113149

INDONESIA SOCIAL ASSISTANCE REFORM PROGRAM

Environmental and Social Systems Assessment

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LIST OF ACRONYMS

ASLUT	Asistensi Sosial Lanjut Usia Terlantar / Social Assistance for the Neglected Elderly
BAPPENAS	Badan Perencanaan Nasional / National Planning Agency
BAPPEDA	Badan Perencanaan Daerah / Regional Planning Agency
BPS	Badan Pusat Statistik / Central Bureau of Statistics
BPJS	Badan Penyelenggara Jaminan Sosial / Social Security Provider
BLSM	Bantuan Langsung Sementara Masyarakat / Temporary Unconditional Cash Transfer
BOS	Bantuan Operasional Sekolah / School Operational Assistance
BRI	Bank Rakyat Indonesia / Indonesia's State-Owned Bank
CCT	Conditional Cash Transfer
EFC	Error, Fraud and Corruption
ESSA	Environmental and Social Systems Assessment
FDS	Family Development Session
FKP	Forum Konsultasi Publik / Public Consultation Forum
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit
GoI	Government of Indonesia
GRS	Grievance RedressallSystem
HHs	Households
JAMKESMAS	Jaminan Kesehatan Masyarakat / Health Insurance
JSK	Direktorat Jaminan Sosial Keluarga / Directorate for the Family Social Protection
KKS	Kartu Kesejahteraan Sosial / Social Welfare Card
KK	Kartu Keluarga / Family Card
KTP	Kartu Tanda Penduduk / Civil ID Card
KPS	Kartu Perlindungan Sosial / Social Protection Card
KUBE	Kelompok Usaha Bersama / Micro-Enterprise Group
M&E	Monitoring and Evaluation
MIS	Management Information System
MoSA	Ministry of Social Affairs
NIK	Nomor Induk Kependudukan / Civil Identification Number
NGO	Non-Governmental Organizations
OM	Operational Manual
PBI	Penerima Bantuan Iuran / Recipients of Government Subsidies for Health Insurance
PforR	Program for Results
PIP	Program Indonesia Pintar / Smart Indonesia Program
PKH	Program Keluarga Harapan / Indonesia CCT Program
PMT	Proxy Means Testing
PPLS	Pendataan Program Perlindungan Sosial / Data Collection on Social Protection Program
RASTRA	Beras untuk Rakyat Sejahtera / Rice for Poor Households
RCA	Reality Check Approach
RCT	Randomized Control Trial
RPJMN	Rencana Pembangunan Jangka Menengah Nasional / National Medium-Term Development Plan
SA	Social Assistance

SBM	School Based Management
SD/MI	Sekolah Dasar / Madrasah Ibtidaiyah / Elementary School
SiLPA	Sisa Lebih Pembiayaan Anggaran / Budget Surplus
SJSN	Sistem Jaminan Sosial Nasional / National Social Security System
SMP/MT	Sekolah Menengah Pertama / Madrasah Tsanawiyah / Junior High School
SMA/MA	Sekolah Menengah Atas / Madrasah Aliyah / Senior High School
SOP	Standard Operating Procedure
SUSENAS	Survey Sosial Ekonomi Nasional / National Social Economy Survey
TKPKD	Tim Koordinasi Penanggulangan Kemiskinan Daerah / The Regional Poverty Reduction Coordination Team
TNP2K	Tim Nasional Percepatan Penanggulangan Kemiskinan / The National Team for Acceleration of Poverty Reduction
ToR	Terms of Reference
ToT	Training of Trainers
UDB	Unified Database
UNICEF	The United Nations Children's Fund
UPPKH	Unit Pelaksana Program Keluarga Harapan / PKH Program Management Unit
UPSPK	Unit Penetapan Sasaran untuk Penanggulangan Kemiskinan / National Targeting Unit

EXECUTIVE SUMMARY

1. Program Keluarga Harapan (PKH - a Conditional Cash Transfer for poor households) is envisioned to be the main pillar for the comprehensive social protection system in Indonesia. PKH was rolled out in seven provinces in Indonesia in 2007, initially to cover just under half a million households. By 2015, the program was set to grow six times larger compared to the initial coverage to over 3.5 million households (approximately five percent of the population) to the new target of six million families nationally (approximately ten percent of the population) by the end of 2016. With the expansion, additional 42 districts were added to cover all provinces in Indonesia including Papua and West Papua, with the highest poverty rates in the country but previously not covered. The program is implemented by Ministry of Social Affairs (MoSA) in collaboration with other line ministries at both national and local level.

2. PKH overall is intended to enable recipient households to cope with short-term economic shocks by smoothing out consumption and increasing spending in health and education. Payments are tied to meeting specific requirements in health and education and therefore incentivize household behavior to utilize those services, which is expected to lead to improvement in health and education outcomes over the long-run.

3. There are no infrastructure and other physical activities that are supported and/or financed through the PKH CCT. Therefore, the program will not generate potential environmental impacts that may result in the loss, degradation or conversion of natural habitats, pollution, and/or changes in land or resource use. The program is not expected to induce significant expansion of health and education services that would lead to construction of new facilities.

4. The program supports the demand for services[1], particularly in the areas of health and education and not the supply side, which is not under the purview of the Ministry of Social Affairs (MoSA). The program, however, could have social risks associated with exclusion from the program and low understanding of the aims, scope, processes and procedures of the program due to and weak outreach and socialization, which could foster perceptions of lack of fairness and suspicion particularly amongst households who do not receive PKH.

5. Issues around PKH implementation were approached in the Environmental and Social Systems Assessment (ESSA) by focusing attention to how the poor and marginalized communities are able to access PKH benefits and how risks and impacts are handled under the program. Specifically, the ESSA took into account issues around targeting, gender issues, timing and means of cash transfers, power dynamics at the community level, the role of facilitators, cadres and service providers in terms of access to the program and lastly existing complaint handling mechanisms. The assessment was done both at the national and sub-national levels, covering several districts (Medan, Serang, Lebak and Serdang Bedagai Districts) that have been participating in PKH and also new districts that were recently included for the program expansion.

6. The social risks for PKH CCT are medium. The Program is fostering inclusion by expanding to mostly cover most disadvantaged population groups (e.g., the disabled, indigenous populations). Social risks are mainly associated with the capacity of the program to correctly target poor beneficiaries, engage with communities and make use of appropriate communication channels, roll out a more responsive

[1] In the area of health, PKH's indicators focus on improving mothers' attendance to village health centers (Posyandus), which provides basic health check-ups and counseling by midwives and occasional distribution Fe tablets and supplementary feeding. In the area of education, PKH aims to stimulate school children's attendance and such an intervention.

Grievance Redress System (GRS) and the creation of an enabling environments to help PKH households to utilize cash transfer to improve their overall welfare, health and education outcomes.

Key Findings

7. <u>Eligibility:</u> enforcing stringent conditionalities for households to stay eligible can be challenging in areas where there are serious supply-side issues and therefore, attempts to make conditionalities and verification protocols more contextual become critical to promote social inclusion for communities in under-served areas. PKH eligibility depends on depends on family resources and demographic composition. A household must fall into the category of "poor" or in the bottom 25 percent of poor households as ranked by the Unified Database (UDB). Starting in 2016, new components will be added, including extending PKH CCT to the elderly (70 years and older) within PKH families previously uncovered by any social assistance programs[2] and the severely disabled members. A number of key challenges with regards to the program's eligibility were observed: *First*, although eligibility criteria are clearly defined in the Operational Manual (page 22 – 28) and facilitators were able to articulate the conditionalities relatively well, community beneficiaries on the other hand and even local government officials met during the assessment, indicate a varying degree of understanding of such criteria and conditionalities, including the timeline and graduation scheme for PKH. *Second*, in some remote locations such as small islands, forests, or highland areas, verification of compliance to conditionalities can be very much compromised by the lack of basic services and previous assessments on the supply-side readiness, such constraints often stem from uneven distribution of personnel such as teachers and midwives, rather than the absence of facilities or infrastructure. Issues around supply-side readiness likely magnify as PKH is beginning to include remote, unserved areas and seeking towards greater inclusion of the elderly and people with severe disabilities.

8. <u>Targeting:</u> understanding of improved targeting accuracy is often not shared by local stakeholders, and such issues are often attributed to lack of information and outreach. PKH targeting system has been improved over time. PKH adopted the Unified Database for Social Protection Program (hereafter the UDB), which contains social, economic and demographic information on around 24.7 million households or 96.4 million individuals in the poorest 40 percentiles across Indonesia. The database was updated in 2015 by resurveying the included households and allowing new households to be included for surveying and subsequent welfare ranking. The 2015 UDB is considered more accurate than the 2011 UDB since the PMT methodology used a much larger sample to predict consumption and an expanded set of variables used to predict consumption. To date, the UDB is considered to be the most comprehensive targeting database in the country. However, lack of socialization, **t**he actual targeting process, including PMT, was often sparsely understood by local government officials, facilitators and beneficiaries. Furthermore, complaints from dissatisfied community members could often not be resolved at the local level due to the centralized management of PKH targeting and the lack of a responsive and effective GRS..

9. <u>Program exclusion:</u> lack of legal documentation was acknowledged to be an emerging issue as PKH is moving towards an e-payment system and seeking complementarity with other SA programs where ownership of a NIK (Civil Identification Number) is a technical requirement. Such an issue may disproportionately affect people who are not formally registered and transient populations including nomadic, seafaring, farming communities, temporary and migrant workers. Unregistered individuals may not be formally recognized by their villages or wards as residents and therefore are often not proposed for social assistance programs. Secondly, these individuals might be registered in their original place of residence and therefore may miss out on censuses and surveys. Furthermore, there are limits to capacity of the Central Bureau of Statistics (BPS) to cover communities or groups living in very

[2] Such programs include ASLUT or the old age assistance program

remote areas. Such constraints may potentially get worse in new PKH areas particularly in Eastern Indonesia where access is limited and logistical costs for surveys are high.

10. People who do not have access to the required health and education services may get excluded and this issue needs serious attention as the program aims to expand nationally. Eligible households living in remote areas, including the elderly and people with disabilities, where there are supply-side constraints will likely be disadvantaged under the current CCT scheme as compliance to conditionalities presents a challenge in terms of access and associated opportunity costs.

11. <u>Meeting the needs of the vulnerable</u>: PKH payments often did not come in a timely fashion, especially when the need for cash is greatest such as the new academic year and this presents greater risks for PKH transfers to be absorbed into other household expenses instead of education and health. The assessment indicates that receiving PKH did not seem to correlate with parents' decision to ensure timely tuition payments and decreased child labor, presumably due to late transfers and little amount of transfers received. Financial needs become greater for PKH families as children start entering senior high school or tertiary education since all school related costs such as pocket money, transport, photocopy may triple. There was some hope that there could be some support for tertiary education since university costs tend to represent a major portion of household expenditures overall.

12. <u>Consultation and Access to Information</u>: the Public Consultation Forums (FKPs), held as part of the UDB updating process, are an innovation introduced to strengthen the role and participation of local governments and community representatives in the identification of potential beneficiaries for social assistance programs, including PKH. The FKPs were reportededly conducted without coordination with district and sub-district governments and did not involve as wide a range of stakeholders as they should have. Secondly, there is confusion over the use of FKP since the PKH targeting in 2016 was perceived to inadequately reflect what was previously proposed and there was no official explanation to the large extent of overlaps and unidentifiable names for PKH expansion. Access to information was considered lacking across levels, and this is often attributed to the widespread lack of awareness and misunderstanding particularly on the issues of targeting, beneficiary selection, and requirements for PKH enrollment. In all districts visited, available resources, both from the national and sub-national governments, were largely inadequate to produce socialization materials and disseminate program information.

13. <u>Grievance Redress System (GRS)</u>: The existing GRS has functioned only weakly and should be strengthened to raise the program's accountability, transparency, dissatisfaction and perceived unfairness exclusion from the program. Currently, there is no decentralized grievance redress mechanism that the district and provincial governments can use to manage grievances or inform complainants about the status of their complaints. Theoretically, PKH households and community members can submit their complaints to facilitators who are responsible to record complaints received by filling standardized forms and relay the complaints to related departments in MoSA for further resolution. In addition, the current system does not provide space for the communities to voice their complaints in an anonymous manner.

14.

15. <u>Positive social impacts</u>: Two Randomized Control Trials (RCT) indicated that the program has positive impacts on the usage of primary health care services and education services. Impacts on education behaviors are particularly greater amongst those already attending school than those who are not. Anecdotal evidence shows that the likelihood for PKH students to continue to secondary education is higher than those non-PKH students. However, such correlation tends to diminish once PKH students graduate high school, presumably because of the associated high costs for tertiary education, the absence of payment components for university students and other factors such as wanting to work or perceptions

of having enough education. Receiving PKH did not seem to correlate with parents' decision to ensure timely tuition payments and decreased child labor, presumably due to late transfers and little amount of transfers received. Since PKH transfers are most likely absorbed into other households' expenses not necessarily associated with health and education, the fact that PKH payments often did not coincide with the academic school year may present some risks with regards to the use of transfers. Similarly, little correlation was observed with enrollment in the program and the likelihood and number of hours students work after school.

16. <u>Negative Social Impacts:</u> Some tension stemming from beneficiary selection and verification was reported. Such tension often involves: (a) those who were receiving PKH and those who were not, (b) those considered being well-off but still receiving PKH and other community members, (c) community members and government staff or facilitators, (d) village leaders and dissatisfied community members, (e) village leaders and government staff or facilitators. The tension could be attributed to lack of understanding of selection processes, inconsistent responses received and no complaint resolution. Some complaints with regards to payment deductions due to lack of compliance were also reported, and this again often stems from lack of understanding of entitlements, conditionalities and sanctions.

Key Action Plan

15. There are several measures that should be considered to strengthen the program's risk management and to promote social inclusion as summarized below:

a. Develop and test out a standardized GRS system including:
   - Putting dedicated staff and defining roles and responsibilities across levels (central versus sub-national implementation) with regards to grievance handling;
   - Socializing and providing training on the new GRS including allocating dedicated resources for communication and outreach;
   - Incorporating GRS indicators into the MIS

b. Develop a communication strategy for the central and local government levels to ensure that the following aspects are in place (i) dedicated staff/communication specialists (ii) resource allocation, (iii) related training, outreach and capacity building activities. As part of this strategy, it is critical to incorporate materials on cross-cultural communication and awareness and risk management (including GRS, communication strategy) into training modules for PKH facilitators;

c. Assess and adapt PKH procedures, conditionalities, and verification protocols for areas with implementation challenges (i.e. difficult access, supply-side constraints, etc.) to increase share of PKH beneficiaries in underserved areas;

d. Redefine and streamline the roles of facilitators and performance management system with emphasis on social work and facilitation responsibilities. Sub action plans under this also include:
   - Develop measures to protect personal safety including providing health insurance (BPJS), increasing oversight, SOPs for facilitators particularly for PKH operations in conflict areas;
   - Assign a team of social specialists within existing structure to monitor and oversee social risks and impacts. This will be reviewed in year 1 of implementation to see adequacy.

The proposed ESSA actions related to social management have been incorporated into the Program's overall design and their implementation is fully embedded in the organizational structure of the Directorate for the Family Social Protection (JSK). Proposed ESSA action plans # 1 and 2 on the development of the program's GRS and communication and outreach strategy fall under the Result Area 1 on strengthening the program delivery system to improve efficiency, transparency and accountability.

The GRS action plan is the DLI #3. The proposed ESSA action plan # 3 on review of implementation modalities in areas with supply-side constraints has been included in the Program Action Plan # 4 and the review is currently on-going under the leadership of the Sub-directorate of Beneficiaries of MoSA. The proposed ESSA action plan # 4 has been included in the Program Action Plan # 5 and 10 on HR review and assignment of social specialists to manage potential risks and impacts respectively.

I. INTRODUCTION

A. BACKGROUND OF THE PROGRAM

17. The Government of Indonesia (GoI) has started to introduce comprehensive social assistance (SA) since 2005 programs as a result of the creation of fiscal savings following the phasing out of regressive fuel subsidies. Between 2010 and 2015, several SA reforms were introduced. One of the key reform areas include establishment of standardized procedures for targeting and identifying potential beneficiaries, drawing on a new national registry of nearly 26 million poor and vulnerable households (The Unified Database, UDB). Several major SA programs were introduced and some were expanded, including: (i) a temporary, emergency, unconditional cash transfer targeted to poor and vulnerable households (BLSM); (ii) a social protection card (KKS), a replacement of the existing KPS card sent to 15.5 million households by 2014, giving beneficiaries access to multiple programs, (iii) benefit and coverage increases for Indonesia's scholarship for the poor program (PIP), targeting 18 million students, the conditional cash transfer (CCT) program (*Program Keluarga Harapan*, PKH), targeting 6 million families by late 2016, the national health insurance for the poor scheme (PBI/JKN), targeting 92 million poor and vulnerable people, and the rice subsidy scheme for the poor (*Rastra*), targeting 15.5 million households. [3] PIP and PBI/JKN are programs outside of MoSA's control but agreements exist to use the same targeting data as MoSA and to coordinate on the targeting of beneficiaries, with PKH being one of the priorities as they are the poorest target group contained within all of the programs.

18. In alignment with Indonesia's National Medium-Term Development Plan (RPJMN, 2015 – 2019), the GoI has recognized the need to improve the social protection system comprehensively and support special programs for the poor by improving targeting accuracy. Despite the increased allocation, these SA programs reach only portions of all intended beneficiaries and are highly fragmented both internally and the rest of the social safety net system. The RPJMN policy direction discusses the need to: (i) integrate several family based social assistance schemes for poor and vulnerable families that have children, disabled and elderly within the CCT and/or through in-kind assistance to support nutrition; (ii) transform the rice subsidy for the poor in a phased way so that it becomes a more nutrition focused program; and (iii) structure temporary social assistance at the central and local level by raising coordination and sharing of authority between ministries/institutions that implement temporary social assistance.

19. Program Keluarga Harapan (PKH), first launched in 2007 as a Conditional Cash Transfer (CCT) for poor households is envisioned to be the main pillar for the comprehensive social protection system in the country. The program is implemented by Ministry of Social Affairs (MoSA) in collaboration with other line ministries at both national and local level. PKH overall is intended to enable recipient households to cope with short-term economic shocks by smoothing out consumption and increasing spending in health and education. Payments are tied to meeting specific requirements in health and education and therefore incentivize household behavior to utilize those services, which is expected to lead to improvement in health and education outcomes over the long-run.

20. PKH was rolled out in seven provinces in Indonesia, initially to cover just under half a million households in 2007. By 2015, the program had grown six times larger compared to the initial coverage to over 3.5 million households (approximately five percent of the population) to the new target of six million families nationally (approximately ten percent of the population) by the end of 2016 at a

[3] For more information on these programs, see World Bank Social Assistance Expenditure Review (SAPER) 2017 (forthcoming) or World Bank SAPER 2012.

planned budget of IDR 11 trillion[4]. With the expansion, additional 42 districts were added to cover all provinces in Indonesia including Papua and West Papua, with the highest poverty rates in the country but previously not covered.

