THE PRO-POOR PLANNING AND BUDGETING PROJECT

Working Paper No. 5

Program Keluarga Harapan – PKH

Two Case Studies on Implementing the Indonesian Conditional Cash Transfer Program

HICKLING

Jakarta
June 2008

This Working Paper has been produced by the Pro-Poor Planning and Budgeting Project (ADB TA 4762 INO). The Directorate for Poverty Reduction at the National Development Planning Agency (BAPPENAS) was the executing agency for the project from September 2006 to June 2008. The project provided technical assistance to build capacity for pro-poor planning and budgeting in eleven districts and also produced Working Papers to contribute to discussions on national program and policy issues related to poverty reduction. Additional information on the work of the Pro-Poor Planning and Budgeting technical assistance (TA) is available on the website: **http://p3b.bappenas.go.id**

The technical assistance team consisted of twelve specialists fielded by the Hickling Corporation under a contract agreement with the Asian Development Bank (ADB). The TA team acknowledges with gratitude the many positive contributions to the Working Papers made by colleagues at BAPPENAS as well as by counterparts in the participating districts (Manggarai, Sumba Barat, Sumba Timor and Kupang in East Nusa Tenggara, Semarang, Wonosobo, Banjarnegara, and Purbalingga in Central Java, and Palembang, Ogan Komering Ilir and Ogan Ilir in South Sumatra).

This Working Paper was produced by the TA team with grant funding support from the ADB and the United Kingdom (Department for International Development, DFID), but neither is responsible for the content of the Working Paper.

Hjalte Sederlof, the Social Safety Net Specialist with the Pro-Poor Planning and Budgeting Project was the lead author for this Working Paper. The research for this Working Paper was carried out in collaboration with counterparts from BAPPENAS and the Ministry of Social Services. The district governments of West Sumba and Kediri supported and assisted with the implementation of the field research.

The complete list of Working Papers produced by the Pro-Poor Planning and Budgeting Project is as follows:

1. Pengentasan Kemiskinan melalui Pembangunan Usaha Mikro, Kecil dan Menengah (Poverty Reduction through Developing Micro, Small and Medium Enterprises)
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3. Review and Evaluation of Pro-Poor Programs in Indonesia – A Summary Overview
4. Improving Local Government Planning for Enhanced Poverty Reduction
5. Program Keluarga Harapan – PKH: Two Case Studies on Implementing the Indonesian Conditional Cash Transfer Program
6. Perencanaan dan Penganggaran yang Berpihak pada Masyarakat Miskin: Studi Kasus dariTiga Provinsi (Pro-Poor Planning and Budgeting: Case Studies from Three Provinces)
7. Kajian Kesejahteraan Keluarga dan Pemberdayaan Gender di Provinsi Nusa Tenggara Timur, Jawa Tengah dan Sumatera Selatan (Planning and Budgeting for Improved Family Welfare)

The project also produced the following publications in cooperation with BAPPENAS:

- Pro-Poor Planning and Budgeting Newsletters (Volumes 1 – 3)
- Buku Panduan – Perencanaan dan Penganggaran yang Berpihak pada Masyarakat Miskin (Handbook on Pro-Poor Planning and Budgeting) (2008)
- Kumpulan Bahan Latihan Pemantauan dan Evaluasi Program-Program Pengetasan Kemiskinan (Resource Book of Training Materials for Monitoring and Evaluation of Poverty Reduction Programs) (2008)
- MDGs Scorecards for District Governments (11 were produced in collaboration with the district governments of Manggarai, Sumba Barat, Sumba Timor and Kupang in East Nusa Tenggara, Semarang, Wonosobo, Banjarnegara, and Purbalingga in Central Java, and Palembang, Ogan Komering Ilir and Ogan Ilir in South Sumatra).

