INDONESIA SOCIAL ASSISTANCE REFORM PROGRAM

Technical Assessment

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I.   Program Description

1.   **The Government of Indonesia had begun investing comprehensively in social assistance (SA) programs in 2005 because of the creation of fiscal space through the phasing out of a regressive fuel subsidy.** In 2010, a redesign of Indonesian SA programs was initiated to accelerate poverty reduction and improve access to and quality of basic social services. As stated in the country's national development plan RPJMN (2015–2019), the Government has determined to establish a comprehensive social protection system for all citizens and improve targeting accuracy of the SA programs for the poor. Its policy direction also discusses the need to (a) integrate several family-based SA schemes for poor and vulnerable families that have children, disabled, and elderly, in the form of CCT and/or through in-kind assistance to support nutrition; (b) transform the rice subsidy for the poor in a phased manner so that it becomes a more nutrition-focused program; and (c) structure temporary SA at the central and local level by raising the coordination and sharing of authority between ministries/institutions that implement temporary SA.

**Figure 1. The Implementation Roadmap of Government program**
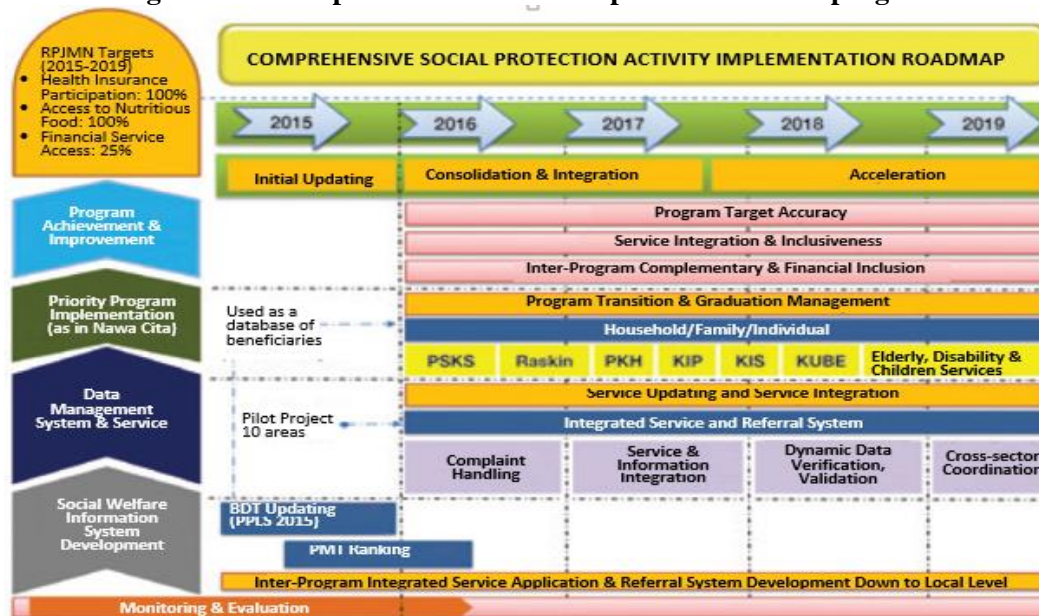
Source: Bappenas 2015, Ministry of Social Affairs Rentra (2015-2019)

2.   **The implementation of the vision of this comprehensive SA system laid out in RPJMN entails a number of actions taken on data, information system, citizen interface, program performance monitoring and evaluation, and cross-sector coordination** (Figure 1). For example, the targeting database containing the bottom 40% population was updated in 2015. Furthermore, the Ministry of Social Affairs (MoSA) and the National Team for Acceleration of Poverty Reduction (TNP2K) have subsequently started a pilot of on-demand application in 12 cities/districts to allow updates and new entries so as to provide more inclusive and updated targeting information to user programs. A citizen interface pilot for service and information integration (SLRT) has been initiated in 50 districts by the Ministry of Planning (Bappenas) and MoSA. This shared citizen interface is a key building block of the envisioned comprehensive system by enabling more standard access to information and government programs by citizens and supporting timely capturing of beneficiary situation change and complaints for all programs. At program level, there are also multiple initiatives that have been put in place to strengthen their delivery systems for enhanced performance. The CCT program named Program Keluarga Harapan (PKH) has been progressively expanding its coverage from "very poor" families to "poor" families and also to additional remote districts. An e-voucher pilot for Rastra, recently launched in a number of cities, aims to bring 1.4

million beneficiary families onto a digital delivery platform. Various reforms and initiatives are also planned in a sequential way, with 2016 and 2017 focusing on consolidation and integration while 2018 and 2019 focusing on acceleration and expansion.

3.   **PKH plays a major role in the comprehensive SA system for family-based support.** It was initiated in 2007 as a pilot in seven provinces to just 382,000 beneficiary families and has been expanding its coverage as a part of a larger effort to build up this comprehensive social protection system to improve poor and vulnerable families' welfare and opportunity. PKH aims not only to help increase the beneficiaries' current consumption so as to alleviate poverty in the short run, but also to ensure their investment in the human capital of their children through education and health conditionalities (also sometimes called 'co-responsibilities'). As PKH will encourage the beneficiary families to access and use basic health, nutrition, and education services, it is expected to promote future generations' opportunity and productivity in the long run.[1]

Figure 2 PKH Coverage, Budgetary Support, 2007-2016
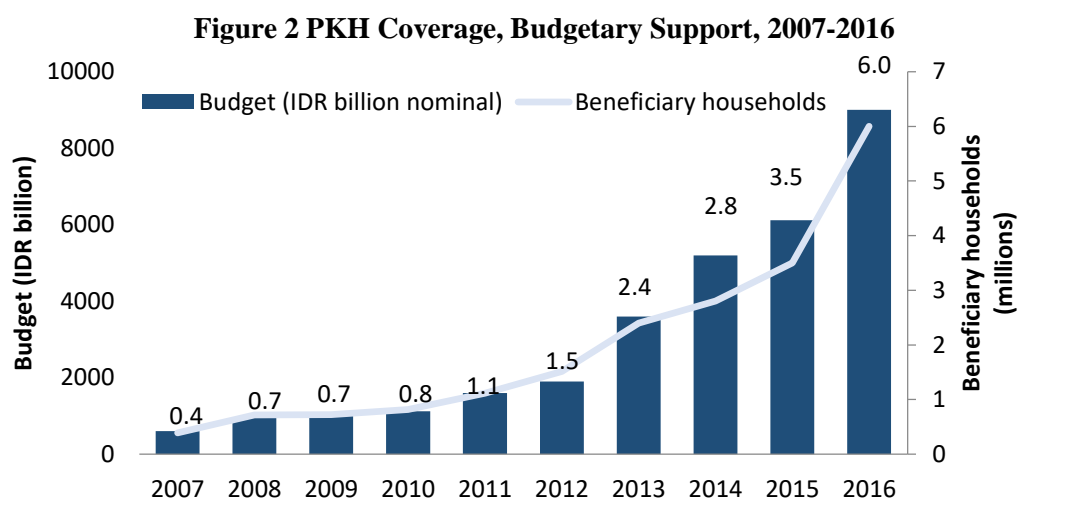
Source: MoSA (2014-2015-2016) and Ministry of Finance (2008-2013)
Note: 2011-2013 data are realized budget; 2014, 2015 and 2016 data are budgeted totals.

4.   **Soon after taking office in 2015, the new administration had decided to review the design, process and systems of PKH, implemented by MoSA, and later to scale up its coverage, from 3.5 million families (5 percent of the population) in 2015 to 6 million families (9 percent of the population) by the end of 2016.** The expansion aimed to cover all districts in Indonesia, including those of Papua, with the highest poverty rates in the country but previously not covered by PKH. As the new areas often have implementation challenges, the program needs to modify and adapt its implementation guidelines and arrangements according to the local context. While the coverage after expansion is still lower than that of similar large CCT programs in other countries (in Mexico, Brazil, and the Philippines CCTs cover between 20 percent and 30 percent of the population), the program has come a long way from when it was first introduced in July 2007.

5.   **PKH eligibility depends on both family poverty status and demographic composition.** To be eligible, a family must be included in the country's targeting database called the UDB, and ranked below a certain cutoff point, which is determined by the program coverage target. They must meet at least one of the following conditions: one family member is pregnant or lactating; one child below age 6 years; one child age 7 to 21 years attending primary or secondary school; or one child age 16 to 21 years who has not yet completed basic education but is enrolling in an education program. Furthermore, PKH beneficiary

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[1] World Bank, 2012, PKH Conditional Cash Transfer – Social Assistance Program and Public Expenditure Review 6.

families must be in compliance with the relevant health and education conditionalities to receive the cash transfers, which are conditional on compliance with the conditionalities. Mothers are the main recipient in the majority of cases. Also starting in November 2016, eligible families that have a severely disabled or an elderly person (70 years and older) living with them will also be receiving additional transfers as long as they have not yet been covered by other old age or disability programs. The implementation rules for these two new components have been put into operation but are expected to be refined in 2017.

Table 1 PKH Operation Scale, 2007-2016

Year	Number of Provinces	Number of Districts	Number of Sub-Districts	Field Staff	Regional Coordinators
2007	7	48	337	1,556	2
2008	13	70	637	2,738	7
.2009	13	70	781	3,370	11
2010	20	88	946	4,565	18
2011	25	119	1,387	5,446	28
2012	33	169	2,001	7,450	37
2013	33	336	3,417	10,590	54
2014	34	430	4,870	14,068	46
2015	34	472	6,080	16,665	43
2016	34	504	6,435	26,168	57

Source: MoSA (2016) "PKH General Guidelines".

6.   **Verifying beneficiary families' compliance with utilizing respective health and education services is done jointly with service providers.** PKH facilitators will visit nearby schools and health facilities every month to confirm that mothers and children from PKH beneficiary families have presented themselves and are acquiring or attending the services required. At some facilities and in some regions, PKH facilitators will join local service provider staff to verify attendance. Verification forms are then submitted to the district/provincial offices to be entered in the PKH program management information system (PMIS).

7.   **PKH benefits represented a small share of beneficiaries' average expenditures.** In 2013, the average PKH benefit was about approximately 10 percent of beneficiaries' average expenditure. Then PKH benefit levels were raised in early 2015 and again in 2016, with the maximum (minimum) annual transfer per household at IDR 3.7 million (IDR 800,000) or approximately $284 ($61). For a PKH beneficiary family with four members (a couple, one under-five child, and one child attending primary school), the total annual PKH benefit is IDR 2.2 million in 2016, which is equivalent to 12.6 percent and 13.3 percent of the official urban and rural poverty lines respectively. In comparison the average PKH transfer is about five times the average out-of-pocket costs of a regular outpatient visit or one and a quarter times the average cost of one year of schooling expenses. In other words, the average PKH transfer can finance multiple health facility visits or only one year of education.

8.   **Beneficiary families would receive PKH transfers for 6 years as long as they comply with conditionality and do not become ineligible**. In addition to the required education and healthcare services utilization, PKH mothers attend monthly meetings organized by program facilitators and receive guidance on fulfilling PKH conditionality. If any beneficiary families are determined to be poor at the end of 6-years cycle, additional 3 years can be granted and complemented by other livelihood support programs such as KUBE-PKH as well as training with Family Development Sessions (FDS) modules, which are designed to raise beneficiary families' knowledge and life skills.

Table 2 PKH Eligibility and Conditionality

Households with…	…must accomplish at least these conditionalities to continue receiving PKH
pregnant or lactating women	1. Complete four antenatal care visits and take iron tablets during pregnancy. 2. Be assisted by a trained professional during the birth. 3. Lactating mothers must complete two post-natal care visits.
children aged 0-6 years (also including 7 years old who are not enrolling in schools yet)	4. Ensure that the children have complete childhood immunization and take Vitamin A capsules twice a year. 5. Take children for growth monitoring check-ups (monthly for infants 0-11 months, and quarterly for children 1-6 years).
children aged 7 - 21 years (also including 5-6 who are already enrolling in schools)	6. Enroll their children in primary school, or junior secondary school, or senior secondary school and ensure attendance for at least 85% of school days.
elderly member (70 years old or more)	7. Receive health care as needed and health checks by health workers through home visits or by visiting elderly friendly health facility (if available). 8. Join social activities if possible or participate in the activities through home care with assistance
member with severe disability	9. Receive health care as needed and health checks by health workers through home visits

Source: Adapted from MoSA (2016) "PKH General Guidelines".

II. Program Strategic Relevance and Technical Soundness

a. Strategic Relevance

9. **The proposed operation is strategically relevant to the government's development objectives.** The National Development Plan (RPJMN) recognizes the need to support special programs for the poor such as PKH CCT and integrate family based social assistance schemes for poor and vulnerable families that have children, disabled or elderly members. The proposed Program-for-Results (PforR) operation responds to a request by MoSA, and its proposed development objective aligns with improving the effectiveness of fiscal spending in poverty and inequality reduction in Indonesia, as stated in RPJMN (2015-2019).

10. **The Program is also well aligned with the World Bank's twin goals of eliminating extreme poverty and increasing shared prosperity.** It supports the Country Partnership Framework (CPF) for Indonesia FY16-FY20, in particular under the Engagement Area (EA) 4: Delivery of Social Services and Infrastructure; EA 6: Collecting More and Spending Better; and the Supporting Beam (SB) II: Shared Prosperity, Equality, and Inclusion. The task is also contributing to the achievement of the CPF objective indicators on: (i) Percentage of mothers and children receiving maternal and child health and nutrition services in community health center and its network in targeted areas (EA4); (ii) Central government spending on health, capital expenditure and social assistance (EA6); (iii) Number of households benefiting from PKH, disaggregated by gender (SB II); and (iv) Increase in the number of social assistance beneficiaries receiving payments digitally (SB II). Finally, with a strategic focus on delivery systems strengthening, promoting human capital, and increasing coordination across social assistance interventions, the Program is aligned with the Bank's Social Protection and Labor Strategy 2012-2022.

b. Technical Soundness

11.   **The proposed Program is technically sound and is expected to have positive impacts on the government's effectiveness in delivering the CCT as one of the core pillars of Indonesia's social safety nets to protect and enable those who otherwise do not have the capability to participate in the economic growth process.** The Program builds on MoSA's past nine years of experience in implementing PKH. Much capacity has been built over that time, and evidence suggests that the program has had important impacts. In addition to the coverage expansion, MoSA has also been continuously reviewing the program's implementation, business processes, and delivery systems and has been making necessary adjustments to improve implementation performance. Three key principles guide this review and revision process: simplicity, clarity, and accountability. As a program scales up in size, those three principles become exponentially more important than with smaller programs.

Figure 3 PKH Workflow
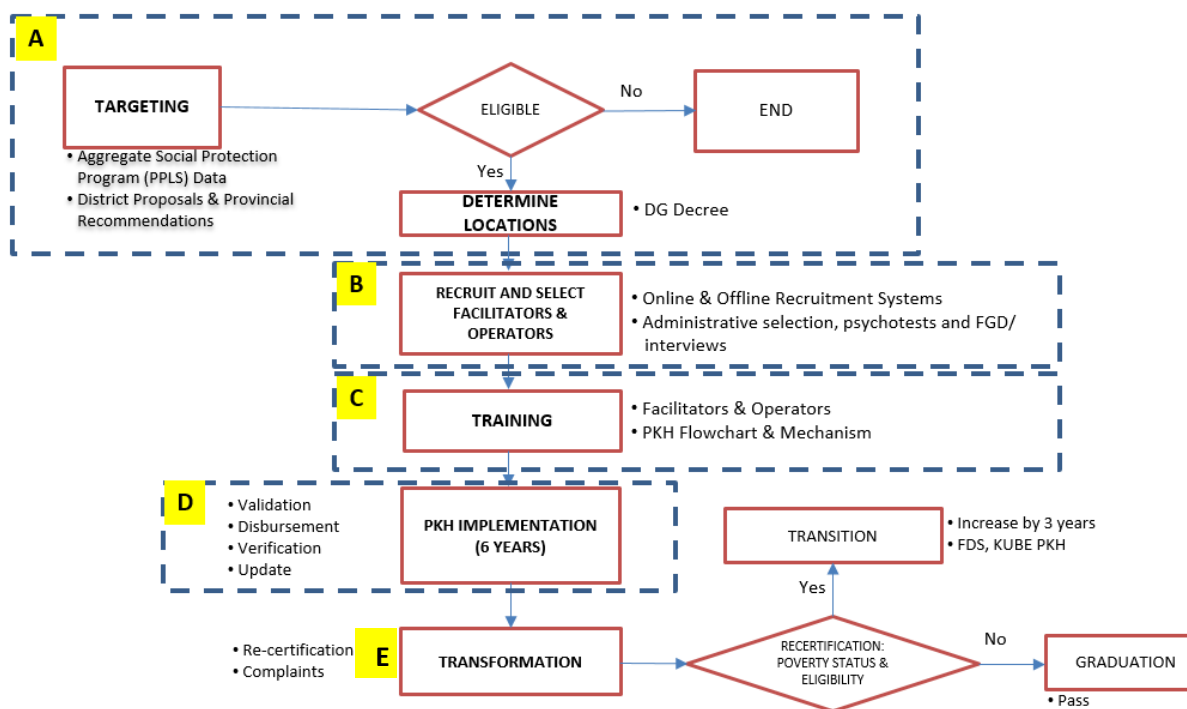
Source: MoSA (2016c).

