SUMMARY OF THE PROGRAM KELUARGA HARAPAN AND ITS TECHNICAL ASSISTANCE FRAMEWORK

1. The Program Keluarga Harapan (Family Hope Program, PKH) is Indonesia's national conditional cash transfer (CCT) program. Operating for more than a decade since it was first piloted in 2007, the targeted social assistance program provides a quarterly cash benefit to eligible poor households with children and/or pregnant women. The cash benefit is conditional on children's school enrollment and attendance, regular health check-ups for kids that include monitoring nutritional status, and pre-natal care for pregnant women.

2. **Objectives**. As set out in Ministerial Regulation No. 10 of 2017, the program's objectives are to:

   (i) improve the lives of beneficiary households through access to education, health, and social welfare services;
   (ii) reduce the spending burden and increase the income of poor and vulnerable families;
   (iii) create behavioral changes and independence among beneficiary families in accessing health and education services and social welfare; and
   (iv) ultimately, reduce poverty and inequality.

3. **Eligibility**. To be eligible to participate in the PKH, a family must (i) be included in the poverty targeting database and ranked below the cutoff point determined by the program, and (ii) have:

   (i) a family member who is pregnant or lactating; or
   (ii) at least one child aged below 6 years; or
   (iii) at least one child between age 7 to 21 years and attending primary, junior secondary school, or senior secondary school; or
   (iv) at least one child age 16 to 21 years who has not yet completed basic education.

4. PKH recently expanded its coverage to include a social pension for the elderly (aged 70 and above) and grants for people with severe disabilities. These benefits are also conditional, with conditions related to health (Figure 1).

5. **Benefit levels and payments**. The cash grants are paid out quarterly through either the post office or ATMs. Households receive grants for 6 years as long as they are in compliance with the conditions and remain eligible under the poverty line cut-off. The grant amount was originally variable according to household composition (e.g., the age and number of children) and ranged from a minimum of IDR 800,000 (about $61) to a maximum of IDR 3.7 million (about $284) per household per year. In 2017, however, the Ministry of Social Affairs (MOSA) simplified the grant amount (Table 1). While this reduces administrative complexity, it may also reduce grant adequacy, depending on the family's composition.

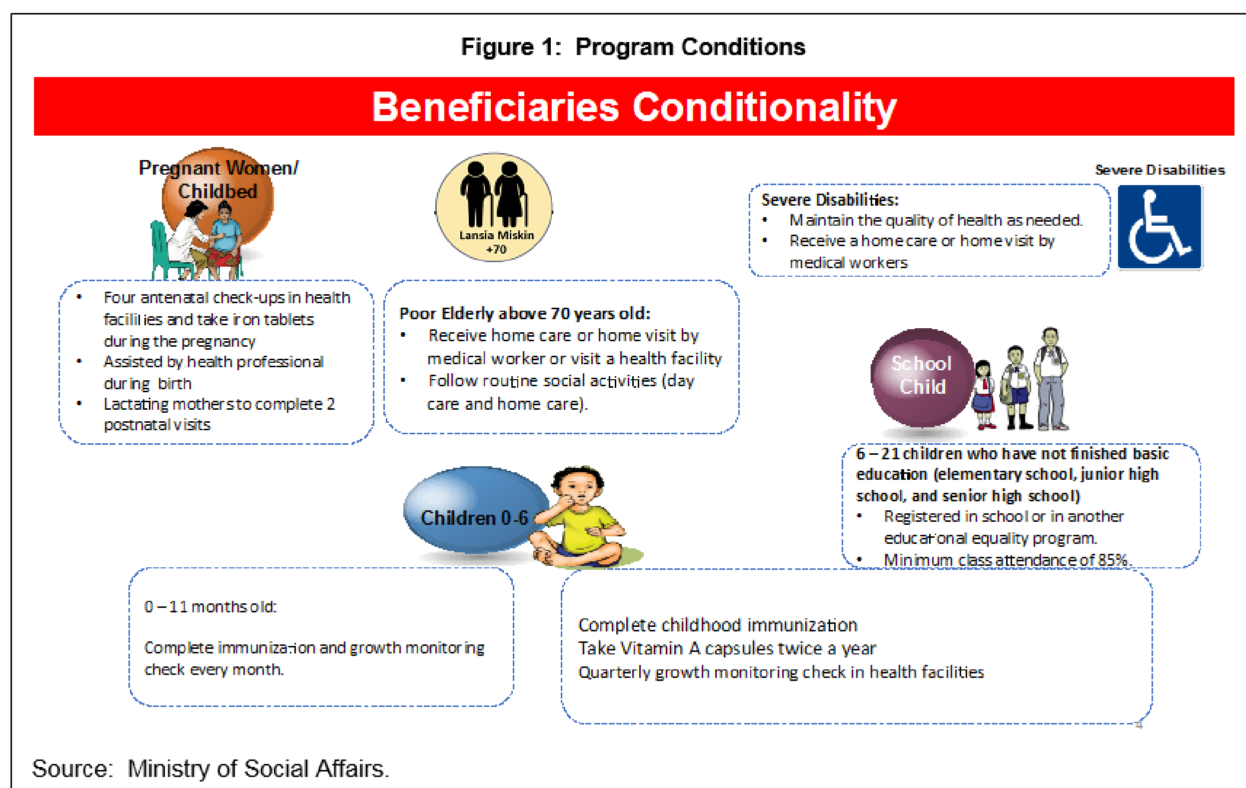
Table 1: Annual Grant Amount (IDR and US$ equivalent)