21. Depending on budget availability, the long-term goal is to expand the program to reduce exclusion errors[5] especially amongst poor families with children or people living in highly marginalized and remote regions such as indigenous populations. Coverage is expected to reach the level between 20 and 30 percent of the population, similar to the levels in Mexico, Brazil and the Philippines.

22. The proposed Program for Results (PforR) operation is to further strengthen PKH as a national platform for social assistance through which an array of social assistance programs can be synergized and strategically targeted to the most deserving recipients. The PforR operation focuses on three priority areas including supporting coverage expansion, strengthening delivery system, and improving coordination with other complementary social programs. The long-term objective of PKH is to encourage better access to health and education services and to alleviate short and long term poverty. Poverty currently stands at 10.7%[6] of the total population or 27.7 million people with the target being a reduction to 7-8% in 2019. PKH is also set to generate a long term impact on reducing inequality; Indonesia has seen a rise in the Gini coefficient from 0.32 in 1999 to 0.41 in 2012, one of the fastest in the East Asia region.

B. SCOPE OF THE ESSA

23. There are no infrastructure and other physical activities that are supported and/or financed through the PKH CCT and therefore it is not expected the program will generate potential environmental impacts that may result in the loss, degradation or conversion of natural habitats, pollution, and/or changes in land or resource use. The program only supports the demand for services[7], particularly in the areas of health and education and not the supply side, which is not under the purview of the Ministry of Social Affairs. The program will not demand nor provide incentives to broader GoI's supported programs to expand health and education services facilities. The program, however, could have social risks associated with exclusion from the program and low understanding of the aims, scope, processes and procedures of the program due to and weak outreach and socialization, which could foster perceptions of unfairness and suspicion particularly amongst households who do not receive PKH. Under such considerations, the assessment has placed an emphasis on:

a. Whether there is equitable access to PKH;
b. Whether the program is meeting the needs of poor and marginalized groups, including the disabled, women and children, the elderly, or minority ethnic groups and whether special measures are installed to promote their participation in and access to PKH benefits;

[4] SA spending has kept its upward trend to reach 0.7% of GDP in 2015 following the phasing out of fuel subsidies. However,, PKH remains the smallest of the national, permanent social assistance transfers, for instance compared to Rice for the Poor (Rastra) which has an expenditure share approximately 2.5 times as large as PKH's in 2016 but is estimated to be far more effective at reducing inequality and poverty. Overall aggregate spending for SA still remains too low to contribute to poverty reduction compared to the world average is 1.6% of GDP. In 2012, less than one quarter of total expenditures in the four permanent SA programs went to poor households while SA benefits eliminated only 16 percent of the poverty gap.

[5] In 2012, less than one quarter of total expenditures in the four permanent SA programs went to poor households while SA benefits eliminated only 16 percent of the poverty gap. In 2014, PKH coverage is much higher in the poorest decile of households, but there are a significant number of households with PKH in in the second, third, and fourth deciles. There are also some households in the richest 60 percent who receive PKH transfers World Bank (2016), source "Social Assistance Public Expenditure Review".

[6] Based on BPS data in September 2015, rural poverty represents around 62 percent of total poverty in Indonesia or 17.89 million people

[7] In the area of health, PKH's indicators focus on improving mothers' attendance to village health centers (Posyandus), which provides basic health check-ups and counseling by midwives and occasional distribution Fe tablets and supplementary feeding. In the area of education, PKH aims to stimulate school children's attendance and such an intervention.

c. Whether the program provides an adequate space for community consultations and feedback, including grievances and;
d. Whether the program has capacity to manage conflict/social tension risks, particularly stemming from distributional equity and cultural sensitiveness.

The first three points (a,b, and c) will be addressed in Chapter III on Assessment of the Program's System and the last point (d) will be addressed in Chapter IV on Program Capacity and Performance.

24. Specifically, the assessment took into account MoSA's current capacity and authority to manage potential risks associated with PKH as well as issues around targeting, gender issues, timing and means of cash transfers, the role of facilitators and service providers in terms of access to the program and lastly existing complaint handling mechanisms. The assessment was done both at the national and sub-national levels, covering several districts that have been participating in PKH and also new districts that were recently included for the program expansion. The districts visited include Medan and Serdang Bedagai Districts in North Sumatera and Serang and Lebak Districts in West Java. The assessment also draws on key findings from public consultation results in Tual Municipality of Maluku Province and Kepulauan Seribu of DKI Jakarta and the GIZ's scoping study, covering nine districts[8] in Papua and West Papua which were selected based on accessibility and the existence of similar programs.

25. Findings of the ESSA are factored into the overall integrated risk assessment and program action plan which will be revisited at the appraisal stage to inform the Bank Management decision making. A list of proposed action items is presented in Chapter V Section C and have been consulted with a broad range of stakeholders for further inputs (see Annex 2).

C. APPROACH OF THE ESSA

26. The assessment builds on earlier work conducted assessing the operation and performance of PKH, including previous impact assessments, studies, and consultation minutes. A series of field trips were completed by the assessment team to meet and learn from a range of stakeholders, including the local government representatives, PKH beneficiaries, facilitators and service providers. The assessment team visited four districts that were intentionally selected based on several criteria including: (a) the size of beneficiaries, (b) geographical characteristics including urban, peri-urban and remote areas, and (c) new and existing PKH areas. The locations for the field visits were jointly selected with the MoSA and the World Bank teams. In each of the districts and municipalities visited, the team used a combination of approaches, including focus group discussions (FGDs), in-depth informal interviews, and casual conversations particularly with community members.

D. CONSULTATIONS FOR THE ESSA

27. Public consultations for the draft ESSA were conducted at both national and sub-national levels. The consultations were jointly prepared by the MoSA and the World Bank. The national ESSA public consultation was hosted by MoSA in Jakarta on March 15th, 2016. The consultation involved a broad range of participants from relevant government agencies, academics, research organizations and NGOs. Two locations with supply side constraints were selected for sub-national consultations, including Tual Municipality in Maluku Province and Kepulauan Seribu District in DKI Jakarta, with the latter being a new expansion area. Both locations are characterized as: island geography, extreme remoteness for some islands combined with lack of basic services, and high transportation costs. The selection of the locations took into account the following factors to assess social aspects of PKH, including: accessibility

[8] Raja Ampat, Nabire, Kaimana, Dogiyai, Deiyai, Paniai, Tolikara, Jayawijaya and Pegunungan Bintang.

for PKH to operate effectively, conflict potentials, and availability of basic services for the program to be sustainable. Further details of the consultations and relevant points raised are documented in Annex 2 of this document.

II. PROGRAM DESCRIPTION

A. THE LEGAL FRAMEWORK FOR PKH CCT

28. The Constitution of 1945 establishes the rights of Indonesian citizens to quality education and health services. The constitutional amendment in 2000, following the ouster of the Suharto Regime and the Asian Financial Crisis, reaffirmed the rights for all citizens to education and medical care. The 2003 legislation obligated the nation to provide education for all children between 7 to 15 years of age. Cash transfer for the poor is envisioned as an instrument for social security and poverty alleviation (Article 34, points 1 and 4). However, there are still a number of gaps to realize such visions.

29. Currently, the legal basis for the PKH is unclear to ensure that the poor receive needed assistance and coordinated action across district governments to support the program to take place in a sustained manner. Operationalization of poverty reduction programs including PKH are regulated mostly by presidential decrees, which need to be upgraded into laws as mandated by the Constitution. The umbrella laws No.11/2009[9] on Social Welfare and Law 13/2011 on Managing and Overseeing the Poor only provide general principles for social assistance. Related presidential decrees to operationalize social assistance programs have often been historically issued due to urgent situations, such as phasing out of fuel subsidies and political promises and therefore, policies related to social assistance are still scattered. There are also possibilities for overlaps with other legislations, such as the National Social Security System (SJSN) No 40/2004[10]. As a result, the implementation of social assistance programs including PKH tends to be temporary and budget allocation may fluctuate depending on the GoI's fiscal priorities. This may present risks as PKH is expanding since there is no multi-year budgeting for SA programs.

30. Regulations to protect the poor are still partial and fragmented. The Law No. 13/2011 on Managing and Overseeing the Poor is intended to integrate various laws related to poverty reduction, including social assistance. However, one of the provisions in this regulation stipulates that all regulations on poverty reduction are still valid as long as they do not contradict with the law. Therefore, this law fails to serve as an overarching framework to promote integration and harmonization of regulations and procedures. The issuance of the Presidential Regulation No. 13/2009 on Poverty Reduction Coordination[11] was driven by the need to improve coordination and synchronization between line ministries and institutions with regards to the implementation of poverty reduction programs both at the national and sub-national levels. Following the issuance of the Presidential Regulation No. 15/2000 on Poverty Reduction Acceleration, the National Team for Acceleration of Poverty Reduction (TNP2K) was established under the Vice-President's Office to support coordination functions across social assistance programs.

31. Poverty alleviation as envisioned by PKH is contingent upon the availability of basic health and education services and complementarity with other SA programs which falls under the purview of sub-national governments. The legal framework for coordination is based on the Regulation

[9] This Law repealed the Law No.6/1974 con the Main Provisions of Social Welfare.
[10] The SJSN Law regulates the national social security programs consisting of protection to health, work accident, old-age savings, pension and death benefit, which are mandatory for all Indonesian citizens, including foreign workers who have been working for minimum 6 months in Indonesia.
[11] This law repealed the Presidential Regulation No. 54/2005 on Coordinating Team for Poverty Reduction

No. 42 of 2010 on the Acceleration of Poverty which defines the roles of the Regional Poverty Reduction Coordination Team (TKPKD) in coordinating strategies and programs to reduce poverty. In a letter signed by the Director General of Social Security and Protection of MoSA No. 260/LIS/12/2013, local governments were requested to contribute to the operational budget of the PKH at five percent of the total transfer value received by PKH beneficiaries. However, local governments' commitments to ensuring supply-side readiness both health and education and support PKH management varies across regions. This is presumably because the PKH was designed as a national program that is coordinated vertically and is not meant to be integrated into local administrative systems, either at the provincial level or district levels.

32. The management of the targeting system, the Unified Data Base (UDB), for SA programs is gradually being transferred to MoSA. The UDB drawing on a new national registry of nearly 26 million poor and vulnerable households, has been adopted by major social assistance programs since 2012. In order to fulfill its legal mandate, MoSA is currently undertaking technology and human resource upgrading to be able to manage the UDB, which is currently hosted in TNP2K. The database will be fully transferred to MoSA once its capacity has been strengthened and will eventually be transformed into a dynamic social registry information system for SA programs.

33. Although MoSA has the legal mandate to manage the overall implementation of PKH, the lack of a higher level policy framework to define coordination and implementation responsibilities with sub-national governments may limit PKH's impacts to alleviate poverty and manage associated risks in a timely manner. Such a lack of clarity affects local governments' buy-in and ownership of PKH. In addition, management issues and complaints related to PKH, particularly with regards to beneficiary selection, could not be resolved in a timely manner at the local level due to the centralized program management.

34. In the case of DKI Jakarta, the national legal framework for PKH is sometimes not synced with sub-national legal framework. There was a reported legal barrier to support PKH complementarity with other SA programs. The issuance of DKI Jakarta Governor Regulation 174 on Smart Jakarta Card (Scholarship for Poor Students/KJP) has outlawed recipients of KJP to receive other social assistance programs. This has often been interpreted by local service providers that KJP beneficiaries are not eligible for PKH and vice versa. There were also reports that schools instructed PKH beneficiaries to choose whether they wish to be enrolled in PKH or KJP and disbursement of KJP benefits have been delayed particularly amongst PKH beneficiaries.

35. In conclusion, inadequacy within the overall legal framework for social assistance particularly around annual budget allocation, provisions of basic services, and beneficiary inclusion in the UDB are beyond the control of MoSA and the proposed program. Since most issues are around social inclusion and social risks (described in Chapter 3), strengthening the current business process and quality of PKH delivery to ensure proper targeting, inclusive facilitation services, access to information and grievance handling are critical to support PKH to meet its development objectives.

Table 1: Analysis of PKH's Legal Framework

Key Elements	Analysis
Social protection for the poor	Indonesia's decentralization reforms placed responsibilities for planning, providing and financing local education and health services on the district governments, thus leaving the central government with less influence over the size and orientation of district-level spending for social service provision. Since the role of the central government over the provision of general social spending waned, social security and social assistance have been identified as avenues to achieve pro-poor central government spending.

	The Law No.11/2009 on Social Welfare, further strengthened by the Presidential Instruction No.3/2010 on Socially Just Development Program and Law the No. 13/2011 on Managing and Overseeing the Poor stipulate that the governments both at the national and sub-national levels are responsible to protect the poor and guarantee their access to basic needs through provisions of social security, social rehabilitation, and community empowerment[12]. In the context of decentralized social service provisions, the legal basis for PKH as a Conditional Cash Transfer Program is not clear to ensure that PKH beneficiaries receive needed services to stay eligible. Access to health and education services falls under the purview of sub-national governments where MoSA has no control. Currently, coordination with sub-national governments is only regulated by a letter from the Directorate General of Social Security and Protection of MoSA MoSA No. 260/LIS/12/2013, requesting cost-sharing contributions from sub-national governments pegged at five percent of the PKH total transfer for each district. However, there were reports that the level of contributions varies across districts. The success of the PKH CCT program depends on ensuring that public service providers are able to respond to increased usage. With the recent expansion, the PKH program may face roadblocks during its implementation process until all agencies have improved coordination and can reliably deliver the right amount of assistance when it is needed. In addition, PKH's MIS system also requires inter-agency coordination and a common understanding of the system's role in sustaining the program.
Social Inclusion for the poor and marginalized groups and Indigenous Peoples (IPs)	One of the key objectives in the national development plan (RPJMN), published in the Presidential Decree No.2/2015 is to integrate family-based social assistance schemes through PKH. One of the key priorities is to perfect the PKH CCT by improving targeting accuracy and complementarity with other SA programs to ensure that the poorest of the poor could access SA programs and receive needed assistance. The PKH expansion is set to increase coverage and therefore, covers more poor people compared to the previous allocation. The current expansion also aims to target people with severe disabilities and the elderly. The assessment did not identify discriminatory legal provisions against certain groups or communities provided that households meet eligibility criteria (see table 2). Under these circumstances, challenges for social inclusion often stem from technical and capacity constraints to target the poor and provide access to needed services rather than the absence of legal frameworks. As described in Chapter 3 on Assessment of the Program's System, targeting

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

	is based on the Unified Database (UDB) where data collection (e.g. household surveys) and updates are carried out by the Central Bureau of Statistics (BPS), an independent agency from MoSA. In this case, reforms introduced into PKH, including the piloting of an on-demand approach where eligible households can apply to be registered in the UDB, may be constrained by the amount of resources and time required to update the UDB (which currently occurs on a somehow ad-hoc arrangement every three years, depending on budget availability). In addition, lack of legal documentation could prevent households and/or individuals to access SA programs. Although PKH does not require NIK (Civil Identification Numbers), the issue of legal documentation or the lack thereof could disproportionately affect households and/or individuals who are not formally registered or recognized (e.g. transient communities, Indigenous Peoples (IPs), immigrants, etc.) as the program is seeking complementarity with other family-based SA programs.
Outreach and access to information	Based on Law No. 14 year 2008 regarding Transparency of Public Information, every Public Information is open and accessible by every User of Public Information. An exception to the Public Information is information that is restrictive and limited. Every Public Information Applicant shall be able to obtain Public Information fast and promptly at low cost and in a simple manner. Line ministries may use electronic and non-electronic media as facilities to disseminate the information. However, it is not clear whether line Ministries should provide the information actively, or passively (only on demand basis). There is no monitoring and evaluation from Ministry of Information whether line Ministries follows the law and regulation on transparency of public information. Socialization and advertising activities were delegated to the Ministry of Communication and Information (Kemenkominfo). There were reports that the program socialization for PKH was lacking in content, frequency and intensity. Some local governments (LGs) made a complaint on availability of PKH information, since the LGs need to provide budget sharing to the program as well as some questions raised by poor families who did not get PKH. It is also noted that PKH posters are limited to local government offices. Lack of socialization and access to information was reportedly to have caused misperceptions and lack of awareness about the program overall across levels. The proposed Program for Results (PforR) is to support PKH's communication and socialization strategies and grievance redress mechanisms (GRMs) which constitute important elements for the management of risks under the program.
Protection of beneficiaries' confidentiality	The Central Information Commission Decision no. 187/v/KIP.PS.MA/2012[13] stipulates that disaggregated UDB information is classified as not public (Law No. 14 of 2008 on Public Information), since the database contains:

[13] Ratified during the Open General Assembly on March 2013

	• The residential address and socio economic status of family members; • The health, physical health and psychological status of individuals; • Individuals' financial information, including assets and income; • Other personal information related to individuals' formal and non-formal education. According to the article 15, par. 1 of the Government Regulation no.82/2012, the management of UDB must ensure that the use of the data is with the consent of the owner and data containing names and addresses are only issued to government agencies (national and sub-national) that manage social assistance programs. Government agencies that use the UDB data must ensure and be responsible to maintain the integrity and confidentiality of the database.
Free, Prior, and Informed Consultations	Provisions for free, prior and informed consultations are not specified in PKH's business process due to the nature of beneficiary selection. PKH utilizes Proxy Means Testing (PMT) exercise on the UDB to select eligible beneficiaries which is carried out by a targeting management unit in MoSA. Provisions for consultations were generally accommodated through the Public Consultation Forums (FKPs) as part of the UDB updating process. The FKPs introduce mechanisms to strengthen the role and participation of community representatives in the identification of potential beneficiaries for inclusion in the UDB. Further details are outlined in Chapter 3 on Assessment of the Program System.