12.   **PKH implementation workflow has five broad steps:** (A) determine where and whom the expansion may cover; (B) recruit additional facilitators and operators required for the additional beneficiaries; (C) train the newly recruited facilitators and operators before they start; (D) implement PKH program; and (E) determine if the beneficiaries are ready to "graduate" from the program and provide additional support if needed. In addition, the PKH program also has strived to put in place a monitoring and evaluation system and a community grievance system to ensure feedback and learning.

c. PKH Targeting

13.   **Indonesia's targeting system is based on the Unified Database [2] (UDB), which has been developed since 2005 in response to the emerging need to scale up social assistance programs.** In 2005, to establish a list of poor and vulnerable households for a new unconditional cash transfer program introduced to mitigate the effects of universal fuel subsidy reforms, the Central Bureau of Statistics (BPS) conducted a survey called Socioeconomic Data Collection for Socioeconomic Trends (Pendataan Sosial Ekonomi, PSE). The final output of PSE-2005 was a database with basic information of 19 million households, which belonged to the three bottom deciles of income distribution in Indonesia. In 2008, a new survey of poor households known as Data Collection for Social Protection Programs (Pendataan Program Perlindungan Sosial, PPLS) was conducted and covered approximately the same number of poor households as the PSE-2005.[3]

14.   **In 2011 the newly established TNP2K under the Vice President's Office coordinated the third round of data collection known as PPLS-2011.** This survey of 24.7 million households contains a set of socioeconomic information and was the basis to build a database (UDB) of the poorest 40 percent of the population (about 96.4 million individuals). From June to July 2015, BPS surveyed over 28 million households in all districts of Indonesia, aiming to cover the 40% poorest population in order to update the 2011 UDB records to incorporate new information coming from the field for the existing households as well as from additional 1.3 million households. The new poor or vulnerable households were added through public consultation forums that consisted of a group of around 20 villagers and community leaders or representatives. Using the 2011 UDB list this group would debate who was not on the list and should be surveyed by BPS. They could also flag households on the list that were deemed ineligible for SA programs; these households would still be resurveyed and ranked.

15.   **The methodology of ranking poor and vulnerable households has also improved over time.** While the 2005 PSE used 14 non-monetary variables and calculated a weighted welfare index, all three later rounds used a Proxy Means Testing (PMT) methodology to score each and every household included in the registry. The most recent PMT methodology applied to 2015 UDB was deemed more accurate due to two key changes made in comparison to the 2012 methodology. The 2015 PMT used a much larger sample to predict consumption by pooling Susenas data between 2011 and 2014 and splitting data into calibration and prediction samples. While many models were tested, simple OLS was found to be the most effective model. In addition, the new methodology expanded the set of variables used to predict consumption, including more information in particular about household members that are not the household head. These changes led to a 60 percent larger sample size and an expanded set of variables, and improved targeting outcomes. The out-of-sample R-squared increased from 0.40 to 0.46 and the error rate was lowered 4.4 % when simulating with low coverage targeting. Because the PPLS survey covers a proportion of the population approximately equal to the size of the largest program that will use it (JKN-PBI had 92 million individuals targeted in 2016), re-ranking and subsequent ineligibility as a result of the adoption of the new model will affect mainly the narrowly targeted programs such as PKH. This implies that the accuracy of large programs like JKN-PBI largely depends on to what extent the PPLS-2015 survey approach had successfully included the intended bottom 40% population.[4]

16.   **Since 2012 all major social assistance programs have adopted UDB as their targeting system, including many local government institutions that have requested UDB data to facilitate the implementation of local poverty reduction programs[5.]** The subsidized rice program Rastra and PKH began using the UDB in 2012 and Jamkesmas (now PIS or JKN-PBI), the health insurance fee waiver component of the national health insurance system JKN, and the poor student scholarship program, PIP,

[2] TNP2K (2015) Indonesia's Unified Database for Social Protection Programmes. Management Standards.
[3] World Bank (2012). Indonesia Social Assistance Public Expenditure Review. Note: The same households surveyed in 2005 were resurveyed in 2008.
[4] Lange, S. Klasen, S. Hadiwijaja, G, Pinxten, J. Wirapati, B.A. (2016) Evaluation of PMT-based targeting in Indonesia. Project report.
[5] TNP2K (2014) An Evaluation Of The Use Of The Unified Database For Social Protection Programmes By Local Governments In Indonesia.

joined in 2013. However, only PKH has fully adopted the UDB standard for use in quota generation, eligibility determination, and beneficiary identification, and only PKH has implemented a bidirectional updating procedure that works in concert with the UDB. Due in part to its low coverage and use of bidirectional updating, out of all the main household targeted SA programs, PKH shows the best targeting performance in the years after adopting the UDB. The latest available Susenas survey data estimated that over 70 percent of the total program beneficiaries are found in the poorest 40 percent of the population.[6]

17.   **Currently, TNP2K and MoSA are piloting an on-demand application (ODA) approach in 12 selected cities/districts to include new potential beneficiaries and update information of existing ones.** The ODA pilot and another ongoing Integrated Service and Referral System (SLRT) initiative led by MoSA and Bappenas would coordinate to harmonize information flow processes to assure better outreach to potentially eligible households and reducing exclusion errors.

18.   **In 2016, the Government initiated a plan to transfer the responsibility of UDB management from TNP2K to MoSA[7].** In early 2016, MoSA launched a nationwide data-matching exercise with all 514 district governments and social affairs offices. The purpose was to agree upon a single version of targeting database to be used for the targeting of social protection programs at the central, provincial and district levels. The matching was done between the 2015 UDB, the 2011 UDB and the district level data (mostly emanating from the 2011 UDB as well). The initiative also included district governments signing an agreement with MoSA to use this validated and verified data. It was also decided that in the transition phase, the UDB would be managed jointly by TNP2K and MoSA through a task force. In early 2017, MoSA has been developing a social registry information system called Siskada, which has also included existing SA program beneficiaries and will eventually allow local government update and certify targeting data.

19.   **Prior to the 2016 expansion, MoSA had selected districts based on essentially three factors – district government's commitment, supply side readiness, and national priority.** In addition to having adequate educational facilities and health facilities to support the PKH program, district governments must provide district and sub-district PKH program management units (UPPKH) secretariats and through local budgets contribute funds, at least 5% of the total annual transfers. Among the districts meeting the first two factors, priority was given to disadvantaged districts, disaster-affected districts (social and natural) and border districts**.**

20.   **The selection of 2.5 million new eligible families when the PKH program was scaled up in 2016 from previous 3.5 to 6 million families was handled by the Directorate of Family Social Security (JSK).** First, province- and district-level quotas were generated and agreed upon. The quotas were calculated as the latest district-level number of poor households estimated using the most recent BPS Susenas data minus the total number of existing PKH beneficiary families in those districts. As a result, the district quotas vary significantly. For example, some districts received zero quota for new eligible families due to a combination of a fall in the poverty rate and a sufficiently high number of existing PKH beneficiaries. Second, of the new 2.5 million eligible families, around 2.1 million would be allocated in the districts with PKH operating already and the remaining 400,000 would be allocated to the new districts in Papua and Maluku. Among the existing districts, it was also decided not to add new villages but rather 'saturate' the existing villages with additional beneficiaries.

21.   **After the quotas for new eligible beneficiary families were decided, the lists of new eligible families at province, district and village levels were created using the validated and verified data.** The JSK office then distributed the lists to the corresponding provincial UPPKH offices and then to the district

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[6] World Bank (2017 forthcoming) Indonesia Social Assistance Expenditure Review Update.
[7] According Law Number 13 (2011) on Handling of the Poor and Needy, the Minister of Social Affairs is responsible for verifying and validating the targeting data.

UPPKH offices. Lastly, PKH facilitators are assigned to carry out initial validation of the new eligible families to ensure their eligibility. Upon validation, the families deemed eligible are registered into the PKH beneficiary master database. In practice, about 3.4 million potential beneficiaries' data was sent out to districts for facilitators to verify. The additional 800,000 plus families were added because of the expectation that some potential beneficiary families would be found to be ineligible upon verification by facilitators.

Figure 4 PKH Targeting Performance
(share of total beneficiaries by consumption expenditure decile)
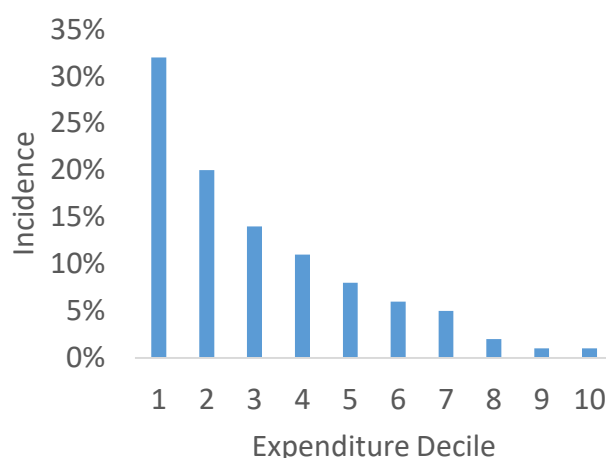
Source: Susenas, 2014

d. PKH Human Resources Management

22.   **Since its inception, thousands of PKH facilitators have been at the forefront of delivering the cash transfer and monitoring beneficiaries' compliance to PKH conditionality.** PKH facilitators are recruited nation-wide through a competitive selection. Their minimum educational background is 3 years of higher education, preferably with experience in social work. The ratio of facilitators to PKH families is usually 1:200-250, but this ratio is lower for islands or areas that are difficult to reach.

Table 3 Ratio of PKH Staff by Location

Occupation	Location of PKH Participants				Remarks
	Easy	Difficult	Very Difficult	Remote	
Facilitator	Average 300	Average 225	Average 150	Average 100	Minimum 1 person for each sub-district
District/City Operator	Average 3,000	Average 3,000	Average 3,000	Average 3,000	Minimum 2 persons for each district
Provincial Level Operator	Average 30,000	Average 30,000	Average 30,000	Average 30,000	Minimum 2 persons for each province

Source: PKH Implementation Guidelines (2015)

23.   **In addition to facilitators, PKH program also has a strong team of operators and coordinators responsible for supporting program implementation and reporting at both provincial and district/city levels.** In total, more than 26,000 staff are expected to work for the program in 2017.

Table 4 HR requirements

No	Type of HR	Total
1	Specialist	21
2	Operator - Central	28
3	Coordinator - Provincial	57
4	Coordinator - District	394
5	Operator - Province	95
6	Facilitator	23,804
7	Operator - District	1,875

24.   **Facilitators carry out myriad core and supporting functions,** ranging from conducting socialization (i.e., outreach, communication, and awareness raising) and advocacy, running initial meetings and validations; assisting beneficiaries in withdrawing cash quarterly at a nearby post office; updating, verifying and entering data; organizing and leading FDS; handling complaints and case management; recording and reporting beneficiaries' utilization of health and education services and compliance with PKH conditionality; reporting on payment reconciliations; distributing PKH cards to participants; preparing weekly activity reports, etc.. In other words, the facilitators are the all-purpose "foot soldiers" of the PKH implementation model currently in place. They carry the bulk of the day-to-day responsibilities to ensure the program is run as designed on the ground.

25.   **The high workload of facilitator has prevented them from focusing more on assisting families and monitoring conditionality.** Firstly, based on the analysis of the implementation guidelines reviewed together and the end-to-end implementation planning, current workload appears to unevenly distributed, with too many hours of work required to complete all duties assigned to the facilitators, and importantly without clear separation of duties between beneficiary management (determining enrolment/eligibility) and disbursement (authentication and manual payments reconciliation). The excessive involvement of the facilitators, present possible pressure points along the delivery chain, and pose internal control risks that could result in error and fraud occurring going undetected. Secondly, overloading the facilitators with an array of manual tasks may hamper the timely achievement of the end-to-end implementation. For instance, some facilitators are taking 1–2 weeks to provide operators with updated beneficiary information, done manually using a large MS Excel data entry (as compared to PT Pos which reconciles electronically directly with JSK), thus lengthening the reconciliation process and delaying payments by several weeks.

26.   **Despite the extensive and heavy workload, facilitators have relatively poor employment conditions and receive little financial or administrative support.** They, like other PKH field staff, are hired on renewable annual contracts with a relatively low pay (not more than IDR 3 million/month) and a minimum benefit coverage (e.g., no health insurance coverage). For some areas the offered wage is below some of the regional minimum wage standards set by government. No additional allowances are provided and this is a problematic feature of the current remuneration design, especially in the more difficult areas (where high transportation costs are very burdensome on the salary of the facilitator). According to a number of anecdotes, PKH field staff often have to cover work-related expenses such as the cost of transportation for field visits, maintenance of the office utilities (e.g., electricity, internet) and stationary/printing out of their own pockets. Originally, it was envisioned that the operational costs, around IDR 400,000 per month, could be paid by local governments as part of the cost-sharing initiative (5% of total benefit value in the district) to actively contribute to the implementation of PKH**.** The perceived lack

of long-term job stability, the low pay, and the difficult working environment leads to a relatively serious challenge of high turnover (around 20 percent a year).

27.   **The need to manage thousands of field-based contracted employees (more than 20,000) all over the very large country from a relatively small central unit continues to be a difficult structural challenge in PKH management.** The 2015 reorganization of JSK was limited to rearranging the organizational structure at the central level and has therefore left the arrangement for managing the field staff untouched. As the recent wave of expansion into 6 million beneficiary families has been completed, the number of PKH field staff has surpassed 25,000, deployed in 34 provinces and 514 districts. How to manage this contingent of centrally-recruited field staff is one of the greatest institutional challenges of PKH management.

28.   **The current performance management and monitoring of facilitators is functioning sub optimally and would benefit from a redesigning and strengthening, pending further analysis**. At the moment, performance monitoring for facilitators is conducted in October, without the use of operational performance indicators but only a type of competency evaluation. Performance monitoring and evaluation is done at the national level which places a heavy burden on the program given the extensive number of facilitators and operators. It is mainly done by observing data entry and progress in the ICT Dashboard which informs on business processes. Every year in November, the local social affairs office will announce whether the facilitators' contract is continued or not and relays these decisions to the central authorities of PKH. Throughout the year however, MoSA faces a significant limitation in monitoring all facilitators' activities on a weekly basis leading to less than adequate program oversight

29.   **Lastly, given the many government agencies that employ facilitation systems to deliver results at the village and household, a key opportunity to enhance PKH results is linking these systems together.** Indeed, a key policy priority espoused by MoSA leadership is accelerating social protection program coverage convergence for poor families at the national Level and the local level. Linking facilitation systems at multiple levels would present a key opportunity to help achieve this policy priority. The Ministry of Villages, Disadvantaged Areas and Transmigration (MoV) has a facilitation system that differentiates roles[8] between different levels (village, sub-district and district). In particular, while this position is still under development, at the district level there will be an Expert on Service Delivery which could open up possibilities to link with other technical agencies, including local social affairs offices. Through its facilitators, MoV is able to reach the villages and the village based organizations and as such there is potential for PKH to build on this system in the long run.

e. Capacity development for PKH facilitators, operators, and coordinators

30.   **MoSA and central PKH management team established a standard training mechanism to ensure that PKH facilitators, operators and coordinators can perform according to their respective job descriptions.** This mechanism stipulates a series of regular trainings and ad hoc technical workshops (called "BimTek", i.e. technical guidance). PKH facilitators and operators are obliged to participate in the BimTek. These BimTek are supposed to be conducted at national as well as subnational (province and/or district) level. According to the standard mechanism, which was developed in 2012, the BimTek are not stand-alone trainings but embedded in the cycle of conditionality verification, payments, payment reconciliations, and regular coordination meetings of PKH field staff with representatives of administrations and social service providers at district, province and national level (called Rakor). By design, various BimTek focus on different content. The 1st BimTek is supposed to address the issues of a) how to facilitate

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[8] Improvement in the system as well as in its implementation mechanisms is certainly possible as The Ministry of Villages is working to get everything in place to provide the necessary support to the 73,000 villages especially in the light of optimizing the opportunities emerging from the implementation of the UU6/2014 Village Law.

and conduct the initial meeting with PKH beneficiary candidates for the validation process, and b) how to conduct the verification process of education and health components (e.g. filling out forms and reporting documents). The 2nd and 3rd BimTek are supposed to refresh, provide more detail to the procedures and more importantly – since PKH guidelines continuously evolve – update on recent changes (e.g. new calculation of PKH transfer per family composition). Additional to this, facilitators, operators and coordinators would likely receive irregular training, which are provided in collaboration with MoSA's internal training unit BADIKLIT. Irregular trainings are conducted to equip facilitators with knowledge to implement the FDS as well in case of significant technical or methodological changes. For example, when the Digital Mark Reader (DMR) technology was introduced to process the conditionality verification forms, operators were required to attend the DMR trainings.

