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Program Keluarga Harapan (PKH): Indonesian Conditional Cash Transfer Programme

By Suahasil Nazara and Sri Kusumastuti Rahayu

I. Introduction

In 2007 the Government of Indonesia launched the Program Keluarga Harapan (PKH), the first conditional cash transfer programme in Indonesia. The programme seeks to improve the quality of human capital by providing cash transfers conditional on households accessing specified health and education services. The PKH helps to reduce the burden of household/family expenditure for very poor households (the immediate consumption effect), while investing in future generations through improved health and education (the human capital development effect). This combination of short- and long-term assistance is the government's strategy to sustainably lift PKH recipients out of poverty.

PKH is administered by the Ministry of Social Affairs (MoSA), with close supervision from the National Planning Agency (Bappenas). It began operating in 2007 as a pilot programme, with a research component inherently built into the programme.

On the policy front, the implementation of a pilot project results in slow progress of the programme, which can be seen in its limited coverage (both in terms of the number of household and the areas covered). Since 2010 the Secretariat of the National Team for the Acceleration of Poverty Reduction (TNP2K), at the Office of the Vice-President, has been promoting the expansion of PKH to widen its coverage, make the programme administration more efficient, and increase its impacts on poor populations.

II. Programme Coverage, Targeting and Impacts

When PKH was launched in 2007, the programme beneficiaries were designated extremely poor—those who were approximately below 80 per cent of the official poverty line at that time. The programme was intended as a pilot; therefore, it started with very low coverage (see Table 1). Up to 2012, the programme only covered 1.5 million households, compared to the total of 60 million households in Indonesia, and approximately 6.5 million households below the poverty line. It is expected that PKH will cover 3.2 million households by the end of 2014. Only in 2012 did PKH operate in all Indonesian provinces, and still it did not cover all of the districts in every province. PKH's expansion is a challenge for the programme if it is to have significant impacts on Indonesia's poor people.

Table 1
PKH Coverage, 2007–2012

	2007	2008	2009	2010	2011	2012
No. of households (millions)	0.388	0.621	0.726	0.774	1.052	1.454
Budget (million USD PPP)	79.244	113.065	126.688	146.049	210.181	228.287
Provinces (of 33 total)	7	13	13	20	25	33
Districts (of 497 total in 2010)	48	70	70	88	119	169
Sub-Districts	337	637	781	946	1387	2001
Villages	4311	7654	9295	10,998	16,154	25,032

Source: Ministry of Social Affairs, PKH Profile, 2013.

The targeting for PKH was conducted by the Indonesian Statistics Agency (Badan Pusat Statistik — BPS). For the first time, with the 2005 registry at hand (by names and addresses), BPS conducted a basic health and education survey (Survei Pendidikan dan Survei Pelayanan Dasar Kesehatan dan Pendidikan — SPDKP) to identify extremely poor households as well as education and

health facilities. The 2005 registry contained about 19.1 million households, supposedly at the lowest income distribution, and had been used as the list for the temporary unconditional cash transfer, the 2005 Bantuan Langsung Tunai (BLT) programme. The SPDKP surveyed not only the households but also the facilities, to fully assess their readiness for the PKH. The SPDKP is conducted every year. In 2008, another registration process was conducted by Statistic Indonesia to update the previous registration (2005 PSE). The 2008 Pendataan Program Perlindungan Sosial (PPLS) employed 14 indicators to identify whether a household was eligible (Nazara, 2013). This new registry was used for PKH targeting in 2009–2011. Since 2012, the targeting of PKH has been using the Unified Database (Basis Data Terpadu — BDT). The database, which is based on the 2011 registry, contains the names and addresses of individuals from households in the lowest 40 per cent of welfare distribution. The BDT, which is managed by the TNP2K Secretariat, is a way to integrate the national targeting system. More about BDT can be found at TNP2K (2013).

