenditure Review Summary in this collection for a description of the responsibilities of regional governments for social spending, including on social safety nets. See also 'Social Assistance Program and Public Expenditure Review 8: History of Social Assistance in Indonesia' in this collection for a description of the historical and political context in which decentralization reforms have taken place.

over the provision of general social spending waned, social protection initiatives (including social security and social assistance) have been highlighted as avenues through which to achieve pro-poor central-government spending.⁴ Recent policy statements indicate that delivery of social services, including social protection, should be improved specifically for poor and vulnerable households – see ‘Social Assistance Program and Public Expenditure Review 4: Jamkesmas’, ‘Social Assistance Program and Public Expenditure Review 5: BSM’, and ‘Social Assistance Program and Public Expenditure Review 7: JSPACA, JSLU, and PKSA’ in this collection.

PKH was designed to address lingering gaps in health and education indicators by making a centrally-funded cash transfer conditional upon participation in locally-provided health and education services. PKH, like conditional cash transfers the world over, delivers cash transfers to very poor households only after a mother’s verified attendance at pre- and post-natal checkups, a professionally-attended birth, newborn and toddler weighings and health checks, or after verification that school-aged children have good attendance records at their schools. PKH explicitly addresses the demand side of education and health investment by intervening at the household level; the supply side – which is composed of the health and education facilities as well as the various levels of government agencies managing and implementing services through these facilities – is not addressed, so the PKH program must work within the existing decentralization regulations and service delivery architecture. The cash transfer component ranges from a minimum of Rp 600,000 to a maximum of Rp 2.2 million per year and the PKH benefit package includes facilitation for beneficiary households to encourage healthy and smart behaviors.

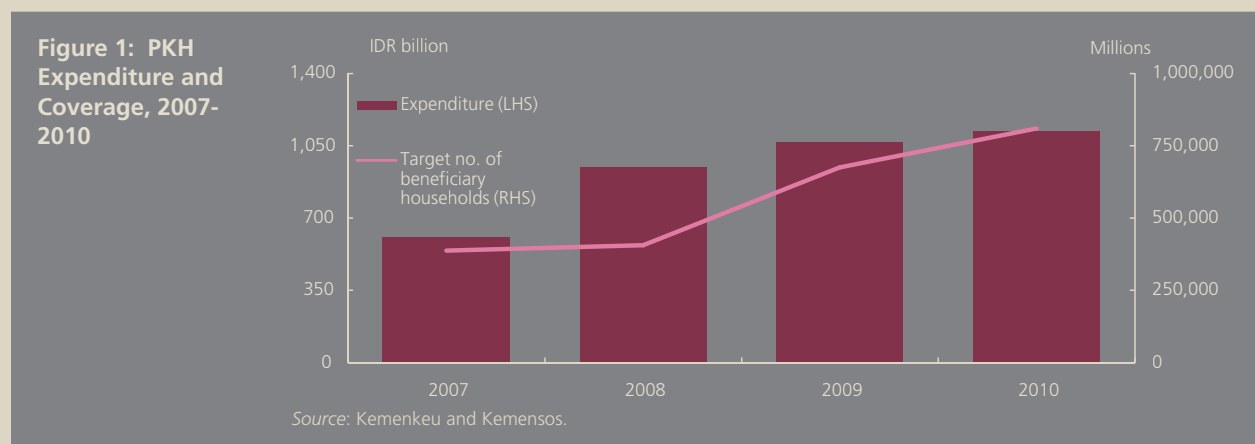
This note summarizes the available evidence on the PKH pilot program to determine how well poor households are served by the program. A quantitative, randomized controlled trial impact evaluation was built into the pilot stages of the PKH program. A “spot check” exercise that recorded and evaluated both *de jure* and *de facto* operating procedures and the capacity of program administrators and implementers, including affiliated service providers, was undertaken by a consortium of Indonesian universities in 2010. Finally, as for the other volumes in this collection, central-level budget and financial reporting data was examined to understand program administrative efficiency and financial management performance. The evidence-based appraisal of PKH in this policy note aims to provide inputs to the GOI as it continues to try to achieve its Pro-Poor development goals and the Millennium Development challenges (MDGs).

4 The decentralization laws do not provide guidance on social assistance initiatives, partly because the introduction of such initiatives coincided with a crisis period and policy makers then viewed them as temporary crisis response measures rather than permanent programs. For the current social assistance initiatives, policy, planning, and budgeting is done nearly exclusively by central government agencies – see ‘Social Assistance Program and Public Expenditure Review 8: History of Social Assistance in Indonesia’ in this collection. Of the Cluster 1 programs covered in this collection plus the community-driven development initiatives under the PNPM umbrella, four provide benefits directly to households (BLT, PKH, BSM, and Kemensos cash transfers for vulnerable groups), two provide benefits directly to community leaders or community-based committees (Raskin, PNPM), and one provides operating expenses directly to service providers (Jamkesmas). However, district governments are often asked to contribute time and funds for socialization and monitoring and evaluation activities. District governments have also been seen to reduce their own social sector spending when social assistance initiatives provide operating funds for service providers; this is most common in Jamkesmas – see ‘Social Assistance Program and Public Expenditure Review 4: Jamkesmas’ in this collection – and BOS, the school operation grants previously provided directly to schools.

2. Objective, Program Size, and Benefit Adequacy

Program Keluarga Harapan is a pilot conditional cash transfer that eligible households receive as long as expectant mothers receive pre-natal checkups, newborns and toddlers receive post-natal care and health check-ups, and 6 to 18 year olds attend school.

The GOI introduced the PKH program to address inequalities in health and education service and to provide a direct cash transfer for very poor households. Conditional cash transfer programs provide cash disbursements to families that fulfill basic obligations related to utilization of health and education services. The cash transfer contributes to immediate poverty alleviation while the continuing commitments to preventative health care practices and education contribute to breaking inter-generational poverty by increasing productive investments in children so that they have better opportunities for the future.⁵ The GOI intends for PKH to produce changes in indicators such as child malnutrition, expenditure on high-protein foods, education, and child labor.



The PKH pilot program began in 7 provinces in 2007 and has expanded to 18 provinces; it serves over 800,000 households in late 2011. In the initial set of pilot provinces – in the islands of Java, Sumatera, Sulawesi, and NTT – the richest 20 percent of districts (according to an index combining poverty rates, malnutrition, and primary-to-secondary school transition rates) were excluded from PKH eligibility. Within the remaining districts, only regions that were supply side ready – according to availability of health and education service providers – were randomly selected to take part in the PKH program.⁶ During scale-up periods (in 2009, 2010, and 2011), the original criteria were again applied to select PKH districts. Local governments must also demonstrate a willingness to support PKH implementation (through help with socialization, provision of facilities and materials for facilitators, and other contributions) before PKH can be deployed in their areas.

⁵ These two objectives – reducing current poverty and improving the quality of human resources within poor households – are the GOI's stated goals for the PKH program. The GOI has identified four more-specific desired outcomes under these two objectives: (1) improving the socio-economic conditions of the poorest households, (2) improving the educational level of children, (3) improving the health and nutritional status of pregnant women, post-partum mothers, and children under 6 years, and (4) improving the access to and quality of education and health services especially for the poorest households. PKH is expected to also contribute to progress towards achievement of six of the eight MDGs.

⁶ Non-Java locations had lower thresholds for supply-side readiness in order to deliver the program to a significant number of non-Java regions.

Table 1: PKH at a Glance

Official name	Program Keluarga Harapan (PKH)
Program type	Conditional Cash Transfer
Program Type and inaugural year (start/usage year)	Pilot, tax-financed, 2007
Coverage (2011)	Pilot: 25 of 33 provinces, 118 of 497 districts
Number of beneficiaries (2010)	778,000 households
Official value of benefit	Between Rp 600,000 to 2,200,000 per year
Public expenditure (2010)	Rp 1,123 billion (US\$ 143 million)
Administrative cost per recipient (2010)	Rp 237,777 (US\$ 24)
Percent of poor households covered (2010)	n.a.*
Key policy and executing agency	<i>Kementerian Sosial</i> , Ministry of Social Affairs (Kemensos)
Key implementation agencies (role)	Kemensos (all), BPS (help with targeting and eligibility); <i>Kementerian Komunikasi dan Informatika</i> (Ministry of Communications and Information Technology) Kemenkominfo (socialization); Public Health and Education service providers (beneficiary monitoring and compliance recording)
Support operations partners (role)	
Local Government participation	Encouraged to address supply-side constraints and must agree to provide help with materials and administration

*Poor households coverage cannot be determined from existing nationally representative data because of PKH's pilot status.

PKH accounts for a large and growing share of Kemensos spending, but remains the second smallest of the household-based social assistance (SA) initiatives, consuming less than five percent of the total SA budget in 2010. The majority of the budget for PKH can be derived by multiplying benefit levels (which have remained unchanged since launch) and the target number of beneficiaries; it is clear that PKH expenditure has increased in line with coverage increases. In 2010, Rp 1.1 trillion (US\$ 115 million) was spent on PKH, representing just 4.3 percent of total central government expenditures on SA initiatives or 0.3 percent of total central government expenditures.⁷ PKH expenditures accounted for almost a third of total Kemensos expenditures in 2010, up from around a fifth in 2007, making it a large program for the agency.