Figure 5 Consolidated PKH yearly agenda

Assumed normal condition (not restructuring or budget cut year)

No.	Events	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
1	Additional Location (districts/cities/subdistrict etc) & Number of Beneficiary for current year, concluded by a DG decree letter		■										
2	Additional Quota Number of Coordinator, Facilitator & Operator for current year, concluded by a DG		■										
3	Procurement documents (TOR etc) for current year, released		■										
4	Procurement Process (MIS, Uniform, Guideline Books, etc)			■	■	■	■				■		
5	Preparation of PKH General and Technical Guideline Books						■	■	■				
6	Verification for 1st, 2nd, 3rd, & 4th payments of existing eligible beneficiaries of the current year			1st		2nd			3rd		4th		
7	1st, 2nd, 3rd, & 4th payments of current year beneficiaries (not additional beneficiaries)				1st		2nd			3rd			4th
8	Reconciliation and Settlement Processes with Payment Service Provider (PT POS)				1st			2nd			3rd		4th&1st
9	Recruitment Coordinators, Facilitators, & Operators for current year												
10	1st regular bimtek: for the new recruited coordinators, operators, and operators: as a preparation of						1st BimTek						
11	2nd/3rd regular bimtek: for the existing (not new recruited) coordinators, operators, and operators							2nd/3rd BimT					
12	Irregular bimtek (if any): Family Dev. Session/ DMR/ New Format Forms/ New Payment Mechanism etc							Irreg. BimTek					
13	District/ Citi, Provincial, Regional, and Central Coordination Meeting							Rakors (national & local)					
14	Releasing the Eligible beneficiary candidates (additional beneficiary) that needs to be validated												
15	Validation process & Initial Meeting of additional beneficiary of current year										■	■	
16	1st payment of current year additional beneficiaries												1st

31. **There are several implementation issues related to this standard mechanism. First, the content needs to be enriched further.** The BimTek focuses on the "nuts & bolts" of PKH, i.e. its broad objectives, basic program facts like calculation of benefits and UPPKH structure, its guidelines, procedures and processes. Given the ambition of PKH and its main target group (i.e. very poor and marginalized households), the facilitators themselves experience and articulate the need for additional capacity development, especially in communication skills, basic knowledge of social protection as well as knowledge of other national and sub-national social programs, which are of relevance for their clients.[9]

32. **Second, the above mentioned defined standard mechanism, however, has not been fully implemented due to budget constraint.** For instance, in 2016, only the initial training (1st regular BimTek) for PKH facilitators, operators and coordinators was conducted and was also belated (after the June payment), while the 2nd and 3rd BimTek were not (yet) implemented.[10] The main reason for this is related to budgeting. Since PKH is a non-permanent program, its budget is planned on an annual basis, budget allocations to the program depend on the overall availability of government finance. Therefore, due to two cross-board budget cuts in 2016[11], MoSA had to maintain PKH benefit payment levels by reducing the allocations to other lower priority tasks. Hence, payment and training cycles for PKH were altered to cope

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[9] GIZ, in 2013, developed and conducted a pilot communication skills development training for PKH facilitators, aiming at improving their communication with their clients. The pilot training was captured on video tapes and handed over to MoSA central UPPKH for further general implementation as part of the *BimTek*. This, however, never materialized due to limited capacities and budget in central UPPKH.

[10] The implementation of the 2016 *BimTek* cycle moreover got disrupted by a) new MoSA leadership on the director and general director level, new organizational structures as well as the upscaling of PKH. The later required as massive recruitment process, which absorbed substantial working time of JSK staff at national level.

[11] Due to decreasing oil and gas revenues, the Government had to cut its budget allocations to all line ministries in 2016.

with this situation. Given the standard one-year contract duration for facilitators and regular re-contracting of the same facilitators the next year, many of them received trainings with identical or similar content (e.g. content of 1st BimTek repeated in 2nd and 3rd BimTek) several times, but are less often – if at all – exposed to additional or new content and therefore stagnate on the same level of capacity.

33. **Third, as PKH is encouraged to utilize MoSA's internal training unit BADIKLIT, the training quality is subject to BADIKLIT's operational and technical capacity.** There have been times that when BADIKLIT could not actually provide the trainings in the expected quantity and quality due to capacity constraint despite budget availability. Going forward, BADIKLIT needs to substantially strengthen its capacity in terms of both staffing and training program development (content and training methods) and MoSA needs to search for multiple channels to carry out trainings.

34. **To improve the standard mechanism and its implementation, a thorough assessment of PKH facilitators', operators' and coordinators' respective skills needs is critical to inform the development of more comprehensive training curricula.** Additional to the "nuts & bolts" of the PKH program itself, these capacity needs are likely to include soft skills like communication, a basic understanding of social protection as well as knowledge of other relevant national, provincial and district level social (protection) programs. Moreover, since one important reason for inadequate capacity of PKH field staff is a lack of trainings due to limited overall budget availability, ensuring sufficient and predictable allocations of national budget to MoSA would go a long way to increase the capacity of PKH implementation staff. Moreover, given the frequent changes to the PKH guidelines as well as the huge costs involved in bringing all PKH-field staff regularly to Jakarta, more cost efficient solutions for their capacity development could be envisioned and developed, e.g. ensure a consequent decentralization of trainings (to be conducted either by the provincial Social Affairs Offices and/or by MoSA's seven regional training facilities) and/or stepping up MoSA's ongoing efforts to develop and implement e-learning modules for their social workers.

35. **In addition to capacity building, PKH human resource management policy needs to be reviewed with regard to other fundamental issues.** The unfavorable employment conditions (which probably lead to weakening of the pool of applicants) and a high rate of turnover also result in weak capacity of the field staff as collectivity. Also of relevance is the fact that facilitators' work load may not be sustainable, hence a more sustainable solution is to reduce their responsibilities and leverage IT to enhance their productive. The facilitators' one-year contract period should be considered to be prolonged in order to keep experienced facilitators and operators and reduce their high turn-over rate and thereby expose facilitators to more and different trainings sessions.

f. PKH Program Management Information System

36. **The PKH PMIS is composed of multiple software applications, which are used at different stages of the program implementation cycle for the purpose of data collection, data validation, data processing, data update, eligibility determination, beneficiary selection, payment calculation, payment list generation, grievance redressal, and reconciliation.** The core PMIS application is the Online SIM Application, which is web-based and was designed and developed using JAVA in 2007. It runs on the PKH main database hosted on Oracle 11g. The application has been modified with some minor revisions, but the required major modification to accommodate recent program changes could not proceed due to lack of application architecture documentation. To support data entry of an improved validation process, a new application called Offline Validation Application was built using VB.NET and MS Access Database and introduced in 2015. The UPPKH/JSK IT team has been able to modify this application several times. All other tasks of data extraction, data sharing, data upload are done either manually using scripts or through custom built small applications in VB.NET.

Figure 6 PKH Information Flowchart
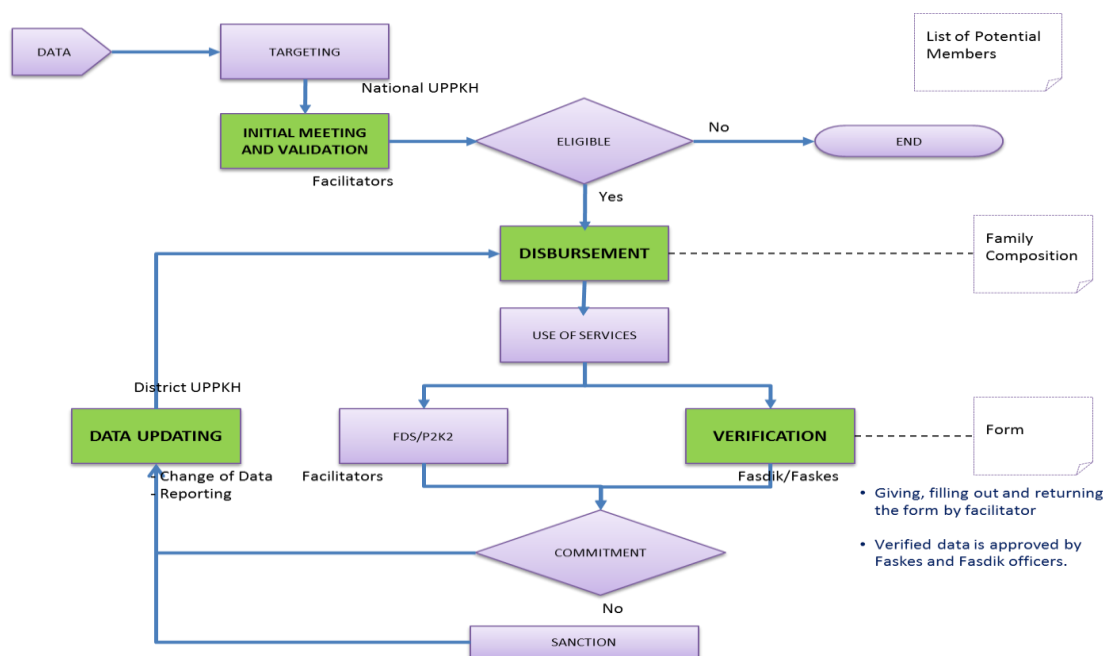
Source: PKH Implementation Guidelines.

37. **The five main business processes supported by the PKH PMIS are:**

- **Validation.** Before any selected poor family can become a PKH beneficiary, the responsible facilitator needs to validate eligibility by checking the family's actual situation against the targeting data. The facilitators use a validation form to collect this information and then update the information in the Offline Validation Application. The initial targeting data for each district is extracted from the PKH database and is placed in the form of text files on FTP Servers. The data is then downloaded and loaded into the Offline Validation Application. The facilitators using a laptop, make any changes in this data based the validation forms, on which data has been captured. The validated data is brought to district operators who further export and merge this data into a CSV file. The file is then shared with UPPKH/SJK through email for its further loading into the PKH database.

- **Verification**. All PKH families must comply with their responsibilities and their receipt of program benefits is contingent on the verified compliance of their conditionality. The facilitators use the verification forms to collect school attendance and health facility visit data of PKH beneficiary families. There are two types of verification forms – one is like a typical data collection instrument and verification data is manually provided on the form; and another is a DMR form, which uses machine readable marks to represent information. As non-compliance is of small percentage, facilitators only collect data for PKH beneficiary family members that did not attend school or did not make the required visits to health facilities. After the Verification Forms are signed and stamped by the providers, the forms are brought back to district operators who either enter data using the verification module of the Online SIM Application, or scan the DMR forms using the dedicated DMR scanners and send the resultant CSV files to the UPPKH/SJK team for further processing. Among 514 district offices, 113 use the manual verification form and the rest use the DMR forms.

- **Final Closing and Payment List Generation**. For each payment cycle after verification data is entered, district operators must use the Final Closing module of the Online SIM Application to review the beneficiary data and "close" the database in order to proceed to the next step that involves payment calculation and payment list generation. Internally, the process calculates payment based on verified conditionality compliance for each PKH family and the rules in case of not meeting the threshold of conditionality. The UPPKH Payment Team uses the Payment module of the Online SIM Application to extract payment related information into a CSV file and share with the payment service providers (PT Pos and partner banks) for their processing. The payment team in parallel also calculates the total funds to be distributed to each district and the report is submitted to the treasure team.

- **Data Updating.** PKH beneficiary families' situations often change over time. As some of these changes are relevant for determination of their benefits and responsibilities under the program, it is important to update beneficiary data in an accurate and timely manner. For example, both a new birth and a new pregnancy would very likely lead to increased need for health and nutrition services as well as increased benefit level. Other important changes to be updated relate to name and address, children's school enrollment status (e.g. graduation or drop-out), marriage status of PKH mothers, and receipt of other complementary services. The recorded change data would be input into the Online SIM Application.

- **Recertification.** After five years of consecutively receiving program benefits, PKH families would be recertified during the sixth year if they are still eligible for the program. Those that are still deemed poor would be given another three years of transition period before cash benefit would cease. Others who have managed to change their situation out of poverty would graduate from the program and the cash benefits would stop immediately. This module also deals with complaints received from the families who are supposed to graduate. Some of them may consider they are still poor and should continue to receive cash benefit. Complaints will be clarified by local community leaders before it is approved.

38.   **From a process perspective, there are several places that additional automation of data collection, entry, and transmission could improve both efficiency and quality.** From an IT perspective, the PKH PMIS needs to be enhanced to address the following system performance, information security, communication technology, and capacity issues:

- **Application.** The Online SIM Application slows down and responds abnormally during the peak load, likely due to sub-optimal application design. For example, the Final Closing module computes payment amount for each PKH participants using their verification data of each month. As it is a user-driven process, the Final Closing module often is stuck when multiple operators simultaneously execute the same module, consequently affecting application performance with severe database deadlocks. In addition, the Online SIM PKH application exchanges data in plain text using a protocol without encryption. Furthermore, the Offline Validation Application and DMR application are both standalone applications and yet to be fully integrated with the Online application.

- **Infrastructure.** UPPKH/JSK has a server room with its infrastructure built in 2007. The server room keeps 5 x Sun Sparc Application Servers with 8 GB Ram and 1 x Sun Sparc Database Server with 16 GB RAM. The Sun Storage has 7 TB of space which is connected through a SAN Switch with the Database Server. The Server room also contains a BI Server from Sun. There is a Disaster recovery site in Batam but it's not functional at the present. The physical load balancer from

Brocade is also non-functional at present. All the hardware and infrastructure are not under active support and maintenance contract at present.

- **Database.** The current size of the PKH Master Database is 60 GB and contains only textual data. The largest table in the database is the table of payments that contains total 37,338,948 rows and has a size of 7.97 GB. There is no regular data archiving in place and the historical data remains in the main tables. The database often receives deadlocks during the Final Closing process as there is large payment computation involved in the process and is dependent on payments table. The database backup is not a regular feature and there is no database backup policy and protocol in place. The tape libraries in the server room are not usable as there are no trained resources to take backups using tape libraries.

- **Network.** All sub-national PKH offices use the Online SIM PKH application and exchange data with UPPKH using a dedicated connectivity. 470 offices use a dedicated VPN over a fixed line connectivity to access the PMIS, while 34 offices use National Telecom VSAT service to access the PMIS. Each year PKH hires a service provider to provide support, maintenance, and dedicated connectivity with sub-national offices. A large extent of the IT budget is spent on supporting the dedicated VPN and VSAT connectivity. More importantly due to lack of appropriate network segmentation, users can make unauthorized access to other computers on the network, which is a serious system security concern.

- **In-house IT Team.** The IT team has technical specialists, including (i) IT manager, (ii) database administrator/Developer, (iii) network administrator. The capacity is far below what is required to support the operation needs of the program as well as to manage the system development process.

Table 5 PKH IMS Gap Analysis

Issue	Solution Options	Urgency
Application performance degradation	Database tuning and separation of payment calculation and payment list generation	Short Term
Database archiving and backup	Developing geographical codes mapping and transforming	Short Term
Mismatched location coding	Automating mapping of location codes between BPS and Ministry of Home Affairs	Short Term
Lack of IT development strategy	Developing a PKH IT strategic plan	Medium Term
Inadequate IT technical capacity	Building in-house capacity based on skill needs assessment and exploring partnership options	Medium Term
Disconnection between software application design and business requirements	Develop/update business requirements in consultation of all users	Medium Term
Fragmented database design	Develop an integrated and coherent data model	Medium Term
Lack of Information System architecture	Develop data, application, and technology architecture	Medium Term
Low reliability of IT infrastructure	Utilize MoSA Data Center infrastructure as well as its platform for Disaster Recovery, network and inter-operability arrangements	Long Term

39. **Furthermore, the current PKH PMIS could have potentially supported three additional functionalities.** First, the existing HR recruitment and training systems do not connect with the existing

applications that mainly serve the beneficiary families. However, lack of integration or interoperability clearly has been detrimental to the program's HR management, including performance management. Second, PKH operational data has not been used adequately for monitoring purpose in a transparent manner. For example, very little operational information has been disclosed regularly to the public on the MoSA website. It is important to build a business intelligence tool to assist the management with information analytics and support information disclosure for the transparency purpose. Third, the current PKH PMIS does not have a regular data exchange mechanism or protocol with other government systems. For example, PKH implementation can benefit from utilizing the existing national ID system's authentication service via API.

40. **A comprehensive gap analysis in reference to business requirements is required for developing a strategic IT plan for the PKH PMIS.** However, in the short term, certain stopgap measures need to be taken to address the most immediate needs, in particular supporting the coverage expansion to 6 million beneficiaries by the end of 2016. In the medium and long term, the PKH Information System needs to be redesigned afresh to support the future scale-up of the program, as well as better integration with other social assistance programs.

g. Payment systems[12]

41. **Indonesia's overall payment systems have continued to evolve in the past decades.** More recently, Bank Indonesia (BI), the Central Bank, has intensified its efforts to promote the use of electronic payment instruments. In 2015, BI upgraded its systemically important payment and settlement systems (BI-RTGS and BI-SSSS) as well as its clearing house (SKNBI). In addition, a series of regulatory reforms have accelerated introductions of new payment services and agent banking. Key regulatory reforms include BI's regulation on electronic money (2009) as well as its revisions (2014 and 2016), and the Financial Services Authority's (OJK) regulation on branchless banking (Laku Pandai) in 2014.