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Abbreviations and Acronyms

ADB	Asian Development Bank
APBN	Anggaran Pendapatan dan Belanja Nasional [National Budget]
ASKESKIN	Asuransi Kesehatan Masyarakat Miskin [Health insurance for the poor]
Bappeda	Badan Perencanaan Pembangunan Daerah [Regional Development Planning Agency
BAPPENAS	Badan Perencanaan Pembangunan Nasional [National Development Planning Agency
BLT	Bantuan Langsung Tunai [Direct Cash Aid]
BOS	Bantuan Operasional Sekolah [School Operational Assistance]
BPS	Badan Pusat Statistik [Central Bureau of Statistics]
Bupati	Head of District / Regent
CCT	Conditional Cash Transfer
Depsos	Departemen Sosial [Ministry of Social Services]
DepKomInfo	Departemen Komunikasi dan Informasi [Ministry of Communication and Information]
Dinas sosial	Regional, operational unit of the Ministry of Social Services
DPRD	Dewan Perwakilan Rakyat Daerah [Regional Parliament]
Kabupaten	District/Regency
Kota	District (urban)
K/K	Kabupaten/Kota [District]
MCH	Mother & Child Health program
MOU	Memorandum of Understanding
NGO	Non Government Organization
NTT	Nusa Tenggara Timor [East Nusa Tenggara province]
Pendamping	Field-level facilitator
PT Pos	Perseroan Terbatas Pos [Indonesian National Postal Service]
PKH	Program Keluarga Harapan [Family of Hope Program]
PNPM	Program Nasional Pemberdayaan Masyarakat [National Community Empowerment Program]
Pusat	Central level
Puskesmas	Pusat Kesehatan Masyarakat [Community Health Center]
RASKIN	Beras Miskin [Rice for the Poor Program]
SMERU	Jakarta based research institute
TK	Tingkat [Level]
UPPKH	Unit Pelaksara Program Keluarga Harapan [the PKH program's policy and supervision unit]

Executive Summary

1. Background

i. The Government of Indonesia recently launched a conditional cash transfer program – *Program Keluarga Harapan, PKH*[1]- on a pilot basis in seven provinces. This working paper analyzes the implementation of two of the pilots – in the districts of Sumba Barat in East Nusa Tenggara and Kediri in East Java. It also draws on the findings of a number of rapid assessments that preceded the case studies. The case studies were undertaken as a collaborative effort between the National Planning Agency (Bappenas), the Ministry of Social Services (Depsos), and the ADB-funded Pro-Poor Planning and Budgeting Project (P3B). Representatives of the case study districts (*kabupaten/kota*) also participated.[2]

ii. Conditional cash transfer programs are relatively complex systems that consist of numerous interdependent elements where disruptions in any one element usually have significant repercussions on the system as a whole. The case studies were undertaken to examine in some detail how the main elements of the program were being implemented in the field in order to draw lessons for future expansion of the program. They focused on the beneficiary selection process, inter-agency coordination, program socialization[3], the monitoring and verification mechanism, field-level facilitation (*pendampings*), the management information system and the payment mechanism.

iii. The working paper provides a synthesis of the case studies. It discusses issues raised and makes recommendations for future expansion of the program. It also discusses aspects relating to graduation out of the program and the economics of conditional cash transfer programs. Finally, it places the PKH in a longer-term perspective of building a formal safety net that provides protection as well as opportunity for poor and vulnerable households.

iv. The program is still in a pilot phase, and the purpose of pilots is to identify and iron out problems prior to expanding the program. The case studies contribute to that process. Their findings are pretty straightforward – problems are mostly ones of execution rather design, and therefore they can be relatively easily corrected. They might even have been avoided altogether if more time and effort had been put into making sure that systems were ready to go. Safety net programs are challenging to execute well and require thorough preparation - people need to know their jobs well at the start; they need to have the necessary tools to do those jobs; and there needs to be buy-in from the community at large. The case studies (and the rapid assessments) have indicated that this was not sufficiently paid attention to in the run-up to implementation, and that may be the principal lesson to draw from the pilots – make sure that the requisite knowledge and skills has been acquired; that institutions are in place; the necessary financial resources are available; and programs are understood

[1] Family of Hope Program

[2] The case studies and earlier rapid assessments were financed by the ADB P3B project (ADB TA 4762 INO)

[3] "Socialization" here is defined as the provision of information and training about the program to coordinating and implementing agencies; and information about it to other public and private stakeholders; and the general public.

and supported by the community at large. When realistic timetables are applied which allow this to be done correctly, the likelihood of successfully expanding the program should be high.