Table 2: PKH Expenditure Summary, 2007-2010

	2007	2008	2009	2010
Total PKH (Nominal, Rp billion)	605	946	1,068	1,123
Analytical series:				
Total PKH (Constant 2009 prices, Rp bn)	775	1,025	1,068	1,040
Total PKH (US\$, Rp million)	66	97	103	115
Share of total Kemensos spending (%)	21.9	29.5	32.8	30.1
Share of central government social safety net (SSN) spending (%)	4.3	2.9	3.9	4.3
Share of total central government spending (%)	0.1	0.1	0.2	0.3
Memo items:				
Target number of beneficiary households	387,887	405,955	675,636	778,000
Average annual benefit per beneficiary household (Rp)	1,286,982	1,992,955	1,360,745	1,149,127

Source: Kemenkeu, Kemensos, BPS and World Bank staff calculations.

⁷ By contrast, Raskin, Jamkesmas, and BSM account for 53, 18, and 14 percent shares (respectively) of SA spending in 2010.

Average PKH benefits are approximately 12 percent of total household expenditures; benefits vary according to a household's demographic characteristics and are larger the more services a household is asked to acquire.⁸ Tables 3 and 4 below present the conditions and responsibilities of beneficiary households and payment amount schedule; yearly payments to households average Rp 1.3 million, or about 12 percent of pre-PKH yearly household expenditure. For reference, the first BLT (an unconditional cash transfer targeted to poor and near-poor households) gave total cash payments over equal to approximately 15 percent of the 2006 household poverty line – see 'Social Assistance Program and Public Expenditure Review 2: BLT' in this collection.

Table 3: PKH Conditions and Beneficiary Responsibilities	Households with....must accomplish at least these conditions to continue receiving PKH
pregnant or lactating women	1.	Complete four antenatal care visits and take iron tablets during pregnancy.
	2.	Be assisted by a trained professional during the birth.
	3.	Lactating mothers must complete two post-natal care visits.
children aged 0-6 years	4.	Ensure that the children have complete childhood immunization and take Vitamin A capsules a minimum of twice a year.
	5.	Take children for growth monitoring check-ups (monthly for infants 0-11 months, and quarterly for children 1-6 years).
children aged 6-15 years	6.	Enroll their children in primary school and ensure attendance for a minimum of 85 percent of school days.
	7.	Enroll junior secondary school children and ensure attendance for a minimum of 85 percent of school days.
children aged 16-18 years with incomplete education (less than 9 years)	8.	Enroll their children in an education program to complete 9 years equivalent.

Cash transfers do not cover the full cost of the corresponding conditions; in addition nominal amounts have never been adjusted resulting in significant erosion in their real value over time. For example, PKH rewards for enrollment combined with 85 percent attendance rates of a junior-secondary-aged child would cover all expenditures (excluding transport) for a year of junior secondary education. However, if transportation costs are included, PKH rewards are only 43 percent of total expenditures on a year of junior-secondary education.⁹ Like most other cash transfer programs in Indonesia, the benefit levels for PKH have not been adjusted annually for inflation. This has resulted in a 22 percent decline in their real value between 2007 and 2010 (adjusted using poverty basket inflation) and thus the purchasing power of benefits has eroded.¹⁰ If left unaddressed, the lack of indexation of benefits to account for increases in the cost of living would ultimately undermine the objectives of the programs.

8 According to PKH survey data, PKH-eligible households spent on average Rp 190,000 per-capita per-month prior to PKH, implying that average PKH transfers are about 12 percent of eligible household expenditures. Given the static nominal benefit levels, PKH transfers today likely represent a smaller share of total nominal household expenditure.

9 See also "Social Assistance Program dan Public Expenditure Review 5: BSM" in this collection.

10 As reference, the BPS-defined poverty line has itself risen from a nominal per-capita value of approximately Rp 167,000 per month in 2007 to approximately Rp 234,000 per month in 2010, a 27 percent increase.

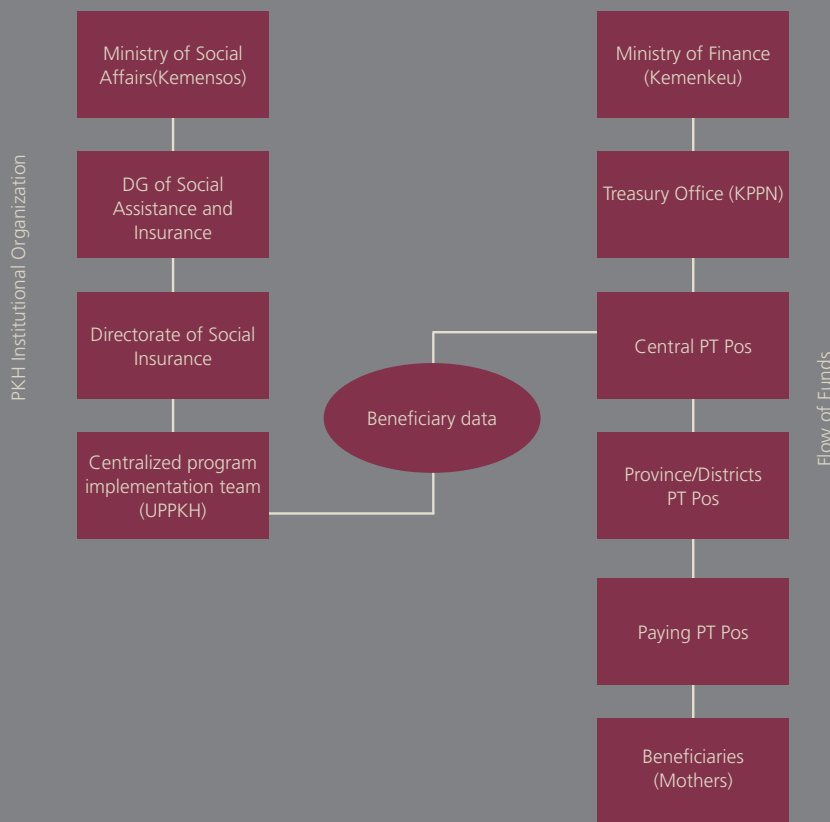
Table 4: PKH Transfer Amounts (per year)

Fixed cash transfer	200,000
Cash transfer per household with	
a. Child age less than 6 years	800,000
b. Pregnant or lactating mother	800,000
c. Children of primary-school age	400,000
d. Children of secondary-school age	800,000
Minimum transfer per household	600,000
Maximum transfer per household	2,200,000

Source: Government of Indonesia, Kemensos

PKH is executed by Kementerian Sosial (the Ministry of Social Affairs, Kemensos) with funds disbursed to households through the Indonesian postal system (PT Pos). A centralized program implementation team *Unit Pelaksana Program Keluarga Harapan (UPPKH)* was established to oversee program implementation and is housed within the Directorate General (DG) of Social Assistance and Social Security within Kemensos. Once payments are authorized by Kemensos, the Treasury Office within Kemenkeu (*Kementerian Keuangan*, the Ministry of Finance) disburses funds to the central office of PT Pos, who in turns transfers funds to regional branches. The PKH cash benefit is then transferred directly to mothers only (see Figure 2 below). Local implementation of the program, meanwhile, falls under the responsibility of program units at the provincial and district/municipality levels. Local governments do not have explicit spending responsibilities, but regional governments sign memorandums of understanding detailing their support for the PKH program.

Figure 2: PKH Organization and Flow of Funds



Sources and Notes: Based on program manuals and conversations with program staff

3. Targeting

PKH has been allocated to very poor households with pregnant or lactating mothers, or with newborns, toddlers, or school-age children. PKH relied on some of the early generation targeting tools.

Households are considered eligible based on their level of poverty and fulfillment of demographic characteristics. Program manuals called for the selection of households that were “very poor” according to *Badan Pusat Statistik* (Statistics Indonesia, BPS) criteria.¹¹ To find this set of households, BPS was delegated the task of reviewing lists of poor households compiled in 2005, determining which households from that list were very poor, and then visiting all potentially eligible households (in only those districts included in the original pilot allocation) to make sure that very poor households left off the 2005 lists would be deemed eligible if they had the right characteristics.¹² After a calculation of expected household-level expenditure¹³, a cut-off point for very-poor households was established. In the set of households below the cut-off, BPS identified those households with pregnant or lactating women, with children 0 to 15 years old, or with children up to 18 years old who had not yet completed nine years of education.¹⁴ All such *surveyed* households below the cut-off with the right demographic composition were eligible for the PKH program while beneficiary quotas meant that only some of the listed eligible households received PKH transfers. Additionally, many poor and PKH-eligible households were not surveyed and not incorporated into the 2005 lists, and any targeting procedure based on those lists will incorrectly exclude some poor households from eligibility lists.¹⁵

PKH did select households that were more disadvantaged than an average listed eligible household. From the BPS-produced lists of poor households, the UPPKH chose the final beneficiary lists based on PKH eligibility criteria. The baseline survey of eligible households¹⁶ reveals that the two sets of households – eligible but not chosen to receive PKH and PKH recipients – are significantly different based on observable characteristics. Overall, PKH recipient households are younger, with more members, more often female-headed, more often working in agriculture, less educated, with fewer assets, more often recipients of other nationally-available social assistance programs like BLT and Jamkesmas, and with lower levels of monthly per-capita expenditure. All of this implies that households selected to be PKH recipients are poorer, larger and less well-educated and more often exhibit characteristics that are non-income correlates of poverty.¹⁷

11 By BPS definition a very poor household is a household that has less-than-poverty line expenditure overall; spends a large portion of available income on basic staple foods; cannot afford medical treatment (except at community health clinic or other subsidized or free public health facilities); and cannot afford sufficient new or replacement clothing. In practice and on average, households with these characteristics have per-capita expenditure levels of approximately 0.8 times the BPS-defined poverty line.