B. THE SCOPE OF THE PROGRAM

36. The Program Development Objective (PDO) is to enhance the results of the PKH CCT program by supporting coverage expansion, strengthening delivery system, and improving coordination with other complementary social programs. The progress towards achieving the PDO will be measured through five key results indicators: (i) total number of PKH beneficiary families, (ii) share of PKH beneficiary families receiving PKH payments via cashless methods; (iii) share of complaints redressed within three months; (iv) share of PKH beneficiary families receiving main complementary programs (Rastra, PBI, and PIP); (v) share of PKH beneficiary families' compliance of their conditionality verified and recorded in PKH MIS;

37. The PforR's boundary is the MoSA's PKH CCT Program and the proposed PforR supports three areas that complement the Government's program priorities:

a) **Results Area 1: Strengthening the program delivery system to improve efficiency, transparency, and accountability.** This results area aims to address a number of gaps and inadequacies in the building blocks of PKH delivery system to ensure smooth expansion and enhance the program results. Program activities cover business process simplification, information management system upgrading, electronic payment modalities rollout, GRS implementation, M&E system strengthening, communication strategy development, HR management, and error, fraud, and corruption (EFC) detection and control mechanisms development. While most of these activities are not completely new, many previous efforts were clearly made under different policy and operation environments than those existing today. Therefore, the existing mechanisms and tools are inadequate to support the

administration's current needs. For example, the existing PMIS was not designed to manage multiple millions of beneficiary families and its performance, capability, and reliability have become so inadequate that many administration tasks cannot be carried out effectively. A comprehensive gap analysis is much needed to develop an action plan in reference of the minimum required protocols and standards of data integrity, security, and operational soundness. Also to build in-house capacity to manage the systems and system development, an industry-standard IT system audit is planned to ensure that the upgraded PMIS continues to be assessed and improved accordingly. The PforR will build on the experience accumulated from the inception of PKH and learn from the good practices of other social programs both inside and outside of Indonesia.

b) **Results Area 2: Improving access to basic social services and complementary SA programs by the CCT beneficiaries.** PKH beneficiary families need to have better access to other social services that are complementary to the cash benefit provided with regard to achieving human development potential. This results area will facilitate the enrollment of PKH families into the Rastra, PBI, and PIP programs, as well as the access to other services. Furthermore, it will strengthen both the content and delivery modality of FDSs to be more effective in reducing malnutrition, particularly through knowledge and behavior change related to good feeding and hygiene practices.

c) **Results Area 3: Expanding coverage and improving inclusivity of the CCT program.** The expansion of PKH has taken advantage of both the updated UDB and a vetting process involving verification and validation with local governments. The program has expanded in December 2016 to reach 6,000,000 beneficiary families, including 42 new districts, with which the program will achieve the coverage of all districts for the first time. More importantly, the majority of the new districts are in Papua and West Papua provinces, which suffer from high poverty but have been underserved by PKH and other public services. This results area aims to support the coverage expansion, particularly to the underserved areas in the Papua region and less connected subdistricts in other regions. As PKH is the most effective SA program with regard to poverty and inequality reduction in the short run and will also contribute to beneficiary families' capability and productivity in the long run, it will be expanded further, particularly after its delivery system is strengthened.

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

39. It is estimated that the PforR financing will represent 3.7 percent of the total PKH budget over the period of Fiscal Years 2017 and 2020. This calculation is made under the assumption that benefit levels remain the same as in 2017, and calculating a constant ratio of 11 percent for administrative costs.

Table 2: Program Financing, FY2017-FY2020 ($ Million)

Source	Amount	% of Total

Government	5228	96.3
IBRD/IDA	200	3.7
Total Program Financing	**5428**	**100.0**

C. DISBURSEMENT LINKED INDICATORS AND VERIFICATION PROTOCOLS

40. The Bank will disburse funds for $200 million over four years through nine disbursement-linked indicators (DLIs) for the Program. These are identified in Annex 3, along with the Program's results monitoring framework provided in Annex 2. The three main criteria for selecting these DLIs are that: (a) the desired results are within control of the implementing agency MoSA; (b) the DLIs are achievable in the program period; and (c) the DLIs are verifiable. The DLIs are designed combining both scalability (financing proportional to the progress towards achievement) and floating (disbursements made when they are met) features.

41. The Program will triangulate DLIs evidence from multiple sources. An Independent Verification Agency (IVA) will verify all DLI evidence submitted by MoSA[14]. Verification data will be drawn from, amongst others, the PMIS module, and random sample surveys. In addition, external sources of verification include, but will not be limited to: operational reviews (spot checks and process evaluations) and payment service provider's validation reports. Calendar year for verification will be from January 1 to December 31 each year. The verification protocols are provided in Annex 3.

Table 3: PforR Results Chain

Results Area 1: Strengthening the program delivery system to improve efficiency, transparency, and accountability			
Assess, design, and develop PKH PMIS architecture	***PKH PMIS Enhancement Plan implemented***	Upgraded/integrated PMIS deployed to support operation	Improved efficiency of Program implementation
Review and re-engineer PKH business processes	PKH Operation Manuals revamped	***Increase in the share of PKH families' conditionality verified and recorded in PKH PMIS****	
Develop a rollout strategy to transition toward cashless payments	Decisions on cashless modalities made and implemented	***Increase in PKH recipients paid through cashless methods**** (**PDO Indicator i**)	
Assess, design, and develop an M&E system	Improved operational M&E system implemented	Improved evidence-based management decisions	Improved transparency of Program implementation
Assess, design, and pilot a GRS system	***Implementation of an enhanced GRS after evaluation of pilot***	Complaints recorded and redressed within one month	

[14] Several IVA options have been explored, including the Financial and Development Supervisory Agency (BPKP).

Develop a communication strategy for the central and local government levels	Improved communication strategy implemented	Increase awareness among stakeholders	
Assess and revamp HR development and management plan, including redefinition of roles and responsibilities of internal units	HR competency and performance monitoring system developed and roles for internal units defined	HR competency enhanced and coordination among units improved	Improved accountability of Program implementation
Develop systems for EFC detection and control	EFC systems implemented	EFC managed properly	
Results Area 2: Improving access to basic social services and complementary SA programs by the CCT beneficiaries			
Identify PKH beneficiaries eligible but excluded for other basic social services (Rastra, PBI, KUBE, and PIP)	***Increase in PKH beneficiaries whose ID numbers have been verified ****	***Increase in PKH beneficiary families receiving other SA programs (Rastra, PBI, and PIP) **** (**PDO Indicator ii**)	Improved access for PKH beneficiary families to social protection programs
Development of an FDS implementation strategy and training of PKH facilitators to implement FDSs	***Number of PKH mother groups that have received FDSs from trained facilitators ****	Increase in use of education services for PKH families (**PDO Indicator iii**)	Improved educational outcomes of PKH beneficiary children
Review and revise health and nutrition module of FDSs and delivery modality		Increase in use of health and nutrition services for PKH families (**PDO Indicator iv**)	Improved nutrition status of PKH beneficiaries, particularly children
Results Area 3: Expanding coverage and improving inclusivity of the CCT program			
Prepare the potential new beneficiaries list using the most recent targeting data	New eligible beneficiaries informed, validated, and registered	***Total number of PKH beneficiary families**** (**PDO Indicator v**)	Progressive expansion of coverage until 2020 based on policy targets, including previously excluded geographical areas
Assess and adapt PKH parameters and procedures for areas with implementation challenges	Share of PKH beneficiaries in previously underserved provinces	***Ratio of number of PKH beneficiary families to number of the targeted families in Papua and other areas categorized by MoSA as remote areas ****	Increased consumption among PKH beneficiaries
Identify existing PKH beneficiaries eligible for disabled/elderly benefits	Adjusting identified PKH beneficiaries to add disabled/elderly benefits	Eligible PKH beneficiaries receive disabled/elderly benefits	

Note: Proposed DLIs are bold and in italic. * indicates scalable DLI.

D. INSTITUTIONAL ARRANGEMENT

42. The Program is implemented by MoSA in collaboration with other line ministries at both national and local levels. The policy decision body is the National Coordination Team consisting of

Echelon 1 level (Directorate General) officers from the following line ministries/agencies including MoSA, Health, Education and Culture, Finance, Planning and Development (Bappenas), Religious Affairs, Communication and Information Technology, Home Affairs, Manpower and Transmigration, Under-developed Regions, Women's Empowerment and Child Protection and Central Bureau of Statistics (BPS). The policies are operationalized by a Technical Coordination Team consisting of Director level officers from those ministries/agencies. There is an equivalent PKH Technical Coordination Team at provincial, district/city, and sub-district levels and these local teams are responsible for implementation coordination.

43. The institutional arrangements for PKH program involve three layers, which all are important for achieving the desired results of PKH program. *First*, as MoSA, with technical support from central UPPKH (management unit) is responsible for planning, setting operation rules, and managing overall implementation. *Second*, there are a large number of sub-national implementation teams involved in carrying out various tasks. Lastly, inter-sectoral coordination at both central and local levels, usually hosted in district and provincial planning departments (BAPPEDA). At each sub-national level, a local UPPKH consisting of contracted personnel carries out virtually all the program implementation functions, while formally being supervised by the Social Affairs Department (*Dinas Sosial*) of each sub-national government.

44. Since its inception, thousands of PKH facilitators have been mobilized to carry out myriad of core and supporting functions. Such functions range from conducting socialization, advocacy, running initial meetings and eligible beneficiary validation, assisting beneficiaries in withdrawing cash, updating, verifying and entering data, organizing and leading FDS, handling complaints and case management, recording and reporting beneficiaries' compliance to conditionalities, reporting on payment reconciliation, distributing PKH cards to participants, preparing weekly activity reports. PKH facilitators are recruited nation-wide through a competitive selection. The ratio of facilitators to PKH families is usually 1:200-250, but this ratio is lower for islands or areas that are difficult to reach. These facilitators carry out the day-to-day responsibilities in order to ensure that the program is implemented on the ground.

III. ASSESSMENT OF THE PROGRAM'S SYSTEM

45. This section will further elaborate the first three aspects of the assessment: (a) whether there is equitable access to PKH; (b) whether the program is meeting the needs of vulnerable and marginalized groups; and (c) whether the program provides an adequate space for community consultations and feedback.

A. EQUITY OF ACCESS

a) Eligibility

46. Eligibility depends on family resources and demographic composition. A household must fall into the category of "poor" or in the bottom 25 percent of poor households as ranked by the Unified Database (UDB). This is the result from an adjustment of the previous eligibility bracket which only covered the "very poor" percentile or the bottom 10 percent to allow inclusion of more eligible households in the face of expansion beyond six million coverage. For the health and education components, households must meet at least one of the following criteria to be considered eligible:

i. A household member who is pregnant or lactating;

ii. One or more children under 6 years of age;
iii. Children from 6 to 21 years of age attending primary or middle school;
iv. Children aged 16 and older to that have not yet completed basic and secondary education[15];
v. A household member with severe disabilities[16];
vi. An elderly household member aged 70 years above[17];

47. Starting in 2016, new components were added, including extending PKH CCT to the elderly (70 years and older) within PKH families previously uncovered by any social assistance programs[18] and the severely disabled members.[19] The current proposals suggest to include conditionalities for these groups. However, in the seventh version of the Operational Manual (OM), the conditionalities for the disabled and elderly were not clearly specified, including types, frequency and compliance criteria. Since these target groups likely face greater difficulties in accessing health services, particularly those living in underserved areas, clarifying conditionalities and sanctions will be critical. It is also currently not clear from the manual that non-compliance would lead to sanctions or whether conditionalities for these beneficiary groups will be monitored. The design of the conditions and implementation rules for the new components is still under development and is targeted to be rolled out in 2017.

Table 4. PKH Eligibility and Conditions

Eligibility Criteria	Conditions to PKH Payments
Pregnant or lactating	- Complete four antenatal care visits and take iron tablets during pregnancy; - Be assisted by a trained professional during the birth; - Lactating mothers must complete two post-natal care visits;
children aged 0-6 years	- Ensure that the children have complete childhood immunization and take Vitamin A capsules twice a year; - Take children for growth monitoring check-ups (monthly for infants 0-11 months, and quarterly for children 1-6 years).
children aged 6 - 21 years	- Enroll their children in primary school and ensure attendance at least 85% of school days; - Enroll junior secondary school children and ensure attendance at least 85% of school days;
children aged 16 - 21 years with incomplete education	- Enroll their children in an education program to complete 9 years of basic education.

Source: adapted from World Bank (2012) and MoSA (2015)

48. PKH beneficiaries would receive PKH transfers for six years provided that they comply with conditionalities. Additional three years can be granted and complemented by other livelihood support programs, including KUBE-PKH and FDS, if upon recertification, beneficiaries are still determined to be poor after six years of receiving the program. However, crosschecking this PKH beneficiaries in one of the districts that has received PKH since 2008, the "graduation" scheme in PKH is not widely understood by beneficiaries and it is often presumed that there was no time limit to PKH provided that their children are still attending school and therefore were unprepared for the graduation.

[15] As per-the current OM, coverage includes high school students and disabled children who attend *Sekolah Luar Biasa*, a school for disabled children, will also become eligible to receive PKH
[16] The current OM currently define severe disabilities as physical, mental, intellectual or sensory disabilities which prevent people from being self-reliant or mobile, therefore requiring assistance from other immediate family members.
[17] The elderly member will be eligible under the following criteria: (1) reach the age requirement of 70 years as per 1 January; (2) the elderly above 70 years who serve as carers of PKH families
[18] Such programs include ASLUT or the old age assistance program
[19] The 2011 PPLS data show that there are approximately 130.572 children with disabilities from poor families, however this figure may underestimate the overall projection since the BPS data in 2007 indicate that there are around 8.3 million children with disabilities (or 10% of total children population).

49. Although eligibility criteria are clearly defined in the Operational Manual (page 22 – 28) and facilitators were able to articulate the conditionalities relatively well, community beneficiaries on the other hand and even local government officials met during the assessment, indicate a varying degree of understanding of such criteria and conditionalities. Common perceptions of such criteria include either having school children, being pregnant, or having a baby whereas the newly introduced components of disabilities and the elderly were as of yet unknown. Facilitators reported that PKH beneficiaries were often confused about the different amounts of cash transfers received and were often not clear about why there were deductions made due to not fulfilling program criteria, how such deductions were made and calculated and also why others who were perceived ineligible or being richer still get payments.

Assessment Note 1:

The unexpected passing of an elementary school teacher in one of the remote islands in the east coast of North Sumatra unfortunately had long-lasting effects on the entire community there. Superstitions began to develop that the island was cursed and people would die if they moved there. The remaining teachers who were previously serving in the only elementary school on the island began to leave and the school was eventually left abandoned. A Christian priest took over and started to run the school on his own for two years until he was assigned to another parish in 2010. On the island, there were 24 PKH families with school children who eventually become ineligible after a series of failed attempts to provide alternative schooling for the community. Efforts to find local people with sufficient teaching skills came to a dead-end after the district government eventually ruled out and decided to relocate local residents to the main island.

(Source: story from a regional Coordinator, who used to be assigned as a facilitator in the District of Central Tapanuli)

50. Since PKH entitlements are tied to conditionalities associated with meeting certain health and education indicators, the availability of services becomes critical for PKH households in order for them to be verified against required indicators and therefore, continue to be eligible. However, in some remote locations such as small islands, forests, or highland areas, verification of compliance to conditionalities can be very much compromised by the lack of basic services and previous assessments on the supply-side readiness, such constraints often stem from uneven distribution of personnel such as teachers and midwives, rather than the absence of facilities or infrastructure (see **Assessment Note 1**).

51. A national study commissioned by the Ministry of Education and Culture indicates that there is still a persisting challenge to reduce teacher absenteeism, with one in ten teachers found to be absent from school when they were scheduled to be teaching[20]. In an earlier study Papua and West-Papua (UNICEF 2012), absenteeism rates were reported to be much higher with one in three teachers being absent during school hours, and such absenteeism was even worse in the highland districts with only one in two teachers being reported to be present. Common reasons identified include attending official teaching-related duties, late arrival, and rotation for days off, which tend to be more of a permanent status in remote districts. Other factors also include education levels, weak School Based Management (SBM), poor living conditions, and lack of incentives. Across Indonesia, schools in more remote and rural areas or smaller schools show a higher level of teacher

"Our parents are always angry when we go home early. But we tell them that we go home early because there is no teacher at school."

(Elementary Student in Papua, UNICEF 2012)

[20] Indonesia has achieved a significant milestone over the past decade to reduce the absence of teachers from school from 19 percent based on a survey conducted in 2003 across a national sample of schools to 9.8 percent in the same schools in 2014.

absenteeism. In the case of Papua and West-Papua, the rates of teacher absenteeism have a linear correlation with the proportion of out-of-school school-aged children, where almost half of primary school-aged children are not enrolled in school in the highland districts of both provinces.

52. Health conditionalities for children aged two to seven years place unnecessary burdens for PKH beneficiaries and service providers. The current design of PKH requires beneficiaries to weigh children aged 2 to 7 years every month. International evidence shows that the 'window of opportunity' for nutrition is from birth to two years of age. Monthly growth monitoring after that age is unlikely to yield in significant growth differentials. Furthermore, such conditionalities tend to place additional strain on the supply side (health facilities), facilitators who need to monitor compliance and the beneficiaries who may suffer from time and resource constraints. Simplifying health conditionalities likely resonates well in areas with supply-side constraints, such as Eastern Indonesia.

53. Enforcing stringent conditionalities can be challenging in areas where there are serious supply-side issues and therefore, attempts to make conditionalities and verification protocols more contextual become critical to promote social inclusion for communities in under-served areas. Once PKH has been expanded nation-wide, introducing flexibility in conditionalities and verification protocols by factoring in local contexts becomes critical to ensure that the poor and marginalized groups have adequate and continued access to PKH benefits. However, this may suggest that the overall goal of PKH in terms of health and education attainment can be potentially compromised. In addition, tailoring conditionalities and verification protocols on the basis of supply-side readiness may stretch the already strained PKH management and resources.

b) <u>Targeting</u>

54. The key challenge to target SA programs to the poor is correctly identifying eligible households without reliable income data since many of the poor work in the informal sector and most likely do not possess variable income records. Under these circumstances, using unreliable information to identify eligible households could result in exclusion and inclusion errors in that funds being channeled to richer households, thus reducing resources for the program's intended beneficiaries.

55. PKH adopted the Unified Database for Social Protection Program (hereafter the UDB) in 2012, which used to be centrally operated by the National Targeting Unit (*Unit Penetapan Sasaran Untuk Penanggulangan Kemiskinan* – UPSPK) in TNP2K and the management of the UDB is currently being transferred to MoSA following the PKH expansion. The 2012 UDB is an improvement over previous targeting systems where different databases were used to identify potential participants across a range of social assistance programs where exclusion errors were reported high. The UDB is an electronic data system containing social, economic and demographic information on around 24.7 million households or 96.4 million individuals in the poorest 40 percentiles across Indonesia[21]. Households' welfare status was ranked using the variables of household welfare obtained during PPLS (Data Collection for Social Protection Programs) Survey 2011 conducted by the Central Bureau of Statistics (BPS) and using proxy means testing (PMT) models to determine the relative poverty of households for each district/municipality. The PMT models predicted households' income by collecting simple information about the assets they own and were tailored to each district and municipality to accommodate variable differences (TNP2K 2015). The consumption index generated by the PMT models

[21] The database was built from data collected from the updated Data Collection for Social Protection Programs (also known as PPLS (*Pendataan Program Perlindungan Sosial*) carried out by BPS in 2011. The efforts were coordinated by the National Team for Acceleration of Poverty Reduction (TNP2K) under the Vice-President's Office. The process tapped into the momentum from the 2010 census which comprehensively updated Indonesia's national population data as baseline. A number of improvements were made in the methodology including consultations with members of other poor households, impromptu conversations and general observations during the process of collecting data. The UDB came into effect in March 2012.

was used as the basis to rank households based on their welfare status[22]. To date, the UDB is considered to be the most comprehensive targeting database in the country.

56. In principle, the aggregated and disaggregated UDB data[23] can be accessed by a variety of institutions for poverty reduction planning and targeting purposes upon request. The UDB has been mainly used to identify beneficiaries of the largest national social protection programs such as health insurance (BPJS), scholarships (BSM, now PIP), conditional cash transfers (PKH), and subsidized rice (Raskin, now Rastra). Local governments have also demonstrated a strong interest in the use of UDB to support the implementation of local poverty programs, with more than 500 district and provincial government institutions being reported to have used the data (Bah et al, 2015, p.26). The UDB is intended to assist government institutions to have streamlined poverty reduction efforts and improve complementarity of SA programs, which have historically been overlapping and also save some resources which would otherwise be diverted to beneficiary identification, targeting and selection.