42. **BI's regulation on electronic money or e-money establishes a regulatory framework for e-money, including licensing for e-money issuers (banks and non-banks) and their agents.** Under this regulation, commercial banks with e-money licenses can have both individual and corporate agents while non-banks can have corporate agents only. On the other hand, OJK's regulation on Laku Pandai establishes a regulatory framework for basic savings account (BSA) and bank agents. BSA does not have any minimum fee or minimum balance to open and maintain, but has a maximum account balance at IDR 20,000,000. A bank can offer such products using agents once it obtains the Laku Pandai license from OJK. The bank can issue debit cards.

43. **While both banks and post offices have been involved in the delivery of PKH cash transfers, PT Pos is the longest running and largest payment service providers (PSP) for the program as of now.** It is delivering payments through 4,261 post offices (almost all online) and community-based delivery for those beneficiaries too far from the nearest branch (offline mechanism). But delivery of payments by PT Pos is in cash, not digital. Because PT Pos has a wider nationwide network of branches in comparison to commercial banks in Indonesia, it is uniquely positioned in the delivery of social assistance payments. When PKH was launched in 2007, PT Pos delivered payments to 388,000 beneficiaries in urban areas through its national remittance service Wesel Pos. In 2013 PT Pos switched from Wesel Pos to Giro Pos, an account-based money transfer system, because it is the cheaper option of its two payment mechanisms. PT Pos plans to launch a simple savings product (SimpulPOS) after modernizing its disbursement channel.

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[12] The payment section is mainly taken from *ISPA Social Protection Payments - Payment mechanism assessment: PKH.*

Table 6 PT Pos Payment Mechanisms

Product	Giro-Pos	Community payments
Payment instrument	Cash	Manual - Cash
Account	Virtual account	None
Payment Point[13]	Post office branch	Community pay point
Payment point administrator[14]	PT Pos staff	
Authentication approach[15]	Manual – PKH program ID or, Electronic – 1 factor	Manual –PKH program ID
Cost to program	IDR 9,000 per transfer[16]	

44. **PT Pos has created a Giro Pos system to enable benefit amounts to be credited into the recipient's Giro account.** For each quarterly PKH payment, the central UPPKH/JSK payment team generates a payroll and then sends both a soft copy file and a hard copy summary to the Head Office of PT Pos in Bandung. The unique identifier for the beneficiaries on the payroll is the PKH program ID number while the National ID number does not appear on the payroll. Recipients have to show their PKH program ID cards to the PT Pos cashier to get paid. The PKH program ID card has no photo and hence identity authentication at the time of payment relies on PKH facilitators verifying the identity of each recipient. This manual authentication predominates, although one factor electronic authentication is possible in some cases, where barcode readers are used to read PKH program ID card. [17] When payments are made in the community, an offline (paper-based) system is used. These records are then processed in batch at local post offices.

45. **The Government undertook several pilots on modern payment models.** As early as in 2011 the state-owned Bank Rakyat Indonesia (BRI) started delivering PKH payments through BRI basic savings accounts to 100,000 beneficiaries[18]. In the following year BRI served 500,000 beneficiaries (one third of all PKH beneficiaries) through 15 BRI branches and 120 bank units in the covered areas. However, BRI's contract was cancelled in 2013, due to complaints on long queuing lines and poor customer service. In 2014, BRI and another state-owned bank Mandiri were invited to join a payment pilot using e-money delivered through individual payment agents of two banks.

46. **During this pilot, BRI and Mandiri delivered two rounds of PKH payments using their e-money products (called Tbank and eCash respectively).** Both products need beneficiaries own mobile phone and hence SIM cards were issued to all participating beneficiaries free of charge. Tbank transactions rely on SMS - beneficiary fills out a withdrawal slip, types the 6-digit Personal Identification Number (PIN) into the T-Bank application on her phone; the T-bank system responds by sending a 6-digit One Time Password (OTP) to her phone; she types the OTP and the amount to be withdrawn on the agent's POS/EDC; the agent produces a receipt with date, time and amount of money withdrawn written in Bahasa Indonesia using the POS/EDC. For eCash, the agent uses their own laptop or tablet to enter the beneficiaries' mobile phone number; the beneficiary then receives a 6-digit OTP via SMS on her phone; the agent types that OTP into the system; both the agent and the beneficiary will receive a transaction confirmation SMS.

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[13] May be more than one type

[14] May be more than one type involved in payment distribution at the pay point

[15] Verification of the identity of the recipient at the point of payment

[16] This is composed of a transaction fee of 7,000 charged for delivering funds to the account and an additional 2,000 charge to cash out the benefit.

[17] Authentication refers to the verification of the identity of person claiming to be the rightful recipient of a payment. Strong systems use two factors of authentication to verify someone's identity for example a card used with a PIN or a card with a biometric fingerprint.

[18] Oxford Policy Management (2012) - *Disbursement of Social Assistance Cash Transfers Through Bank Accounts: A Study of PKH Payment mechanisms and options for social assistance cash transfers*.

Table 7 e-money Payment Pilot

PSP	BRI	Mandiri
Size of pilot	517 families using 10 agents	1343 families using 10 agents
Product Name	Tbank	eCash
Account	Limited purpose account[19]	Limited purpose account
Payment Point	Bank agent	Bank agent
Authentication approach[20]	Electronic – two factor (PIN & OTP)	Electronic – two factors (PIN & OTP)
Transaction Device (electronic)[21]	POS (EDC) (provided by BRI)	Laptop computer (owned by agent)
Total Cost to program:	IDR 7,500	IDR 7,500
Agent commission	IDR 5,000	IDR 6,000
Bank fee	IDR 1,000	IDR 1,000
Communication cost	IDR 1,500	IDR 500

47.   **The pilot revealed several implementation challenges.** Connectivity was not as reliable as required for smooth transaction experience. On average three USSD[22] sessions were needed to successfully complete one registration. Secondly the need for beneficiary education was significant. Some beneficiaries were having difficulty remembering their PIN and not all beneficiaries were familiar with SMS functions on their phones. As a result, the pilot did not improve payment delivery from the beneficiary point of view. At a focus group discussion with participating beneficiaries, the majority expressed preferences for PT Pos delivery mechanism over the BRI agent model because of the relatively straightforward process for collecting transfers from PT Pos. Neither test model appeared to be commercially viable or scalable.

48.   **In November 2016, President Joko Widodo launched the National Strategy for Financial Inclusion together with a presidential regulation on financial inclusion. Government-to-Person (G2P) payments are considered instrumental to the ambitious financial inclusion agenda.** Since G2P payments such as PKH cash transfer would significantly contribute to an increase of access to transaction accounts, the government has committed to fully shifting social transfer payments from paper-based (cash) to digital accounts (e.g. bank accounts, e-money accounts) by 2019, which certainly requires further development of payment systems infrastructure in Indonesia. Meanwhile, PT Pos' role as PSP for PKH is expected to be reduced significantly.

49.   **To ensure effective PKH benefit payment delivery while switching to cashless payment modalities, MOSA needs to ensure the following minimum requirements to be followed by all PSPs:**

- **Accessibility**:
    1. The cost, both financial and non-financial costs (e.g., distance traveled by a beneficiary to reach a pay point) should be minimized; and
    2. The method of payment is appropriate to the needs and the capacity of the beneficiary (e.g., it may not be appropriate to require use of a password to an illiterate beneficiary); among other considerations.

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[19] May be issued by a bank or non-bank and may have restrictions regarding transaction types e.g. e-money account or virtual account.
[20] Verification of the identity of the recipient at the point of payment.
[21] Only in cases where the payment instrument is electronic.
[22] USSD (protocol known as unstructured supplementary service data) create secure, verifiable channels for transactions including those for mobile banking. These mobile phone entries require the use of special characters and start with an asterisks *.

- **Robustness**:
    1. The payment delivery should be reliable and secure in terms of the timing, the amount delivered, etc.; and
    2. The process should be properly monitored, controlled and reported on so that there is clear traceability of money flow and accountability for the entire transactions.

50.   **There are multiple payment models for PKH to leverage when moving from cash to electronic payment.** Access points for financial services are key to success for non-cash delivery of social assistance payments. In Indonesia networks of both Laku Pandai bank agents and LKD e-money agents are rapidly expanding.

- **Laku Pandai** is an agent banking program under OJK's financial inclusion efforts, which allows banks to use agents, both corporate and individual[23]. This was expanded to Sharia (Islamic finance) bank in December 2015. The bank accounts that are opened under this program will bring access to services such as savings, microloans and micro-insurance policies.

- **LKD (digital financial services)** is one of several types of registered e-money that are provided for under BI regulation. Those licensed as e-money issuers are allowed to recruit corporate entities as agents. The 2014 amendments to the e-money regulation expands the type of agents from only businesses with a money remittance license to both fund transfer businesses or incorporated businesses and individuals. The 2016 regulation only allow commercial banks to recruit individual agents in addition to corporate entities. This means that e-money issuers that are commercial banks and non-banks are only allowed to operate fund transfer businesses and to use incorporated businesses as their agents, not individuals. Thus agency rules in Indonesia allow only commercial banks more options for service delivery.

51.   **The transition of PKH payments to cashless methods depends on the spatial distribution of Laku Pandai and LKD networks.** MoSA has been working with the Association of State-owned Banks (Himbara) since early 2016 to plan the transition. Himbara currently consists of four banks – Bank Mandiri, Bank Negara Indonesia (BNI), Bank Rakyat Indonesia (BRI), and Bank Tabungan Negara (BTN) – and it is currently using the Link network. PKH's transition to cashless payment started in 2016 in 69 cities and districts where the Himbara's ATM/POS network and PKH beneficiary families are most overlapping. For 2017 and beyond, further expansion of PKH cashless payment would follow the expansion of the Himbara's payment network infrastructure. For each sub-district to be considered for switching to cashless payment methods, there must be at least two agents already in service and their capacity to serve the existing PKH families is deemed adequate.

52.   **In addition, the Government will also introduce a "Combo card" to facilitate disbursement of social assistance cash and in-kind benefits.** This Combo Card combines both functions of a program card for social assistance programs (called "Family Welfare Card" or KKS) and a payment card (a debit card and an e-money instrument). All social assistance benefits, including subsidies, will use electronic money. Such subsidies will be credited to e-money accounts. The beneficiaries would need only one card to receive cash benefit payments from different programs and make payments for goods (at times limited goods) and services. Currently, BNI is the only acquirer of merchants and all four banks are issuers of Combo Cards. PKH beneficiaries can receive and make payments for purchases with the Combo Cards with the debit card function.

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[23] Branchless banking services and/or other financial services that are not conducted through physical office but through networking with other parties and should be supported by information technology. OJK issues the license for LAKU-PANDAI (OJK Number19/POJK.03/ 2014, SE OJK Number6, 6 Feb 2015).

53.   **Another innovation is a shared delivery platform called e-Warong for cash and in-kind benefits.** It actually has two types – KUBE-PKH and market vendor – with different genesis. While KUBE-PKH[24] is a graduation strategy for PKH beneficiaries to own and learn to operate a new business via a cooperative structure, market vendors are tapped to disburse in-kind Rastra benefits under the e-voucher pilot on top of their existing operation. From a financial sector regulators' point of view, e-Warong is a merchant acquired by banks for card payments. Laku Pandai banks and bank e-money issuers may have e-Warong as their agents. Since this is a new way of disbursing social assistance payments, a proper assessment and adjustments are required before implementing the model at a full scale.

54.   **The Government has started an e-voucher pilot (non-cash food assistance or BPNT) with 44 cities in 2017, although a full conversion of social assistance payments into non-cash payments requires further development of payment systems infrastructure, acceptance of new payment instruments, and awareness among beneficiaries among other things.** Further, in order to make non-cash payments sustainable for financial inclusion, beneficiaries should continue to use the accounts for multiple purposes, not only one particular purpose (e.g. PKH disbursements). The planned effort to consolidate different social assistance program cards into one "Combo card" is a step in the right direction.

h. Grievance management

55.   **PKH has established a Public Complaints System (SPM) as a mechanism both at central and local levels to handle complaints from PKH beneficiaries, stakeholders, and the general public related to PKH program implementation. The** SPM is perceived as a way to increase community participation and social interaction to channel both suggestions and complaints on performance of facilitators, abuse of power, political interference, and other program related issues. By design, complaints can come from multiple channels – in-person reporting, fax, letter, email, phone, SMS, MoSA website, or one online application developed by the central UPPKH/JSK. Usually the complaints fall into four categories:

(1) Inquiry or clarification due to lack of information;
(2) Incorrect or to-be-updated beneficiary information;
(3) Behavior or performance issue of a facilitator or other staff;
(4) Benefit cut or termination.

Figure 7: Complaints by Type (2016)
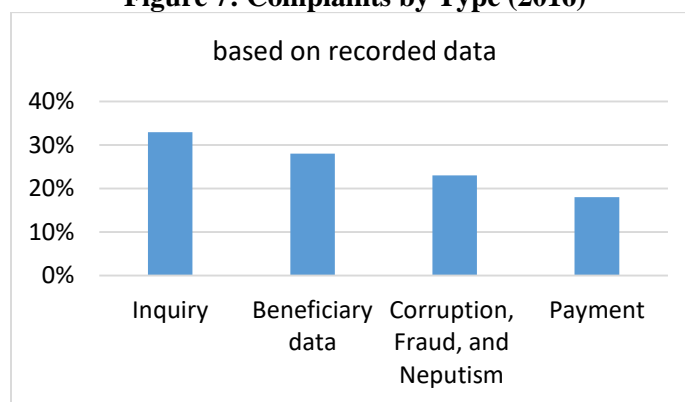
Source: MoSA "PKH Public Complaints System Report 2016"

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[24] Currently it serves three roles: as a bank agent to disburse social assistance transfers cards and POS terminals, a distribution agent to disburse subsidized rice and other in-kind food items, and as a trader to market local products made by community members. While it is assisted by the government through initial seed money and management support, it is designed to be self-sustained in the long run.

56.   **In principle, all complaints must be responded to within one month.** Depending on the nature of complaints, there are two response options – administrative response and field investigation. Most complaints can be handled administratively. If a complaint is related to a certain business process, it would be handled by the nearest staff of the responsible team. If there is a complaint about a member of the PKH implementation team, it would be handled by someone senior to that person. However, if the complaint involves corruption or fraud or otherwise deems important and involving multiple parties, then a field investigation is initiated and the facts and findings subsequently become the basis of decision or action. For example, it may require holding a village meeting to discuss the issues and find a solution together with the community. Sometimes a special meeting is needed even after a complaint is settled or the follow-up action is taken. This meeting is to ensure a common understanding in the community that the solution is the most appropriate and the process is transparent.[25]

57.   **However, not all complaints have been recorded in one centralized system for analysis and reporting purpose.** It is estimated that in 2016, on average there are between 10 and 20 complaints received by the PKH program every day via SMS, website, email and letter. Besides complaints either coming in via digital media or deem important to trigger field investigation, most other complaints are likely not recorded. Furthermore, it is not very clear if the complaints have been handled in a satisfactory manner to the people who have raised them. Lack of potential impact may discourage people from raising complaints in the first place. As this mechanism is critical to the expansion, which likely leads to an increase in complaints, it is important that MoSA conducts an assessment to understand if the current SPM is serving the program as it is designed to do and what changes can be made to improve its effectiveness. [26]

i. Family Development Sessions (FDS)

58.   **FDS originated from a group-based learning approach introduced in PKH in 2012.** A group of PKH mothers or grandmothers who live close by and if possible share similar education and health characteristics would elect a leader among themselves. Then facilitators would organize monthly meetings with group leaders and then with each group to disseminate new information on PKH, discuss day-to-day problems faced by the beneficiaries, and provide a venue to share thoughts. Later the government wanted to transform these monthly group-based learning meetings into FDS with structured training modules in order to provide knowledge and training on life skills to PKH mothers and promote positive behaviors that can help lift their families out of poverty. At the time FDS was designed as an instrument to prepare PKH beneficiary families to graduate from the program at the end of their six-year cycle.

59.   **With the technical support of the World Bank and the United Nations Children's Fund (UNICEF), four modules and seventeen sessions were developed, building on consultations with PKH beneficiaries, other key-informants in the community and lessons from other countries (e.g. the approach taken in the Philippines' CCT).** The World Bank supported the development of the Education and Economy modules, while UNICEF supported the development of Health and Child Protection modules. Each module consists of step-by-step guides for activities and discussions on specific practices, delivered in an interactive-participatory learning process:

1. **Education** (4 sessions) and **Economy** (3 sessions) modules are equipped with Buku Pintar (smart book), brochures, flipcharts, films and posters. In addition, tutorial videos were made for FDS trainers and facilitators as training refreshment.
2. **Health** (8 sessions) and **Child Protection** (2 sessions) modules are equipped with Buku Prestasi (handbook), films, and games tools.

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[25] MoSA 2016 "PKH Public Complaints System Report.
[26] Ibid.

3. In 2016, following the introduction of two new components on elderly and severely disabled, MoSA Training Center has developed the respective FDS modules - **Elderly** (1 session) and **Disability** (1 session).