12 In practice, this sweeping exercise was limited and only five percent of eligible households were added after the BPS visits.

13 Expected expenditure was based on the observable characteristics recorded in the 2005 lists and those observed in the newly added households. The 29 characteristics included housing characteristics, education levels, fuel sources, working sector, and distance and cost to access health and education service facilities.

14 This information was collected in the BPS Health and Education Basic Service Survey (Survei Pelayanan Dasar Kesehatan dan Pendidikan).

15 See *Targeting Poor and Vulnerable Households in Indonesia*, World Bank (2012a).

16 Together with the follow-up survey of the same households, the baseline survey of eligible households together with the random allocation of PKH across subdistricts (within the pre-identified set of eligible districts) is the basis for the impact evaluation results discussed below. See ‘Program Keluarga Harapan: Impact Evaluation Report of Indonesia’s Household Conditional Cash Transfer Program’, World Bank (2010a).

17 The baseline survey (which randomly drew equal numbers of eligible households from as many PKH-receiving subdistricts as non-PKH-receiving-but-eligible subdistricts) also reveals that in 2007, for all households deemed eligible by BPS, average monthly per-capita household expenditure was approximately Rp 190,000; malnutrition rates for 0 to 3 year olds were approximately 23 percent; and about 85 percent of heads of eligible households had primary education or less. In other words, BPS activities did on average identify very poor households.

4. Impact

PKH's impacts on healthy behaviors and consumption were substantial and positive. PKH's impacts on education and child labor were muted.

The PKH program was directly responsible for greater investments in healthy behaviors and health services despite all the initial operational difficulties described above.¹⁸ Of the conditioned behaviors for pregnant or lactating mothers or households with children from zero to six years old, pre-natal care, delivery at facility, post-natal care, immunizations, and growth monitoring check-ups all saw significant increases for recipients of PKH cash transfers. Figure 3 below shows the magnitude of these impacts expressed as a percent increase over baseline (pre-PKH) levels.¹⁹ Figure 3 also shows that the eligible households in PKH subdistricts that were not chosen to receive PKH (sometimes called “spillover” household) also experienced some positive increases in some of the behaviors that were part of the PKH conditions. These within-subdistrict spillovers indicate that in addition to the cash and the facilitation, the PKH initiative was successful in raising awareness of the healthy behaviors for all households.

Unconditioned health behaviors also increased, indicating that PKH was responsible for increases in general health-seeking behavior in beneficiary households. For example, Figure 3 shows that visits by any household member to either private or public health facilities increased more in PKH households than in eligible households in non-PKH areas. In addition, both reports of diarrhea and treatment for diarrhea increased, suggesting that this too-common ailment is, for PKH households, becoming a greater cause for concern and also a treatable condition.²⁰

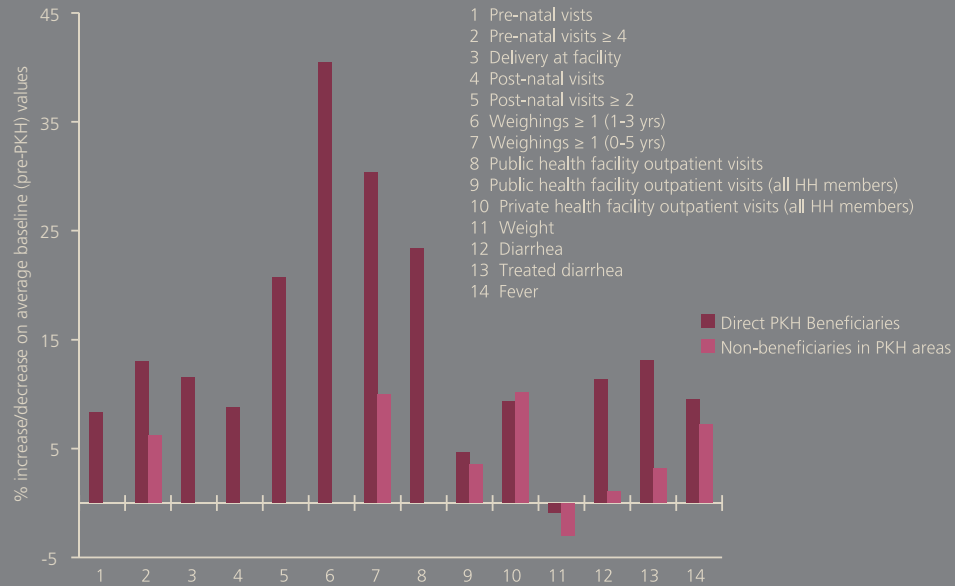
Longer-term health outcomes showed no outsized changes in PKH areas, but the study period was relatively short. For example, while average weight for zero to five year olds increased in both PKH areas and non-PKH areas, there was no statistically detectable difference in average weights two years into the program. The incidence of most of the common illnesses (fever, cough, acute respiratory infection) and newborn mortality also fell, but by approximately similar amounts in both PKH and non-PKH areas. The absence of major differences in these indicators in PKH and non-PKH areas most likely reflects the short study period (2007 to 2009) and the slowly evolving outcome indicators.

18 The summary in this section is based on the results from the randomized design impact evaluation described in ‘Program Keluarga Harapan: Impact Evaluation Report of Indonesia’s Household Conditional Cash Transfer Program, World Bank (2010a). That impact evaluation examined changes in household behaviors (both conditioned and unconditioned) for both PKH households and similar PKH-eligible households in areas not receiving PKH. As stated earlier, PKH was allocated randomly among the set of subdistricts that were pre-determined to be eligible. Within a subdistrict, PKH was allocated to households on a pre-determined list of eligible households that were poor and met demographic profiles. The survey recorded data for a random sample of eligible households in eligible subdistricts that randomly received PKH and eligible subdistricts that randomly did not receive PKH. All the results from the impact evaluation report that are discussed here refer to increases or decreases in behaviors relative to the increase or decrease in those same behaviors that eligible households in eligible-but-not-selected subdistricts experienced. This group (of eligible households in eligible but randomly-not-selected-for-PKH subdistricts) is often referred to as the “control group” of households. When a like group from like areas is randomly selected not to receive an intervention, what happens to that group is often the best guess (or expectation) for what would have happened to households had there been no intervention.

19 The following conditioned behaviors did increase in PKH households, but not by a statistically-detectable larger amount for PKH households than for similarly eligible households in areas that did not receive PKH: rate of uptake of the recommended 90 iron tablets during pregnancy and the number of times children zero to six received vitamin A.

20 One unconditioned healthy behavior that did not increase by more in PKH areas than non-PKH areas was breastfeeding, but both incidence of breastfeeding (96 percent) and length of breastfeeding (13 months) were already high prior to the introduction of PKH.

Figure 3: Healthy Behaviors Impact Summary



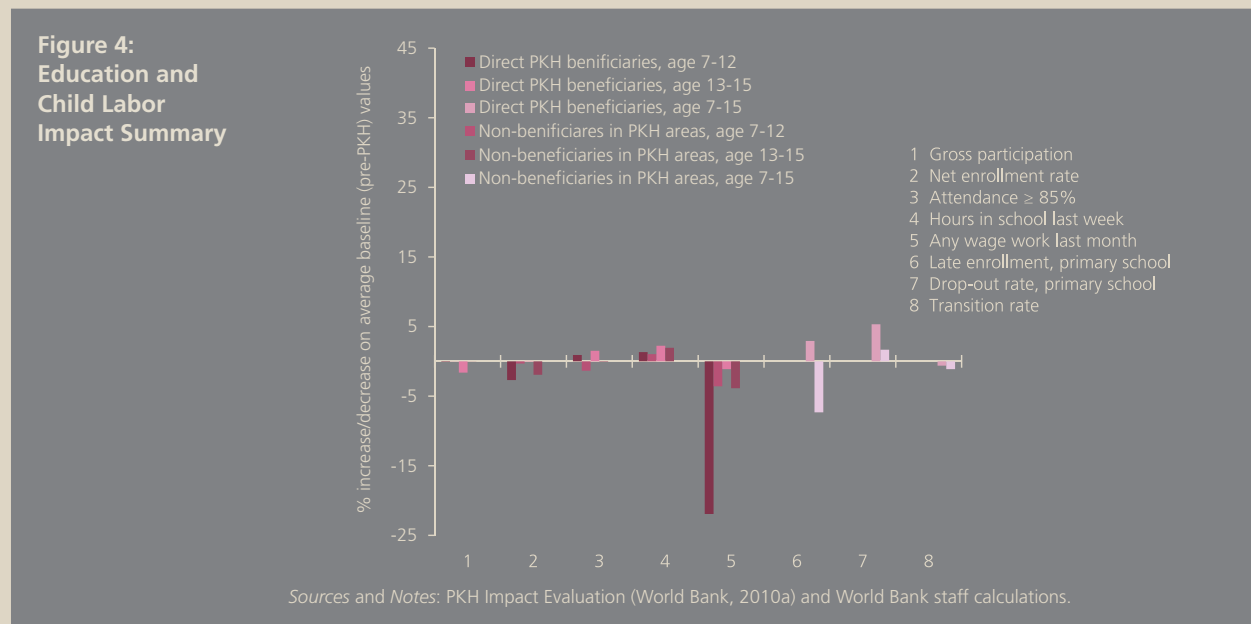
Sources and Notes: PKH Impact Evaluation (World Bank, 2010a) and World Bank staff calculations.