Assessment Note 2:
An evaluation of the UDB suggests that local government officers were hesitant to use the UDB because they were not sufficiently informed how the database was established and how poverty deciles were determined. The proxy means testing (PMT) method was not clearly understood and/or sufficiently socialized and therefore could not explain the data sources and how rankings were made to local communities *(Bah et al, 2015, p.26)*

57. The 2011 UDB was updated in 2015 by resurveying the included households and allowing new households to be included for surveying and subsequent welfare ranking[24]. The new poor or vulnerable were added through Public Consultation Forums (FKPs) attended by community leaders and representatives. Through these forums, the 2011 UDB lists were debated by participants to determine ineligible households for social protection programs. These households would still need to be re-surveyed by the BPS and ranked with the new PMT methodology. The 2015 UDB is considered more accurate than the 2011 UDB since the PMT methodology used a much larger sample to predict consumption and an expanded set of variables used to predict consumption.

58. At a national aggregate level, PKH's leakage to non-targeted populations is reported to be minimal, although there are occasions where transfers have been made to the near and non-poor deciles. The World Bank's forthcoming Public Expenditure Review indicates that the share of PKH beneficiaries from the lowest three poorest deciles has risen by approximately 8 percent between 2010 and 2014, thus suggesting growth in coverage and improved targeting accuracy for the poorest households (WB 2016 – forthcoming). The latest SUSENAS (National Socio-Economic) survey indicates that over 70 percent total program beneficiaries are found in the poorest 40 percent of the population[25].

59. The selection of eligible households is done centrally. Following the PKH expansion, the selection of additional 2.5 million households was handled by the JSK team and central UPPKH office in MoSA. The district quotas were determined based on SUSENAS data on the number of poor households minus the number of existing beneficiaries in each district.

[22]The UDB categorized households into deciles which divide households into 10 groups. Decile 1 refers to the 10 percent of the poorest households, Decile 2 refers to households within the 10 – 20 percent poorest and so on.
[23] Aggregated UDB data (without names and addresses) can be used as a reference for various analysis of poverty reduction programs as well as projected budgetary requirements. Disaggregated UDB data (with names and addresses of the individuals and households) can be used as a targeting platform to identify eligible individuals and/or households for social assistance programs. The latter is given to government offices (national and sub-national) managing social protection upon request at no cost.
[24] From June to July 2015, BPS surveyed over 28 million households in 514 districts in Indonesia, aiming to cover the 40 percent of the poorest population in order to update the 2011 UDB records to incorporate new information coming from the field as well as from additional 1.3 million households.
[25] World Bank (2017 forthcoming) Indonesia Social Assistance Expenditure Review Update.

60. However, understanding of improved targeting accuracy is often not shared by local stakeholders, including local and village government officials and community beneficiaries themselves. There were a number of misperceptions around targeting, which remain not clarified. Targeting was often perceived as problematic.

61. The actual targeting process, including PMT, was often sparsely understood by local government officials, facilitators and beneficiaries. Since this database is centrally managed and baseline data were collected by district and provincial BPS offices[26], which sit outside the local government structures and directly report to the President, there is a perceived lack of local government involvement and the actual targeting processes were not fully understood by local stakeholders. Furthermore, existing means of communication were largely ineffective to socialize targeting mechanisms and processes including grievance handling. A boilerplate response such as "selection was made by the Ministry (red-MoSA), so it is beyond our control" was commonly used to respond to complaints from dissatisfied community members who felt they were excluded. However, such a response was often met with skepticism by local communities since local governments, including village governments, were somehow perceived to be involved in beneficiary selection. Perceptions of exclusion errors in the UDB data were often fueled by the general public's complaints particularly in beneficiary selection and such weaknesses were often attributed to TNP2K and BPS.

"The data came from the central (-government), so we can do nothing but be patient"

(PKH female beneficiary, carer to one granddaughter, D2, NS)

"People come to our office every day to complain why they didn't get PKH"

(Head of Social Agency, District 1 NS)

62. In one of the sub-districts visited, there was no additional quota for PKH expansion, however no official explanation was given, thus leaving people with their own speculations that there was something wrong with the system. Additional quota allocation is based on district poverty levels and therefore, a combination of a fall in poverty rates and the number of existing beneficiaries tends to reduce such allocation and there were cases where some districts received zero additional quota. The reasoning behind zero additional quota was also not easy to be accepted since FKPs were also held in these districts where proposed households perceived that they should have received some sort of social assistance, including PKH. Under such circumstances, facilitators were often not certain about such reasoning and therefore were unable to provide convincing answers when there were questions.

63. Following the PKH expansion, there were also local perceptions that there were flaws in the targeting management. In the one of the districts visited in North Sumatera, out of the additional 6,194 new beneficiaries, it was reported that around 800 were already on the previous list and another 800 could not be identified upon data validation. This in total represented more than 25 percent of the new quota, which could not practically be reallocated to other potential beneficiaries since targeting is centrally managed. Social Agency officials in one of the

"In one of the villages I assisted, almost 50 percent of the names already on the previous list appeared again. I don't know why how this happened… "(Facilitator, District 1 NS)

[26] The rationale of central institutional control for the PKH program is to make it less likely that local preferences and administrative capacity affect program outcomes.

districts visited were somehow disgruntled since the unused PKH budget would eventually need to be returned to the State Treasury as a budget surplus (SiLPA), whereas they continue to receive complaints from the communities which they could not resolve. The recent targeting mechanism was considered as inefficient since reallocation could only be made at the central level would take another year to process. The unused quotas were widely considered as a waste of resources.

64. In addition to perceived exclusion issues stemming from misperceptions and lack of awareness, there were reported some technical constraints associated with UDB, which consequently affected local stakeholders' satisfaction with the program's targeting system, including:

- *First*, FKPs represent a major undertaking for BPS, some officers from District Social Agencies reported isolated cases that not all proposed households were surveyed and that village heads complained no FKPs were held under their jurisdictions. In addition, there were also potential risks of elite capture during the FKP processes which need to be further substantiated.
- *Second*, the overlaps and unidentifiable names were reported suspectedly due to technical errors during data processing in MoSA;
- *Third*, data error was also associated with the quality of data collection processes. PPLS data were collected by district and provincial BPS offices through their enumerators. These enumerators were often recruited from community members, and some local government officials in the districts visited suggested that selection of enumerators, capacity building, and oversight should be improved;

65. In addition, improvements in PKH's communication strategy, awareness raising across stakeholder groups and GRS with regards to targeting and selection processes is key to improving transparency as well as management of risks. Investments in effective communication and outreach will release some of the unnecessary burdens shouldered by facilitators and government staff to be able to effectively respond to queries and complaints from dissatisfied community members due to misperceptions around targeting and beneficiary selection. Selection of public campaign media and information dissemination materials should take into account accessibility and frequency of outreach and socialization.

c) Program Exclusion and Inclusion

"I have no registration documents here and was not provided with a transfer letter by the village I left"

(Widow in her 60s with three dependent children, two are grandchildren, and one is orphaned – RCA 2015)

66. Across the bottom 40 percent of poverty deciles in the UDB, the average PKH household may look very much similar to average non-PKH poor households across income and non-income variables. In addition, since micro-level poverty situation often changes rapidly and many households exit and enter poverty year to year, consumption and welfare-related indicators may not necessarily serve as accurate measures of well-being. Since the UDB may only be updated periodically due to the large resources required to conduct updating, capturing such rapid changes is a challenge to be addressed in the coming years. This means that exclusion and inclusion errors will continue to persist as far as PKH coverage cannot reach all the poor. The PKH expansion with a target coverage of 6 million households, including in those Eastern Indonesia where poverty rates are highest, is expected to reduce such errors. However since the program cannot reach the total number of poor in Indonesia, complaints

from communities associated with exclusion issues will still have to be anticipated regardless the expansion of the program.

67. Another challenge facing PKH and any SA programs is the limited quotas available. Even with the best targeting and other beneficiary identification approaches, the program with their current resource level is largely limited in coverage.

68. Although Civil Identification Numbers (NIKs) is not a requirement for PKH enrollment, people without NIKs have a greater chance to miss out on social assistance and this was reported as a persistent problem. This includes people who are not formally registered and transient populations including nomadic, seafaring, farming communities, temporary and migrant workers. Unregistered individuals may not be formally recognized by their villages or wards as residents and therefore are often not proposed for social assistance programs. Secondly, these individuals might be registered in their original place of residence and therefore may miss out on censuses and surveys. Article 15 of the Law No. 23/2006[27] on Population Administration stipulates that any individual who leaves his/her original place of residence must obtain a transfer letter from village heads or authorized officials in order to be registered in his/her new place of residence. Family and/or ID cards could only be amended upon obtaining the transfer letter. This presents challenges for individuals who may not be aware of the procedures or who may perceive that such procedures are cumbersome and entail some cost. In addition, such a provision becomes difficult to be applied for transient populations, such as nomadic, seafaring, farming communities or temporary and migrant workers, and therefore have a higher likelihood of being excluded.

69. PKH's complementarity, however, may be impeded by the lack of documentation since other social assistance programs often require NIKs. The medium and long-term vision for PKH is to enable beneficiaries to have better access to other social services that are complementary to the cash benefits with the hope to support recipient households to move out of poverty and achieve human development potentials. However, various social assistance programs such as JKN-PBI (fee waiver to access Indonesia's public health insurance scheme) or PIP (scholarship for poor students) technically require eligible beneficiaries to have NIKs and/or formally registered in their place of residence and/or schools for the latter.

70. Lack of legal documentation was acknowledged to be an emerging issue as PKH is moving towards an e-payment system. Partner Banks would normally require PKH recipients to have a NIK for them to be able to issue bank account numbers. In the interim, one of the state-owned Banks (BRI) was reported to provide some flexibility by only requiring PKH card numbers in lieu. However, this issue may likely and will continue to set further barriers for PKH beneficiaries as the system is being advanced and linked to other e-platforms.

Assessment Note 3:
Issues around complementarity were reported by one of the village heads met during the assessment. To date there were still many poor households in his jurisdiction not receiving any social assistance programs such as KIP, KIS, KKS and PKH. In a letter he received from one of the directors in the Ministry of Health whom he previously wrote to two years earlier, he and his staff were requested to list and propose these households to the District Social Agency to be then verified and conveyed to MoSA. However, his proposal was returned on the ground that many of these households did not have ID and family cards. In response, he mobilized his staff to process the required documents and eventually managed to get family cards (KK) issued for around 400 households but less for ID cards (KTP) due to logistical issues. Due to the perceived slow response from the District Social Agency and BPS to verify and process his proposal and mounting pressure from his constituents who believed they had been listed, he was planning to send the list of 400 households compiled by his team directly to the Minister of Social Affairs, with the hope for a response.

[27] The Law No. 23/2006 on Population Administration was amended through the Law No. 24/2013.

71. In addition to the issue of not being formally registered as residents, there are limits to BPS' capacity to cover communities or groups living in very remote areas. Such constraints may potentially get worse in new PKH areas particularly in Eastern Indonesia where access is limited and logistical costs for surveys are high. Field data collection for the UDB is administered by district BPS offices through their field enumerators who are hired on a temporary basis. In one of the municipalities visited, these enumerators are responsible to survey on average 200 households within one month of their contract. Such an arrangement may present a logistical challenge in areas where coverage is widespread or mobility is high. In some cases, BPS enumerators were reported to rely on village and/or sub-hamlet heads to provide them with information on the households to be surveyed without physically meeting each household or in some other cases, surveys were conducted by telephone which may not be accessible for people living in areas with poor phone reception. In addition, this "quick" approach could potentially distort data since some variables need to be determined through enumerators' observation, which was originally intended to minimize potential manipulation by respondents in order to have a higher chance for social assistance (Bah, Nazara, Satriawan 2015, p.2).

"It took two years before somebody from Jakarta wrote me back…and the letter says I need to speak to the Social Agency, so I went. But my proposal was returned since many people here don't have KTP and KK… "

(Village Head, District 2, NS)

72. Some technical issues were also reported in a rapid assessment by SMERU (2012) where compliance with the UDB operational guidelines was often weak during fielding exercise. In some cases, enumerators or community leaders often removed households considered non-poor from the pre-lists. In some other cases, consultations with poor households rarely took place[28]. Under these circumstances, if the UDB is the only source used to identify beneficiaries, missing out on surveys or not being registered in the database would imply being excluded from PKH, and other social assistance programs which use UDB for targeting. Some improvements were reported to have taken place during the UDB updating process in 2015, where enumerators could only suggest perceived ineligible households for removal and these households still had to be surveyed before a decision for removal could be made.

73. When it comes to Indigenous Peoples (*Masyarakat Adat*), challenges with regards to targeting are amplified by a number of factors. First, IPs are often located in remote, difficult to access areas not accessible by survey teams. Second, although there has been an increasing number of datasets pertaining to IPs based on variables such as ethnicity, religion and language[29], there were issues with regards to classifications which tend to retain a number of lumpen categories, such as the Dayak and Batak, which the censuses treat as singular ethic groups. In the absence of accurate disaggregate data on IPs, it could be difficult to target programs and services or to understand whether such programs and services have reached these groups.

74. People who do not have access to the required health and education services may get excluded and this issue needs serious attention as the program aims to expand nationally. Eligible households living in remote areas, including the elderly and people with disabilities, where there are supply-side constraints will likely be disadvantaged under the current CCT scheme as compliance to

[28] To ensure adequate coverage and representation, UDB enumerators were required to also survey households that were not on the pre-lists but appeared poor or were recommended to be included by three poorest households on the pre-lists based on consultations with poor households (Bah, Nazara, Satriawan 2015, p.2).

[29] The variables of ethnicity, language and religion were for the first time collected as part of the 2000 population census and again in 2010 (BPS-RI, 2011)

conditionalities presents a challenge in terms of access and associated opportunity costs. Example of such cases are presented in points 26 and 27.

Table 5: Typologies of Exclusion

Categories	Factors of exclusion
People without legal identification	• May have access to PKH but not to other programs such as national health insurance for the poor scheme (Jamkesmas/PBI/JKN) and scholarship for poor students (PIP); • Are characterized as living although not necessarily in remote areas. Young families, or single parent families due to divorce or early marriage may have greater representation under this category; • May not be recognized by local administrations where these groups reside;
Transient populations (e.g. seafarers, border populations, swidden/seasonal farmers, asylum seekers, etc.)	• May not have a legal identity and could be categorized as stateless particularly in border areas; • Are characterized as being highly mobile, and sometimes, not having permanent residence; • Have a higher likelihood for missing out on surveys and therefore are not registered; • May not have access to basic services
Populations in remote areas, including Indigenous Peoples (Adat Communities)	• May not have a legal identity or documentation; • May not a member of a certain administrative jurisdictions where social assistance is usually channeled; • May not have access to basic services or appropriate services which reduces demand; • May be skipped from surveys due to geographical access;
Note: households with overlapping categories face a greater likelihood of exclusion	

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

76. Partnerships with non-governmental organizations (NGOs) and community-based and religious-based organizations to extend the availability of basic services in underserved PKH areas could be considered as a short-term solution with regards to the lack of access to basic health and education services. The GIZ's scoping assessment report indicates that there are a number of

international and local organizations[30] providing services in the areas of health, education and governance in Papua and West-Papua provinces where access to services required by PKH is either limited or not available. With the expansion of PKH in remote and underserved areas, reliance on formal service providers could potentially disadvantage PKH beneficiaries and therefore is not sustainable. Under these circumstances, simplifying and diversifying options for conditionalities and verification requirements, for instance, by allowing conditionalities to be linked with non-formal health and education services such as provided by NGOs and/or CBOs could be an alternative solution to address service gaps. However, to do so effectively, this requires not only stronger multi-stakeholder coordination to improve access and quality of service delivery, but also clarification of the role of local governments to ensure that such coordination takes place and is maintained. In addition, a more robust M&E system to track is critical to ensure tracking of conditionalities, which may need to be tailored based on needs.

B. GENDER

77. No systematic differences were found on access to program benefits by gender. Data from SUSENAS 2014 (Table 6) shows that for primary school enrollment, four percent more male children in PKH families were enrolled than female children. However, for junior secondary school level, 80 percent of females and 75 percent of males were enrolled in 2014. The national rates for non-PKH families were similar with 1 percentage point additional enrollment among males in primary, and 2.5 percentage points more for females in junior secondary. For senior secondary education, males tend to have higher enrollment rates among PKH families, 49 vs. 46 percent (among non-PKH families, the difference in favor of males is 1 percentage points). In terms of immunizations, female under-sixes were receiving full immunization coverage by 5 percentage points more than males in the same age group; at the same time, the difference is almost absent for non-PKH children (64 to 63.5 percent). While no systematic differences are found across gender indicators, there are important differences in outcomes in favor of PKH beneficiaries vs. non-PKH counterparts, suggesting that PKH is making a difference in raising enrollment and health behaviors across gender, as espoused by the programs goals and conditionalities.

Table 6: School enrollment and immunization by gender

Indicator	PKH beneficiaries		Non-PKH beneficiaries	
	Females	Males	Females	Males
Primary School (ages 7-12)	90%	94%	85%	86%
Junior Secondary School (13-15)	80%	75%	78.50%	76%
Senior Secondary School (16-18)	46%	49%	54%	55%
Immunization (0-5)	71%	66%	64%	63.5%

Source: Susenas 2014

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

[30] Some of the NGOs and CBOs working in Papua and Wes Papua include: Kinerja-USAID, Global Fund (Nabire, Dogiyai, Deyiai, and Paniai), The Clinton Foundation (Dogiyai and Deyiai), the Islamic Education Foundation (YAPIS), Catholic School Education Foundation (YPPK) Adventist Education Foundation (YPA), the Injili Kingmi Church Schooling and Educational Foundation (YPPGI),

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

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

i. Tailoring outreach and socialization materials by taking into account literacy levels, prevalent languages/dialects, frequency, timing, etc. to ensure that they are inclusive, accessible, and socially and culturally appropriate;
ii. FDS contents need to accommodate practical lessons, particularly for women across age groups and backgrounds. FDS needs to strengthen its function as mother support groups;
iii. Incorporate more explicit gender perspective and gender equality guidelines in the manual for facilitators;
iv. Strengthen partnership with NGOs, CSOs, and other organizations that have concern on gender issues.

C. MEETING THE NEEDS OF THE VULNERABLE

81. PKH beneficiaries met expressed gratitude for the PKH payments they received and mentioned that they felt assisted in meeting basic needs particularly paying school fees, purchasing school kits, and high-nutrition foods for infants. Not much was reported on the correlation between PKH transfers and health expenditures, presumably because health care has now become increasingly affordable for the poor through the universal health insurance (JKN).