Beneficiaries	Benefit per household per year	
	IDR	US$
Regular beneficiaries	1,890,000	$140
Elderly, disabled, or in Papua or West Papua	2,000,000	$148

Source: Ministry of Social Affairs.

6. **Conditions.** The PKH conditions for each type of participant are in Figure 1. In addition to complying with these conditions, mothers attend a monthly family development session (FDS). PKH introduced FDS in 2013, first aimed at families who were found to be still poor after 6 years, to give them extra support and help them graduate from the program. FDS is now being expanded to include all PKH families, similar to the CCT program in the Philippines which was has included FDS from the start. The sessions are delivered by PKH facilitators or field staff, to provide group-based training on topics related to early childhood education, parenting, health and nutrition, household finances, small business development, and entrepreneurship.

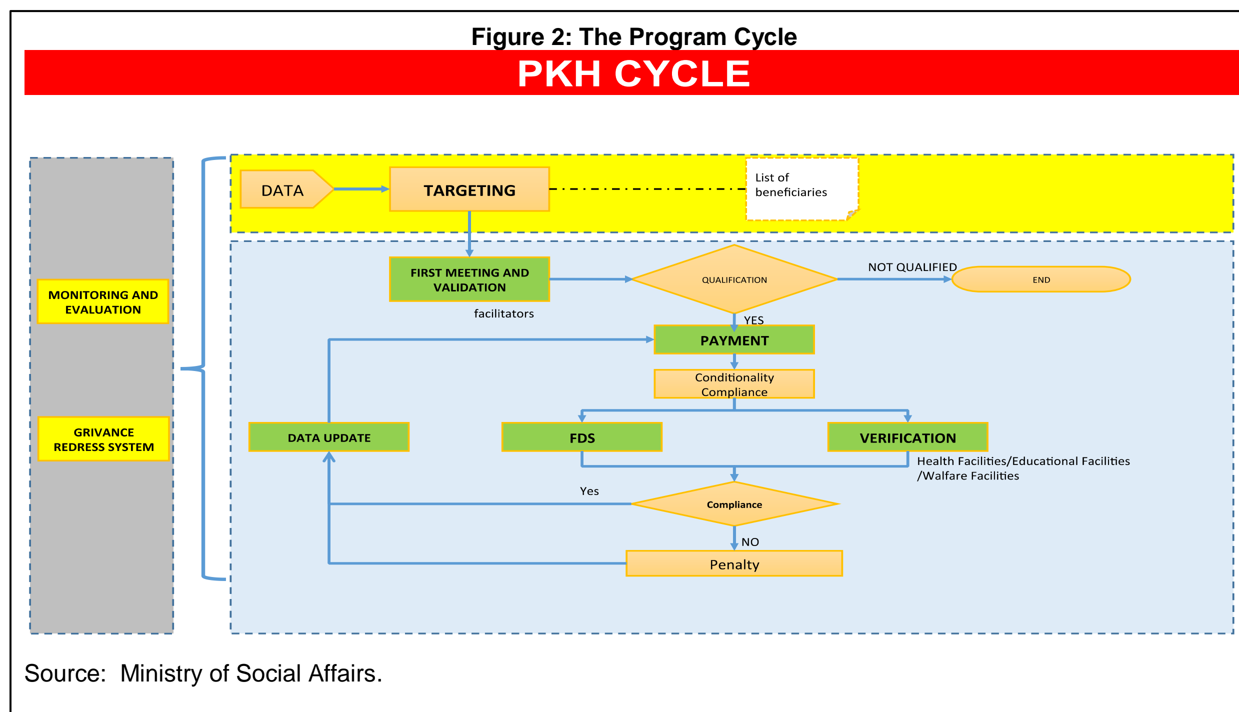
Figure 1: Program Conditions



Source: Ministry of Social Affairs.