PKH impacts on education and child labor were muted. Figure 4 below summarizes the magnitude of the impacts of the PKH program on conditioned education behaviors and child labor expressed as a percent increase over baseline (pre-PKH) levels; as for Figure 3 above, impacts for eligible households in PKH subdistricts that were not chosen to receive PKH are also illustrated. For most of the education-related indicators, PKH impacts are very small and often statistically insignificant. In fact, only on “Hours in school last week” does PKH have an estimated impact that is statistically distinguishable from zero, but the improvement over baseline levels is less than 5 percent. The largest estimated impact, a 22 percent reduction in wage work for 7-12 year olds, is also statistically distinguishable from zero because of very low baseline levels (approximately 2 percent of surveyed eligible households had 7 to 12 year olds engaged in wage labor during the previous month previous to baseline survey enumeration).

High baseline levels and similarly-sized improvements in areas without PKH contributed to limited education impacts. For all age groups in all regions (PKH-receiving or not), gross participation, net enrollment, and transition rates rose (from high levels), while primary school late enrollment and primary school drop-out rates fell (from very low levels); the end result was that improvements in these indicators in PKH regions were no greater than improvements in the same indicators in regions without PKH. Prior to PKH, gross participation rates among PKH-eligible households were already 93 percent for 7 to 12 year olds. For enrolled individuals age 7 to 15, attendance rates of 85 percent or greater were the rule – only 6 in 100 enrolled children from PKH-eligible households attended school at less than an 85 percent rate (before PKH). The incidence of child labor was less than 3 percent for 7 to 12 year olds and about 10 percent for 13 to 15 year olds. In other words, for many education indicators, and especially for those indicators for primary-school age children, further improvements were marginally more difficult to achieve because of already-high baseline levels. Other studies have shown that drop-out is overwhelmingly a transition-period phenomenon. That is, in a given school level, enrolled students (from all backgrounds) tend to stay enrolled year to year, but drop-out rates spike (again, across all backgrounds) when students transition from elementary to junior secondary or from junior to senior secondary.²¹ PKH had no specific outreach for beneficiaries facing the elementary to junior secondary transition and disbursements were initially not timed to coincide with education expense schedules (see Section 6 below). Furthermore, while primary enrollment was already high everywhere, qualitative studies show that there were several reasons why junior secondary enrollment increased even

21 See “Social Assistance Program and Public Expenditure Review 5: BSM” in this collection.

in areas without PKH. The SMERU field study (in urban and rural, Java and non-Java areas in five *kabupaten* from two provinces) notes that junior secondary enrollment increased in areas with and without PKH because parents realized that desirable jobs – migrant worker, factory employee, and village or community official, for example – required at least a 9-year basic education.²²



Operational bottlenecks constrained PKH’s ability to apply penalties for non-attendance while supply constraints at the school and facilitator level were not addressed by PKH; these issues further limited education impacts. Early in the program, bottlenecks in household verification, compliance monitoring, and payment delivery, compounded by a weakly functioning MIS system, meant that payments to households were not synchronized with due date for school fees, meaning households could not expect PKH transfers to ease the burden of high secondary school enrollment costs (also see above on the size of PKH education benefits relative to the real costs of education). In addition, PKH status was not automatically linked to existing scholarship or tuition fee waiver programs for poor households while the number of school buildings, the teachers and administrators to fill them, and the number of books, chalkboards, and public transport options (and other education-related capital) did not increase appreciably in PKH areas during the survey period (2007 to 2009). Finally, PKH facilitators did not pursue students who left school and schools themselves were not necessarily aware of the financial consequences for a PKH household of a child leaving school.

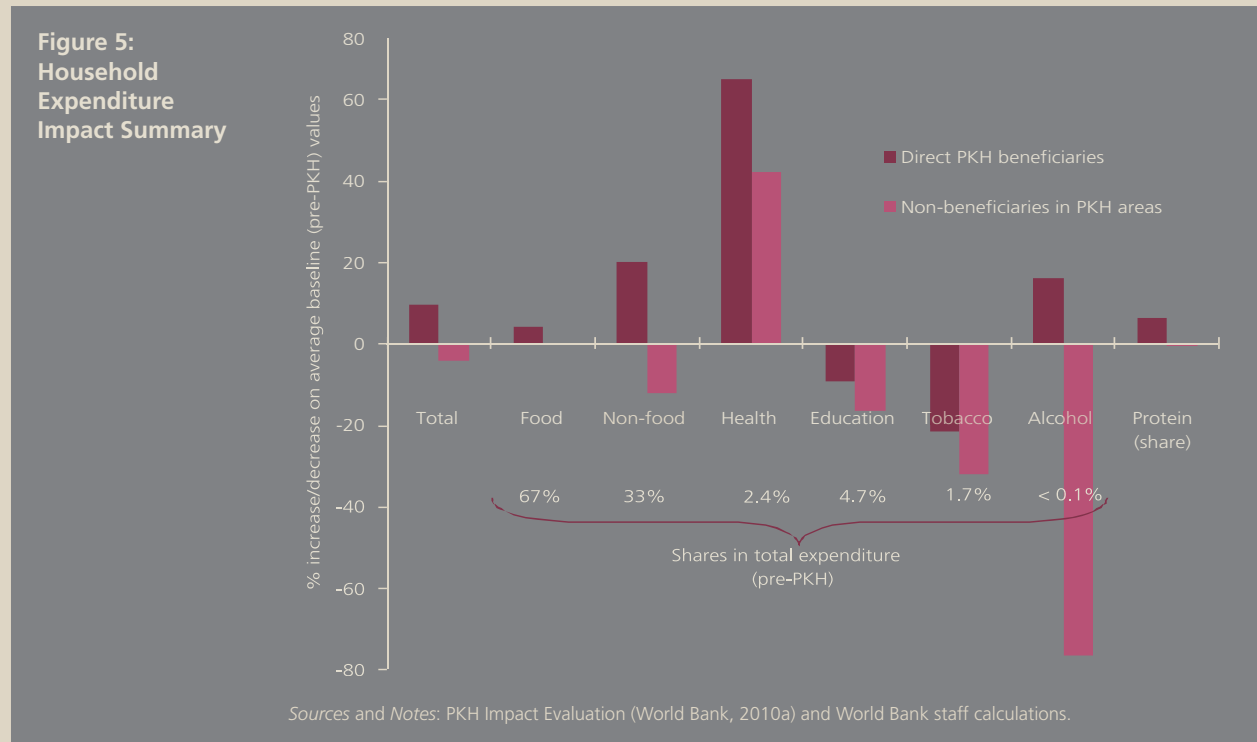
Cash transfers do not cover the full cost of the corresponding conditions, further limiting expected impacts. As mentioned above, PKH rewards for junior secondary schooling can cover total expenditures for a year of junior secondary education, but less than half (43 percent) if transportation expenditures are included. However, PKH households are usually larger and so face education and health expenses for more than just one child. SMERU notes that in its five-district sample, midwife delivery charges ranged between Rp 200,000 and 800,000, which at the high end is equivalent to the PKH transfer for pregnant mothers.²³ There also may be formal or informal charges for a hospital birth, for pre- and post-natal visits, and other conditioned services.

Consumption increased for direct PKH beneficiaries while shares of expenditure on health and high-protein foods increased. Figure 5 below summarizes (as a percent of baseline average levels) the changes in expenditure for both PKH beneficiaries – who received on average an additional Rp 1.3 million per year – and eligible households in PKH

22 SMERU (2008).

23 SMERU (2008).

areas who were not chosen to receive PKH.²⁴ For PKH households, total expenditures have risen by about 10 percent of pre-PKH levels while health expenditure has risen by nearly 65 percent and all non-food expenditure by 20 percent. The increased food expenditures (in PKH households) were directed more frequently towards high-protein items like meat, fish, eggs, and dairy so that PKH households' share of food expenditure on protein have risen by about 7 percent. Given pre-PKH levels of expenditure for those PKH households (Rp 184,000) overall expenditure increases were just enough on average to bring most PKH households to March 2009 poverty line expenditure of Rp 200,262.²⁵



PKH transfers allowed households to increase expenditures while simultaneously allowing a reorientation towards significantly higher health expenditure. Before PKH, eligible poor households spent approximately two-thirds of total expenditures on food alone. PKH allowed increases in most categories of expenditure including food and health. PKH transfers and associated conditionalities meant that households receiving PKH reduced their *share* of expenditure on food by about three percentage points while increasing health expenditure's share by two percentage points – see Table 5 below. As previously mentioned, the increased *absolute* expenditure on food was more often spent on high protein items. In other words, PKH increased spending generally while also encouraging a healthier expenditure mix. A similar reorientation towards a healthier spending mix was not possible in eligible households in PKH areas who were not chosen to receive PKH.

24 Figure 5 details changes in education, tobacco, and alcohol expenditure, but for both types of household the magnitudes of changes in these categories were small and not statistically distinguishable from no change at all. For all other categories including "Protein share", and for both groups of household, the changes in these categories are statistically different from zero.

25 As described above, from the set of eligible households the ones chosen to receive PKH were on average poorer along many dimensions including overall expenditure. Thus, average baseline expenditure for eventual PKH recipients is slightly less at Rp 184,000 than for the set of eligible households who did not receive PKH of Rp 199,000.

Cash inflows from PKH were rapidly spent on pressing needs and was not saved or invested in assets for later consumption.²⁶ PKH funds were most often spent on what was immediately necessary, meaning basic daily necessities, rather than saved to make payments necessary for completing conditionalities. If PKH benefits did happen to arrive shortly before school fees were charged or when a health center visit was necessary, then a portion of PKH transfers would be spent to acquire those goods and services. This same phenomenon was witnessed during both instances of Indonesia’s temporary unconditional cash transfer, BLT²⁷: there too households receiving cash spent it rapidly on daily basic necessities, or on payments to service providers when the cash disbursement happened to coincide with bill due dates.