82. Several mothers met during the assessment mentioned that PKH transfers, although useful, often did not come in a timely fashion, especially when the need for cash is greatest such as the months when school tuition fees are due or the beginning of new school enrollment when large amount of cash is often needed to pay registration fees and new school kits. In a private elementary school visited, late PKH payment was acknowledged to affect parents' timeliness in paying their children's tuition fees and consequently, the school often had to offer some flexibility by giving PKH parents some extra time until they receive transfers. However, this was seen as creating another problem since the school relies on fees collected from parents to pay their teachers and supplement their already meager operational costs from BOS (School Operational Assistance)[31]. In some other cases, there were occasions where PKH beneficiaries were reported to sell or use their cards as a loan collateral due to the need for quick cash.

"PKH payments never come on time, we often miss paying our children's tuitions …"

(Mother, PKH Beneficiary D1, NS)

83. Financial needs become greater for PKH families as children start entering senior high school or tertiary education since all school related costs such as pocket money, transport, photocopy may triple. There was some hope that PKH can be extended to tertiary education since university costs could represent a major portion of their current household expenditures overall.

[31] The BOS program provides funding to schools for non-salary operational expenditures. It aims to reduce schools fees as well as supports quality-enhancing spending for all public and private primary and junior secondary schools in Indonesia.

84. Associated costs with regards to PKH payments borne by beneficiaries could act as a disincentive for them to fully engage in the program. There need further assessments with regards to payment cycles and logistical costs for beneficiaries and whether payment schedules need to be bundled or streamlined to reduce costs. E-payment could be considered as an option, however areas that suffer from high transportation costs are usually areas not covered by banking services.

85. MoSA recently launched a new initiative namely Family Development Sessions (FDS)[32], which consist of a series of group learning activities in several thematic areas including economic development, child rearing, health, education, etc. FDS is aimed to equip PKH households with knowledge and needed life skills to improve their welfare and health status, particularly to prepare them at the end of their six-year cycle to graduate from the program. Starting Nov 2014 until Dec 2015, FDS was piloted in three 2007 cohort provinces i.e. DKI Jakarta, West Java and East Java. The pilot involved 122 sub-districts in 33 districts. Since the initiative is still new, the assessment team's understanding whether this program helps address some of the challenges faced by PKH families or whether the program is relevant is still preliminary. However, anecdotal evidence shows that FDS was positively received by PKH mothers, and such acceptance tends to hinge upon the skills of facilitators to deliver and tailor the FDS modules to the needs of PKH households. One PKH mother mentioned that she already felt some positive change in her child rearing behavior after attending several sessions, and she mentioned that she managed to develop more constructive approaches to educate her children.

86. As a new initiative, there are several areas to make FDS more inclusive and responsive to the needs of PKH beneficiaries, which include among others:

- FDS is considered under-resourced since facilitators were not equipped with necessary tool kits to make the sessions more interactive and engaging. There are videos and visuals to be displayed in the training package, however there were no media such as laptop or projector being provided. Facilitators, as a result, had to use their own laptops and FDS participants could only watch the videos and visuals on a small screen. Some facilitators mentioned that they collected some cash to purchase their own projector and used it in turn;
- The training modules were considered too standardized and do not accommodate the diverse needs of FDS participants, for example, health modules for the elderly who become carers for PKH children. The modules often need to be modified by facilitators and require some resources if new materials need to be developed;
- FDS contents need to accommodate practical lessons;
- There is a greater need for strengthening facilitators' facilitation skills to deliver the FDS rather than only understanding of the contents of FDS modules, which eventually often need to be improvised. The FDS Training of Trainers (TOTs) facilitators received prior to the roll-out was considered insufficient to equip them with confidence to deliver FDS effectively, particularly amongst new and young facilitators;
- Specific to areas with high prevalence of HIV/AIDS such as Papua and West-Papua,

"When I found my son sniffing glue, I was really mad and wanted to punish him so bad. I used to call my son "bastard" and any bad words I could think of. However, this didn't seem to work, my son would talk back at me. Only after being told by my facilitator through the FDS [red-how to best handle such behavior], I started to think that perhaps I must soften the way I educate my son. Since then I start to sit with him and talk, and he seemed to understand me better and so do I….

(Mother, PKH Beneficiary D2, NS)

[32] FDS was initially a group-based learning approach introduced in PKH in 2012. Organized by facilitators, a group of mothers and/or grandmothers who live close by would meet to share thoughts and day-to-day problems faced by beneficiaries. MoSA eventually transformed these monthly group-based learning meetings into FDS with structured training modules to equip beneficiary households with life skills.

FDS could be used as an outreach platform for awareness raising and prevention

87. Although livelihood and income support programs such as KUBE-PKH are generally perceived to support recipients to improve their economic status, more work needs to be done to ensure that this initiative becomes more sustainable and inclusive. KUBE-PKH is a livelihood development initiative implemented by MoSA since 1983 to encourage the creation of group-based micro businesses through the provision of seed capital in the form of a onetime grant of IDR 20 million or approximately USD 1500 to groups of seven to ten people from PKH households. In 2015, around 20,000 KUBE-PKH groups were formed and are to receive the KUBE grant. The vision of this program is to encourage eligible beneficiary families to set up sustainable micro-enterprises and eventually graduate from the PKH program. Some groups took the initiative to manage the seed capital as a revolving fund where there is an obligation for members to return the loaned money to the group on an installment arrangement. However, further capacity strengthening and oversight are required to support KUBE-PKH groups to be able to run their business sustainably, particularly business and financial management as well as leadership. KUBE-PKH participants reported that despite an increase in households' income due to KUBE-PKH support, the meager profits they earn are often absorbed into consumable goods and daily expenses, and therefore may threat the health of their businesses. Since, KUBE-PKH is mainly targeted to PKH households who have prior engagement in some sort of business activities, partly as a form of risk control, the majority of PKH households may get excluded from the program and therefore other complementary support will be needed, possibly with different modalities.

88. By 2019, PKH's payment modality is expected to fully transition from cash to digital accounts (i.e. bank accounts, e-money accounts). The assessment indicates that such transition is more of an issue in remote areas than in urban and peri-urban areas where financial infrastructure is more developed. In this case, access points are critical for the delivery of non-cash payments and therefore, further feasibility assessments and testing different models are required before implementing the model at a full-scale. Typical to remote districts, case studies in Papua indicate that access to banking services could be severely restricted and the costs of transport both for PKH beneficiaries and financial services to reach remote areas can be prohibitive. Two key considerations need to be taken into account including, (i) accessibility and associated costs borne by PKH households to reach pay points, (ii) appropriateness of the payment modalities, i.e. use of identifiers (passwords/PIN), requirements for bank account application (e.g. legal identity), etc.

Assessment Note 4

The combination of remoteness and low population density in some isolated areas in Papua and West Papua Provinces often means the lack of affordable transportation available. A boat rental for a one-day roundtrip could costs as much as 17 – 20 million IDR (1300 – 1500 USD). The costs could double or triple to charter a prop plane or helicopter if such areas are not accessible by boat or land transportation.

Source: GIZ Scoping Assessment

D. CONSULTATION AND ACCESS TO INFORMATION

89. The Public Consultation Forums (FKPs) are an innovation introduced to strengthen the role and participation of local governments and community representatives in the identification of potential beneficiaries for social assistance programs, including PKH. Resurveying and the use of FKP were held as part of the UDB updating processes given that the PPLS survey was last conducted in 2011 and therefore circumstances may have changed over time. The updating process aims to ensure that the households listed in the UDB are correctly categorized according to their predicted poverty status. The FKP were led by BPS and consultations were held nation-wide at the village and urban-ward level, involving a wide range of stakeholders, including village governments, community representatives and other interested stakeholders. The purpose of the FKPs was to verify and get community representatives agree on the UDB pre-lists and include new participants who may not be registered in the UDB at the

village levels. The proposed names and agreements on the pre-lists had to be endorsed by district heads and/or mayors, which would then be validated by BPS through a household economic survey for inclusion in the UDB. TNP2K reported that 3,514,488 households, or approximately 14.3 % of the previous PPLS data in 2011 have been added to the UDB (TNP2K 2015).

90. FKPs were received by local stakeholders with a mixed response. The FKPs were reported to suffer from lack of coordination with district and sub-district governments and did not involve a wide range of stakeholders as they should have been. Secondly, there is confusion over the use of FKP since the PKH targeting in 2016 was perceived to inadequately reflect what was previously proposed and there was no official explanation to the large extent of overlaps and unidentifiable names for PKH expansion. In another district in West Kalimantan, BAPPEDA officials reported that not all villages were involved in FKPs, and this was based on reports from several village heads.

Assessment Note 5:
The Regional Coordinator in one of the districts visited took the initiative to print a banner prohibiting extortion and speed-money for PKH-related enrollment and payment processes. She used portion of her salary to have some banners displayed in villages. However, no further funds were available to support this initiative and after a while, these banners became faded and were eventually taken down.

91. Access to information was considered lacking across levels, and this is often attributed to the widespread lack of awareness and misunderstanding particularly on the issues of targeting, beneficiary selection, and requirements for PKH enrollment. People also tend to confuse PKH with other Temporary Unconditional Cash Transfers program (BLSM) and associated conditionalities attached to PKH. Such confusion tends to generate questions, complaints, and suspicion over channeling of PKH funds. When there were questions or complaints, people would refer to district government officials (Social Agency or District Planning Department/*Bappeda*), facilitators, village heads, or service providers for which no clear answers could be provided, and therefore adding to their perceptions of lack of transparency. An earlier study by Reality Check Approach (RCA - a qualitative research firm), indicates that communities often assume there is some corruption and misuse of funds due to confusion of how selection took place and what their entitlements were and had no means and channels to voice their concerns and demand accountability (RCA 2015). In addition, the plethora of social assistance programs both from national and local initiatives and the many changes that have taken place tend to further confuse people.

92. In all districts visited, available resources, both from the national and sub-national governments, were largely inadequate to produce socialization materials and disseminate program information. PKH socialization strategies have suffered from the lack of consistency, partly due to previous institutional arrangements where the Ministry of Communication and Information Technology was responsible to manage PKH socialization and outreach activities, including planning and budgeting. However, due to reportedly lack of sustained coordination across line ministries, such arrangements became ineffective. Furthermore, the five percent cost-sharing by district governments to support socialization and other operational costs is often unevenly and disproportionately allocated for communication and outreach activities. In one of the districts visited, facilitators took the initiative to create information display materials such as sign boards and posters using their own sources, initially to contain constant questions and complaints from people who did not get selected for PKH. However, such initiative did not last due to the absence of support.

93. Strengthening the capacity and knowledge, including access to information, to facilitators and PKH group leaders were considered strategic since PKH beneficiaries often use such communication channels through direct and interpersonal communication with facilitators and

PKH group leaders. Reliance on the facilitators and PKH group leaders (*Ketua Kelompok*) to relay information about the program to PKH beneficiaries and this was perceived effective. However, there was no formal capacity building interventions available for PKH group leaders to strengthen their leadership and communication skills. Exploring innovative communication channels such as social media were also proposed.

94. Targeted strategies for outreach and awareness raising through the adoption of appropriate media and communication channels is key to fostering stakeholders' understanding about the program and in the long run, could prevent potential conflicts that may arise due to misperceptions and misunderstanding about the program. The GIZ's scoping assessment in Papua and West Papua indicates that tailored measures are needed to ensure that program information is accessible to local communities particularly around selection of beneficiaries and eligibility criteria. Use of language, publication materials, selection of facilitators, frequency and timing of socialization need to take into consideration local constraints to absorb, access and accept information. In some circumstances, women may not have the same literacy level as men. In addition, partnership with local organizations and/or community figures who are perceived to have mutual trust with target communities is important to foster local acceptance and legitimacy of the PKH business processes.

IV. PROGRAM CAPACITY AND PERFORMANCE

95. This section summarizes the assessment of the capacity of the relevant institutions to implement the program's social management system and manage risks associated with the program.

A. INSTITUTIONAL ORGANIZATION AND DIVISION OF LABOR

96. Following the program expansion, the PKH program management has undergone reform where the overall program implementation now falls in the purview of the entire JSK Directorate. Prior to the reform, a sub-directorate within JSK oversaw PKH implementation with a lean administrative structure with most of implementation responsibilities being delegated to a consultancy team housed in the PKH program management unit (UPPKH). PKH's integration into MoSA's organic structure presents an opportunity to strengthen the program's institutional sustainability over the long-term. However, since this program is mandated to expand in a relatively short period, such reorganization leads to further complexity of PKH's implementation arrangement, including division of labor and strained the existing JSK's capacity to run the program, including managing potential risks at least in the short-term.

97. Distribution of roles and responsibilities across JSK's internal units, particularly in the day-to-day management of the program is unclear and currently undergoing changes. Under the previous UPPKH structure, PKH management operated with a centralized command structure with three regional coordinators, however in contrast, such a command structure is now divided into four sub-directorates where field staff are required to report to. The relatively rapid expansion to almost double the program within a tight deadline, JSK operated on an ad-hoc arrangement with different task teams being assigned to myriad, not coordinated tasks. In addition, there are also challenges to institutional capacity within JSK since some staff were just recently re-assigned. Under the current structure, there are risks associated with the current institutional arrangement where priorities are diverted to ensuring the achievement of set targets and less efforts are mobilized to oversee and manage potential risks and impacts which are often not anticipated.

98. At the sub-national level, local UPPKHs staffed with contracted personnel are responsible to manage all program implementation functions, and formally supervised by the provincial and district Social Affairs Departments. Facilitators interact directly with PKH households under the supervision of district coordinators. The ratio of facilitators to PKH beneficiaries varies depending on the geographic locations of placement with an average 1:200-250. The ratio is lower for islands or areas that are difficult to reach. However, there were reported issues around facilitator recruitment and retention, particularly in remote, underdeveloped areas. The perceived lack of long-term job stability, the low pay, unclear career paths, and the difficult working environments lead to a relatively serious challenge of high turnover (around 20 percent a year). Under such circumstances, such high turnover could potentially jeopardize the program's overall objectives since mutual trust is key to being able to work effectively with PKH beneficiaries.

B. MANAGEMENT OF RISKS AND IMPACTS

99. The program's monitoring and evaluation (M&E) function to track grievances as well as potential impacts and risks is currently not formally defined. Similar to other key tasks, the M&E team is operating on an ad-hoc arrangement and under the new organizational design, the unit that should be responsible for M&E is not clearly defined. A team of consultants previously assigned in the UPPKH is in charge of managing M&E responsibilities and is currently placed under the Sub-directorate 3 (Beneficiaries)[33]. Such an arrangement presents limitation to the level of independence that the M&E function should assume and potential conflict of interest since Sub-directorate 3 is also implementing parts of the program. Good practice globally is to elevate the M&E function in the hierarchical structure and keep them independent of implementation.

100. PKH facilitators are in the frontline when there are implementation issues and complaints and therefore their roles become very critical in the overall management of risks and impacts. The myriad of other administrative responsibilities that each facilitator is required to perform[34] presents trade-offs in terms of time and resources that should have been mobilized to strengthen their social work responsibilities, including referring PKH households to complementary programs and program socialization, including clarifying misperceptions around the program. Capacity building for facilitators has been mainly focused on program administration and there is an articulated need expressed by facilitators to have additional capacity particularly with regards to communication and facilitation skills, knowledge of social protection programs both at the national and sub-national levels through which linkages with PKH could be strengthened.

101. In some difficult locations where access is remote, there were safety issues reported by facilitators. Facilitators reported that the ratio between the number of facilitators and household beneficiaries is sometimes not in proportion despite ratio differentiation based on geographical characteristics. Some facilitators mentioned that they often need to spend long hours in the field until late at night and there were safety concerns that they believed need a particular measure. These issues are likely more serious in areas with conflict hotspots such as the highland districts of Papua and West-Papua where there is a prolonged history of armed conflicts fueled by heavy militarization to crack down on separatist movement and inter-communal conflicts in the region.

> *"I sometimes feel scared every time I have to travel to that particular school. The road is muddy and rumor has it that there are thugs along the way. I now always asked my husband to accompany me every time I go there…"*
>
> *(Facilitator, D2, NS)*

[33] Sub-directorate 3 (beneficiaries) is responsible to physically locate beneficiaries, verify their compliance to conditionalities, and provide capacity building to beneficiaries through FDS.

[34] An earlier assessment on HRD, there are myriad of responsibilities borne by PKH facilitators starting from preparing for the initial meeting with potential PKH families (including coordinating with local government officials to issue invitation letters, going door-to-door to organize the meeting with families, socializing the PKH program, coordinating with the heads of the families, the village chief, the education and health representatives at the local level, and community leaders to participate in the first meeting), doing cross-checks and filling in validation forms, making enrolment decisions to making payments schedules for districts with the operator and PT Pos, making decisions on excluding beneficiaries from the program for failing to fulfil criteria, being physically present when beneficiaries receive payments at PT Pos in order to physically authenticate their identity, reconciling the benefits transfer amounts received by each PKH family in order to close the payments process, verifying conditionalities compliance through field visits to homes, education and health facilities, updating conditionality monitoring forms and sending them for data entry, and conducting family development sessions for PKH families.This, amongst other issues, are supported by conversations had during two meetings (April and June 2016) with the HR division in the MoSA JSK team as well as an implementation planning exercise conducted during a previous mission.

102. The program currently does not have a systematic risk management plan for operation in conflict areas. Existing conflicts due to political rivalry, tribal tension, and land disputes were reported. Although such conflicts were not reported to have been directly exacerbated due to PKH, existing conflicts have prevented access for facilitators and other service providers from entering the communities in dispute. In addition, the safety of beneficiaries and facilitators could also be at risk when they have to encounter their oppositions or if they were perceived as enemies by people in conflict. There were two casualties involving PKH facilitators in Papua who were killed during tribal wars. Some beneficiaries were reported to have to carry protective weapons when they picked up payment at PT. POS in anticipation of meeting their enemies. Local inventions to avoid clashes such as organizing different payment schedules to avoid direct encounter and strengthening facilitation through KUBE and FDS to improve inter-communal relations were reported. However, this heavily relies on facilitators' communication and facilitation skills and currently, there are no effective mechanisms to flag potential conflicts where inexperienced facilitators could receive additional support.

103. Turnover rates have been low amongst senior facilitators who seem to have found their place in the communities where they have been assigned. Most of these facilitators have started their work since the first roll-out of PKH[35]. However, an inverse trend for the new batches of facilitators was reported particularly in expansion areas where there is a higher level of turnover. Applicants were often not fully informed or aware of the remuneration rate and some of those who were successful turned down the offer upon knowing the amount of salary to be received (on average less than 3 million IDR or USD 230 with an incremental increase of 100,000 IDR or 7.6 USD annually). In addition, there was some misunderstanding that appointment as PKH facilitators would pave the way to a civil servant status, which could act as a demotivator when such expectation fails to materialize.

104. Facilitators[36] are centrally procured by MoSA both during selection and placement and this often results in mismatch of facilitators, procurement delays and lack of local governments' ownership over the management of facilitators. Although placement is based on residential addresses as indicated in ID cards (KTP), there were occasions where facilitators were placed remotely from their usual place of residence and this was reported to affect their attendance level. Such a mismatch was also reported to affect facilitators' performance due to lack of familiarity with local contexts, particularly local languages. Under the centralized management, the roles that the district and provincial governments could play are limited, particularly in the areas of oversight and guidance. The terms of references (ToRs) for recruited facilitators were reported to have been developed without prior consultations with the local governments. This consequently reduced ownership and incentives for collaboration both from the local governments and facilitators' sides. One district official complained that in his view some of the facilitators assigned in his jurisdiction perceived the local governments as only users, instead of owners, which presents challenges to enforce coordination and reporting. Furthermore, centralized facilitator management is also attributed to replacement delays and consequently absence of facilitators.