Table 2
PKH Benefit Amount

Details of Transfer	Amount of Benefit (Rp) 2007–2012	Amount of Benefit (USD) 2007–2012	Amount of Benefit (Rp) 2013 Onward	Amount of Benefit (USD) 2013 Onward
Fixed cash transfer	200,000	20.75	300,000	31.13
Variable transfer for each beneficiary:				
a. Child up to 5 years old	800,000	83.01	1,000,000	103.77
b. Pregnant or lactating mother	800,000	83.01	1,000,000	103.77
c. Children of elementary-school	400,000	41.51	500,000	51.88
d. Children of junior-high-school	800,000	83.01	1,000,000	103.77
Minimum transfer per year	600,000	62.26	800,000	83.01
Maximum transfer per year	2,200,000	228.29	2,800,000	290.55
Average transfer per family per year	1,390,000	144.24	1,800,000	186.78

Source: PKH Guidelines.

Conditional requirements for receiving PKH benefits include expectant mothers receiving prenatal check-ups, newborns and toddlers receiving post-natal care and health check-ups, and children aged 6 to 18 attending nine-year compulsory education. The benefit is paid quarterly. Between 2007 and 2012, the annual benefit ranged from Rp600,000 to a maximum of Rp2.2 million per year, depending on the family's status (with an average of Rp1.4 million per family per year). In 2013 there was an increase in the benefits, with the average benefit increasing to Rp1.8 million per family per year.

III. The Impact of PKH

There is a vast amount of literature recording the impacts of conditional cash transfer programmes such as PKH. These programmes have increased the educational achievements of poor families (Schultz, 2004) and had spillover effects on the educational achievements of non-poor families (Bobonis and Finan, 2005); created multiplier effects of transfers through self-investment (Gertler, Martinez and Rubio, 2005); improved the health status of mother and children (Gertler, 2004); reduced nutritional deficiency (Hoddinott and Skoufias, 2003); increased local economies (Coady and Harris, 2001); and further reduced inequality and poverty (Soares et al., 2006).

In particular for PKH, since it began, there have been a number of studies attempting to assess its impacts. Different spot checks and field surveys have been conducted

by various agencies, both domestic and international. In an early attempt, Bappenas (2009) tried to conduct a quantitative assessment using a randomised household-based intervention, with measurements before and after the intervention in both treatment and control.

The study found that overall PKH had positive impacts. The results show average effects on a range of health indicators (e.g. visits to Posyandu increased by 3 percentage points, child growth monitoring increased by 5 percentage points, and immunisation activities increased by 0.3 percentage points) and education indicators (e.g. attendance increased by 0.2 percentage points). PKH also managed to significantly increase the monthly per capita household expenditure on both education and health.

Another impact analysis comparing PKH in a control–treatment fashion was released by the World Bank (2010). From the World Bank study, one conclusion is that there are improvements in PKH areas with respect to access to health facilities. Women's pre- and post-natal visits to health facilities in PKH areas were 7–9 percentage points higher than in the control areas.

The number of children below 5 years of age weighed in health facilities was also 15–22 percentage points higher in PKH areas. Deliveries in health facilities, or assisted by health staff (midwives or physicians), were about 5–6 percentage points higher in PKH compared to the non-PKH areas.

The study also suggested that PKH impacts are stronger in urban areas, where there are more health facilities and of a better quality than in rural areas. There is also a spillover effect from PKH among non-beneficiary households within the same sub-district— i.e. their access to health facilities is higher than among other households in sub-districts without PKH.

On education, the impact evaluation did not show significant differences in educational status between PKH and non-PKH areas, and that is true for all levels of the Indonesian nine-year compulsory education. One reason for this is that enrolment and participation rates in Indonesian elementary schools are quite high, at more than 95 per cent.