	Baseline share of Total Expenditure	PKH Beneficiary	Spillover
		Share after PKH impacts added	
Food expenditure	0.65	0.62	0.68
Non-food	0.35	0.38	0.32
Education	0.05	0.04	0.04
Health expenditure	0.02	0.04	0.03

Sources and Notes: PKH Impact Evaluation (World Bank, 2010a) and World Bank staff calculations.

Health expenditure increased even for non-PKH households while overall expenditure did not increase; this indicates that a facilitated conditional cash transfer delivers information about the value of health to a larger community. Eligible households in PKH areas who were not chosen to receive PKH (spillover households) did increase expenditures on health and food but as a result had to cut back on expenditure in all other areas leaving them no better off expenditure-wise in 2009 than in 2007. These spillover households increased their health seeking behavior (see above) but did not receive any cash transfers for doing so, so decreasing expenditure in one category to increase in it another was the only available option for such households. In addition to giving cash and facilitation to beneficiary households, PKH also delivers new information to all eligible households and the community at large about the benefits of certain healthy behaviors.

The positive impacts of the PKH program are often greater where services are more accessible. For example, breastfeeding, rates of immunizations, and diarrhea treatments all experienced larger increases in urban areas compared to rural areas. This is likely because facilities, personnel, supplies, and transport options are more readily available and accessible, lowering both the direct and opportunity costs of visiting health service providers. The same relative density and lower cost of health service provision also occurs in Java, where over 60 percent of the Indonesian population lives; the impacts of the PKH program on pre- and post-natal checkups, assisted delivery, weight checkups for newborns under 12 months old, and outpatient visits were greater in Java than the non-Java PKH locations.²⁸

26 SMERU (2008).

27 see ‘Social Assistance Program and Public Expenditure Review 2: BLT’ in this collection for more detail.

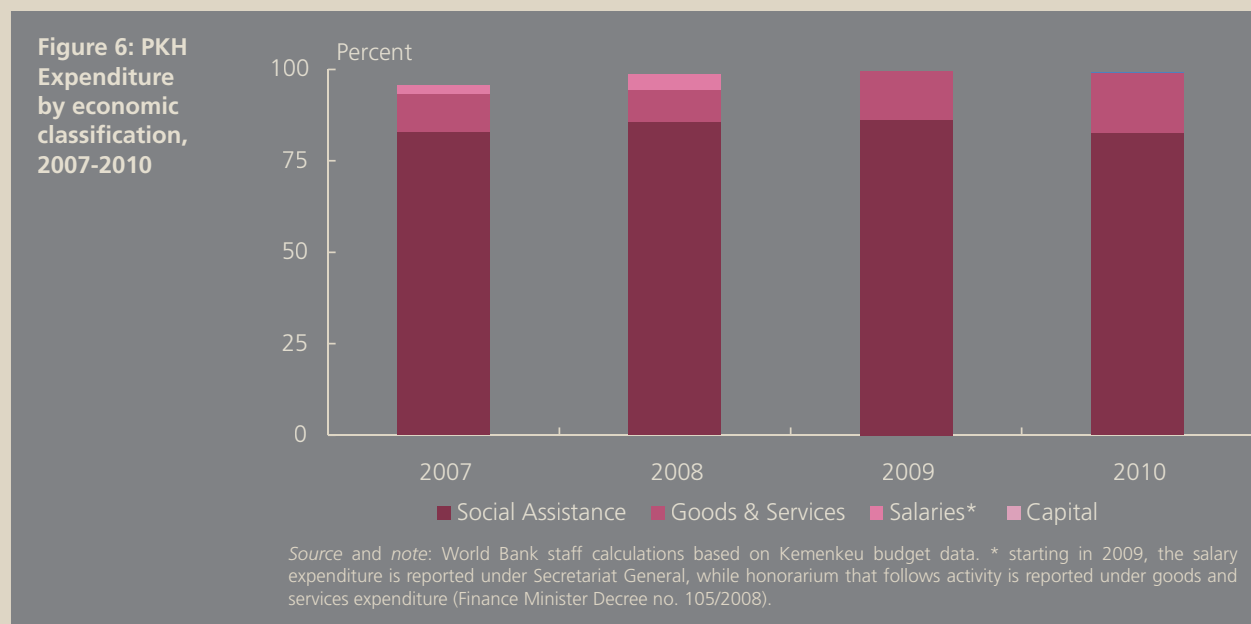
28 Not all healthy behaviors saw greater increases in urban or Java areas: treatment for acute respiratory infection increased most in rural areas (and did not increase at all in urban areas), while treatment for diarrhea increased most in non-Java areas.

5. Cost Effectiveness

PKH's administrative cost per dollar of benefit is roughly similar to international examples of well-run conditional cash transfers at similar stages of maturity. PKH's administrative cost per beneficiary is in the middle of the pack within the Cluster 1 programs.

PKH's highlevel budget classifications indicate that administrative costs declined as the pilot program matured.

PKH's highlevel economic classifications indicate that benefits – classified as social assistance – account for 86 percent of total spending (Figure 6). Administrative costs – classified mainly as goods & services – accounted for 17 percent of total spending in 2010; this increase from 14 percent in 2009 is due to PKH expansion over 2010 and 2011, which brought the program to 5 new provinces and 18 new districts.²⁹ These high-level budget classifications exclude civil servant salary costs, however, which are instead recorded under the overall Program/Directorate General's budget. This makes it difficult to quantify staff costs for individual activities or interventions.



A detailed examination of spending confirms that PKH's administrative costs are moderate, despite the program's relatively small scale and pilot status. Administrative costs per beneficiary have been between Rp 220,000 and 340,000 (roughly US\$ 23 and 35) per year, while the overall administrative overhead ratio was 14 percent in 2009 (the last non-expansion year), slightly less than 18 percent in 2007 (Table 6). These costs appear moderate compared to other cash transfer interventions in Indonesia, all of which have weaker administration and management structures.³⁰ For example, the temporary, high-coverage unconditional cash transfer (BLT) – with similarly-sized benefits as PKH – has estimated administrative overhead of approximately 5 percent and average administrative costs per beneficiary of \$US 5 (2008). Two low-coverage social cash transfer programs for the severely disabled and abandoned elderly – with much higher benefits – had estimated overheads of between 11 and 13 percent (2009), but high per-beneficiary administrative costs of around US\$ 50 per year.

29 Indonesia's geography - a large archipelago with many remote regions and populations - is such that when provinces and districts are incorporated into the PKH program, virtually the entire administrative apparatus (including information technology and personnel) must be replicated in those new areas. Coverage expansion in areas that have already been receiving PKH, however, typically leads to economies of scale and falling per-beneficiary administrative costs.

30 See 'Social Assistance Program and Public Expenditure Review 2: BLT', 'Social Assistance Program and Public Expenditure Review 5: BSM', and 'Social Assistance Program and Public Expenditure Review 7: JSLU, JSPACA, and PKSA' in this collection for more detail.

As PKH has matured, administrative costs have fallen closer to those in mature CCT programs in other countries. For example, an international survey of nine CCT programs found that average administrative costs were around 8 percent (Grosh et al, 2008). National scale, mature CCTs in Latin America with positive impacts confirmed by credible impact evaluations exhibit administrative costs on the order of 6 to 12 percent (Lindert, Skoufias and Shapiro 2006). At 14 (17) percent in the most recent year without (with) significant expansion to new areas, PKH’s administrative cost indicators appear reasonable in an international context. As PKH continues to mature and expand, average administrative costs may decline further; however, as Indonesia remains a large archipelago with many remote and difficult-to-access regions and populations, the non-benefit costs for PKH may remain elevated compared to a geographically “average” country.

Table 6: Spending Efficiency Indicators, 2007-2010

	2007	2008	2009	2010
Unit cost (Total spending/No. beneficiaries, Rp)	1,561,767	2,332,197	1,581,519	1,386,904
Administrative costs per beneficiary (Non-benefits/No. beneficiaries, Rp)*	274,786	339,241	220,775	237,777
in US\$	30	40	25	24
Administrative overhead ratio (Non-benefits/Total spending)*	18%	15%	14%	17%
Cost of delivering benefits ratio* (Non-benefits/Benefits)	21%	17%	16%	21%
Civil servants per 10,000 beneficiaries	n.a.	n.a.	n.a.	n.a.
Memo items:				
No. of beneficiary households	387,887	405,955	675,636	810,000
Number of civil servants	20	20	20	20
Avg. value of annual CCT (Rp)	1,286,982	1,992,955	1,360,745	1,149,127
Total spending (Rp bn)	606	947	1069	1123
o/w Benefits	499	809	919	931
o/w Non-benefits	107	138	149	193
o/w Civil servant salaries **	0.3	0.3	0.3	0.3
o/w General admin/other	56.6	109.3	121.3	156.6
o/w Socialization	24.6	10.5	8.5	11.0
o/w Evaluation (M&E)	0.0	3.2	8.8	11.4
o/w Training	0.1	0.0	10.2	13.2
o/w Targeting	25.0	14.4	0.0	0.0
o/w Follow-up	0.0	0.0	0.0	0.0

Sources and notes: World Bank staff calculations based on Kemenkeu budget data. *Includes estimates of social worker honoraria found in the deconcentration budget reporting. **While original budget data allocates personnel expenses to the DG as a whole, expenses for PKH have been estimated based on staff numbers.