60. **From September to December 2014, MoSA implemented FDS training for 455 facilitators who were responsible for the first cohort of PKH beneficiaries (those enrolled in 2007).** Following the training, the Education and Economy modules were piloted in 122 sub-districts located in 33 districts in West Java, DKI Jakarta and East Java from November 2014 to December 2015. However, the originally planned RCT evaluation was aborted due to implementation issues[27]. The Health module was piloted as part of Prestasi Program II in Brebes, Central Java from April 2015 to June 2016. The Child Protection module was also implemented in some areas.

61. **Both a FDS Qualitative Study[28] and the observations from the field visits to 7 districts during February to December 2015 revealed that FDS implementation often did not comply with the design.** In some areas there was lack of teaching and learning materials (Buku Pintar) and brochures. Furthermore, most sessions were not implemented monthly and delivered less than the 120 minutes of training required by design. The Prestasi pilot evaluation has not been able to identify strong impact of the PDS Health module, likely due to implementation issues. Hence the FDS implementation process needs to be improved.

62. **Since 2014, MoSA has conducted 3 rounds of FDS trainings.** Also in 2015, MoSA's internal Training Center, BADIKLIT, with technical support from GIZ developed FDS e-learning modules. MoSA piloted e-learning on Education and Economy Modules to 26 facilitators in Banjar, South Kalimantan in May 2015.

Table 8 Evolution of FDS

	2014	**2015**	**2016**
Participant	Facilitators of 2007 Cohort	Facilitators of 2007 & 2008 Cohorts	Area & District Coordinators
Number of trainee	455	1,041	9 Area Coordinators 30 District Coordinators
Trainers	BBPPKS and Pusdiklat	BBPPKS and Pusdiklat	BBPPKS and Pusdiklat
Training evaluation	No	Yes	No

63. **There are several areas that can be strengthened to improve FDS implementation and impact.** First, FDS implementation should be monitored much more closely at every PKH management level, particularly when FDS is widely implemented**.** For example, in Lamongan district, there could be as many as 200 FDS meetings for 7,429 beneficiaries in 7 sub-districts in one month. District coordinators should work closely with sub-district teams to plan and monitor the FDS implementation. Information on how sessions being conducted in the field, including session duration, contents, technical problems, the challenges and suggested solutions, could be collected systemically to support the further development of FDS.

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[27] The pilot was supposed to be evaluated using RCT approach. However due to implementation issues, in October 2015, TNP2K, Bappenas, MoSA, DFAT and WB decided to drop the RCT evaluation study.
[28] Akatiga Consulting Firm, conducted in Mar-Apr 2015 and Nov 2015.

64.   **Facilitators' skills and knowledge are critical to the success of the FDS sessions. In addition to the knowledge of the messages of each session, facilitators need to learn how to listen and how to help PKH mothers who may feel uncomfortable to speak in public to talk**. This type of facilitation skill should be introduced as a core element of the FDS training of facilitators. Another useful skill is how to plan each session – not only schedule it to fit into the mothers-group's availability, but also clearly list what should be said and done in sequence. Facilitators need to prepare related posters, flipcharts, and films and make best use of the venue's space, so that it is possible for both poster and flipcharts to be displayed. Facilitators also need to manage the time efficiently to go through the listed activities.

65.   **In addition to further adjustments to the FDS contents based on practical lessons and to the delivery method, lack of financial support at provincial and district level needs to be addressed.** The 5% fund contribution by districts should also include the FDS operational expenses in the field for CCT facilitators. Alternatively, MoSA may consider a collaboration with other programs that employ similar instruments. For example, it might be more efficient – and possibly also effective – to embed the FDS Health module within the wider range of locally administrated health and nutrition services and thereby share the implementation responsibility with local governments. This would require a more horizontally integrated and owned implementation arrangement and may need some time to develop and stabilize. MoSA has planned to strengthen FDS implementation in the future by: (1) developing FDS technical guidelines, (2) providing FDS to PKH beneficiaries at an earlier time, from the second year onwards, (3) developing a FDS monitoring and evaluation system and link with HR performance management system, and (4) establishing a FDS operational fund.

j. Transition and Graduation

66.   **Based on a recertification process, any PKH family determined to be poor after 6 years of the program is granted an additional 3 years of transfers, complemented by additional livelihood and income support from programs like KUBE.** KUBE is a livelihood development and empowerment program implemented by MoSA since 1983. It encourages the creation of group based micro businesses through the provision of capital to groups of 7 to 10 people from poor households (a onetime grant of IDR 20 million or approximately US$ 2,000) as well as entrepreneurship and business trainings. It has been linked to the PKH program since 2013 to encourage eligible PKH beneficiary families to set up a sustainable business as a group and graduate from the PKH program. In 2013, 1,000 KUBE-PKH groups were formed, across eight districts in five provinces, making use of existing PKH facilitators who received extra training to manage PKH beneficiaries' progress in receiving the KUBE grant. In 2015, around 20,000 KUBE-PKH groups were formed and are to receive the KUBE grant. A new development to the existing KUBE program is that PKH facilitators receive continued web-based trainings to better facilitate beneficiaries with the creation of business proposals and are tasked with managing a KUBE-PKH business database and MIS to monitor the development of KUBE-PKH businesses.

67.   **Additional support to access sustainable livelihood development opportunities is critical for PKH families to be "empowered" to emerge from a state of dependence and vulnerability to one of independence and resilience.** For example, within PKH families both secondary school graduates who are ready to enter labor market and under-skilled individuals who are already working would benefit from labor market activation programs or job centered skill training and enhancement programs. Bappenas launched the Program Penghidupan Berkelanjutan (P2B) in 2015 in response to this un-met need by poor and vulnerable population in general. PKH families can benefit from various P2B initiative and other livelihood programs implemented by central and local governments as well as civil society organizations. In 2013 and 2014, 39% and 31% of PKH beneficiaries of the respective 2007 and 2008 cohorts graduated. The graduation rate could be further improved in the future if PKH's graduation strategy could be enriched.

Figure 8 PKH Transition and Graduation Cycle
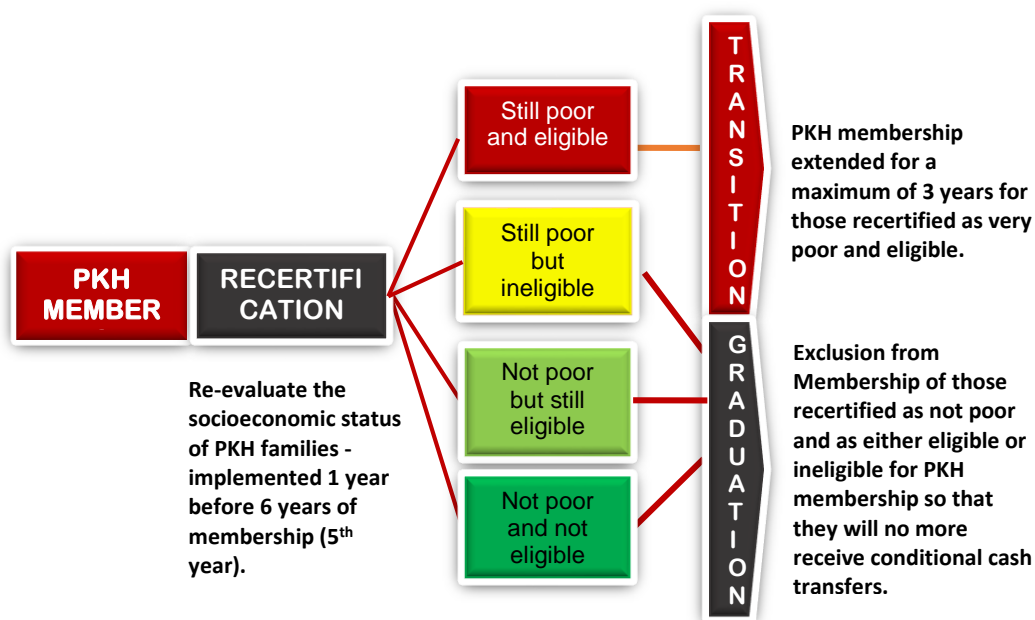
k. Institutional Arrangements for PKH Implementation

68.   **The institutional arrangements for PKH program involve three layers, all of which are important for achieving the desired results of PKH program.** First, as MoSA is responsible for planning, setting operation rules, and managing overall implementation, the central management unit's internal organizational structure and institutional capacity are critical. Second, there are a large number of sub-national implementation teams involved in carrying out various tasks and hence the adequacy of their capacity and clarity of their roles and responsibilities affect the actual implementation on the ground. Lastly, inter-sectoral coordination at both central and local levels is essential to ensure the program is smoothly implemented and the beneficiaries have complementary access to basic services which are necessary for achieving the program objectives.

l. Institutional Arrangements for PKH Implementation: National level

69.   **MoSA through JSK under the Directorate-General of Social Security and Protection, is the agency responsible for setting policies and implementing PKH.** PKH program management structure has been reformed recently. In October 2015, MoSA issued a ministerial decree[29] to reorganize the institutional arrangement for PKH implementation and made the entire directorate of JSK fully in charge of the program. In the structure that prevailed prior to the 2015 reorganization, a sub-directorate (Subdit) within JSK oversaw PKH implementation with a lean administrative structure with most of the actual program management delegated to a team of about several dozens of contracted "experts" under the central UPPKH. It consisted of functional units handling management information system, data and disbursement, implementation, monitoring and grievance handling, and administrative support. Other than the sub-director and the two section heads, no civil servant was directly involved in managing PKH.

70.   **While the UPPKH arrangement – essentially a parallel structure of a program management unit – served its purpose while PKH's scale was relatively limited, its steadily growing scale and importance raised a concern about its institutional sustainability.** Therefore, the restructuring approved

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[29] Ministerial Decree, October 2015.

in 2015 and implemented gradually throughout 2016 was intended to "mainstream" the responsibilities for PKH implementation squarely into the core functions of the JSK with direct involvement of career civil servants. The ministerial decree rearranged the configuration of these internal units into four Subdits and one administrative support unit. The units are:

1) **Validation & Termination Sub-Directorate** (Subdit 1) responsible for validating eligibility of potential PKH beneficiaries identified from the Unified Database (UDB) and program exit for those beneficiaries who no longer meet the eligibility criteria;

2) **Social Assistance Sub-Directorate** (Subdit 2) responsible for benefit payment and monitoring of benefit use by the beneficiaries;

3) **Beneficiaries Sub-Directorate** (Subdit 3) responsible for physically locating the beneficiaries, verifying their compliance with the conditionality, and providing "capacity building" for beneficiaries through activities such as family development sessions;

4) **Resources Sub-Directorate** (Subdit 4) responsible for recruiting and training PKH field staff and coordinating with other agencies involved in PKH implementation; and

5) **Administration Sub-Division** (TU) tasked with handling administrative affairs, staffing and budgeting for the Directorate – TU is headed by an officer one rank below the Subdit heads.

Figure 9 Directorate of Social Security for Family Organizational Chart
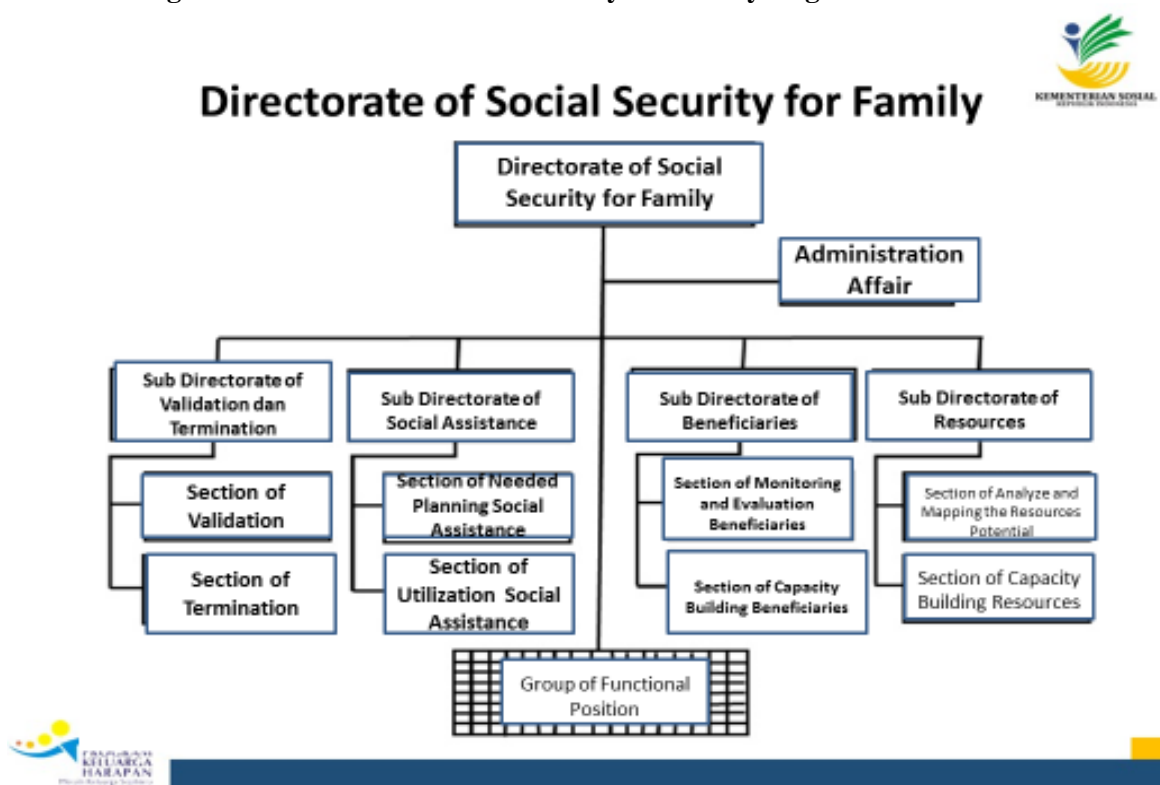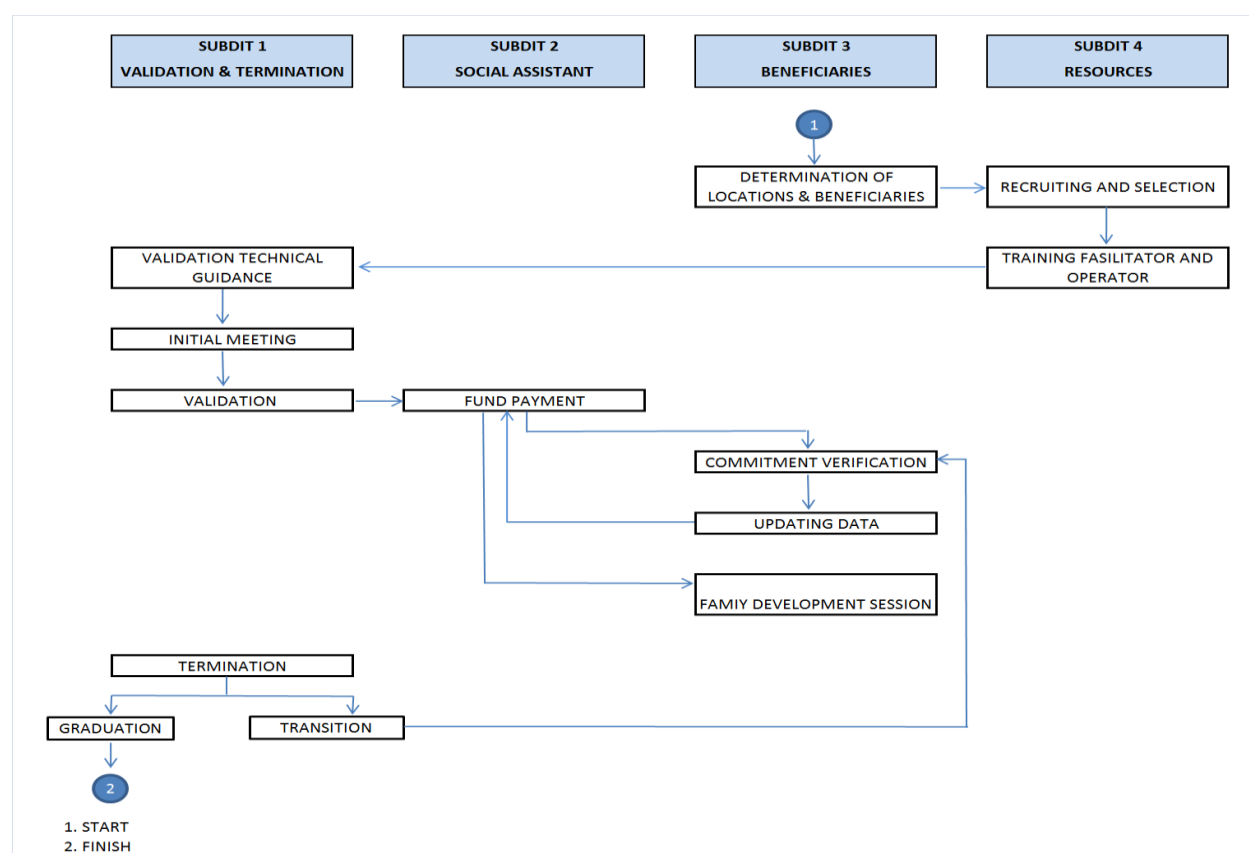

Source: MoSA

71. **Each sub-directorate has two sections under it to carry out the following in their respective areas of responsibility: policy formulation and implementation; drafting norms, standards, procedures, and criteria; providing technical guidance and supervision; and monitoring, evaluation**

and reporting. JSK is headed by a Director, each sub-directorate is headed by a sub-director and staffed with two section heads (echelon 2-4) and around two civil servants in each section.