2. Issues and Recommendations

i. The issues and related recommendations drawn from the case studies are set out below. They deal with targeting and perception problems in selection; the implications of insufficient socialization on program performance and broader concerns of acceptance in the beneficiary community, among stakeholders and the community at large; and the slow start to compliance monitoring. While the main data base is in place and actively managed, the larger management information system to monitor activity, output and outcome indicators is still being built. Field-level facilitation is functioning; and payments are being made, albeit with some, presumably temporary, issues of accuracy and timing.

ii. The main recommendations can be summarized as follows:

(a) **Beneficiary selection: introduce transparency into the selection process by making it participatory** (paragraph 23)**;**

(b) **Inter-agency coordination: introduce detailed agreements concerning the responsibilities and commitments of participating administrations** (paragraph 30);

(c) **Socialization: strengthen socialization strategies: base them on how to do things as well as on what to do; and include feedback from local authorities, other stakeholders and the general public during the pilots** (paragraph 41);

(d) **Monitoring and evaluation: ensure that service providers are adequately resourced and ready to undertake verification and reporting prior to launching a program** (paragraphs 43 to 52).

iii. The detailed recommendations are as follows:

(a) **Beneficiary selection**

Issues: there is concern about (i) targeting errors; and (ii) the transparency of the selection process.

Recommendations: (i) with a cash constrained program, errors of exclusion are likely to be high, irrespective of method used; instead, the focus is more usefully placed on reducing errors of inclusion, and here a well-performed field level validation system should give rise to few errors of inclusion *(para.21)*; (ii) the validation process requires stronger supervision of field-level enumerators and also can significantly benefit from community review *(para.22)*; and (iii) transparency (and validation) of the selection process can and should be improved by publicizing selection criteria; opening the validation process to public scrutiny (f.i. by means of community committees); and providing public listing of beneficiary households *(para. 23)*.

(b) **Inter-agency coordination**

Issues: (i) fiscal-financial arrangements are inadequately defined to ensure availability of on-time resources at sub-national levels; and (ii) program coordination at the local level (who does what, how) is not sufficiently specified and adversely impacted by discontinuities in information flows (in socialization,

inter-agency vertical and horizontal communications, insufficient availability and distribution of written materials).

Recommendations: (i) develop a detailed Memorandum of Understanding to agree on the distribution of responsibilities between the center, the provincial and district levels *(para. 30)*; (ii) allow enough time for socialization and the putting into place of coordination mechanisms – never rush to implementation *(para. 31)*; (iii) emphasize the need for a close working relationship between the main field-level agencies – Bappeda (regional Development Planning Agency) and Dinas sosial (regional, operational unit of the Ministry of Social Services) – this is key to strong field-level coordination and to maintaining momentum in implementation *(para. 31)*; (iv) revisit the role of the provincial level, perhaps in providing technical support and training, a depository of information and a mechanism for exchange of experiences between districts about PKH implementation *(para. 32)*; (v) draw on NGOs as an additional resource in encouraging compliance, publicizing the program and promoting asset creation among beneficiaries with the opportunities that benefit moneys create *(para. 33)*; and (vi) as the proram expands, develop mechanisms that address administrative constraints and principal-agent situations *(para. 34)*

(c) **Socialization**

Issues: (i) socialization has been too rushed to meet its main aims of facilitating program implementation for participating entities, and raising awareness of and mobilizing support for the PKH in the community; in particular, it has largely bypassed service providers, political entities, the media, grassroots organizations, the general public; and it has failed to sufficiently support the *pendampings* in their socialization role.