6. Implementation

Many crucial support processes – compliance verification, frequent MIS updating, penalties for noncompliance – are only recently acquiring momentum.

Spot checks by Indonesian universities and research groups during 2009 and early 2010 found that Management Information Systems were not yet used everywhere; these MIS systems generate the incentives that encourage households to continue investing in health and education. Without a functioning MIS and the flow of information it manages, disruptions to several subprocesses within the PKH program become more frequent. For example, beneficiary households can be expected to continue changing demographically after receiving PKH and these demographic changes often mean either reduced or increased benefit levels (see Table 6 above). The spot checks revealed that updates to the beneficiary roster and the consequent automatic update of payment levels were not being reliably transmitted through the MIS system.³¹

In addition to being demographically eligible, PKH mothers and children should have attendance at service providers verified before cash benefits are delivered. Without a functioning MIS system, both compliance verification and recalculation of benefits (both of which rely on MIS data and automatic program actions that follow from MIS results) were also not fully completed during PKH's first two years of operation. For example, the few beneficiary households who did not acquire a full course of vaccines for children or the even smaller number of beneficiary households with children who were unenrolled continued to receive full benefit levels in some areas.³²

The spot checks team documented several factors contributing to these process-flow bottlenecks. Initially, there were too few human resources at service providers including *PT Pos*, the postal service; *Kementrian Pendidikan dan Kebudayaan*, Ministry of Education and Culture (Kemdikbud); and *Kementerian Kesehatan*, Ministry of Health, (Kemenkes); as well as at the local UPPKH offices to efficiently handle the flows of information that were being generated: almost immediately there were backlogs in data entry and processing. In addition, forms chosen to record the new information were not always available to personnel at the relevant offices. Service providers found the forms confusing and struggled to fill them out in a timely manner. Finally, some regions suffered from a stalled MIS system, meaning the flows of information generated and recorded on forms did not enter an MIS system capable of aggregating information and transmitting it on to the PKH units responsible for managing demographic updates and compliance verification results.³³

Over 2009 and 2010, reforms to many of these processes eased earlier bottlenecks. In particular, the MIS system is nearly fully functional and staffed and demographic updates are being processed.³⁴ In 2011, nearly 100 of PKH households are now captured in the compliance verification system (a component of the MIS system). The content of the verification forms has been revised to make them easier for service providers to use while the printing and supply chain of those forms has been rationalized in consultation with *PT Pos*, who is responsible for delivering the forms, and the PKH facilitators, who are responsible for alerting households to actions they must take as well as scheduled delivery of PKH funds.

31 "PKH Spot Check: Quantitative and Qualitative Assessments to Monitor Household CCT Operations", Centre for Health Research University of Indonesia (2010)

32 However, both SMERU (2011) and Center for Health Research, University of Indonesia (2010) found that some households in some areas were motivated to acquire conditioned services when benefit cuts for noncompliance were threatened; households likely had no way of knowing that compliance verification systems were not fully functional.

33 Additional complications occurred because of power outages; a mismatch between BPS household data (which higher-level PKH implementing units were using) and PKH-collected demographic data on the same households (which lower-level PKH implementing units were collecting); and a lack of advance awareness of service providers and beneficiaries regarding the conditions households are responsible for meeting in order to receive the cash transfer portion of PKH.

34 Improving mismatches and eliminating conflicts in data sets will occur naturally as a result of upcoming system-wide improvements in the database of poor households kept by BPS. Though they are not specifically targeted with the assembly of the year-2011 registry of poor households, the evidence-gathering activities at the front end of the compilation of the list will by default involve the majority of already-existing PKH households. Likewise, alongside any expansion of PKH there will be an incorporation of all new PKH households into BPS's nationwide list of poor households. By the time the first PKH payments were made in 2007, the household demographic data provided by BPS was already two years old, having been collected no later than 2005.

Payment delays may have weakened PKH's impacts on education. PKH households are large (at over five members on average), so an average PKH household will have to meet education *and* health fees for two, three, or possibly even four children at once. In addition, education expenditures can be quite high and are much larger at the beginning of the academic year than later.³⁵ In the first two years of PKH operation, the quarterly payment schedule, intended to deliver exactly one-quarter of a household's yearly transfer in each payment, accidentally became a three-times-yearly schedule with not one of the three payments delivered shortly before yearly start-up school fees were due. Because of steep costs, multiple obligations, and the tendency for poor households to spend benefits quickly on basic and pressing necessities – see Section 4 above and 'Social Assistance Program and Public Expenditure Review 2: BLT' in this collection – this accidental revision to the PKH payment schedule was costly for households.³⁶

Payment schedules have been revised to meet original designs while disbursements remain equally-portioned and less effective for meeting front-loaded education expenditures. The revision and delays in quarterly payments were due in part to the mismatch between records, lack of household verification, and lack of information throughput in the MIS system. In the end, delays with forms (printing, content, and filling out and delivery by service providers) and weaknesses in the MIS system's capacity led to payment backlogs that in turn led to decreased impacts in education. For a sophisticated program like PKH, disturbances in one part of the process carry through all the way to beneficiary households. The improvements mentioned above to the sub-processes in the overall MIS system as well as to the form printing and delivery supply chain have already alleviated the payment backlog problem and UPPKH has explicitly enforced the original quarterly payment schedule; this payment schedule is synchronized with the school fee schedule. Currently, however, a household's total yearly benefits are equally split into four disbursements but education expenses are not evenly split between periods: there are larger burdens at the beginning of the school year and smaller burdens later. PKH policy and design should incorporate not only a disbursement timing that coincides with necessary expenses from conditioned behaviors, but also a benefit amount that is commensurate with the total cost of conditioned behaviors and a division of total benefits (into disbursements) that coincides with the chronological profile of expenditures on conditioned behaviors.

Socialization to affiliated service providers, local governments, and beneficiary households was ineffective.

Socialization and advertising activities for PKH were delegated to Kemenkominfo (the Ministry of Communication and Information). An operations engineering report found that PKH socialization was deficient in content, frequency, and intensity. Spot checks revealed that local governments and service providers as well as local authorities and the community at large did not receive even printed flyers with an explanation of the PKH program. Common sources of program exposure were in sensational media reports of malfeasance by program operators or word of mouth. PKH program officers were sometimes unable to answer simple questions about program goals or eligibility criteria. As it was a delegated function, there was no monitoring of the socialization activities actually carried out and misunderstandings lingered: for example, beneficiaries and PKH facilitators alike were unaware that PKH beneficiaries are eligible for all other GOI social assistance schemes for poor households.³⁷

The complaints and grievances system is mostly unoperational and contributes little to real-time monitoring, on-the-ground improvements or the long-term continuous improvement cycle. There are specific provisions in the PKH operating manual for a Complaints and Grievances System (CGS). When the program began in 2007, the majority of beneficiaries did not know how to file a complaint and were unaware of the existence of the official system. The few complaints, grievances, or suggestions that were submitted (to various officials associated with the PKH program) received

35 Total costs for a year of secondary education represent approximately 30 percent of total expenditure by a household in the poorest 20 percent of the expenditure distribution. Total yearly costs (including transportation) are estimated at approximately Rp 2.6 million for one senior secondary school student and Rp 2.1 million if he or she is coming from poor household. See 'Social Assistance Program and Public Expenditure Review 5: BSM' in this collection for more information.

36 Several other factors contributed to a lack of PKH impacts on primary and secondary school enrollment; see Section 4 'Impacts' for more discussion. Reasons include the following: (1) In the first years of the program there were no payment reductions for non-compliant households. (2) Among PKH households participation rates and attendance rates were already quite high before PKH – above 90 percent participation rates and above 93 percent of enrolled individuals at greater than 85 percent attendance for 7 to 12 year olds. (3) PKH did not make junior secondary school access any easier or closer for poor households and it did not have an effect on the supply of buildings, teachers, books, or any other educational capital. (4) PKH did not produce any changes in the cost of attending secondary school which remained high for all students, including students from very poor households (5) PKH households did not very often benefit from the GOI's Scholarships for the Poor program (only 18 percent of PKH beneficiaries also received scholarships) or tuition waivers. (6) PKH facilitators did not make outreach to school-leavers a priority and essentially allowed them to exit the school system with no change to household PKH transfers. (7) Socialization to education providers was weak and service providers may not have understood the conditionalities nor the penalties associated with non-compliance; filling out the verification forms was "business as usual" for them and they did not take care to record the true enrollment situation of children from PKH households.

37 SMERU (2008), CHR UI (2010), and Ayala (2010).

no response. More recently, PKH facilitators have been recording (with a standard form) more complaints and grievances by the PKH households they serve, but the complaints and grievances recorded still await entry into PKH's MIS system.

Ensuring reliable coordination between service providers and PKH has proven difficult, contributing to implementation delays.³⁸ For example, PT Pos occasionally distributed verification forms to those in the community they knew and trusted rather than to the PKH facilitator from the area, which caused delays in the form delivery schedule. PT Pos also found that sending forms to difficult-to-reach areas was costly and in some cases they simply did not deliver forms unless extra incentive payments from PKH could be agreed. Furthermore, PT Pos delays in delivering and collecting the forms led to lower rates of compliance (with form completion) at the service providers themselves; PT Pos was responsible for delivery only, not compliance, and had no authority or stake in the rate of compliance by service providers. Non-compliance with forms led to PT Pos not delivering an acceptable amount of completed forms on time to the UPPKH offices, which led to delayed MIS functioning, delayed delivery, and initially no recalculation of benefits or application of penalties.