72. **MoSA has been managing PKH competently, steadily expanding its coverage from less than half a million families in seven provinces in 2007, to 3.5 million by 2015, to about 6 million families in virtually all provinces by end 2016.** However, the relatively effective implementation in the past is not necessarily an accurate indication of MoSA's capacity to manage PKH going forward due to the following recent changes: 1) the decision to overhaul the organizational arrangement for PKH management;[30] 2) the increase in PKH coverage from 3.5 million to 6 million families in 2016, including by entering into challenging geographic areas such as Papua and West Papua where PKH had hitherto not reached; and 3) the introduction of a range of enhancements to PKH's design, such as the addition of elderly and disability benefits, which adds complexity and taxes JSK's capacity to manage the program.[31]

73. **On the surface, JSK's current organizational design follows a relatively straightforward logic based on a linear sequence of PKH implementation process from eligibility determination and enrollment to benefit payments and other beneficiary interfaces** (Figure 9).

Figure 10: JSK Subdits and PKH Business Process

Source: MoSA

74. **In practice, however, JSK is still going through a "growing pain" to hammer out some of the finer details of role definitions across units or among individuals within each.** For example, there appears to be a residual level of ambiguity regarding the locus of responsibility for handling beneficiary

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[30] Ministerial Decree, Oct. 2015.
[31] In addition to elderly and disability benefits, other enhancements include introduction of cashless payments and efforts to facilitate PKH beneficiaries' access to a set of complementary programs.

data. The quality and timely availability of beneficiary data is essential for a range of PKH business processes including eligibility determination and enrollment (Subdit 1), compliance verification (Subdit 3), and benefit payments (Subdit 2). Multiple Subdits make use of the beneficiary data to do their jobs and yet it is not clear whether any single unit is ultimately responsible for their completeness, veracity, timeliness, etc. The new organizational design also does not clearly specify which unit would be responsible for cross-cutting functions of M&E and grievance handling. The assignment of some of the contracted "experts" who used to handle M&E and grievance handling in the old UPPKH to the Subdit 3 (Beneficiaries) in late 2016 appears to reflect JSK's de facto decision in this regard. Apart from the question about the appropriateness of assigning strategic cross-cutting functions like M&E and grievance handling to one Subdit, the assignment of these roles to the Subdit 3 has not been formalized, unless these core functions are considered to be aspects of "monitoring and evaluation of beneficiaries" which is one of the Subdit 3 sections. Another ill-defined functional responsibility of JSK's current structure is the day-to-day management of the field staff. Subdit 4 (Resources) recruits and pays the field staff but the other three Subdits heavily rely on their work to carry out their respective institutional roles. In the end, it is as though the field staff report to all four Subdits. In contrast, the previous UPPKH structure operated with a centralized command structure with three regional coordinators (also contracted "experts") in the Implementation Division, sitting at the top of the pyramidal structure of reporting lines to oversee a set of provincial coordinators within their respective regions. For accountability, it is important that the new arrangement consolidates itself into an efficient working model with clear definitions (and mutual understandings) of the roles and responsibilities of each unit, roles and skill profiles of each individual within it, and working relationships between units.

75.   **Some of the ambiguity might be because of the 2015 ministerial decree itself, which lacks precision in defining exactly what is entailed in each Subdit's key mandate.** The decree merely lists a range of common generic responsibilities (e.g., formulate policies, issue norms, etc.) in each Subdit's respective domain (e.g., validation and termination, social assistance, beneficiaries, resources) without clearly specifying what the tasks of each domain actually entail. It is therefore ideal to prepare a more detailed description of the core responsibilities of each Subdit, in light of the assessed business needs and step-by-step identification of key tasks along the business processes for PKH implementation.

76.   **The JSK leadership is in principle committed to prepare more detailed "job descriptions" to guide more precise demarcation of organizational responsibilities across its internal units.** It is recommendable to complete this exercise as soon as possible. While an early resolution of the remaining ambiguity is relatively urgent, it is also recommendable to take those definitions of Subdits' "job descriptions" as preliminary, conduct a mid-term review, say, after a year or so, to assess whether additional adjustments would make sense, and consolidate the arrangement based on this review, at which time a new ministerial decree, if necessary, might be issued to consolidate the new structure.

77.   **Under this evolving context, the most critical consideration in assessing JSK's capacity to manage the expanded and more complex PKH is the fact that this is a unit on its learning curve because of its recent (and still-unfolding) organizational change**. In the previous arrangement, virtually all the work on PKH implementation was handled by contracted "experts" at the center and the PKH field staff on the ground. But since the 2015 restructuring formally dismantled the previous UPPKH structure, the new structure has been put in place gradually and the entire JSK staff (of around 50 civil servants) have been learning about specific aspects of PKH implementation and business processes through "learning by doing." In practice they continue to rely extensively on services rendered by around 50 contracted UPPKH "experts" who have remained in JSK. Furthermore, the contracted "experts" are currently working under the contracts that refer to the previous organizational structure (UPPKH) and are not in that sense formally assigned to any of the current Subdits, although renewal of their contracts for 2017 may rectify this situation.

78.   **On capacity, some of the civil servants assigned to specific Subdits are not necessarily specialists in the subject matter.** They are all learning by doing, with help from the contracted "experts"

with longer experience in PKH implementation. They have not benefited from any formal training, even a minimum orientation on the basics of a cash transfers operation or specific aspects of the business processes they have been tasked to manage. Besides, some of the staff have been reassigned either within JSK or within MoSA in less than one year since their initial appointments. Short tenures in posts, without formal training/orientation, further limit the effects of learning by doing, and hence deter the whole Directorate's institutional capacity building. Both some form of minimum formal training/orientation and longer duration in their assignments seem necessary to encourage gradual building of JSK's institutional capacity.

79.   **Another possible obstacle to building Subdits' institutional capacity is the degree of informality in PKH implementation.** Facing tight deadlines to deliver on a variety of tasks to meet the ambitious expansion target in 2016, JSK has at times operated with informal arrangements in assigning specific tasks to staff/units. A case in point is the assignment of the task to oversee the recruitment of around 10,000 additional field staff to the sub-director who was initially appointed to head the Beneficiaries Subdit, when on paper this was the responsibility of the Resources Subdit. While a particular circumstance may have necessitated or even justified this decision, it appears to have generated a degree of confusion among the staff. Such an informal arrangement should ideally be kept to a minimum as it would dilute unit-level accountability and could also hamper capacity building by way of learning by doing.

80.   **The rationale behind the change (to "mainstream" PKH management for the sake of ensuring institutional sustainability) is justified and a degree of uncertainty is unavoidable in any organizational change.** However, unless this transition is managed well, it could have negative impacts on JSK's ability to deliver the ambitious goals by diluting accountability and stunting necessary development of JSK's institutional capacity, at least in a short to medium term.

**m. Institutional Arrangements for PKH Implementation: Subnational level**

81.   **While PKH is a national government program, its implementation relies heavily on the nationwide network of field staff.** The institutional arrangement for PKH implementation at the sub-national level has mirrored the original organizational arrangement at the central level of relying on a program management unit (UPPKH). Previously 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 Office (Dinas Social) of each sub-national government. Going forward, the Social Affairs Offices are responsible for PKH implementation with support of contracted personnel. The number of field staff to be deployed follows pre-defined ratios and the geographic characteristics of the areas to be served.

82.   **At province level there are 'Provincial Coordinators' and 'Provincial Operators'.** Provincial coordinators are recruited to coordinate PKH activities at the provincial level, supervise District/City Coordinators and ensure local education and health services are available and functioning. Responsibilities of provincial operators include: (i) scanning paper forms of beneficiary compliance with PKH conditionality; and (ii) entering weekly activity reports of facilitators into the MIS. The provincial PKH unit is formally led by eight members from the Social Affairs Office including the department head as Advisor, the head of Social Division of the Social Affairs Office as Chairman, the head of the section responsible for PKH at the Social Affairs Office as secretary. The other five members are staff from the Social Affairs Office responsible for data, community grievance system, assistance distribution, verification, monitoring and evaluation.

83.   **Similarly at district/city level there are also Coordinators and Operators.** Coordinators are contracted to coordinate PKH implementation at the district/city level. They are required to supervise the facilitators at the sub-district level, monitor and assist service facilities to ensure steady supply of services,

oversee and assist sub-district-based administration and MIS teams. Operators are contracted to input data, including uploading data of validated PKH families entered by the facilitators, to the National PKH MIS. Each district is also supposed to constitute five PKH-dedicated working groups: the data team, the health and education services team, the fund allocation team, the verification team and the M&E team. The district PKH office is also responsible for supervising and liaising with the sub-district PKH implementation staff.

Figure 11 Structure of District/City UPPKH
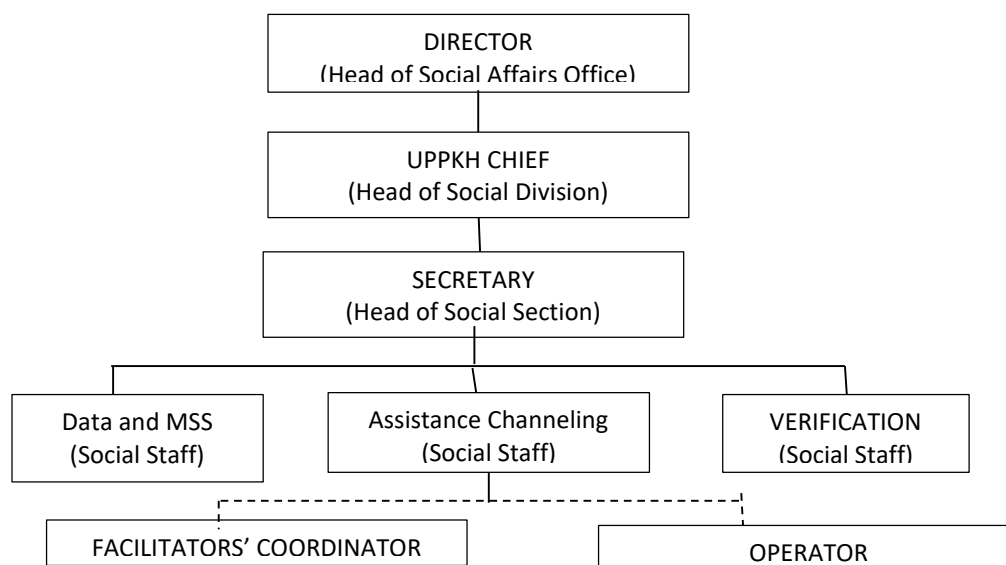
84. **The sub-district PKH unit is staffed with facilitators who interact directly with PKH beneficiaries/families.** If there is more than one facilitator in a sub-district, then one of them is assigned to be a 'Facilitator Coordinator' for that sub-district.

85. **Adding to the ambiguity of responsibility over managing the field staff at the central level, the supervisory structure connecting facilitators to JSK is also inefficient.** Facilitators are connected to JSK through a long reporting chain with a district and a province as "intermediaries" along the way (through the coordinators at the respective levels, but sometimes requiring formal letters signed by the head of the provincial/district social affairs office). As a result, certain managerial decisions regarding field staff can take an inordinate amount of time. For example, months of delay are said to be common in simple HR transactions like formally terminating the contract of a facilitator who has been let go. The inadequate use of information technology for reporting on program activities (some of which require scanning of paper reports by provincial operators) further increases the inefficiency in the supervisory and reporting arrangement.

n. Collaboration with Local Government

86. **MoSA has hoped for, and formally requested, collaboration and support from the sub-national governments.** The Director-General of Social Security and Protection has issued annual letters "requesting" local governments to allocate the equivalent of 5 percent of the PKH benefit budget allocated for a particular local jurisdiction as administrative budget to support PKH implementation. The 5-percent budget is meant to support activities such as "socialization" (communications & outreach activities), secretarial and other office support for PKH field staff, field-level operational costs (e.g., cost of printing a form for compliance verification, stationaries, facilitators' travel costs to reach beneficiaries, etc.), monitoring and supervision of PKH activities by local government staff, etc. While comprehensive statistics

are unavailable, the extent of compliance with this request among the provinces and the districts seems uneven, although almost all sub-national governments do provide at least a minimum level of support by "housing" PKH field staff (however, there are cases where PKH field staff themselves are shouldering the cost of office rentals and other maintenance expenses).

87.   **A 2015 study[32] on the role of local governments in PKH implementation, found that local PKH teams formally headed by the local social affairs office, were generally performing well in implementing the program.** It did, however, note that lack of personnel, both in terms of the number and capabilities, could be a hindrance to more extensive and effective support for PKH implementation. The study also noted weaknesses, especially with respect to the levels of ownership and understanding of the program among various local institutional stakeholders, starting with the social affairs office but also health and education offices. One of the reasons cited is ineffective communication and information sharing between PKH and these departments.

88.   **But the challenge of managing the extensive PKH implementation structure at the local level may go beyond better information sharing, strengthened human resources in the local social affairs offices, or even improved coordination among local sectoral agencies. It is clearly inefficient and ineffective to manage such an extensive local-level bureaucracy as the local PKH teams from a small central unit.** But the way MoSA manages this situation, reflecting the overall institutional architecture of the country's inter-governmental relations, seems to represent an inefficient mix between a fully devolved model and a deconcentrated model of decentralization. In a fully devolved model (e.g., Brazil's Bolsa Familia), local governments, through their own staff rather than through centrally recruited personnel, are fully entrusted to handle a full range of tasks related to the program implementation. In a deconcentrated model (e.g., Mexico's Prospera, Peru's Juntos, Philippines' 4Ps), the central government directly manages local-level implementation tasks through its regional offices.[33]

89.   **The Indonesian situation appears to be in-between in that it is constitutionally a unitary state in which sub-national governments are considered extensions of the national government – the Law of Regional Autonomy includes a provision that assigns the role of representing the national government to independently elected provincial governors – but is organizationally fully decentralized.** Unlike some other unitary states (e.g., Philippines which has retained relatively strong presence of regional offices), the central government of Indonesia has relinquished much of its ground presence at the regional/local level. Yet, perhaps given the relatively limited maturation of the decentralized governance framework in Indonesia, which embarked on major decentralization only a little more than a decade ago, modus operandi of inter-governmental coordination does not seem to be fully institutionalized.

90.   **There is no easy, short-term fix to this situation but given the nature of inter-governmental relations in Indonesia, a long-term solution may require an arrangement closer to Brazil's fully devolved model.** One option would be to delegate the responsibility of operational supervision to provinces, perhaps on the basis of the legal provision cited above that requires governors to act as central government representatives.[34] Irrespective of the applicability of such a legal basis, however, a fundamental question remains with regard to the provinces' incentives to play such a role. An anecdote from a field work conducted for this institutional assessment suggests a possibility that even when a provincial government

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[32] PKH Program Management: A Study in 6 PKH Implementing Areas, GIZ SPP Team, June 2015.
[33] Where the central government lacks sufficiently strong regional presence and is unable to rely on sub-national governments for supporting core CCT implementation activities, such as in Pakistan, the government has relied on a contracted third party (e.g., compliance verification). But such an arrangement is even more unsustainable than the arrangement in place for PKH. In recognition of the limitation inherent in the contracted-out model of CCT implementation support, the Government of Pakistan is also preparing to transition away from this arrangement and strengthen the regional/local presence of the implementing agency (Benazir Income Support Programme).
[34] Legal viability of this option would need to be reviewed by a competent expert.

is fully capable of supporting PKH implementation, it has its own competing priorities that may dilute its interest in devoting resources for PKH.

91.   **For any arrangement that relies on more extensive roles of sub-national governments to work, additional maturation in functional relationships between the national government and the sub-national governments may be a prerequisite.** Given the varying capacities and incentives among sub-national governments, a logical approach would be to delegate some of the PKH implementation functions to those that demonstrate both willingness and adequate capacity. But managing such a process of asymmetric functional decentralization would be a complex task that is likely to be beyond JSK's current institutional capacity. Furthermore, asymmetric decentralization is typically a politically difficult proposition and acceptability of the idea in general seems low in Indonesia as well.

92.   **Mirroring the reorganization at the central level, MoSA has recently issued an instruction to the provinces and the districts to eliminate the sub-national UPPKH and incorporate the responsibilities of managing PKH implementation fully into their respective Social Affairs Offices.** But, it is unclear if this formal restructuring will result in tangible change in the ways in which the sub-national social affairs offices will approach PKH implementation. Given the oft-reported lack of ownership by provincial and district governments to fully support PKH and the staffing constraints at the provincial and district social affairs offices, it is likely that actual implementation will continue to depend on the contractual staff, whether they are nominally placed under the core structure of the social affairs offices or in a separate program management unit.