For junior high, the enrolment rate was actually not that high, thus PKH should show some differences. The fact that the evaluation did not show any differences suggests that there are some problems that need to be addressed in the PKH programme. Other assessments suggest two issues on this account:

- (i) the PKH payment schedule is not always on time; therefore, households with graduating elementary students do not have enough money at the time of enrolment to junior high school; and
- (ii) the benefit available for the education element of PKH is not enough for enrolment in junior high school.

Another challenge faced by PKH is that evaluation could not find any impact on reducing child labour. In most part, this is mostly due to inadequate mechanisms within PKH to deal with child labour issues. Additionally, the PKH benefit is supposedly not enough to provide incentives for those children to quit work and go back to school.

On consumption, the study suggests that between 2007 and 2009 PKH households experienced a 10 per cent increase in their average monthly consumption. Cash received by PKH households is typically used for daily expenditures (consumption) and education (uniforms, transportation expenses). Some households also use the transfer to improve their housing conditions and to pay debts. Incurring debts is one of the survival mechanisms for poor families, along with selling off existing assets and reducing consumption.

IV. PKH Strategic Challenges

There are several strategic challenges in the future for PKH. They can be categorised under three issues:

- (i) expansion and institutional set-up;
- (ii) exit and graduation strategy; and
- (iii) complementary issues with other programmes.

Expansion and institutional set-up

The PKH impact evaluation results mentioned above form the basis to continue the expansion of conditional cash transfers in Indonesia. Ideally, as a poverty alleviation programme, PKH should cover all households living below the poverty line. By way of the Indonesian Unified Database, that translated into approximately 7.2 million households in 2011.

However, the current administration has set a target of 3.2 million beneficiary households by the end of 2014, and that would only cover less than half of the projected number of poor households.

Increasing PKH coverage gets more complicated as one considers which new areas the programme should expand to.

As shown in Table 1, although PKH operated in all provinces in 2012, it did not cover all districts and, therefore, all sub-districts or villages.

The expansion strategy for PKH would have to combine two important features. First is the need to go national. Once all the provinces are integrated into the programme, PKH should then ideally operate in all of the 497 districts (municipalities and cities) in Indonesia, which is planned for 2013. Second, PKH expansion also needs to consider another perspective that may contribute to its operational efficiency.

In that perspective, it is important for PKH to saturate coverage in existing areas. That can be done at the sub-district level. As Table 1 suggests, PKH is not operating in all villages within a sub-district. Of course, too much emphasis on the saturation principle will hamper the objective of national coverage, and vice versa.

Expansion also requires adequate human resources. In 2012, PKH employed about 6700 facilitators. An estimate made by the TNP2K Secretariat suggested that, to serve 3 million beneficiary households, PKH would require close to no less than 12,500 facilitators.

The current IT centres that are spread over district offices would need to be handled at the provincial level to enhance efficiency in the programme's administration.

Another important feature to which PKH needs to pay attention if it is to expand is the payment mechanism. Payment is currently made through post offices. However, it is important as PKH aspires to expand that payments be made through the banking system.

Indeed, extremely poor households are not currently bankable, but the bank-based payment would benefit them, as they could learn how to save, and saving can then be later used to help consumption.

Typical conditional cash transfer programmes require extensive management information systems. It is, therefore, mandatory that PKH administrators pay a great deal of attention to the continuous improvement of its management information systems.

Exit and graduation

PKH encompasses dual objectives of short-term poverty alleviation and long-term development of human capital. It is understandable that PKH should not create long-term dependency; therefore, an exit strategy is important to the programme's successful operation. PKH households exiting the programme are also a matter of horizontal equity. Exiting households allow their places in the programme to be used by others who are not yet in it.

Current PKH guidelines are designed to alleviate short-term poverty and, therefore, allow the removal of beneficiaries for three reasons:

- they no longer satisfy eligibility conditions;
- they are no longer poor; or
- they have reached the time limit of six years as a recipient.