105. Limited documentation that exists on the implementation of the GRS shows the system should be improved. . The system by design utilizes multiple channels, including in-person reporting, fax, email, phone, or online application developed by the central UPPKH. The current GRS design shows that complaints or issues associated with field implementation will be

Assessment Note 6:
Perceived lack of fairness and nepotism with regards to the distribution of SA benefits were reported to have fueled communal conflicts in some of the districts in Papua and West-Papua where there is a long history of on-going armed conflicts. In the district of Kaimana and Raja Ampat, a demonstration was reported to be staged by disgruntled community members who perceived that distribution of the KKS (Welfare Family Cards – a basic identifier for poor households) was in favor of in-migrants and households from other tribes who were considered to be better off than members of the local tribes. Such conflicts often occur against the backdrop of prolonged tension between local communities and in-migrants.

[35] Medan Municipality is one of the first areas where PKH was introduced in 2008. Serger District received PKH starting in 2013.
[36] North Sumatra Province currently has 1400 facilitators spread across 3 regions.

followed up based on an area approach, by the nearest officer in the UPPKH unit. However, lack of authority and capacity to resolve complaints at the local level has rendered the program's GRS ineffective.

106. Based on a PKH 2016 GRS report, complains received by the central PKH office were categorized in the following way: information and questions (33%), PKH recipient data (28%), Corruption, collusion and nepotism (23%) and payment delivery (18%). Complementing this with anecdotes from the field visits conducted for the ESSA, the majority of complaints in the first category center around why some families are not included in the program and how they can become members of the program[37]. The report also indicates key challenges with regards to the GRS implementation, such as delayed responses, lack of integration with the MIS, and lack of information and awareness of the available avenues and channels for complaint resolution amongst PKH beneficiaries.

107. There is no functioning grievance redress mechanism that the district and provincial governments can use to manage grievances or inform complainants about the status of their complaints. Theoretically, PKH households and community members can submit their complaints to facilitators who were responsible to record complaints received by filling standardized forms and relay the complaints to related departments in MoSA for further resolution. An operational manual for grievance reporting and redress is available, however, was reported not operational. In addition, the current system does not provide a space for the communities to voice their complaints in an anonymous manner.

"It is not our place to ask as we are not educated…"

(SA Beneficiary RCA household, SL)

108. However, there were cases reported where people are not comfortable or have the courage to complain. RCA (2015, p. 36) findings indicate some people may refrain from asking questions about social assistance due to concern of being perceived as poor or needy, or fear of being perceived as entering somebody else's authority. This suggests that GRS indicators alone may not be sufficient to inform issues around program implementation and further efforts to identify risks, potentially through M&E functions, need to be made.

109. Under the current management, which is highly centralized, local governments have a limited capacity to resolve complaints at the local level. Complaints are only recorded in the District/Provincial Social Agencies and no follow-up actions can be effectively mobilized. Such a lack of authority is perceived problematic because community protests and discontent are often targeted at local governments (Social Agencies in most cases and occasionally, the Planning Department/Bappeda). Such complaints were often left stalled the local governments seem reluctant to take full responsibility or be held accountable for programs where they have limited involvement. There was a report that the Social Agency office in the District of Tolikara was burned down by angry protesters who perceived that the distribution of social assistance was unfair and only favored certain groups.

110. In light of PKH's recent expansion where increasing complaints should be anticipated, a better functioning GRS is critical to maintain the legitimacy and social trust of the program. The following possible suggestions can apply to the GRS:

- The extent to which the GRS can be optimally utilized and respond to complaints effectively is contingent upon various factors. In addition to the availability of resources and local capacity to manage the system, greater clarity over what can be resolved at the local level by district and provincial governments is important. Since most complaints reported stem from exclusion

[37] The MoSA 2016 PKH GRS record in 2016

issues, there is a strong need for a review of the targeting mechanism and strategies to ensure that district proposals of new beneficiaries can be accommodated in a timely manner;
- Agreed SOPs for GRS need to be developed in consultations with local governments;
- Selection of means for GRS should take into account accessibility and opportunity costs for complainants to file complaints (i.e. simplified procedures, confidentiality, no repercussion, etc.) and;
- Socialization of the program's GRS should be done in a manner that is iterative and continuous, instead of one off events and adequate resources should be allocated to information dissemination.

C. COORDINATION WITH SUB-NATIONAL GOVERNMENTS

111. Stronger coordination with local government is critical to strengthen the program oversight functions and for PKH beneficiaries to have adequate access to the needed basic health and services. MoSA has formally called for collaboration and support from sub-national governments to strengthen PKH implementation through a letter from the Directorate General of Social Security and Protection. The letter requested cost-sharing contributions from sub-national governments pegged at five percent of the PKH total transfer for each district. However, perceived lack of involvement in PKH management by the local governments and clarity over their roles and responsibilities were reported to affect their level of ownership and amount of contributions. Although comprehensive statistics is currently not available, the level of sub-national governments' contributions to PKH is uneven. Furthermore, given the often reported lack of ownership and dedicated government staff to support PKH implementation, reliance on consultancy teams at local UPPKH offices will likely continue.

112. Lack of clarity over responsibilities, authority for decision making and ownership amongst sub-national governments undermine the effectiveness of local-level GRS that the current design aims to strengthen. This suggests that clarifying the roles of local governments, including delegation of authority is a precondition for the functioning of the GRS to be able to resolve complaints at the local level. However, such tasks likely require a long process of political negotiations to mature. In the short-term, it is important to streamline GRS coordination and equip the current local UPPKH staff with the capacity and authority to be able to address grievances locally.

113. There is also lack of understanding and awareness of the PKH across various local institutional stakeholders, likely due to ineffective communication and information sharing. Misperceptions about the program's objectives and modalities were reported to be prevalent amongst staff from local health, education and social affair departments, as well as service providers. During the assessment, there was some level of skepticism about the benefits of PKH and the program is often perceived to unintentionally create complacency and poorly target the most deserving households. This suggests that strengthening coordination often involves strategies to improve socialization and consultation processes across local stakeholder groups who are directly responsible for the functioning of health and education services.

114. It is difficult to ascertain how active the national-level coordinating bodies have been and how central their roles have been in improving inter-sectoral coordination. At the local level, however, available information[38] all point to the high likelihood that they are not fully functioning. In order to improve PKH beneficiary families' access to complementary benefits and services, MoSA recently has issued a Minister's Decree to further require that all benefits and services targeting the poor

[38] Including the 6-province study by GIZ.

and vulnerable should use the integrated database for targeting purpose (MoSA has worked with Ministries of Education and Health on PIP and PBI to synchronize the data or provide priority access to PKH beneficiaries).

115. Finally, recent changes in PKH program design to include elderly/disability benefits and facilitate beneficiaries' access to a set of complementary programs, will require greater clarity and specification of institutional arrangements. In order to improve PKH beneficiary families' access to complementary benefits and services, MoSA has recently issued a Minister's Decree to require that all benefits and services targeting the poor and vulnerable should use the integrated database for targeting purpose.

V. IMPACT ASSESMENT, RISK RATING AND ACTION PLAN

A. SOCIAL IMPACTS ASSOCIATED WITH PKH

116. A series of impact evaluations of PKH (2011)[39] using Randomized Control Trials (RCTs) indicates that PKH has led to positive impacts on health behaviors, school enrollment, poor household consumption and investments in education[40]. Such impacts could potentially be associated with the health and education conditionalities where beneficiaries are required to be in compliance to stay

[39] See World Bank (2011), "Program Keluarga Harapan: Main Findings from the Impact Evaluation of Indonesia's Pilot Household Conditional Cash Transfer Program', and TNP2K (2015), "Evaluation Longer-Term Impact of Indonesia's CCT Program: Evidence from a Randomized Control Trial." Final publication forthcoming.

[40] Results from these evaluations indicate that the PKH program was directly responsible for greater investments in education and healthy behaviors while providing consumption budget support. The midline evaluation demonstrated that PKH was responsible for statistically significant increases in pre-natal care by nine percentage points while newborn delivery at a facility or attended by a professional increased by five percentage points. Post-natal care improved by almost ten percentage points while, immunizations, and growth monitoring check-ups increased by three percentage points and 22 percentage points respectively. The likelihood of children receiving immunization also increased by of seven percentage points, while severe stunting (height for age) decreased by three percentage points. PKH improved neonatal visits by 7.1 percentage points but had no significant impacts on outpatient visits or increased intake of iron tablets. In terms of education, according to end-line results there were statistically significant increases of two percentage points in the gross participation rate for elementary school and almost ten percentage point increase in the junior high school gross participation rate. The probability of a PKH child to continue to secondary school increased by 8.8 percentage point but there was no significant impact on decreased child labor attributable to PKH.

eligible. These impacts tend to more pronounced in areas where the supply of health and education services is greater.

117. The RCT results indicate that the program has positive impacts on the usage of primary health care services. The likelihood of completing pre-natal checks and post-natal visits are higher amongst PKH households with percentage improvements of 9 and 10 percentage points over baseline respectively. There were also reported spill-over effects where some changes in health behavioral were observed among neighboring households who did not receive cash transfers.

118. PKH is reported to have positive impacts in terms of utilization of educational services and such impacts are particularly greater amongst those already attending school than those who are not. Anecdotal evidence shows that the likelihood for PKH students to continue to secondary education is higher than those non-PKH students. However, such correlation tends to diminish once PKH students graduate high school, presumably because of the associated high costs for tertiary education, the absence of payment components for university students and other factors such as wanting to work or perceptions of having enough education.

"I work as a waiter in a coffee-shop and usually go home late after midnight. I always come to school late…"

(PKH High School Student, D2 NS)

119. Receiving PKH did not seem to correlate with parents' decision to ensure timely tuition payments and decreased child labor, presumably due to late transfers and little amount of transfers received. Since PKH transfers are most likely absorbed into other households' expenses not necessarily associated with health and education, the fact that PKH payments often did not coincide with the academic school year may present some risks with regards to the use of transfers. In one of the private schools visited, teachers reported that PKH parents did not necessarily use the transfers to pay their children tuition fees and this consequently affected their perceptions of the benefits of the program. Similarly, little correlation was observed with enrollment in the program and the likelihood and number of hours students work after school.

120. PKH transfers are perceived as "small gifts" from the government and the average amounts per-transfer are often regarded inconsequential vis-à-vis overall household expenses (RCA 2015, p. 17). The PKH benefit levels were raised in early 2015 and 2016, with the maximum annual transfer per-household at IDR 3.7 million (USD 284) and minimum IDR 800,000 (USD 61) – see table 7. School costs represent major household expenses in PKH households and the costs become exponentially higher as students move up to higher grades. Although public education is supposed to be free from primary to high school, other costs associated with transportation, pocket money, contributions to school management committees and allowances for volunteer teachers (*guru honor*) and other mandatory costs often far exceed the amounts that PKH households received from PKH transfers.

Table 7: PKH Payment Components

Payment components	Annual amount (IDR)
Base payment (fixed, no conditionalities tied)	500,000
Children aged < 6 or mothers who are pregnant or lactating	1,200,000
Children attending elementary school (SD/MI/Paket A)	550,000
Children attending junior high school (SMP/MT/Paket B)	750,000
Children attending senior high school (SMA/MA/Paket C)	1,000,000
Household member with severe disabilities	3,100,000

The elderly aged above 70 years	1,900,000

Source: adapted from World Bank (2012) and MoSA (2015)

121. Payments are directly transferred to mothers or adult female members who act as carers for PKH families with the premise to empower women as decision-makers and ensure that cash transfers are better managed. The World Bank's Impact Evaluation of the Pilot PKH (2011, p. 38)[41] indicates some level of empowerment by putting women in charge of managing PKH transfers. However, since the amounts are relatively small in comparison to household monthly expenditures and the fact that women met during the assessment were often already in charge of managing family expenses, understanding whether PKH payment modality has impacts on women empowerment warrants further assessments.

"Sometimes fortune comes like a sudden windfall, however the seasons become unpredicted recently. There are more bad days than good days now than in the past. We sometimes must make a living by selling small fish or working as a paid laborer in the port"

(PKH beneficiary, a widow with one granddaughter enrolled in PKH, District 2 NS)

122. Aggregated evidence from an RCT (2015)[42] indicates that there is little evidence that PKH transfers discourage work, either for men or women and induce larger spending on temptation goods such as alcohol and tobacco. Since the amounts of PKH transfers are small if spread across household members and daily costs throughout the year, PKH presumably does not provide enough incentives for households to work less or consume more tobacco and alcohol although such findings need to be further triangulated. Qualitative findings from RCA (2015) indicate that PKH transfers are spent on food, consumable goods and other daily expenses.

123. Some service providers were reported to charge PKH households and/or facilitators speed money or fees for services they provide or to sign off verification forms. Verification exercise is performed jointly between PKH facilitators and service providers. PKH facilitators are required to physically confirm by visiting schools, health centers, hospitals or meet with service providers to confirm that mothers and children from PKH households have met the required conditionalities. In one of the districts visited, anecdotal evidence indicates that additional fees, although in small amounts between IDR 2000 and 5000 or USD 15 and 38 cents, were requested by a midwife for each health check-up or verification of conditionalities. On this note, whether or not PKH has some correlation with encouraging service providers to charge extra for the same services they provide warrants further study.

124. Some tension stemming from beneficiary selection and verification was reported. Such tension often involves: (a) those who were receiving PKH and those who were not, (b) those considered being well-off but still receiving PKH and other community members, (c) community members and government staff or facilitators, (d) village leaders and dissatisfied community members, (e) village leaders and government staff or facilitators. The tension could be attributed to lack of understanding of selection processes, inconsistent responses received and no complaint resolution. Some complaints with

[41] World Bank (2011), "Program Keluarga Harapan: Main Findings from the Impact Evaluation of Indonesia's Pilot Household Conditional Cash Transfer Program',

[42] Banarjee A, Hanna R, Kreindler G, Olken BA (2015), "Debunking the Stereotype of the Lazy Welfare Recipient: Evidence from Cash Transfer Programs Worldwde", Center for International Development, Harvard University.

regards to payment deductions due to lack of compliance were also reported, and this again often stems from lack of understanding of entitlements, conditionalities and sanctions.

B. SOCIAL RISK RATING

125. The social risks for PKH CCT are Moderate. The Program is fostering inclusion by expanding to mostly cover most disadvantaged population groups (e.g., the disabled, indigenous populations). Social risks are mainly associated with the capacity of the program to correctly target poor beneficiaries, engage with communities and make use of appropriate communication channels, roll out a responsive GRS and the creation of an enabling environments to help PKH households to utilize cash transfer to improve their overall welfare, health and education outcomes.

Table 8: Key Risks and Proposed Mitigation Measures

No.	Description of Risk	Mitigation Measures
1.	**Inclusion of the marginalized groups, particularly those in remote districts with supply-side constraints** The scale up of PKH from 3.5 to 6 million households presents implementation risks including the inclusion of the vulnerable, quality of program implementation and facilitation, complementarity, grievance redress, oversight, etc. This issue is more pertinent in remote locations where PKH is aiming to continue to expand. Lack of access to basic health and education services will likely disadvantage PKH beneficiaries since their enrollment may get dismissed if they persistently fail to meet conditionalities. Such issues will likely be amplified in the context of weak program management, lack of coordination, and oversight.	- A review of conditionalities and verification protocols particularly in remote and under-deserved regions to accommodate supply-side constraints. A road map for social inclusion is currently being discussed under the Sub-directorate of beneficiaries, including strengthening the MIS system and facilitators' roles to have adequate capacity to accommodate the new demands. - Clarify roles and responsibilities and strengthening coordination with local governments to support access to basic health and education services, program operation, and oversight; - Build the capacity of facilitators to be able to work across communities with different socio-economic backgrounds and cultures. This includes streamlining facilitators' job descriptions with focus on facilitation and social work responsibilities. - Strengthen the functions of GRS (point 2) and communication strategy (point 3).
2.	**Weak and ineffective Grievance Redress System** The program's GRS is still currently under development and a major overhaul is currently being planned. To date, lack of authority and capacity to resolve complaints at the local level has made the current GRS ineffective	- Develop and test GRS models that are accessible and can protect the confidentiality of complainants; - Develop and test GRS modules and operation manuals in the MIS to ensure that grievances are consistently recorded and analyzed; - Designate and formalize a unit or partner, ideally independent from implementing functions with clear structure and coordination arrangements with JSK and local UPPKHs; - Strengthen the role of facilitators and operators to operationalize the GRS;

		- Develop and implement a comprehensive communication and socialization strategy on GRS. Means and approaches for communication should take into account literacy levels, prevalent languages/dialects, frequency, timing, etc. to ensure that they are inclusive, accessible, and socially and culturally appropriate; - Clarify and agree on GRS structure, including aspects and cases that should be resolved locally. This includes devolution of roles and authority to local implementing entities including the sub-national governments and consultancy teams;
3.	**Lack of sensitivity to local norms and inappropriate delivery of the program.** Centralized procurement of facilitators was reported to have caused inappropriate placement of facilitators where assigned facilitators are not familiar with local contexts or reside in far-away locations.	- Train and mentor facilitators on cross-cultural understanding; - Whenever possibly, employ local people with sufficient level of competency or people with sufficient level of familiarity about local contexts to facilitate the program; - Incorporate consultations and stock-taking exercise in the M&E activities to gain inputs and feedback from beneficiaries about the program implementation.
4.	**Ineffective communication of the program** Access to information was considered lacking across levels, and this is often attributed to the widespread lack of awareness and misunderstanding particularly on the issues of targeting, beneficiary selection, and requirements for PKH enrollment.	- Develop and test a communication strategy to ensure that there is sustained socialization, dissemination of program information, and documentation. Information about targeting including processes and criteria should be clearly communicated down at the community level. This could potentially reduce complaints and grievances that are often associated with beneficiary selection; - Recruit a team of communication specialists and develop training modules and facilitate training sessions on communication strategies targeted at implementing entities;
5.	**Targeting errors** As the program expands in coverage, program exclusion is expected to reduce. However, risks related to targeting errors and weak technical oversight become greater as JSK is currently undergoing institutional reform.	- Strengthen oversight and technical expertise within the targeting team; - Strengthen the GRS implementation (point 2) and test the program's communication strategy (point 3) with necessary capacity building and socialization to implementing entities; - Facilitate coordination and strengthen engagement with sub-national governments and other local stakeholders both public and private to mobilize efforts to ensure inclusion of marginalized groups and address exclusion issues (e.g. lack of documentation, not being surveyed, not having access to basic health and education services)
6.	**Exacerbating conflicts and/or**	- Review the budget requirements for M&E, including

tension The key constraint to enforce implementation oversight is the lack of both human and financial resources to respond to social risks and impact. The roles of facilitators are not well defined and no effective means for social work responsibilities, including socialization of the program and responding to queries and complaints.	personnel, travels, socialization, capacity building, tracking grievances, and documentation; - Assign a team of social specialists within JSK to oversee risks and impacts and advise on responses and mitigation measures; - Strengthening the M&E function with GRS responsibilities that operates independently from implementing entities. Such a function needs also be reflected in local UPPKHs; - Establish protocols for regular monitoring and reporting and recording of complaints in the GRS MIS; - Strengthen the capacity of facilitators and operators to be able to perform oversight functions and respond and/or elevate grievances in a timely manner; - Develop a program-level risk management including red-flagging potential or existing conflict areas to identify additional support or to suspend the program.