7. **Program cycle.** Once the beneficiaries are identified, the list is validated in local meetings and confirmed (Figure 2). Families then start receiving quarterly payments. Household members are expected to comply with the program conditions. Compliance is monitored by field staff and certified by the schools or health facilities in the area. Reports on compliance are submitted to field and central program managers, and the beneficiary information is updated. This is then followed by the next round of payment, compliance, and verification.

Figure 2: The Program Cycle



Source: Ministry of Social Affairs.

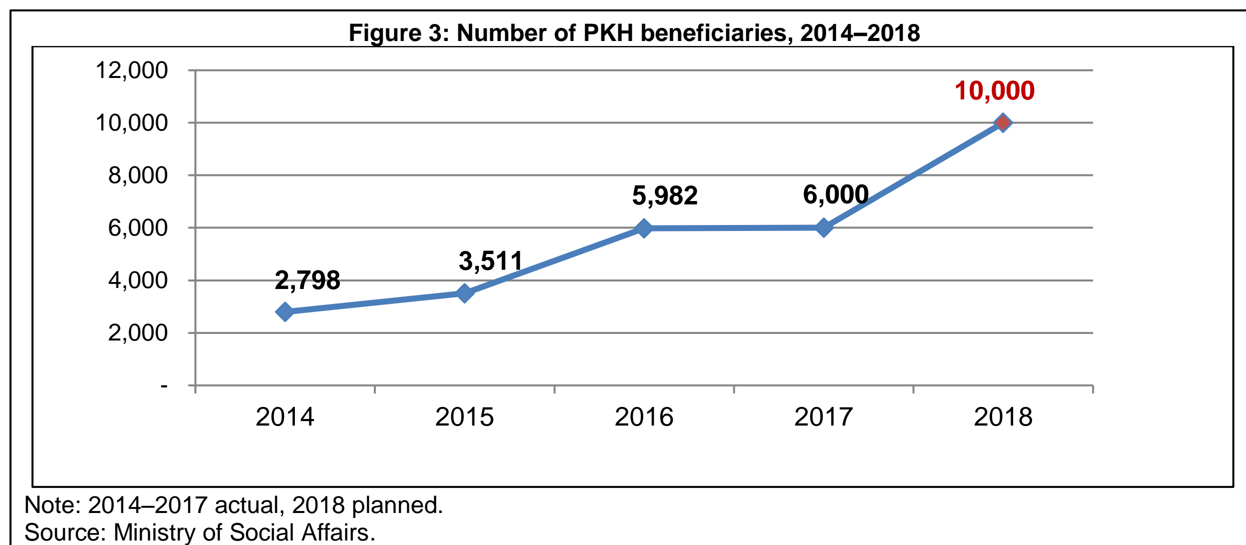
8. **Expansion**. MOSA has expanded PKH significantly since the program was first piloted in 2007 with 500,000 families in seven provinces. The expansion was relatively gradual at first, reaching 20 provinces by 2010. As of 2016, PKH is present in all 34 provinces and 514 districts (Table 2). The number of beneficiaries has seen a dramatic increase since 2014 and is expected to reach 10 million by 2018 (Figure 3). This major increase has staffing implications. To implement the program with 10 million families, MOSA estimates that it will need an additional 16,000 field staff, in addition to the more than 26,000 hired by 2017.