Exiting the programme because of the first reason above is natural. An example is a child completing nine-year education who will no longer receive support from PKH. However, the second reason is a bit tricky. For one thing, the programme needs constant surveillance to identify graduating families. A scheduled recertification activity can be an option for surveillance. However, there is another reason why exit by graduation may also be tricky—namely, some households' incomes fluctuate around the poverty line.

Households around the poverty line are still very vulnerable to any economic shocks. PKH should not graduate any family from the programme while there is a significant chance that the family may end up below the poverty line again because of their inability to support themselves after leaving the programme. The third reason for exiting the programme, the six-year limit, is the easiest rule to enforce but is not appropriate for PKH as a social transformation programme.

A household or individual's ability to climb out of extreme poverty takes place in the context of, and is, therefore, shaped by, both intra-household dynamics and the wider social, economic and political context in which households live (e.g. regions constrained by lack of infrastructure, or services affected by disasters).

The first batch of PKH beneficiaries —i.e. the 2007 cohort—should no longer be part of the programme starting in 2013, because they will already have been enrolled for six years. However, it was considered that a final and unprepared termination of the first cohort would not be in the best interests of the families or the Indonesian poverty alleviation programme. A strategy must first be developed to ensure that PKH can best address the needs of its beneficiary households and poverty alleviation in Indonesia in general.

Such a strategy is referred to as the Transformation Process. In this process, an annual recertification would be conducted in the fifth year of participation to assess a family's income status. Recertification is the process of assessing the socio-economic status of PKH recipients to determine if they are still eligible based on their poverty status. Recertification for PKH will also be designed to assess other factors that affect the capacity of PKH recipients to move out of poverty.

Data obtained from the results of recertification will then be used to establish the households' continued participation in the program. In addition, recertification may gather information about the recipient's access to complementary social assistance or poverty reduction programmes to be used in developing the exit strategy.

The recertification in the fifth year of participating in PKH will allow sufficient time for the PKH management to prepare the next phase of transformation, which comprises the following rules:

- A PKH household which, based on the recertification results, is still poor (in the bottom 10 per cent of households in the BDT) and meets PKH eligibility criteria will enter a transition phase. These households will receive a cash transfer for another three years, along with other social protection programmes such as Jamkesmas (health insurance), BSM (education assistance), Raskin (subsidised rice for poor households) etc.

Within the three-year transition process, the recipients will receive the same amounts of cash transfer as other PKH participants. After the three years in the transition phase, the recipients will automatically leave PKH without a recertification process.

- PKH recipients, who, based on the recertification, are no longer poor (i.e. above the bottom 10 per cent of households in the BDT) and/or no longer meet PKH eligibility criteria will not receive PKH and will enter a graduation phase, where they will continue to receive other social protection programmes such as Jamkesmas, BSM and Raskin, as well as other available livelihood improvement and poverty reduction programmes.

The success of such a transformation strategy would depend on a number of key factors.

First, the recertification activity must be conducted regularly for each cohort—except for the first time, as the 2007 and 2008 cohorts would be recertified together, since the first cohort has already passed the six-year point.

Second, PKH must ensure the readiness of other social protection programmes to take graduating households into their respective programmes. Coordination across programmes becomes a must.

Third, intensive socialization—understood as the process of informing beneficiaries of the operational rules of the programme— must be conducted for the beneficiaries.

Complementary programmes

The poverty alleviation programmes in Indonesia are divided into three different clusters. PKH is one of several programmes in Indonesia's Cluster 1 of poverty alleviation programmes. Cluster 1 is the poverty alleviation programme that targets individuals and households. Other programmes in Cluster 1 are Raskin (subsidised rice), Jamkesmas (health insurance) and BSM (education cash assistance).

Cluster 2 comprises several PNPM programmes, which are a set of community-driven development programmes.

Cluster 3 is the development of micro and small enterprises through the Kredit Usaha Rakyat (KUR), which is essentially a credit guarantee programme administered by participating public and private banks.