93.   **Short of a major overhaul in the inter-governmental arrangement for PKH implementation, one option would be to explore administrative measures to elicit a minimum level of operational support from the provinces and the districts.** For example, MoSA could transfer a fixed amount as estimated administrative and operational costs to sustain the PKH teams in each sub-national jurisdiction, instead of asking the sub-national governments for financial and in-kind support. In any case, it would be helpful to first collect relatively accurate information on the actual cost of delivering PKH at the local level. The 5-percent contribution that MoSA requests is not based on any such estimation, and it is quite likely it does not fully reflect the actual cost. In addition, portions of the costs are incurred privately by PKH field staff, which are not captured in any available financial reporting.

o. Supply Side Readiness for Health and Education Service Delivery

94.   **Like any conditional cash transfer, PKH also depends critically on the proper implementation of health and education services.** Although availability of these services is generally considered quite reasonable in Indonesia, it is possible that certain services that PKH families require to meet program conditionality might not be available in certain locations. Service gaps are more likely in certain geographic (mostly rural and remote) areas. For example, while 62 percent of puskesmas[35] nationally report having stocks of Vitamin A, availability varies widely from above 80 percent in East Java and DI Yogyakarta, to under 50% in nine provinces, including just 28% in Bengkulu.[36]

95.   **This is true for education as well.** Although Indonesia has made remarkable progress in improving access to basic education in general, regional disparities between and within provinces remain. Substantial

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[35] Health services for PKH families can be accessed at any public health facility which includes puskesmas and its network of posyandu, pustu, polindes and puslinglity facilities. However, PKH beneficiaries are more likely to use front-line facilities, especially posyandu, which is a community-managed integrated health service post. No health professional is permanently posted at posyandu. Services are offered on the basis of regular visits by designated health professionals (midwives).

[36] Indonesia: National Medium-Term Development Plan (RPJMN), 2015-2019, Health Sector Review: Service Delivery and Supply-side Readiness. June, 2014.

shares of the populations in sub-districts in Aceh (11 percent on average), West Papua (16 percent), and Papua (41 percent) had no elementary school (SD) available within 1 km from the village in 2011. The Minimum Service Standard (MSS) goal of a junior secondary school (SMP) facility within 6 km of villages in remote areas, was also not fulfilled in 14 percent of Indonesia's rural villages, with the largest gaps in the Maluku provinces (20%), Kalimantan (26%), and Papua / West Papua (52%). In fact, there were 173 sub-districts in which no village had such access in 2011.[37]

96. **Inadequate funding and/or lack of staff are also issues of concern, as they hamper both service availability and quality.** World Bank (2013a) estimated that about 340,000 teachers, or 17 percent of the teaching force, would need to be transferred to ensure all schools have the minimum number of teachers. The problem of shortages is amplified by absenteeism. Surhati (2013) estimates an approximately 33.5% and 43% of Indonesian teachers were absent on any given school day in Papua and remote schools respectively, compared with 14% nationally. In fact, the average length of absence among a sample of absent teachers in Papua was 70 days and some even a year.[38] This could not only make it difficult for beneficiaries to comply with conditionality but also prevent PKH families from achieving better human development outcomes.

97. **In Indonesia's decentralized service delivery arrangements, the primary responsibility for ensuring availability of primary health care and primary education rests with the district level, while secondary education is a provincial responsibility.** The national ministries, however, retain formal authority for policy and standard setting, as well as considerable financial leverage through discretionary fiscal transfers. In case supply-side shortages make it impossible or difficult for PKH beneficiaries to access the required services, there will be a need to coordinate between the social affairs and the health or the education sectors.

98. **Logically, the only way to be certain that whatever commitments to address supply-side constraints are fulfilled in practice is to track them systematically.** Since JSK's MIS has the capability to track those data, and yet it does not seem these are regularly and systematically reported, it may be worthwhile starting the practice of regular tracking of the supply-side readiness and service availability (if not quality) as part of the routine program monitoring. Also PKH can learn from other CCT programs about establishing different conditionality and/or frequency of compliance monitoring, taking into account supply side issues as done elsewhere (Brazil in the Amazonia, Philippines in conflict Mindanao or indigenous isolated areas).

p. Institutional Arrangements for inter- sectoral coordination

99. **Formal structures for inter-institutional coordination for PKH exist at both the national and the subnational levels.** At the national level, the PKH 'National Coordination Team', advised by the Coordinating Ministry of Human Development and Culture and chaired by MoSA, has been set up for the purpose of high-level policy coordination. It consists of Echelon 1 level (top rank civil servant) officers from the following ministries/agencies: MoSA, Health, Education and Culture, Finance, Planning and Development (Bappenas), Religious Affairs, Communication and Information Technology, Home Affairs, Finance, Manpower and Transmigration, Under-developed Regions, Women's Empowerment and Child Protection, and Statistics Indonesia (BPS).

100. **PKH policies are operationalized by a 'National Technical Coordination Team', steered by the Minister of Social Affairs, chaired by the Directorate General of Social Security and Protection,**

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[37] TNP2K 2011
[38] OECD 2015 citing Surhati (2013)

with the Director of Family Social Security as Secretary. It consists of echelon 2 and/or echelon 3 (Director level) officers assigned by the member ministries and agencies of the National Directive/Coordination Team. The technical team is supposed to act as a bridge between the National Directive/Coordination Team, JSK and the field-level PKH implementation teams. Its responsibility is to review operational plans, coordinate sectoral activities, establish an inter-sectoral team with the mandate to select PKH participants and monitor program implementation progress. There is an equivalent PKH Technical Coordination Team at provincial, district/city, and sub-district levels.

101. The **PKH Technical Coordination Team** at the provincial level has the Governor as Advisor, Provincial Secretary as Chairman of the Steering Team, Chairman of Provincial Bappenas as Chairman of Technical Team and Head of Social Affair Department as the Secretary. Other members of the team are the heads of the following offices/agencies: Education, Health, Provincial Statistics Indonesia (BPS), Regional Office of the Ministry of Religious Affairs, Communication and Information Technology, Manpower, Population and Civil Registry.

102. The **District/City PKH Technical Coordination Team** consists of the Head of District as Chief Advisor, Secretary to the Local Government as the Chairperson of Directive Team, Head of Bappeda at the District/City level as the chairperson of Technical Coordination Team, Head of Local Office of Social Institution as Secretary. Other members of the team are the heads of the local offices of the following agencies: Education, health, BPS, Ministry of Religious Affairs, Communication and Informatics, Ministry of Manpower, and Population and Civil Registry.

103. The **Sub-district PKH Technical Coordination Team** consists of the Head of Bappeda as the Chief of Advisor, Head of Local office of MoSA as the head of steering committee, Head of sub-district as the chairperson of Technical Team, Coordinator of Facilitators as Secretary**.** The other members of the team include the Heads of Local Units of Primary Education, Secondary Education and Healthcare; PKH Facilitator; and Head of Village where PKH is provided.

104. **An additional mechanism for MoSA to promote inter-sectoral coordination is the national coordination meeting.**[39] Led by senior MoSA officials, these meetings take place periodically in various locations with participation of senior officials from the partner ministries as well as representatives of the local sectoral departments. While topics apparently vary from one meeting to another, these meetings are reportedly used as opportunities to highlight relevant issues such as gaps in supply of health or education services that MoSA has identified and may entail relevant sectoral authorities formalizing a commitment to address them. However, MoSA apparently does not follow up on the extent to which these commitments have actually been fulfilled. It was also reported that these commitments are signed by ministry officials rather than representatives of the local sectoral departments. It is not clear whether the ministry commitments are transmitted to the relevant level that is responsible for addressing the gap and what mechanism, if any, each sector uses to ensure compliance.

105. **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[40] 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 and vulnerable should use the integrated database for targeting purpose (MoSA has worked with Ministries of Education and Health on PIP and JKN-PBI to synchronize the data or provide priority access to PKH beneficiaries)

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[39] Coordination Meeting serves as a forum to disseminate information about PKH implementing policies, to identify problems in implementing PKH, formulate solutions to issues faced by program, coordination and strengthening commitment from line ministries as well as to achieve synergy and supports of PKH
[40] Including the 6-province study by GIZ.

106. **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.

III. Description and Assessment of Program Expenditure Framework

107. **While the central government has been increasing social assistance spending since 2010, its share of GDP has remained constant.** The total expenditure on household/family based social assistance is US$ 5.74 billion in 2016, or approximately 0.6% of GDP. The four largest programs in terms of expenditure are JKN-PBI (health insurance for the poor), RASTRA (subsidized rice), PIP (scholarship for poor students), and PKH. While these four programs account for more than 90 percent of the total spending on the poor and vulnerable families, their combined spending is still dwarfed by the fiscal cost of untargeted subsidies, which is over 12% of central government budget. Even with the latest expansion in 2016, PKH expenditure is still the smallest among the four. Because the government will continue to reduce the untargeted subsidies and move the saved budget to the more effective social assistance programs such as PKH, its budget is expected to increase further.

Figure 12 Central Government Expenditures on Social Assistance

Central Government Expenditure on Household Based Social Assistance (2004-2016)
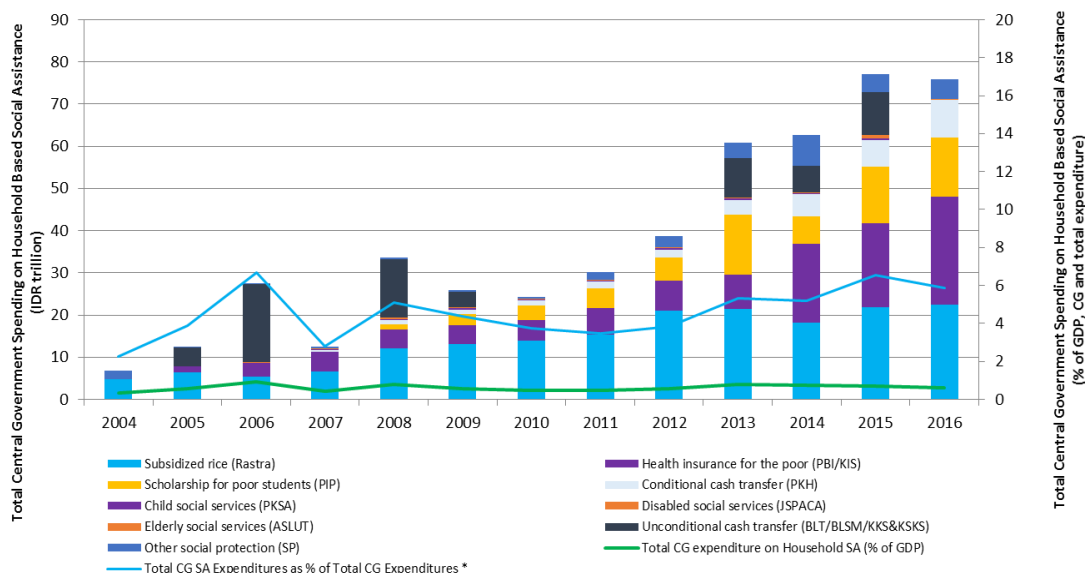
Source: MoF and Bappenas

a. PKH Budget

108. **PKH budget has seen significant increase in recent years, from IDR 1.9 trillion in 2012 to IDR 8.7 trillion in 2016.** Except in the first year of its inception, MoSA has been quite successful in executing its PKH program budget, including when program coverage was expanded. In mid-2016 the Government had to make a rather drastic budget cut across the board after the overly optimistic revenue growth did not materialize. As a result, PKH's revised budget was reduced by 13% in comparison to the initially approved

budget. Its 2017 budget is increased by 59% relative to its revised budget and by 36% relative to its initial budget in 2016, respectively. The increase mainly reflects its expanded coverage.

Figure 13. PKH Budget Execution (2007-2016)
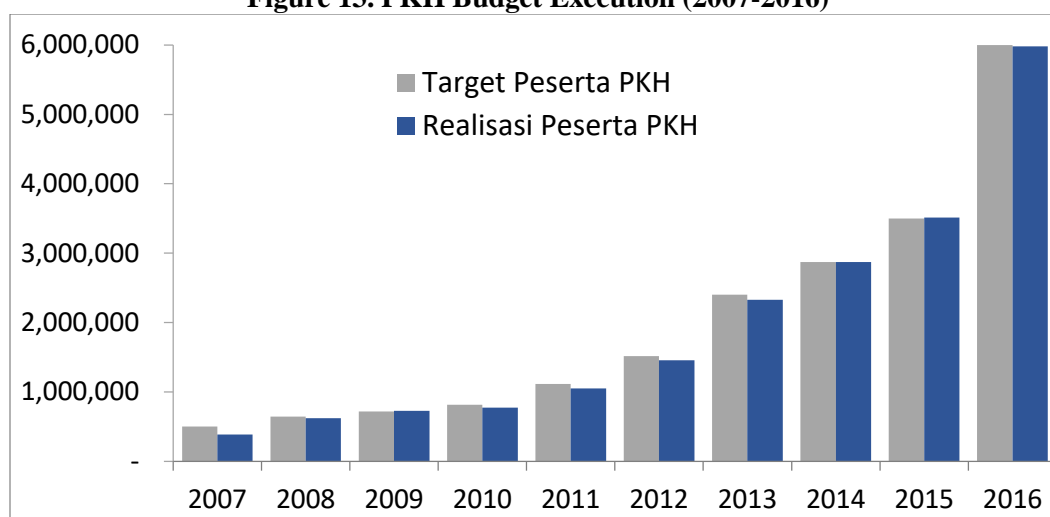
Source: Bappenas

109.   **The administrative cost of PKH is relatively high, when compared to large CCT programs in other countries, mainly due to its extensive program-specific facilitation process.** Out of the 2016 initial budget, 13% of the total PKH budget was required to implement the program. While the ratio is already reduced from the previous years – 14% in 2009 with no expansion and 17% in 2010 with expansion – it is supposed to fall further to 11% of the 2017 planned budget. Within the administrative cost, the top three biggest elements are compensation for labor inputs by tens of thousands of field level staff (facilitators, district operators and coordinators), fee to PT Pos for payment services (14%), and training cost for 19,000 facilitators to carry out FDS (10%). Moving forward, the fee to PT Pos is expected to be greatly reduced due to transitioning to bank account centered cashless payment methods. Also the training on FDS is not expected to be repeated. Furthermore, MoSA will continue to streamline PKH's business processes and further automate data entry, transmission, and information generation related tasks that are currently manual, the program efficiency is expected to be gradually improved.

Table 9 PKH Budget, 2015-2017

PKH Budget (IDR billion)	2015 Planned	2015 Realised	2016 Planned	2016 Revised	2016 Realised	2017 Planned
Total	6,385	6,266	9,998	8,683	8,964	12,748
Benefit Transfer	5,580	5,580	8,708	7,621	7,965	11,340
as % of Total	87%	89%	87%	88%	89%	88%
Administration Cost	805	686	1,290	1,011	999	1,408
as % of Total	13%	11%	13%	12%	11%	12%

Source: MoSA DIPA (2016, 2017) and MoF Financial Note

Table 10 Share of PKH Administration Cost by Main Categories, 2016-2017

Administration Cost by Activity Type	2016 Realized	2017 Planned
Compensation for contracted staff	66%	64%
Fee for payment services (PT Pos)	15%	14%
Training cost on FDS	0%	10%

Field implementation (IT, basic trainings for field staff, M&E, socialization, HRM, etc.)	19%	12%

Source: MoSA DIPA (2016,2017)

b. Budgeting Process

110. **The budget preparation is based on two Laws – Number 17 of 2003 on the State Finances and Number 1 of 2004 on the State Treasury. Indonesia follows a unified budgeting system that recognizes no distinction between routine and development budgets.** The single budget document, known as DIPA, is produced for Echelon 1 officials (highest ranked civil servants, such as Directorate Generals) and for each spending units (e.g. Directorates) in line ministries. A number of regulations have been issued since to support the implementation of the two Laws on budget preparation, execution, and revision.

Table 11 Government Budget Cycle

Budget Activities and Agencies Responsible	Time line
Line Ministry/Agency reviews activity list prepared by its spending units and makes adjustments	January – February
Line Ministry/Agency prepares annual work plan (Renja) for next fiscal year based on its strategic plans (Rentra)	March – April
MoF and Bappenas jointly issue program priorities for each Echelon 1 official, including priority targets and an indicative budget; Line Ministry/Agency revise its Renja incorporating the specified program priorities.	March – April
Bappenas prepares the government's annual work plan (BKP) based on Renjas and presents it to the Parliament (DPR); Line Ministry/Agency has consultation sessions with the relevant commission counterparts in the DPR and introduce new activities if needed; An interim overall budget and budget ceilings are agreed upon.	May – June
Line Ministry/Agency prepares a budget work plan (RKA-K/L) based on the budget ceilings and submit to MoF. The Directorate General of the Budget of MoF, along with Bappenas review RKA-K/L to ensure its consistency with the prescribed priority programs and activities and appropriateness of detailed budget allocation.	July – September
MoF prepares the Consolidated budget work plan and final budget ceilings (by unit, expenditure type, function, program, and activity) and submit to a full session of DPR for approval to become the Annual Budget Law (APBN)	October
MoF issues definitive budget ceilings; Line Ministry/Agency accordingly prepares its definitive budget work plan and discuss with the Directorate General of the Budget of MoF	November
Line Ministry/Agency prepares the budget authorization documents (DIPA) based on a Presidential Decree issued following APBN; Once DIPA is approved by MoF, Line/Ministry/Agency prepares internal operational guidelines (POK) for each working unit	December

111. **In July and August each year, the Government and DPR discuss the necessary changes to APBN of current year in response to the adjustments needed to be made to the macroeconomic framework.** The revised national budget (APBN-P) may require line ministries to revise their work plan. Examples include budget cuts, top-ups, and re-allocation. Individual revisions may be made throughout the year, though the deadline date for revision may change. Either MoF or line ministries can initiate budget revisions, but the process between the initial proposal and the approved revised budget may take as long as 12 weeks.