Table 2: PKH Geographic Spread and Staffing, 2007–2016

Year	Provinces	Districts	Sub-districts	Field staff	Coordinators
2007	7	48	337	1,556	2
2008	13	70	637	2,738	7
2009	13	70	781	3,370	11
2010	20	88	946	4,565	18
2011	25	119	1,387	5,446	28
2012	33	169	2,001	7,450	37
2013	33	336	3,417	10,590	54
2014	34	430	4,970	14,068	46
2015	34	472	6,080	16,665	43
2016	34	514	6,435	26,168	57

PKH = Program Keluarga Harapan
Source: Ministry of Social Affairs

Figure 3: Number of PKH beneficiaries, 2014–2018



Note: 2014–2017 actual, 2018 planned.
Source: Ministry of Social Affairs.

9. **Evidence of effectiveness.** PKH works when it reduces poverty and improves health and education outcomes. This is achieved through beneficiaries' improved use of education, health, and social services. The cash increases household consumption and the conditions catalyze behavior change, incentivizing the use of basic services.[1] Consistent with findings from other CCT programs worldwide, several evaluations conclude that the PKH has been effective in reducing poverty and in improving human capital.[2] Impact evaluation results include:

(i) an increase in per capita expenditure by an average of 4.8%, mainly from increases in non-food and education expenditure;
(ii) improvement in pre-natal visits and completion of scheduled immunizations;
(iii) increase in junior secondary net enrollment rate by 7.1%;
(iv) a 7.6% increase in gross participation rate among children aged 13–15;
(v) improved elementary attendance by 6.8%; and
(vi) reduced working hours of children between the ages of 7–15.[3]

10. **Challenges**. The government's ambitious plans to expand coverage of an already very large program is not without challenges. In a 2017 review of Indonesia's social assistance system, the World Bank summarizes four major PKH challenges: (i) unequal coverage, (ii) low benefit levels, (iii) inadequate training and support to field workers, and (iv) limited coordination with health and education service providers.[4] Its recommendations for MOSA include expanding the program while strengthening implementation capacity, revamping information technology systems, improving human resources management and ensuring adequate training of facilitators, and expanding the family development sessions to reach all PKH families. The World Bank also

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[1] Government of Indonesia 2017. *Ministerial Regulation Number 10 of 2017*. Jakarta.

[2] Tim Nasional Percepatan Penaggulangan Kemiskinan (National Team for the Acceleration of Poverty Reduction) and World Bank. 2016. *Evaluating Longer-term Impact of Indonesia's CCT Program: Evidence From A Randomized Control Trial*. Jakarta; Hadna & Kartika. 2017. *Cogent Social Sciences (2017), 3: Evaluation of poverty alleviation policy: Can conditional cash transfers improve the academic performance of poor students in Indonesia?* http://dx.doi.org/10.1080/23311886.2017.1295548; and World Bank. 2011. *Program Keluarga Harapan: Main Findings from the Impact Evaluation of Indonesia's Pilot Household Conditional Cash Transfer Program.* Washington, DC.

[3] A 2009 study by the Indonesia Statistics Office and the International Labor Organization estimated some 1.8 million children involved in child labor. The study can be accessed through: http://www.ilo.org/wcmsp5/groups/public/---asia/---ro-bangkok/---ilo-jakarta/documents/publication/wcms_123585.pdf.

[4] World Bank. 2017. *Toward a Comprehensive, Integrated, and Effective Social Assistance System in Indonesia. Indonesia Social Assistance Public Expenditure Review Update*. Jakarta.

recommends increasing benefit levels and improving information sharing with service providers local governments. Two potential obstacles identified in the study include that the budget to expand the program and strengthen the systems need to be guaranteed, and that better coordination the supply-side agencies (health and education service providers) will require better and more formal coordination mechanisms. MOSA is implementing several reforms to address the challenges confronting the expansion of PKH and its integration with the wider social assistance system (para. 13), but capacity is low and technical assistance (TA) is required.

11. **Toward a common PKH TA framework.** Working with its development partners,[5] MOSA has identified a set of 20 critical technical support focus areas under the following four broad categories (Table 3):

(i) strengthening the PKH delivery system;
(ii) improving access to basic services and complementary programs;
(iii) expanding PKH inclusion and coverage; and
(iv) strengthening the foundation of PKH.