Recommendations: (i) provide sufficient time for socialization prior to program start-up; (ii) focus socialization of implementing agencies on how to do things, as well as what to do; (iii) apply the socialization strategy that has been designed, and reinforce it with tracer studies to determine impact on different target groups; and (iii) maintain socialization as a continuous information and education mechanism about PKH progress, targeted at the general public *(all relate to para. 41)*.

(d) **Monitoring (verification) and compliance**

Issues: (i) monitoring of compliance does not yet work, reflecting weak socialization of and insufficient coordination with service providers - whatever monitoring is taking place, is done *ad hoc* by supportive providers, and by *pendamping*s; (ii) no needs assessments or assessments of supply and demand barriers have been made, which potentially may cause supply bottlenecks and unduly penalize eligible households later on as the program progresses.

Recommendations: (i) involve line ministries more closely in the program; (ii) undertake a concerted effort to enroll service providers in the program, by means of workshops that focus on verification and reporting logistics; and (iii) as the program expands, include assessments of potential supply constraints – physical access, quality - and non-financial demand barriers to participation *(paras. 48 and 49).*

(e) **Information management**

Issues: The information management system is not ready to accommodate the needs of a pogram in implementation

Recommendations: In expanding the program, ensure that the management information system is sufficiently operational to allow monitoring of performance, as well as maintaining beneficiary rolls up-to-date *(para. 55)*.

(f) **Pendampings**

Issues: (i) *Pendampings* need additional, in fact continuous, training; (ii) contractual arrangements are still not orderly; and, in some instances, (iii) the number of families covered by a *pendamping* may be too high, especially in areas where beneficiary families don't live in close proximity of one another.

Recommendations: (i) provide *pendampings* with planned work programs, put in place performance management and feedback arrangements, in-house training and workshops on special issues *(para. 50)*; (ii) resolve contractual and salary issues – these appear to relate to temporary issues at the national level *(para. 50)*; (iii) adapt coverage to geographic realities – this is being recognized by Depsos *(para. 50)*; and, as the program matures (iv) broaden the role of pendampings towards household and community empowerment roles *(para. 51)*.

(g) **Payment mechanisms**

Issues: (i) payments have been irregular and of varying amounts, which generate welfare costs to beneficiaries; and (ii) revisions to beneficiary lists occur with a lag, leading to errors in payment.

Recommendations: (i) maintain the regular payment schedule that was originally set; this should be possible, and a priority, now that the immediate APBN (Indonesian national budget) issues are over; (ii) consider decentralizing the approval of the tri-monthly beneficiary lists to district levels, and introduce implementation audits instead *(para.59)*.

(h) **Payment amounts**

Issues: Inflation may erode the real value of the benefit

Recommendations: Consider introducing some form of inflation indexation in situations of double-digit inflation *(paras. 65 and 66)*.

(i) **Graduation**

Issues: (i) it is unlikely that household/consumption levels will exceed the cut-off point at graduation in very many instances;

Recommendation: (i) encourage families to invest at least part of their benefits in productive activities *(para. 62)*; and (ii) link exiting families to other social assistance schemes and care services; and/or into employment related services that can raise productivity and income of household members *(para. 63)*.

1. Introduction

1. In mid-2007, the Government of Indonesia launched a conditional cash transfer program – *Program Keluarga Harapan* (PKH) – on a pilot basis in 40 districts (*kabupaten/kota*) in seven provinces.[4] Some 500,000 households are currently (April, 2008) beneficiaries of the program. It is envisaged that the program will be gradually expanded nationwide and benefit some 6.5 million very poor households.