There are two notions of complementarity, which will be discussed below. First, in terms of coverage— i.e. the poorest should receive in an integrated fashion all Cluster 1 programmes; second, in terms of programme operation.

Up to 2011, programme complementarity was very challenging in Indonesia, stemming from the fact that each programme came up with its own beneficiary database.

Conceptually speaking, since PKH covers extremely poor households in its distribution, and its coverage is the lowest among other Cluster 1 programmes, then all PKH beneficiaries should have also received Raskin, Jamkesmas and BSM. But that is not the case. However, there were attempts to ensure that the programmes complemented each other. For example, in 2009 the Minister of Health issued instructions to all health facilities that all members of PKH households should also be covered by Jamkesmas; therefore, a PKH card is enough for PKH family members to claim free health services in any health facility.

Another example of complementarity is between PKH and BSM. For 2010 and 2011, the PKH administrator extracted a list of names and addresses of PKH children at schools, and, facilitated by the TNP2K Secretariat, the list was submitted to the Ministry of Education and Culture to be included in the BSM beneficiary list. This kind of program complementarity is ad hoc, and does not guarantee systematic long-term implementation.

In the example of the coordination between PKH and Jamkesmas, the coverage of PKH expanded every year, and the new areas covered had no knowledge about the arrangement. As a result there are still many complaints about PKH cards being rejected by health services.

A foundation for complementary coverage was started when Indonesia set up the national single registry, the BDT, in 2011. It should ensure that complementary coverage can be maintained. Since 2012 all names and addresses submitted to PKH for the programme's expansion have also been included in the targeting for Jamkesmas, Raskin and BSM. Different ministries still administer the programmes separately, but the individual and/or household targets for each programme come from the same national BDT.

Another perspective on complementarity is in terms of programme objectives. PKH is meant to provide cash supplements for household expenditures. However, it is also meant to improve the quality of human capital through, among other things, access to health and education facilities. To that effect, PKH operates with facilitators in assisting poor households.

The role of the facilitator should actually be more than that of just serving poor households with respect to PKH services. Facilitators should also enable PKH beneficiaries to access different public services and development activities. For example, PKH facilitators are the right agent to ensure that PKH households can buy the right allotment of Raskin rice at the right price. They should also be in close contact with PNPM facilitators to allow PKH households to participate and be heard more during the village planning sessions.

Facilitators could also play essential roles in the link between PKH and BSM. That would be in addition to the official statement in the BSM Guidelines to automatically include children of PKH households in the programme.

In essence, facilitation should not merely focus on internal programme operations. PKH can also serve as a focal point through which poor households can access all public services in their area. These might include not only health and education services but also other services such as community participation, civil registration for identification purposes and other civil documents, labour-intensive works for local infrastructure maintenance etc. If PKH would like to transform into such a focal point, a close coordination with other government agencies, central and local, is essential.

Another important issue in programme complementarity derives from the fact that PKH relies heavily on the existence of infrastructure such as schools and health facilities.

In areas which lack such infrastructure, PKH would not perform successfully as a conditional cash transfer programme. As such, the PKH expansion should also pay attention to the availability of infrastructure in the region. The challenge is, however, that the availability of infrastructure in a certain area does not depend solely on the central government. In lots of cases, infrastructure is also the responsibility of the local government; therefore, cooperation with the local government is essential.

V. Closing Remarks

Despite being in operation for seven years, Indonesia's PKH is still facing a number of challenges. It still needs to expand substantially to cover a significant proportion of the poor households in Indonesia; the programme needs many efficiency improvements; expectations must be managed with respect to the graduation and transition of PKH beneficiaries; and, finally, PKH needs to improve its coordination with other poverty alleviation and social protection programmes.

Despite those challenges, PKH remains a crucial programme for poverty alleviation in Indonesia. However, programme reforms leading to greater efficiency and efficacy are continuously needed.



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