12. Categories (i), (iii), and (iv) broadly correspond to the three direct causes of the core problem in the Asian Development Bank (ADB) problem tree (Supplementary Appendix 2). Category (ii) is much broader in scope. MOSA's development partners have coordinated to establish a lead agency for each technical support area, with others contributing as partners. Under the proposed ADB TA for Building Inclusive Social Assistance, ADB will support five of the focus areas by taking the lead in 3n) PKH-Akses and 4q) communications strategy; and by partnering on 1c) payment systems and on 1g) institutional arrangements, human resources, and training systems—with a focus on FDS training for supervisors and facilitators, which therefore also supports 1i). Table 3 highlights the proposed ADB focus areas in gray.

13. **Other social assistance programs**. PKH is one of several targeted social assistance programs in Indonesia. In 2005, the Indonesian government developed an unconditional cash transfer to minimize the impact of rising fuel prices on the poor. In 2010, an array of social assistance programs was in place for poor families, people with disability, elderly, with cash and rice subsidies or vouchers. Programs included:

(i) unconditional cash transfers under the Bantuan Lansung Tunai (BLT) or Bantuan Lansung Sementera Masyarakat (BLSM), Kartu Keluarga Sejahtera (KKS) or Kartu Simpanan Keluarga Sejahtera (KSKS);
(ii) social assistance for the elderly under the Asistensi Sosial Lanjut Usia Terlantar program (ASLUT);
(iii) social assistance for persons with disabilities (Jaminan Sosial Penyandang Cacat (JSPACA);
(iv) social assistance for children (Program Kesehjateraan Sosial Anak (PKSA);
(v) subsidized rice under the Beras Untuk Rakyat Sejahtera (RASTRA); and
(vi) subsidized social health insurance under the National Health Insurance Program also provides fee waivers for the poor through the JKN-PBI program.

[5] The key partners supporting social assistance in Indonesia are the Department of Foreign Affairs and Trade of Australia, the Deutsche Gesellschaft für Internationale Zusammenarbeit, the World Bank, and the World Food Program. The United Nations Children's Fund has primarily supported early FDS modules.

Table 3. PKH TA Framework

Category	Technical support focus areas	Lead Agency	Partners
1. Strengthening the PKH delivery system *In ADB problem tree:* PKH staff capacity and program delivery systems are weak	a) Business process and operations manual	WB	
	b) PKH MIS	WB	
	c) Conditionality and compliance verification	WB	
	d) Payment systems	WB	ADB
	e) Grievance redress system	WB	
	f) M&E systems	WB	
	g) Error, fraud and corruption	WB	
	h) Institutional arrangements, HR and training systems	WB	ADB GIZ
	i) Beneficiary recertification	DFAT	WB
	j) Family development sessions	WB	ADB UNICEF WFP
2. Improving access to basic services and complementary programs *Beyond the scope of the ADB problem tree.*	k) Coordination and integration of complementary programs	WB	
	l) Legal identity management		WB
	m) Productive inclusion and livelihood support	WB	
3. Expanding PKH inclusion and coverage *In ADB problem tree:* Institutions and mechanisms to reach disadvantaged areas and vulnerable groups are not effective	n) Expansion planning	WB	
	o) PKH Akses	ADB	WB GIZ
4. Strengthening the foundation of PKH *In ADB problem tree:* Communications and advocacy for PKH and other social assistance programs are ad-hoc	p) Legal and regulatory framework for PKH	WB	
	q) Social assistance information systems		WB
	r) Communications strategy	ADB	WB
	s) Social risk management and mitigation	WB	
	t) Fiduciary management	WB	

ADB = Asian Development Bank, DFAT = Department of Foreign Affairs and Trade of Australia, GIZ = Deutsche Gesellschaft für Internationale Zusammenarbeit, MIS = management information system, M&E = monitoring and evaluation, PKH = Program Keluarga Harapan, UNICEF = United Nations Children's Fund, WB = World Bank, WFP = World Food Program.
Source: Ministry of Social Affairs and World Bank.

14. Development partners, under the lead and guidance of MOSA, regularly meet to coordinate with each other and share activities to ensure coherence and avoid duplication.