C. PROGRAM ACTION PLAN

Based on the ESSA findings, the following matrix outlines the proposed action plans to improve the program's management of social risks and impacts, along with responsible sub-directorates/units within MoSA and indicative timelines.

Core Principles	Gaps	Actions	Remarks
The program procedures and processes are designed to: Incorporate environmental and social management measures to: a. avoid, minimize or mitigate adverse effects; b. promote social inclusion and sustainability; c. promote transparency; d. promote free, prior, and informed consultations with regards to the management of the program's social risks and impacts;	The following gaps with regards to the management of risks and impacts were observed: a. The current GRS is ineffective to capture and respond to grievances; b. The program's communication and socialization are not streamlined (under multiple coordination arrangements) and under-resourced; c. The M&E function is not clearly defined and does not operate independently from implementing functions;	a. Develop and test out a standardized GRS system including: - Putting dedicated staff and defining roles and responsibilities across levels (central versus sub-national implementation) with regards to grievance handling; - Socializing and providing training on the new GRS including allocating dedicated resources for communication and outreach; - Incorporating GRS indicators into the MIS	Has been included in the DLI (#3). The GRS is to be designed and developed in 2017 and piloted in 2018. **PIC:** JSK Monitoring and evaluation team
Protect communities and program staff against risks associated with the program, including: a. tension and disputes due to exclusion issues; b. fraudulent use of cash transfers; c. lack of personal safety	a. Processes and procedures related to the program (e.g. targeting, selection of beneficiaries, conditionalities, verification protocols) are not fully known across various stakeholder groups including local governments and communities; b. There is also lack of concerns and measures to protect facilitators' safety; c. In some cases, PKH households had to travel long distances to pay points with potential safety risks;	b. Develop a communication strategy for the central and local government levels to ensure that the following aspects are in place (i) dedicated staff/communication specialists (ii) resource allocation, (iii) related	Has been included in the result framework. Program communication strategy to be developed in 2017 and piloted in 2018. **PIC:** Sub-directorate of Resources
Promote equitable access to PKH	e. Conditionalities and		

benefits in a manner that is socially and culturally appropriate and responds to the needs and concerns of marginalized people and groups	verification protocols for the elderly and people severe disability were not clearly defined; f. Compliance to conditionalities will likely be a key challenge for PKH beneficiaries in areas with supply-side constraints to stay in the program; g. Due to the centralized procurement, there were reported cases where facilitators were placed in unfamiliar environments and where they lack local knowledge and skills to interact with PKH families; h. Less emphasis on facilitation skills and No capacity building, guidance, or SOPs with regards to free, prior, and informed consultations in the current OMS and training; i. Administrative responsibilities of PKH's facilitators tend to outweigh social work responsibilities;	training, outreach and capacity building activities. As part of this strategy, it is critical to incorporate materials on cross-cultural communication and awareness and risk management (including GRS, communication strategy) into training modules for PKH facilitators; c. Assess and adapt PKH procedures, conditionalities, and verification protocols for areas with implementation challenges (i.e. difficult access, supply-side constraints, etc.) to increase share of PKH beneficiaries in underserved areas; d. Redefine and streamline the roles of facilitators and performance management system with emphasis on social work and facilitation responsibilities. Sub action plans under this also include: - Develop measures to protect personal safety including providing health insurance (BPJS), increasing oversight, SOPs for facilitators	Has been included in the Program Action Plan # 4 (Currently on-going and to be included in the program's Operational Manual (OM), subject to Year 1 of implementation **PIC:** Sub-directorate of Beneficiaries Has been included in the Program Action Plans # 5 and 10 and the Result Framework on the HR strategy on capacity building and performance monitoring plan to be designed in 2017 and implemented in 2018. **PIC:** Sub-directorate of Resources

		particularly for PKH operations in conflict areas; - Assign a team of social specialists within existing structure to oversee social risks and impacts, train PKH facilitators on safeguards, develop training materials and advise on PKH's communication and outreach strategies and GRM. The TORs for these specialists will be discussed during the project's appraisal and will be reviewed in year 1 of implementation to see adequacy.	

The proposed ESSA actions related to social management have been incorporated into the Program's overall design and their implementation is fully embedded in the organizational structure of the Directorate for the Family Social Protection (JSK). Proposed ESSA action plans # 1 and 2 on the development of the program's GRS and communication and outreach strategy fall under the Result Area 1 on strengthening the program delivery system to improve efficiency, transparency and accountability. The GRS action plan is the DLI #3. The proposed ESSA action plan # 3 on review of implementation modalities in areas with supply-side constraints has been included in the Program Action Plan # 4 and the review is currently on-going under the leadership of the Sub-directorate of Beneficaries of MoSA. The proposed ESSA action plan # 4 has been included in the Program Action Plan # 5 and 10 on HR review and assignment of social specialists to manage potential risks and impacts respectively.

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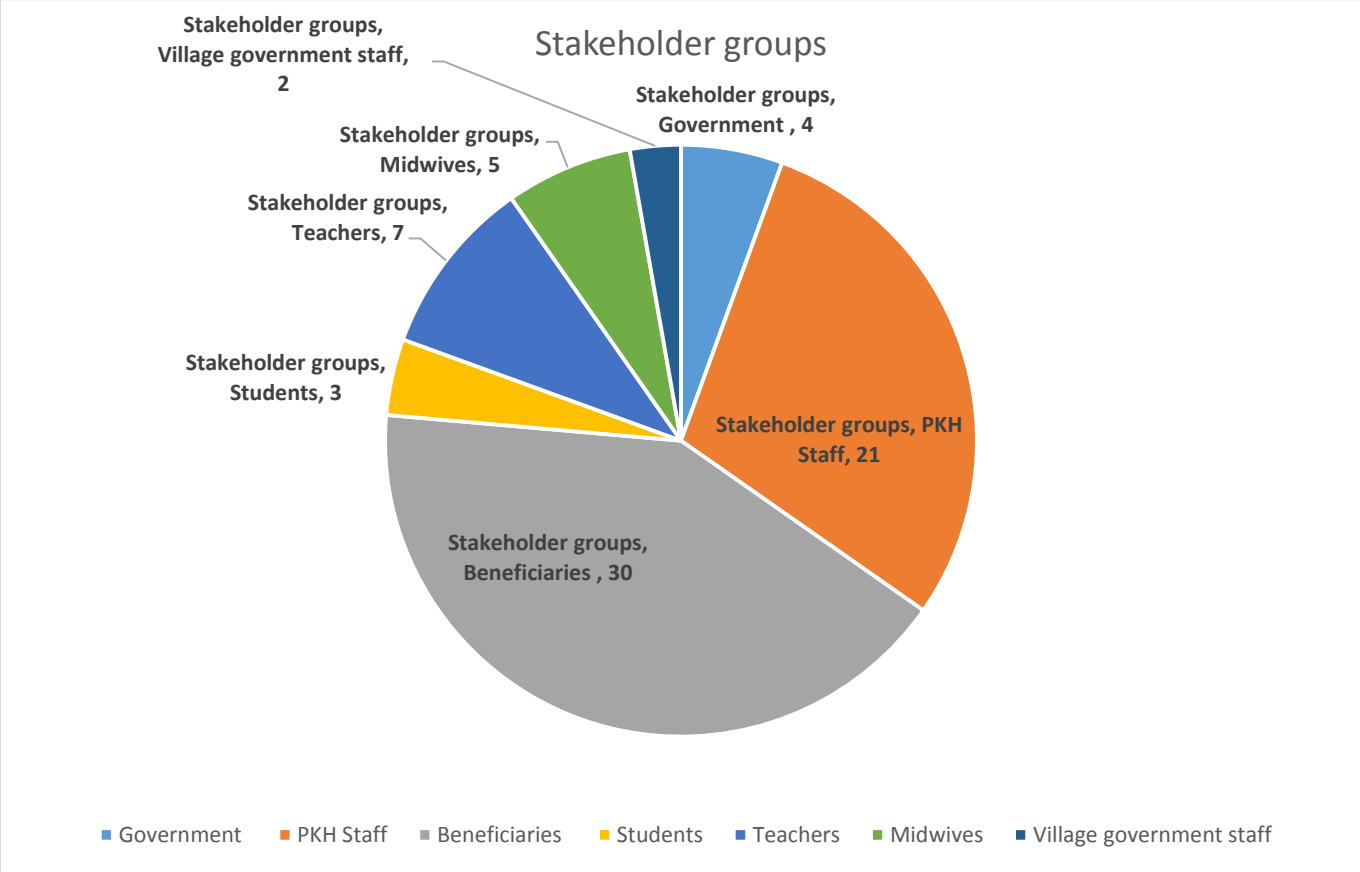
LIST OF ANNEXES

ANNEX 1: STAKEHOLDER GROUPS MET DURING THE ASSESSMENT[43]

Locations : Medan and Serdang Bedagai Districts of North Sumatera (with additional data collection from Lebak and Serang of West Java Province

Total : 75 respondents



[43] To protect the confidentiality of respondents and people met, their names were not disclosed.

ANNEX 2: PUBLIC CONSULTATION RESULTS

ESSA Sub-National Public Consultation 1

Dates and locations : 9 – 12 March, 2017, Kotamadya Tual, Dullah Darat and Dullah Laut Villages, Maluku Province

Number of participants and people met : 108 individuals – see Annex 3 point A

Key themes	Comments and feedback	Responses
Accessibility due to remote locations and island geography	Allocation for operational support is currently sourced from district governments' contribution, which tends to fluctuate over the years depending on political will. Lack of financial means has consequently limited facilitators' ability to reach remote districts and provide PKH beneficiaries with needed facilitation, including FDS. Some facilitators reported that they have not met with PKH beneficiaries due to the distance and costs associated with transportation to and within islands and logistics. This is problematic since verification protocols which could not be closely attended by facilitators. In addition, the high transportation costs also reduce incentives for PT. POS to provide extension services to ensure timely payment. Although PT. POS has in some occasions provide services at the sub-district office, beneficiaries in remote locations are often unable to receive transfers due to the high costs and availability of transportation to reach the payment centers. Lack of accessibility for payment has also encouraged PKH beneficiaries to wait until the amount of transfers is sufficient to cover costs associated with travels.	Lack of districts' ownership and contribution to the program was acknowledged and this issue will be monitored during PforR implementation. Facilitators' remuneration and the program's business process in remote areas will be reviewed to identify needed adjustments. Facilitators are encouraged to proactively communicate with MoSA in the event that PT. POS requests financial support to reach beneficiaries.
Conflict management	Existing conflicts due to political rivalry, tribal tension, and land disputes were reported. Such conflicts were not reported to have been exacerbated due to PKH. However, existing conflicts have prevented access for facilitators and	Issues with regards to PKH's operations in conflict areas, personal safety and relevant SOPs have been noted and will be raised during the national public consultation.

	other service providers from entering the communities in dispute. In addition, the safety of beneficiaries and facilitators could also be at risk when they have to encounter their oppositions or if they were perceived as enemies by people in conflict. Some beneficiaries were reported to have to carry protective weapons when they picked up payment at PT. POS in anticipation of meeting their enemies. Local inventions to avoid clashes such as organizing different payment schedules to avoid direct encounter and strengthening facilitation through KUBE and FDS to improve inter-communal relations were reported. However, this heavily relies on facilitators' communication and facilitation skills and currently, there are no effective mechanisms to flag potential conflicts where inexperienced facilitators could receive additional support.	SOPs for conflict areas have been included in the ESSA action plan and a team of social specialists in MoSA will be responsible to monitor PKH operations in these areas in coordination with facilitators, district and regional coordinators. Capacity building strategies for facilitators will be reviewed and based on needs, communication and facilitation skills will be mainstreamed in the curricula.
Coordination	Coordination was reported to be lacking across levels and this was attributed to lack of awareness and understanding of PKH amongst key stakeholders, particularly service providers. Coordination meetings facilitated by the Social Agency and UPPKH were reported not transparent and did not allow participation of PKH facilitators. The outcomes of the coordination meetings and agreed follow-ups were not clearly communication and acted upon. The level of contribution for PKH operational costs and the allocation were considered not transparent and there were suspected issues of corruption with regards to the use of the district's cost-sharing contributions. The lack of inter-agency coordination was exacerbated by the weak leadership of Social Agency to ensure relevant agencies stay abreast of the program overall. There were also criticisms from the Health Agency that PKH facilitators never took the initiative to keep them in the	Lack of coordination was noted. District Social Agency is expected to lead this coordination and PKH facilitators are expected to proactively inform line agencies with regards to the program to improve collaboration.

	loop with regards to program implementation and consequently were largely uninformed of the current status, number of beneficiaries that Community Health Centers have to serve, and whether the program has impacts if at all towards reduction in maternal mortality and nutrition. Facilitators were reported to rarely report to relevant officials from service agencies and village governments with regards to program implementation. However, there were reports from facilitators that such coordination is difficult to manage as relevant officials from line agencies and village governments often lack the incentives to be involved in the program since there were no kick-backs or financial returns.	
Access to information and Communication	Access to information is limited, not only for beneficiaries but also facilitators. This has limited their knowledge of their entitlements, updates, and other important information about the program, including districts' agreement with MoSA on counterpart funds for operational costs. Facilitators also reported that they have minimal knowledge of the allocation of counterpart funds and decision making processes at the district and ministerial levels. Strengthening the capacity and knowledge, including access to information, to facilitators and PKH group leaders were considered strategic since PKH beneficiaries often use such communication channels through direct and interpersonal communication with facilitators and PKH group leaders. Reliance on the facilitators and PKH group leaders (*Ketua Kelompok*) to relay information about the program to PKH beneficiaries and this was perceived effective. However, there was no formal capacity building interventions available for PKH group leaders to strengthen their	Issues with regards to lack of access to information and outreach were noted. PKH Communication strategy has been included as PforR's focus and adopted as one of the DLIs.

	leadership and communication skills. Exploring innovative communication channels such as social media were also proposed.	
Human Resource	There were issues with regards to the capacity of existing facilitators to effectively reach beneficiaries who are spread across far, remote islands. Lack of remuneration has also encouraged facilitators to take another job and therefore, reduces their focus on the program.	Noted and HR management will be reviewed under the PforR operation.
Beneficiary selection	Some villages were reported to refuse PKH due to the small number of beneficiaries selected and this was perceived to have caused potential conflicts. In the case of other social assistance programs, such as RASTRA, some village heads and apparatus often decided to distribute evenly rice allocation to all households in their jurisdictions to minimize conflicts. However, such an arrangement is not possible within PKH and tends to discourage village heads to receive the program if the allocation is too small. There were aspirations from current PKH beneficiaries that their poor neighboring households should receive PKH and there needs to be a mechanism in place for registration into the program.	Noted as program risks and will be raised during the national consultation. MoSA is currently piloting SISKADA 1 as a platform to register eligible households who are previously excluded from the program.
Personal safety	Facilitators are not insured although they are required to work in difficult and challenging locations, including areas with low accessibility and conflicts. Facilitators carry out their daily work without SOPs for personal safety and health insurance. Such an issue has increasingly become relevant for PKH as the program seeks to expand in remote, hard-to-reach and unsafe locations such as Papua. Two facilitators were reported to have been killed during tribal wars in highland districts in Papua and three were killed in road accidents in Papua and West Papua Provinces.	Noted and this issue will be raised during the national consultation. As part of ESSA action plan, SOPs for personal safety will be developed under HR management.
Database	There were reported delays with regards to data updating processes due to the lack of personnel and there were suggestions to include Dinas as the data administrator.	Noted.

Legal documentation	To ensure PKH beneficiaries have access to legal registration and documentation, there needs a strong collaboration between facilitators and village governments to identify and assist unregistered households with regards to registration processes. This also requires formal collaboration with the district's civil registration agency (Dukcapil) to support such an endeavor.	Noted.
Understanding of the program	There was a pronounced perception amongst line agencies that PKH does not address what the program intends to address and therefore seen as a waste of resources. At the local level, PKH's impacts towards health and education behavior as shown by analytics were largely unknown. Current beneficiaries indicate minimal knowledge about the program, let alone the selection process. A common response such as "it comes from above" is prevalent in areas visited.	Noted and PKH Communication and Outreach Strategy will be developed under PforR operation and will be reviewed periodically to assess their effectiveness.
Grievance Redress Processes	Grievances and complaints are usually reported to facilitators without clear coordination and reporting lines to ensure timely responses and resolution. The majority of grievances reported were around selection of beneficiaries, amounts of transfers and eligibility. Direct reporting to facilitators was perceived by PKH beneficiaries to be the most effective means to report on issues, however this is highly contingent upon facilitators' reputation and beneficiaries' trust level to them.	Noted and GRS strategy will be developed under PforR operation and such development will be based on comprehensive assessments on existing channels to identify the most and feasible avenues and alternatives for GRS.