IV. Description and Assessment of Program Results Framework and M&E

112. **PKH has two mechanisms to monitor and evaluate the program.** (i) Routine monitoring activity under PKH uses several types of data collection forms including the following, among others: family data update form, student attendance verification form, health verification form, PKH beneficiary complaint form, and non-beneficiary complaint form. This collected data becomes the input for the PKH MIS and is carried out by field workers. Data analysis is conducted by JSK/national UPPKH and seeks to answer the following questions:

(1) Has the validation process been implemented to ensure that PKH helps the right persons?
(2) Have PKH beneficiaries fulfilled their responsibilities?
(3) Have PKH beneficiaries received benefits in accordance with the rules?
(4) Have PKH beneficiaries' data been updated to ensure that all components and responsibilities are correctly accounted?
(5) Have PKH beneficiaries in the designated areas attended FDS?

The data so collected is used to establish a set of performance indicators, which span across input, process and output aspects and the comparisons between the target values and actual achievements measuring the program implementation progress. The data are regularly collected (monthly, quarterly, and yearly) and reported hierarchically upwards. (ii) The second mechanism is evaluation, which is selectively carried out to identify causes of either success or failure in achieving results and to provide lessons and options, often specific to certain business processes. The 2015 PKH M&E, for example, focused exclusively on assessing three activities: verification of commitments, cash transfer distribution and data updating. Also, it is unclear how useful such an exercise is, in large part due to study design including sampling (purposive sampling method[41] with a sample size of maximum 15 poor beneficiary households per selected location). The goal is to carry out such evaluations (previously done by TNP2K) annually, although it was not done in 2016.

113. **Thus, in PKH's context M&E mainly covers its business process, but do not to assess impacts or outcomes.** Evaluation of these other dimensions would also be required at regular intervals. The program guidelines envisage other forms of M&E, including monitoring by community and local government, but these are yet to be operationalized.

114. **Although some program monitoring data is produced upon request, more regular standardized reporting needs to take place for the PKH management and be made available to other stakeholders and eventually to the public.** While JSK has a dedicated M&E Wing, the new organizational design does not clearly specify which unit would be responsible for M&E. However, the assignment of some of the contracted "experts" who used to handle M&E in the old UPPKH to the Subdit 3 (Beneficiaries) in late 2016, appears to reflect JSK's de facto decision in this regard. In the immediate run, it would be beneficial to formalize this arrangement so as to clarify roles, responsibilities and accountability for this crucial function. However, assigning the M&E role to the same unit that is involved in key aspects of program implementation runs counter to a good practice worldwide, which has been to elevate the hierarchical status of these functions and keep them independent of implementation. JSK may want to revisit this arrangement over the medium term as a necessary part of reviewing its organizational arrangement based on actual experience on the ground.

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[41] The criteria for selecting districts differed with the objective. In the case of verification of commitments, districts/cities selected were a mix of those with a high level of verification (above 95%) and a low level (under 3.5%). To evaluate cash transfer distribution, districts/cities selected were those with high levels of "dormant accounts". And finally evaluation of data updating was carried out in districts/cities with unchanged data over time on household members and change of address as well as continually changing data on beneficiary caretakers. (PKH M&E Report 2015)

115. **The Results Framework will be monitored using PKH program's own M&E capacity.** In particular, the PMIS will be an important instrument to assess quantitative indicators at the level of the families receiving the program such as compliance to conditionality, receipt of transfer, complementarity of PKH with other social assistance programs. The indicators on FDS implementation, complete training of facilitators and the roll out of the GRS are best to be tracked also by the M&E team supported by three regional coordinators and 514 district coordinators. The remaining indicators which are measured via outputs or deliverables (completion of a communication strategy and HR competency and performance monitoring system implemented) are to be monitored by JSK and other stakeholders jointly.

V. Error, Fraud, and Corruption

116. **As PKH channels a large amount of public resources to eligible poor families, error, fraud, and corruption (EFC) would not only reduce the economic efficiency of the program by decreasing the amount of money that goes to the intended beneficiaries, but more importantly erode political and public support for the program.** Like most CCT program, PKH faces particular implementation challenges from a governance and anti-corruption perspective, because it is large in scope, with 6 million beneficiaries and a high volume of financial transactions. It is politically high-profile and engages multiple government actors at the national and sub-national levels. And by targeting the poorest of the poor, project locations are often in remote and inaccessible areas, exacerbating implementation challenges and increasing risk.

117. **While PKH does not have an explicit strategy, the program contains some features that could be consolidated into a clear and practical EFC strategy.** Availability of data from PMIS, spot checks, and a SPM likely have already reduced the potential for EFC. A strong EFC strategy built on various existing mechanisms can be institutionalized within the M&E framework. As detailed below, the potential major vulnerabilities of PKH are a mixture of technical, governance, and political risks, and can be addressed with potential mitigation measures:

- **Interference or errors in the process of targeting and registering beneficiaries:** Unintentional survey or enumeration errors could exclude eligible beneficiaries. Beneficiaries could provide false information to bias eligibility decisions. Politicians or government officials could register supporters or exclude opponents for political purposes. Updating the status of beneficiaries is also another area of potential fraud or corruption. When beneficiaries move to non-Program areas, an eligible recipient passes away or other status changes occur, there are few incentives for beneficiaries to report such changes in circumstances.

- **Interference or errors in the process of monitoring compliance with program conditions:** Compliance monitoring is a complex process, demanding significant capacity to collect and manage data. Failure to effectively manage this data can either delay payment or effectively create an unconditional cash transfer program, which would not only undermine project outcomes but be politically untenable in the Philippines context. Compliance monitoring must be made as simple as possible.

- **Interference or errors in the payment process**: PKH has two main exposures on fraud and corruption payment risks, especially at the lowest level. The first risk is illegal deduction of the payment from the Post payment officer. Beside internal control procedures in the PT Pos Indonesia, PKH has set up complain handling mechanism that recipients can report and submit any issue on the payment process. The PT Pos Indonesia includes regular staff rotation and supervision to the post payment unit into PT Pos Indonesia internal control procedures.

- **Political risks:** Political abuse of power could take several forms: (i) politicians or officials seeking to expand the program into new areas without following poverty criteria; (ii) registration of supporters or exclusion of opponents from PKH's beneficiary list; or (iii) local officials imposing additional conditions or "taxes" on beneficiaries.

118. **Some degree of fraud, error and corruption is inevitable.** However, many of the possible risks can be prevented, and are related to the strengthening of the implementation system that MoSA is undertaking and this proposed Program is supporting through the activities and DLIs in Results Area 1:

- **Objective targeting system:** The main preventive strategy in CCTs is the establishment of an objective, scientific, poverty-based mechanism to select geographic areas and individual household beneficiaries. As mentioned before, in Indonesia, PKH uses a proxy-means test (PMT) to identify individual households based on the UDB that it is regularly updated.

- **Improved oversight and monitoring:** Aside from the regular Program audits mentioned before, preventive measures can be underpinned by a strong monitoring framework. While the PforR will support the revamp of the PMIS and the GRS, a recommendation is for the program to undertake regular spot checks. To be executed by an independent third party organization (NGO, university or private firm), the spot check methodology combines quantitative and qualitative assessments to assess the integrity of targeting, compliance monitoring and payment systems. In addition to generating valuable monitoring data, the threat of a spot check also acts as an incentive for officials to follow Program guidelines. In addition to its own GRS, PKH beneficiaries should be made better aware of additional complaint handling mechanisms operating in Indonesia, such as the Ombudsman, on-line community complaints (LAPOR), and the anti-corruption commission (KPK).

- **Move to more secure and efficient payments:** The recent move towards delivering payments through cash cards can help mitigate most of the concerns regarding payment disbursements to the correct beneficiaries and improve liquidation process, and mitigate the risk of facilitators "taxing" beneficiaries.

- **Sanctions and remedies:** The final element is a set of sanctions and remedies that back-stops the preventive and corrective measures detailed above. Program staff or officials are subject to prosecution if evidence exists of corruption. Protocols are articulated in the Program Operational Guidelines as to the process for addressing such cases, though need to be strengthened. Related to political risks, many other CCTs have frozen new registrations three months before elections to prevent possible perception of abuse. As a measure of last recourse, in cases of widespread or systemic abuse of power, entire Municipalities can be excluded from the project or the transfer of funds suspended or terminated.

V. Program Economic Evaluation

a. Rationale for Public Provision and Financing

119. **PKH is one of the key programs comprising Indonesia's social safety net and warrants sustained government intervention for several reasons.** A comprehensive social safety net is an important prerequisite for sustained and inclusive economic growth. Generally, it reduces poverty by providing direct income support, through cash transfer such as PKH and PIP, and protects the poor and vulnerable against economic shocks by fostering their access to social insurance through JKN-PBI (fee

waiver to access Indonesia's public health insurance scheme). It also leads to increasing overall employment and employability of poor and vulnerable households by providing skills training and so promoting access to the labor market. Direct transfers to poor and vulnerable households through programs such as PKH and PIP in particular, can make government-driven policy reform more palatable, thereby encouraging robust economic growth.

120. **PKH directly encourages positive change in health and education behaviors of poor families by tying cash disbursement to the fulfillment of conditionality.** PKH can thus assist poor and vulnerable households as they mitigate risks to their welfare by encouraging larger or more consistent investments in family members' human and financial capital as well as reducing reliance on negative coping behaviors which can sacrifice those productive investments in the future for the sake of higher consumption now. This helps households absorb and mitigate negative shocks flexibly so that welfare losses are less severe and do not compound. Furthermore, the provision of cash transfers itself, have been proven to result in significant micro economic effects at the individual level in the short to medium term, while also leading to longer term human development outcomes. The microeconomic effects of PKH, proven in the two rounds of impact evaluations, and the relatively higher efficiency in reducing poverty and inequality versus the other main social assistance programs, shown in recent Bank publications detailed below, justify the programs expansion in coverage, adequacy and complementarity with other social protection programs in Indonesia.

b. Program's Economic Impact

121. **Evidence has shown that PKH has led to significant effects on household consumption, reduced child labor, school enrollment and health behaviors.** In Indonesia, both a mid-line and end-line impact evaluation have been conducted; the former re-visited families after approximately three years of experience with the program, while the latter re-visited families after more than six years of experience. Results from these evaluations, indicate that the PKH program was directly responsible for greater investments in education and health, while providing consumption budget support. The midline evaluation demonstrated that PKH was responsible for statistically significant increases in pre-natal care. The likelihood of attending at least four prenatal visits increased by 9 percentage points while newborn delivery at a facility or attended by a professional increased by 5 percentage points. Post-natal care improved by almost 10 percentage points while, immunizations, and growth monitoring check-ups increased by 3 percentage points and 22 percentage points respectively. Significant impacts were registered in the likelihood of children receiving immunization (PKH households saw an increase of 7 percentage points), while severe stunting (height for age) decreased 3 percentage points. PKH improved neonatal visits by 7.1 percentage points but it had no significant impact on outpatient visits or increased intake of iron tablets. In terms of education, according to end-line results there were statistically significant increases of 2 percentage points in the gross participation rate for elementary school and almost 10 percentage point increase in the junior high school gross participation rate. The probability that a PKH child continuing to secondary school increased by 8.8 percentage point but there was no significant impact on decreased child labor attributable to PKH. [42]

122. **At the macro level, the provision of cash transfers supports the costs of access to health and education services, while also decreasing the poverty rate. Increased consumption leads to lower rates of poverty while the steady provision of cash also reduces income uncertainty and so helps to protect the beneficiaries against economic and social shocks.** Concretely, the mid-line evaluation demonstrated that PKH households experienced a statistically significant 10 percent increase in average monthly expenditures. The increase was used mainly to buy high-protein foods and to cover health costs. The end-

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[42] 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.

line evaluation showed that beneficiary expenditure increased by 3.3 percentage points while beneficiary households' expenditure on food was 3.4 percentage points higher than non-beneficiary households. For protein consumption, the impact was considerably lower, at 1 percentage point.

c. World Bank's Value-Added

123. **By supporting the implementation of the CCT, the Program is expected to benefit approximately 6 million poor Indonesian families** who will be receiving non-reimbursable contributions aiming to increase household consumption and human capital investments and to increase beneficiaries' health, education, and productivity.

124. **The World Bank is well placed to advise MoSA as it supports CCT programs in over 40 countries, and in 22 with lending operations, including in Mexico, Brazil, Colombia, Kenya, and the Philippines.** The World Bank in Indonesia has been supporting MoSA since 2010 when it supported among others the development of the first generation information system. Since then, the bank has also developed most of the FDS modules and advised in their implementation and operation design, including monitoring and evaluation of its implementation as it was piloted in 2015. More recently, in response to the requests from MoSA, the Bank team has been providing technical inputs across all of the programs operation. The Bank team is made up of key international experts on CCT implementation from the Social Protection and Labor GP and also includes experts from several other key GPs to provide advice on aspects of payments, targeting, human resource development and the institutional set up.

d. Results of Economic Evaluation

125. **By providing cash to poor households, PKH contributes significantly to poverty reduction.** The observed reduction in the poverty headcount of about 0.3 percentage points in early 2016 has in part (almost 30 percent) been attributed to expansion of PKH from 2.8 to 3.5 million households.[43] In addition, simulations of the expansion of PKH from 3.5 to 6 million households using the latest available Susenas data (2014 September) predict a reduction in the poverty head count of about 0.8 percentage points, ceteris paribus. Inequality was also simulated to fall slightly by 0.25 Gini points.[44]

126. **Moreover, recently completed World Bank fiscal incidence analysis based on 2012 survey and expenditure data further support the claim that PKH is an effective tool to reduce poverty and inequality in the short term.** The analysis shows that PKH has the highest effectiveness in reducing inequality and poverty of all main social assistance programs as well as compared to subsidies and in-kind transfers on health and education.[45] Yet, to date PKH has received lower budget than other, less effective, programs; for instance Rastra, is expected to cost IDR 22.5 trillion in 2016, while PKH is expected to cost IDR 9 trillion.[46] In addition, based on the socio economic household survey, PKH has consistently revealed high and improving targeting accuracy; in 2014, the poorest 10 percent of households received over one third of the benefits available; the bottom 20 percent received over half of the benefits available; and the bottom 30 percent received over two-thirds of the benefits available while exclusion errors are also the lowest among the main social assistance programs. This puts PKH on par with similar programs such as Brazils' Bolsa Familia and Philippines' Pantawid Pamilya which had CCT benefits accruing to 57 and 52 percent of the poorest 20% of households, respectively.[47] While the poverty headcount rate fell by about 2 percentage points between 2010 and 2014, the share of PKH benefits accounted for by the poor group

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[43] Indonesia Economic Quarterly October 2016. Pressures Easing. World Bank Indonesia.
[44] Susenas 2014 data & World bank staff calculations & internal documentation. World Bank Indonesia.
[45] Jellema, Wai-Poi and Afkar (2015) The Distributional Impact of Fiscal Policy in Indonesia and Ministry of Finance and World Bank (2015) Taxes and Public Spending in Indonesia: Who pays and who benefits.
[46] MoF Financial Note 2016.
[47] World Bank Aspire Database 2016.

increased by approximately 8 percentage points.[48] This trajectory indicates that as the micro-level poverty situation changes – many households exit poverty year to year, while fewer enter – PKH has continued to add significant numbers of the poor households that remain.

VI. Technical Risk Rating

127.   **The technical design related risk is Substantial.** The Program supports an expansion of the CCT that includes new geographic areas, including remote and hard to reach areas (e.g. Papua region) and expansion to new components (elderly and disabled), at a time when its delivery systems (technological, human resources, institutional) are in need of strengthening. The risk is mitigated by the fact that several ongoing experiences in the country, as well as abroad, will provide lessons for the design.

128.   **The implementation capacity risk is Substantial.** MoSA has been implementing social assistance interventions for a long time. However, PKH has been implemented by a program implementation unit largely staffed by consultants and attached to one sub-directorate within MoSA. The current MoSA leadership has begun to mainstream and transfer the responsibilities of PKH implementation to regular civil servants of a whole directorate. This is a welcome change that, if successful and sustained, would enhance sustainability of efficient PKH implementation over time. However, changes in institutional leadership may jeopardize these efforts. The new design package within PKH which would increase implementation workload, could also pose implementation risks by further overwhelming MoSA's implementation capacity. These risks will be mitigated by ensuring that staff are appropriately trained, IT support strengthened, GRS and M&E systems are strengthened, and linkages with experienced partners in this area (other government agencies and international development partners as well as local governments) fostered.

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[48] Susenas 2014.