2. Conditional cash transfer programs are relatively complex systems that consist of interdependent elements where disruptions in any one element usually have significant repercussions on the system as a whole. Consequently, a series of rapid assessments were undertaken at startup of the pilots to determine the readiness of provincial and district authorities to implement the program and identify any significant problems that might need to be corrected at an early stage.[5] Subsequently, two case studies were done – one in Sumba Barat district in East Nusa Tenggara (NTT) and one in Kediri district in East Java – to review in more detail institutional aspects of program implementation. (<u>Attachment 1</u> briefly describes the methodology for the case studies and the outline for the questionnaires.) The case studies were undertaken as a collaborative effort between the National Planning Agency (Bappenas), the Ministry of Social Services (Depsos) and the Asian Development Bank funded Pro-Poor Planning and Budgeting Project (P3B) – (ADB TA 4762 INO) Representatives of the case study districts (*kabupaten/kotas*) also participated in the studies. The rapid assessments and the case studies were financed out of the Pro-Poor Planning and Budgeting Project.

3. The working paper provides a synthesis of the two case studies. Drawing on the findings of the case studies, and to some extent on the results of the rapid assessments, it looks at the implementation of key components of the PKH, and raises issues and makes recommendations that may improve current performance and could be introduced to facilitate any future expansion of the program. The working paper starts with a general presentation of the program. It then looks at the implementation of key components in the two pilots, focusing on the beneficiary selection process, inter-agency coordination, program socialization, the monitoring and verification mechanism, field-level facilitation, the management information system and the payment mechanism. It also discusses aspects relating to graduation and the economics of conditional cash transfer programs.

4. While only two case studies were undertaken, the findings should nevertheless provide a reasonable guide to problems that arise in the early stages of PKH implementation – PKH startup follows a standard approach, and while the experience in districts may differ, the differences are ones of degree, rather than substance. The problems are also remarkably similar to ones encountered in other countries. That should not, however, be a reason for complacency, but rather be seen as an opportunity to draw on lessons learned. And recommendations in the working paper, while tailored to the specificity of Indonesia, do so.

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[4] The seven provinces are West Sumatra, the Special Region of Jakarta, West Java, East Jawa, North Sulawesi, Gorontalo and East Nusa Tenggara.

[5] Rapid assessments were done in nine districts in six provinces during the period August to early December, 2007.

Sumba Barat and Kediri – Basic Characteristics

	Sumba Barat	Kediri	National
Population (000)	410	1,430	229,000
Poverty rate	71.6	27.9	16.7
Education, enrollments			
Primary	81	97	95
Lower secondary	81	85	
Health			
Infant mortality rate	55	40	35

5. The program is still in a pilot phase, and the purpose of pilots is to identify and iron out problems prior to program expansion. The case studies contribute to that process. Their findings are pretty straightforward – problems are mostly ones of execution rather design, and therefore they can be relatively easily corrected. And they might have been avoided altogether in the pilots, if more time and effort had been put into making sure that the systems were ready to go. Safety net programs are challenging to execute well and require careful preparation - people need to know their jobs well at the start, and they need to have the necessary tools to do those jobs; and there needs to be buy-in from the community at large. The case studies (and the rapid assessments) have indicated that this was not the case, and that may be the main overarching lesson to draw from the pilots and correct as the program expands – make sure that the requisite knowledge and skills has been acquired; that institutions are in place; necessary financial resources are available; and programs are understood and supported by the community at large. When realistic timetables are applied that allow this to be done correctly, the likelihood of successful program expansion should be high.

2. General Features of The Program

(a) Basic design parameters

6. The PKH is a conditional cash transfer program aimed at very poor households with children and/or with pregnant women. The program provides a quarterly cash benefit to eligible households, partly calibrated to family size and conditioned on school enrollment and attendance, regular health check-ups and monitoring of nutritional status, and monitoring of pregnant mothers. (Details on conditions are set out in Attachment 2.) The program currently covers some 500,000 households. Benefits are expected to average IDR 1,390,000 per household per year, or about 27 percent of the national poverty line;[6] they are topped off at IDR 2.2 million per year. Penalties are imposed on households that do not comply with the conditions, following a grace period of one month. (Details on benefits are set out in Attachment 3.)