In another example of coordination difficulties, the implementation spot checks found that only 1 of every 6 PKH school-age children from PKH households received the Kemdiknas Scholarships for the Poor (BSM) program, though every PKH child would have been technically eligible. As school fees are expensive and have been growing in real terms, the BSM program would have allowed PKH households to freely choose more schooling without worrying about reducing expenditure in other areas: combined, the BSM and PKH education benefits would have covered 80 percent (or more) of average education-related expenditures (including transportation) for elementary and junior secondary students.³⁹ The health fee waiver program, Jamkesmas, was much more frequently received by PKH households and it was health-seeking behavior that increased most for PKH households. Coordination with affiliated service providers is essential for better outcomes.

PKH had no built-in mechanism for monitoring or encouraging reliable and high-quality supplies, a lack of which contributes to weaker household outcomes. For both health and education, the quantity and quality of services provided was highly variable. The provision of education *providers* (teachers) was mostly adequate and met minimum National Education Standards (*Standar Nasional Pendidikan*, SNP), but SNP standards for students per classroom, learning sessions per classroom, and physical capital (science labs, offices, bathrooms, clean water and electricity, playgrounds, recreation areas, etc) were not met, indicating a relatively low level of well-maintained and comfortable classrooms. Quality was also variable, especially off Java, where both elementary and junior secondary teachers with bachelor degrees (the minimum SNP requirement) were rare.⁴⁰

In health, the overall density of basic health service posts and village-level midwives (a substitute healthcare provider when there is no health post) is still low, especially off Java, making access difficult and costly for some PKH households. As for education, the supply of primary providers (doctors, nurses, and midwives) *in areas with health posts* is mostly adequate and they supply the conditioned services PKH households must acquire.⁴¹ Also like education, the supply of materials is variable: some health posts do not have complete courses of vaccines or go out of stock at some point during the year and some weight-check posts had to charge fees for producing logbooks and had nonfunctioning weight and height-measurement appliances. Some health posts have protocols that are at odds with PKH conditionalities: for example, pre- and post-natal protocols that call for fewer of the PKH-recommended check-ups, examinations, supplements, and nutrition and diet information packages. In addition to causing confusion for PKH beneficiaries and possibly leading to incorrect sanctions, the difference in protocols and lack of a guaranteed minimum treatment may be partially responsible for the lack of improvement in final health indicators discussed above.⁴²

38 This and the following three paragraphs are based on the CHR UI Spot Checks – See “PKH Spot Check: Quantitative and Qualitative Assessments to Monitor Household CCT Operations”, CHR UI (2010)

39 See “Social Assistance Program and Public Expenditure Review 5: BSM” in this collection for additional information on the rising costs of education as well as targeting and allocation rules in the BSM program.

40 This paragraph is based on “PKH Spot Check: Quantitative and Qualitative Assessments to Monitor Household CCT Operation”, CHR UI (2010), but SMERU mostly agrees with this characterization, noting that the number and density of elementary schools was adequate, while for junior high schools off Java it was inadequate; that teachers off Java are often not as highly educated; and that some of its study regions did improve the physical quality of schools during the study period by adding additional facilities for both school-based and extracurricular activities.

41 However, CHR UI noted that village health posts (Posyandu) experienced high staff turnover and frequently lacked dedicated buildings for service provision. Posyandu staff often performed services in their own home, which made some beneficiaries uncomfortable.

42 See “PKH Spot Check: Quantitative and Qualitative Assessments to Monitor Household CCT Operation”, CHR UI (2010)

The PKH program requires formal “letters of agreement”, countersigned by regents or mayors and indicating willingness to participate in the PKH program, before it expands coverage. These letters set out the obligations of local governments, including to ensure the availability of education and health services for PKH households. In order to ensure minimum standards in conditioned services, however, PKH needs to develop protocols for coordinating with regional health and education service providers to determine whether (a) supplies of conditioned services and treatment schedules (in health) are reliably available throughout the year and (b) the conditioned services are delivered with a standard of care that is acceptable to the PKH teams. If either supplies or quality are less than what a PKH beneficiary would require, the PKH program should develop protocols (together with the relevant agency) to remedy shortcomings.

Facilitators, who are PKH’s primary motivation and monitoring tool, do not yet provide a consistent level of service everywhere. A PKH household’s support network should be as broad and as deep as possible including village officials, health and education officials and staff, community and religious leaders, neighbors, NGO staff and other advocates⁴³, PKH group leaders, and most importantly, PKH facilitators. PKH facilitators should be the first and most direct interface between the PKH program and households. However, field studies indicate that facilitators’ contributions are limited when the physical area they must cover is too large. For example, a SMERU study notes that “in NTT and rural areas in West Java, the small number of recipients per village caused the work area of facilitators to cover many villages.⁴⁴ Consequently these facilitators were more preoccupied with administrative tasks and less able to focus on mentoring.” Similar to the difference in protocols at health service providers described above, minimum protocols for facilitators varied. In only one area out of four were facilitators responsible for motivating parents to send their children to school, and for monitoring PKH beneficiaries’ school attendance and progress. This lack of minimum protocols may limit improvements in education especially when the cash transfer alone does not fully cover the cost of education.

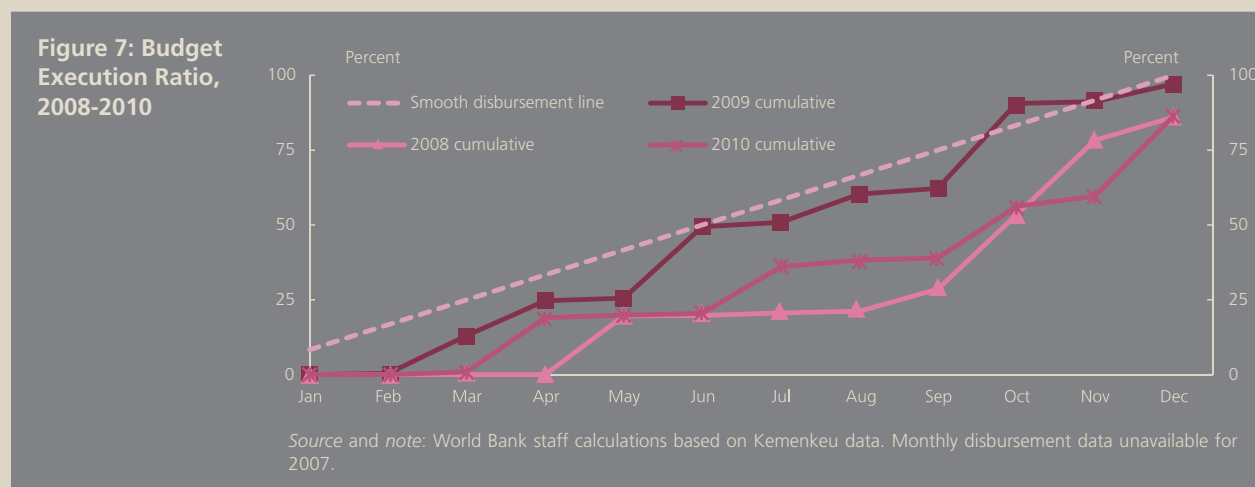
43 SMERU (2008) shows that all these actors were involved in PKH in many different ways. Unlike facilitators, however, all these actors get involved voluntarily and are not specifically remunerated by the PKH program even if they are providing valuable services like conditionality enforcement or remedial assistance.

44 SMERU (2008).

7. Public Financial Management and Sustainability

PKH is unique among Cluster 1 programs in its consolidated, stand-alone budget, allowing a relatively straightforward examination of budget formulation, execution and implementation. Within Indonesia's budget classifications, PKH is treated as a standalone activity under the Social Assistance and Insurance "program" and thus its total budget (and breakdowns by sub-activity and economic classifications) is recorded in standalone *Petunjuk Operasi Kegiatan* (Operational guidelines, POK) and *Daftar Isian Pelaksanaan Anggaran* (Budget Authorization Document, DIPA) documents, allowing for relatively easy examination of the level and composition of expenditures.⁴⁵ Longer-term budget planning is informed by Indonesia's Medium Term Development Plan (*Rencana Pembangunan Jangka Menengah*, RPJM) 2010-14, which explicitly outlines indicative PKH beneficiary numbers and budget ceilings out to 2014.

Budget execution and fund disbursement have improved markedly after some inaugural year hiccups. In line with broader implementation issues in the first year of the program, slow budget execution fund disbursement delays occurred in 2007. Thereafter the budget execution ratio (relative to the final revised budget) rose to 100 percent in 2009 before falling back to 86 percent in 2010 (Figure 7). This is consistent with most cash transfer expenditure in Indonesia (cash has a better disbursement record than other types of expenditure). Monthly budget disbursement also shows improvement: in March 2008, no funds had been disbursed from Treasury to PT Pos; by 2009 the first payment to households was made in March 2009. Likewise, while 0 percent (23 percent) of funds were executed in the first quarter (first half) of 2008, this rose to 13 percent (51 percent) in 2009. The smooth disbursement of funds to PT Pos appears to have translated into ontime payment of benefits: according to UPPKH officials at Kemensos beneficiaries received three payments on time in March, July and October/November in 2008 and 2009.⁴⁶



With plans to expand to 3 million households, the future budget implications of PKH are limited. The RPJM for 2010 to 2014 outlines only modest expansion plans for PKH: the target number of beneficiary households rises to 1.5 million by 2012, before declining in line with an expected fall in poverty rates. Under this scenario, PKH's budget allocation, peaks at Rp 2.2 trillion in 2012 and remains unchanged as a share of total central government spending at just 0.2 percent. A revised expansion plan developed by the poverty reduction unit in the Vice President's office envisions approximately 3 million PKH households by 2014. Under this scenario, total PKH expenditure could rise to over Rp 4 trillion, but PKH would remain as the 5th largest of the six current Cluster 1 household-targeted programs.