ESSA Sub-National Public Consultation 2 (new expansion area)

Dates and locations : 13 March, 2017, Pulau Pramuka and Pulau Kelapa, Kepulauan Seribu District, DKI Jakarta

Number of participants and people met : 31 respondents

Key themes	**Comments and feedback**	**Responses**
Accessibility due to remote locations and island geography	Due to island geography and limited number of beneficiaries in remote islands, there is a lack of economies	Noted and acknowledged in the ESSA. MoSA is currently reviewing PKH business

	of scales particularly in terms of resource and cost requirements to reach these areas. Facilitators expressed the need for operational support as currently the district has not allocated the five percent cost sharing contribution. Beneficiaries in distant islands were not aware of the amount of transfers and spent far higher costs for transportation than the amount received.	processes in remote, hard to reach areas, including needed adjustments. Issues with regards to lack of sub-national government support was also acknowledged and will be raised during the national consultation.
Understanding of the program	There was observed lack of understanding among local government officials with regards to the introduction of the PKH and the program's operations overall. District officials from the Kabupaten Office requested MoSA to facilitate a workshop with regards to PKH, involving relevant agencies including the Health, Education and Civil Registration offices. New beneficiaries demonstrated lack of knowledge about the program, including selection criteria, eligibility, conditionalities, program objectives. There was confusion reported with regards to beneficiary selection and there was no means for beneficiaries to cross check or seek further information. Some limited information was provided by facilitators that selection was carried out by the MoSA, however, no further explanation was given, partly due to facilitators' limited knowledge about the program. Facilitators also reported to have only received preparatory training for beneficiary validation and not on the technical processes and substance of the program.	Noted and MoSA has agreed on the workshop schedule on March 20th, 2017. Program communication and outreach strategy will be developed under the PforR operation, including necessary capacity building for facilitators with regards to the content of the program to enable them to serve as an effective conduit for the program.
Complementarity	There was a reported legal barrier to support PKH complementarity with other SA programs. The issuance of DKI Jakarta Governor Regulation 174 on Smart Jakarta Card (Scholarship for Poor Students/KJP) has outlawed recipients of KJP to receive other social assistance programs. This has often been interpreted by local service providers that KJP beneficiaries are not eligible for PKH	Noted and this will be raised during the national public consultation.

	and vice versa. There were also reports that schools instructed PKH beneficiaries to choose whether they wish to be enrolled in PKH or KJP and disbursement of KJP benefits have been delayed particularly amongst PKH beneficiaries.	
Database	There were perceptions that the current database used for PKH targeting was not accurate. In the context of high-growth tourism activities in the region, poverty tends to fluctuate fairly rapidly due to income opportunities and therefore, the database should be able to accommodate such rapid changes in socio-economic status and be flexible. Beneficiaries reported that the amount of transfers received did not reflect the entitlements, and this created confusion and suspicion of corruption.	Noted and the MoSA is currently developing SISKADA 1 as an attempt to address such issues. On validation data, there were timing issues to synchronize validated data with payments. However, MoSA has been working to fix this issue and the second tranche should reflect the actual data.
Empowerment	PKH needs to invest in capacity building for beneficiaries to ensure they are equipped with needed skills to improve their socio-economic status. It was also suggested that innovations introduced through PKH, for instance e-warung does not act as a competitor for local enterprises	Noted and will be raised during the national consultation.
Communication	There needs to be tailored strategies to ensure confidentiality of beneficiaries and minimize jealousy. Mass media or public announcement were not considered appropriate since such a strategy will expose beneficiaries to the public.	Noted and will be considered in the PKH's communication strategy.

ESSA National Public Consultation

Date/Venue : March 15, 2017 / Directorate JSK, Ministry of Social Affairs

Number of participants : 71 participants

Key themes	**Comments/feedback**	**Responses**
Human Resources	There is a practical need to equip facilitators with needed skills to work with people with disabilities. Clarification of facilitators' responsibilities with regards to data collection,	Issues with regards to incentives, absence of insurance coverage, lack of operational support have been acknowledged in the

	validation and verification is also important to ensure that people who are excluded could have a systematic process to be registered. PKH should make efforts to ensure that facilitators have needed prior skills and therefore, candidates with social work experience should be prioritized. It is also widely acknowledged that there is an urgent need to review remuneration rates, operational needs for facilitators and to ensure that PKH facilitators are fully covered with health insurance (BPJS). It is also important to ensure that salary payment for facilitators can be handled in a timely fashion to reduce high turnover. Due to centralized facilitator recruitment, there have been issues with misplacement of facilitators which contributed to high turnover and replacement has often been delayed, thus leaving large number of beneficiaries without facilitators. Facilitators' responsibilities should be reviewed so that such responsibilities are not heavy on administrative tasks rather than social work. There also needs further assessment whether facilitation and empowerment are effective under the current ratios of facilitators to beneficiaries.	ESSA. To address some of these issues, HR sub-directorate in the JSK is currently reviewing PKH remuneration rates and operational subsidies and is in negotiation with BPJS on types of health covers for facilitators. Methodology for facilitator recruitment is currently being formulated to ensure proper placement and timely replacement.
Grievance Redress Mechanism	Complaints received are usually associated with data issues particularly on ineligible households who still remain in the database. Such an issue often stemmed from flawed data collection processes at the community level. Currently, there is no mechanism to capture rapid changes in poverty indicators and ensure fast responses to grievances filed/submitted and database modification.	This issue requires further analysis on various strategies to develop a responsive GRS that can be linked to other databases, e.g. list of eligible beneficiaries/UDB. GRS has been included as a DLI # 3 and its implementation will be monitored and reviewed to ensure its effectiveness. Analysis on how GRS could be linked with SLRT will also be conducted with this regard.

	It is also important to ensure that there is an integrated mechanism for GRS, possibly using various channels that are currently being piloted particularly SLRT and ensure that there is a single set of database. GRS should also need to be geared towards a dynamic and responsive system and linked to other database platforms (e.g. SISKADA 1) to accommodate proposals from excluded poor households that are eligible for PKH. SLRT (Integrated Service and Referral System, currently piloted in 50 districts to promote better coordination, referral and update beneficiary information can be further developed as a one-stop gate for grievance handling and information center at the district level. However, this requires coordination and agreement with MoHA to ensure the presence of a legal framework for its operation in order for local agencies to participate and provide needed resources for the initiative to function effectively.	
Database	PKH database will be used as the basis for PBI (Health Insurance for the poor) and this responsibility to ensure data synchronization falls under the purview of Pusdatin of MoSA, and therefore is playing a central role to ensure that the SA database is valid and updated. Pusdatin provide capacity building to TKSK (Tenaga Kesejahteraan Sosial Kecamatan/Sub-district Social Workers) for data collection. In order to support Pusdatin's function, PKH facilitators need to be equipped with required skills to effectively validate and verify field data (UDB). Village/sub-village deliberation meetings in determining the poor were often not participatory and biased towards village elites. FKP (Public Consultation Forums) to update the UDB was often based on invalid data and therefore could not completely resolve exclusion and inclusion errors.	Issues related with database and perceptions of inaccuracy were acknowledged in the ESSA. To improve SA database, it would require a systematic process that involves a stronger role of district governments to provide information about the poor in their jurisdictions and this has been piloted through SISKADA 1, subject to review with regards to their effectiveness and feasibility. Verification mechanisms with regards to conditionalities, particularly in remote, underserved areas are also being reviewed and this requires strengthening the program MIS to be able to capture

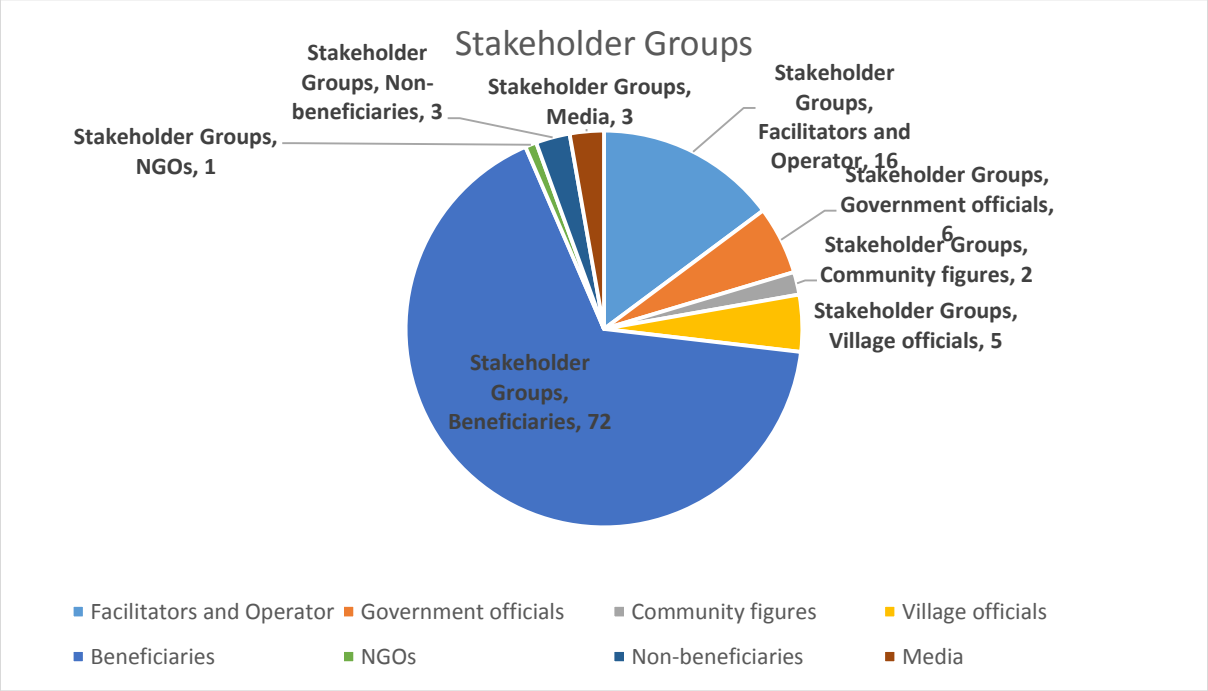
	The graduation system needs to be reformed to enable the program to cover the most deserving. PKH program is BDT data user and doing validation. Going forward, JSK want to ensure exclusion errors are reduced due to people that were not even surveyed. For the PforR, it should be taken into account that DLI should be measured on aspects that can be achieved. For instance, in some areas there are no schools so measuring compliance in those areas isn't accurate. BPKP/State Program Auditor should understand the field conditions	
Legal documentation	Although in the past, PKH did not require its recipients to have NIK (Civil Registration Numbers), the current approach to foster PKH complementarity with other programs and shifting cash to non-cash payment would require PKH beneficiaries to be legally registered in their current place of residence with NIK as a legal proof. However, for communities in remote areas or with high mobility, such an objective may present a challenge for the program and therefore, active involvement of facilitators to ensure that PKH beneficiaries have access to NIK becomes critical.	This issue was acknowledged in the ESSA and one of the PforR's outputs is to ensure that PKH beneficiaries have NIK as the program is seeking greater complementarity with other programs such as Rastra, PBI, KUBE and PIP. This would require a stronger collaboration with sub-national governments, particularly with Dukcapil to ensure that needed infrastructure for PKH beneficiaries to be legally registered by respective village governments is in place.
Program operations in conflict areas	It is important to ensure that PKH facilitators do not take side with conflicting parties and to the extent possibly, act neutrally. Such skills should be incorporated in their capacity building program. Providing needed protection and SOPs for facilitators working in conflict areas is indispensable. There is a need to develop mechanism to detect conflict areas and mobilize needed support. It is important to handle conflict areas. How to handle sudden poverty due to natural and social disasters..	Noted and will be included in the HR and capacity building review. SOPs for conflict areas and health insurance have been included as recommended action plans under HR development.
Coordination with local	Local government contribution and participation in the	Noted and this issue has been underlined in

governments	program still requires further strengthening. Lack of operational support from cost-sharing agreements was acknowledged. During the Technical Coordination Meeting, local governments responded well in terms of cost-sharing allocation to support PKH operations. However, realization of operational support in fact varies across district.	the PAD and ESSA. Further mechanism and strategies to improve coordination with local governments will be further strengthened by MoSA as part of PKH improvement. However, challenges with regards to enforcing such agreements in the context of decentralization were acknowledged.
Social inclusion	Use of PKH payments need to be clarified in the POM and whether such payments need to be earmarked for tuition fees need also to be clarified. Similarly, eligibility criteria for KUBE PKH participants also need to be revisited. Approaches to interact and work with people with disabilities need to be strengthened by ensuring facilitators have required skills and support to do proper facilitation with these groups. It is important to refer to UU no 8/2016 on using disability terminology. PKH operations in remote areas need to be further assessed and lessons learnt from the roll out of PKH in new districts should be reflected as part of program improvement. Associated costs with regards to PKH payments borne by beneficiaries could become a disincentive for them to fully engage in the program. There need further assessments with regards to payment cycles and logistical costs for beneficiaries and whether payment schedules need to be bundled to reduce costs.	Noted and thank you. This will be included in the POM and business process reviews particularly in remote areas and capacity building strategies.
Access to information	Communication and outreach strategies for PKH were previously handled by Kemenkominfo, not MoSA. There needs further assessment whether the current multi-sectoral platform with distinct delegations of responsibilities is effective to address program needs.	Noted. PKH Communication and Outreach Strategy has been mainstreamed into PforR priorities and will be handled in-house by MoSA with support from experts.
Budget to implement recommended measures	It is important to discuss with Bappenas and MoF with regards to budget allocation to implement social measures	Noted and will be followed up for further discussion.

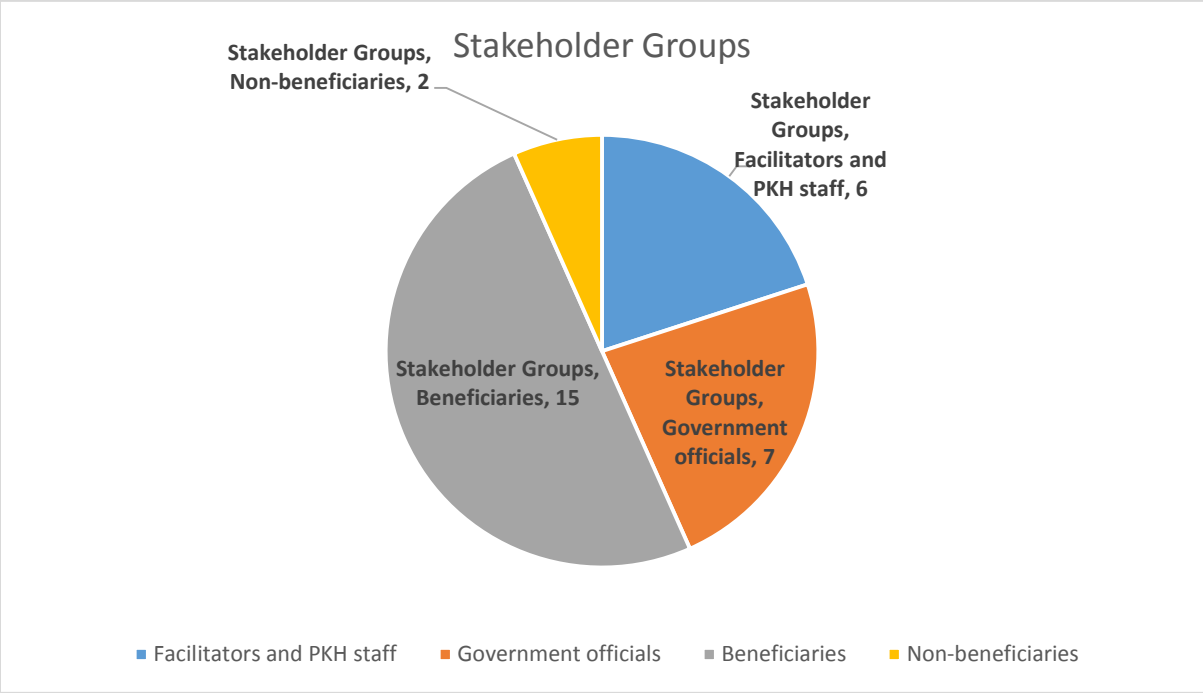
	prior to the finalization of AWP FY 2018.	

ANNEX 3: PUBLIC CONSULTATION PARTICIPANTS

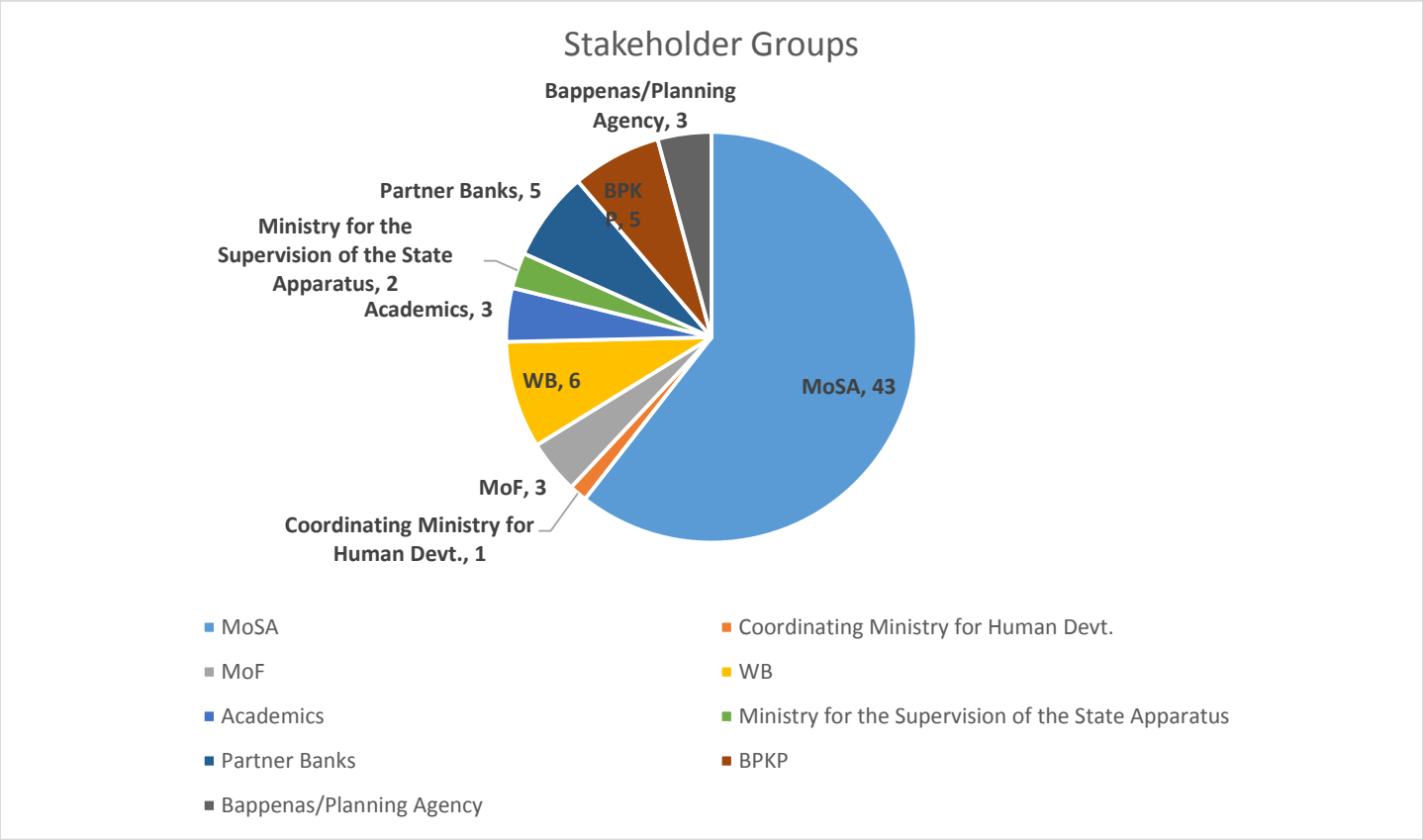
A. Sub-national Public Consultations (9 – 12 March, 2017, Kotamadya Tual, Dullah Darat and Dullah Laut Villages, Maluku Province)



B. Sub-national Public Consultations (13 March, 2017, Pulau Pramuka and Pulau Kelapa, Kepulauan Seribu District, DKI Jakarta)



C. National Public Consultations (15 March, 2017, MoSA Office, Jakarta)



ANNEX 4: PHOTO DOCUMENTATION

National Public Consultations (15 March, 2017, MoSA Office, Jakarta)

Sub-national public consultation 1: 9 – 12 March, 2017, Kotamadya Tual, Dullah Darat and Dullah Laut Villages, Maluku Province

Sub-national Public Consultations (13 March, 2017, Pulau Pramuka and Pulau Kelapa, Kepulauan Seribu District, DKI Jakarta)