45 As for most Cluster 1 programs, civil servant salary costs are not recorded in the PKH activity budget but rather grouped together with other salary costs and recorded under the budget of the overall "program" and DG's budget (within the Secretariat Unit), so staff costs specific to PKH cannot be distinguished making a precise determination of cumulative PKH administrative costs difficult.

46 This is a marked improvement on the situation in 2007 when the first payment was made in November, with the final two payments delayed into early 2008.

PKH's target group is chronically poor families: expanding coverage to all such families, with upward and frequent revisions to benefit levels, would require significantly more resources. A scenario⁴⁷ including (1) an expansion in coverage to the roughly 4.5 million chronically poor households that are eligible (based on current Susenas surveys); while (2) bringing benefit levels into line with current estimates of education and health expenses for conditioned services; and (3) adjusting benefit levels annually for inflation; and (4) further small declines in administrative overheads to around 8 to 10 percent would require that PKH's current budget increase tenfold to almost Rp 18 trillion by 2014, equivalent to around 1.6 percent of total central government spending. This scenario is represented as a "Big Push" scenario in Figure 8 and Table 7 below.

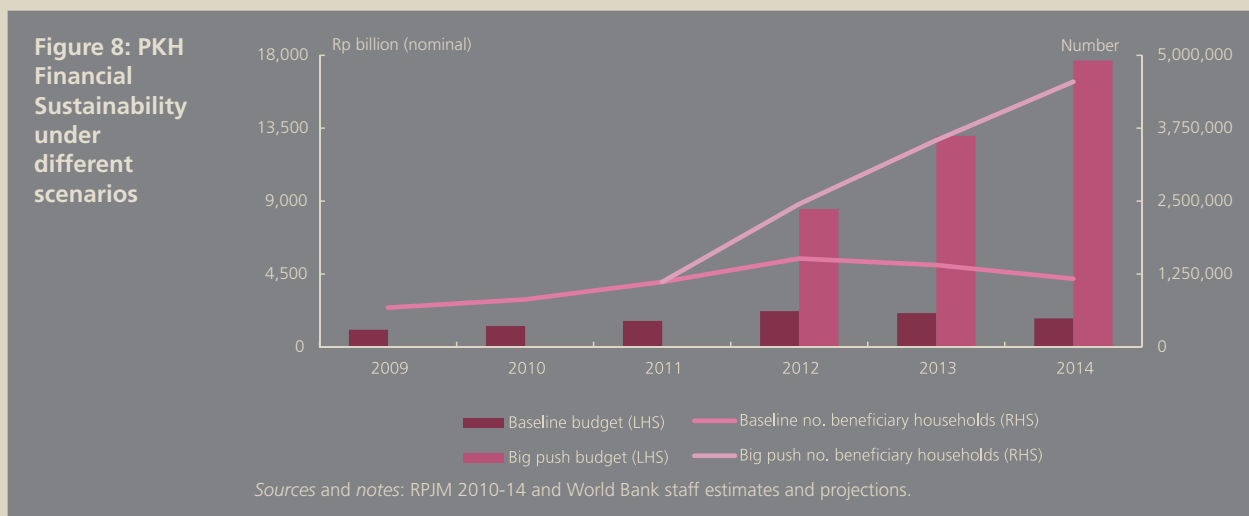


Table 7: PKH Financial Sustainability under different scenarios

	2009	2010	2011	2012	2013	2014
Baseline (RPJM)						
Total budget allocation (Nominal, Rp billion)	1,068	1,123	1,610	2,217	2,093	1,765
Share of central government spending (%)	0.2	0.3	0.2	0.3	0.2	0.2
Average unit cost per beneficiary HH (Rp)	1,581,044	1,386,904	1,442,652	1,462,401	1,490,741	1,508,547
Target number of beneficiary households	675,636	810,000	1,116,000	1,516,000	1,404,000	1,170,000
Share of potential target population covered (%)	12	16	22	31	30	26
Big Push						
Total budget allocation (Nominal, Rp billion)				8,510	13,026	17,679
Share of central government spending (%)				1.0	1.3	1.6
Average unit cost per beneficiary (Rp)				3,472,297	3,674,529	3,889,010
Target number of beneficiaries				2,450,962	3,544,953	4,545,924
Share of potential target population covered (%)				50	75	100

Sources and notes: RPJM 2010-14 and World Bank staff estimates and projections.

47 This scenario includes overall population increases of approximately 1.2 percent per year from 2010 (based on the IMF World Economic Outlook database); poverty headcount reductions of 0.6 percent per year from 2010 onwards (based on near-historical averages for Indonesia); and taking households with expenditure levels equivalent to 0.8 times the poverty line as the set of "chronically poor" households. PKH -eligible households in this scenario still include only those with pregnant or lactating mothers or those with children under 18 years of age who have not completed a basic primary and junior secondary education.

8. Summary and Recommendations

PKH's success in delivering real benefits to the very poor and in changing behaviors deserves further support and encouragement. PKH has submitted both its implementation and final outcomes to detailed scrutiny by several independent researchers. The positive behavioral changes it has directly produced are significant achievements for any social assistance program, much less one that focuses on the very poorest households. The cash transfers to very poor households are a significant addition to their incomes, are spent rapidly, are spent on productive goods like health and more protein, and have allowed an unexpected reorientation of spending towards health even while spending in every category increases. Furthermore, cash transfers are not noticeably reduced along the delivery chain through malfeasance or re-distribution by program or village officials, which is a common weakness in other Indonesian social assistance transfers.⁴⁸

PKH's initial weaknesses in implementation and delivery deserve continuing attention and thoughtful solutions for greater effectiveness. While PKH expansion continues, it should continue to refine all implementation subprocesses. The MIS system, its operators, and most importantly the quantity, quality, and timeliness of the data and reports that feed into the MIS system all need continued monitoring and process engineering to make sure that PKH's internal machinery is efficient and effective for achieving PKH program goals. Several on-the-ground reports observe that delays or poor implementation at one point in the chain affect all subsequent subprocesses and can result in incorrect payments, delayed payments, and misapplied penalties, all of which will make it more difficult for beneficiary households to acquire the conditioned services. The final products of the MIS system – automatically-generated reports that indicate where and why there are delays, implementation weaknesses, or “hot spots” – should be the first source of information for all monitoring and evaluation activities and program reform.

PKH should continue coordinating and collaborating with affiliated service providers in health, education, and local government services. PKH cannot immediately alter either the quantity or the quality of the locally-provided services on which PKH households rely. However, the motivated participation of stakeholders from these agencies (as well as from other community members) is crucial for encouraging healthy and productive behaviors in beneficiary households and for providing a comfortable and low-cost introduction to unfamiliar systems. Better results for PKH households will depend on service provider participation as well as on quality increases in services provided. PKH should pursue a constant collaboration with affiliated agencies and service providers at both the village level and the central level in order to encourage better service provision for PKH households (and others).

PKH can benefit additionally from explicit links to local government, community development programs, and Civil Society Organizations (CSOs). PKH's positive impacts in consumption and health, for both beneficiaries and other eligible nonbeneficiaries, have been proven. Local governments interested in pro-poor planning and budgeting should promote and facilitate the introduction of PKH in their localities, including taking the lead in coordinating PKH efforts with the health and education service providers (at the local level) that will be partially responsible for better outcomes. Likewise, the Cluster 2 community development programs – PNPB-Mandiri and PNPB-Generasi at least – could also coordinate poverty reduction and pro-poor development efforts with the PKH program and PKH facilitators. For example, local governments in collaboration with the PNPB program could develop a matching grant for helping service providers provide outreach to and recruitment of both PKH and other marginalized or remote households. PNPB facilitators should assist in spreading the information component of the PKH package, which details what healthy behaviors are expected of recipients, to wider audiences of poor households and community members. PNPB facilitators can coordinate monitoring activities – of both household, service provider, and local government activities – with PKH facilitators and other CSOs interested in the quality of social service provision.

48 See “Social Assistance Program and Public Expenditure Review 2: BLT” and “Social Assistance Program and Public Expenditure Review 3: Raskin” in this collection, for example.

PKH facilitators should benefit from better organization and frequent skill upgrading. PKH facilitators are the primary interface between the PKH program and households and typically the first source of information for households on PKH expectations and responsibilities; they are crucial for household success with the PKH program. Currently, standards of facilitation vary, partly because some facilitators must cover much more ground but also because skills and knowledge vary widely. Facilitator forums such as *bimtek* (*bimbingan teknis*) should be conducted more often in all regions so that facilitators learn from each other and share effective ways to reach and motivate households. Facilitator training or refresher training should be increased to at least once per year while the content of the training should reflect the maturity of the PKH program.

Benefit levels should be reviewed and revised with cost of living increases. Benefits, which are unrevised since 2007, do not account for increases in the cost of living. This could ultimately undermine the objectives of the program as the cost of acquiring the conditioned services is rising in both real and nominal terms. Indexation should be addressed through periodic reviews (with Bappenas and Kemenkeu) or an automatic indexation mechanism. Such an index could be applied contemporaneously at the beginning of the delivery schedule or retrospectively when benefit delivery has finished. The index, possibly the Poverty Basket or the Poverty Basket with greater weights on health and education goods, should account for general and specific changes in the cost of living faced by poor PKH households. This should be coordinated with policies being developed by Kemenkeu in the context of a transition towards a medium term expenditure framework.

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