7. There are no restrictions attached to the use of the money, but in order to improve the likelihood that it is put to the best use of the family, the benefit is primarily paid to the mother or another adult woman in the household.

8. As in many other conditional cash transfer programs, the PKH is expected to provide some measure of poverty relief, as well as mitigate inter-generational poverty. It is complementary to other social assistance-type programs, i.e. school assistance (BOS), health assistance for the poor (ASKESKIN) and rice for the poor (RASKIN).

9. Currently, the program is expected to run until the year 2015[7], at which time all potentially eligible households should have benefited from the program. Beneficiary households can participate in the program for a maximum of six years; formal recertification of eligibility is performed every three years.[8] If households remain in the very poor category after their six year participation in the program, arrangements will be put into place to facilitate exit, either into other assistance schemes or into active safety net programs that offer ways out of poverty.

(b) Organization

10. The PKH is a national program[9] whose successful implementation depends on close vertical and horizontal coordination - between national and sub-national, especially district, level administrations; and among district level administrations.

11. At the national level, program oversight and inter-sectoral coordination is provided by a central coordinating team that includes representatives of all government departments involved in the program. A technical team headed by the Director General of Social Assistance in the Ministry of Social Services acts as its secretariat. A central implementation unit in the Ministry of Social Services, UPPKH-P[10], is the program's

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[6] The national income poverty line is at about IDR 5.2 million per year, using USD 1.55 per day.
[7] The time frame relates to the MDGs: directly and indirectly, the PKH is expected to reduce poverty, raise completion rates in elementary education, promote gender equity, decrease infant and child mortality, as well as mortality among pregnant women.
[8] This is a fairly common threshold for conditional cash transfer programs
[9] *National* program as contrasted to *central government* program – an important distinction, as the first one emphasizes the participatory nature of the program and its pursuit of a common interest; as contrasted with a purely centrally mandated activity.
[10] Unit Pelaksana PKH Pusat

policy and supervision unit and provides operational guidance on program implementation, mainly through district-level offices of the Ministry of Social Services (Dinas sosial); and it maintains the data base. Relevant provincial and district administrative units have been assembled in coordinating teams (*Tim koordinasi*); they are supported by small centrally administered units – UPPKH-K – at the district level, charged with maintaining data systems and reporting on the program. At the sub-district levels, these UPPKH take the form of networks of field-level facilitators (*pendampings*), who mobilize and support PKH participants. The *pendampings* play a key role in encouraging PKH beneficiaries to comply with conditionalities; they serve as a point of first contact between the community and the PKH program; they support the monitoring function; and they help keep the data base on beneficiaries up-to-date.

12. Detailed manuals spell out specific roles and responsibilities of each entity in the organization. The organizational structure of the PKH is set out in Attachment 4.

13. Drawing on the experience in implementing conditional cash transfer programs in Latin America, strong institutional coordination between line ministries and different government levels is a basic requirement for successful program implementation. In federal (decentralized) systems such as Brazil and Argentina, coordination becomes crucial, since it cannot be expected that local governments will automatically comply with expected behavior. It may be even more important in an environment like Indonesia, which not only is strongly decentralized, but also lacks an extensive and permanent social protection infrastructure to deliver complex public social safety net programs. In that sense, the PKH design, with its coordinating committees and relatively light UPPKH structure, is a good one. Attachment 5 sets out PKH responsibilities at central and district levels, respectively.

3. Program Elements

3.1. The selection process

Selection of participating provinces

14. Selection of provinces and districts occurs in two phases: (i) provinces are selected on the basis of interest in the program expressed by the provincial government and a variety of regional characteristics that provide diversity in the pilot phase[11]; and (ii) districts (*kabupaten/kota*) in the provinces are selected on the basis of poverty, nutrition status, transition rates from primary to secondary school, availability of health and education services, and commitment to implement the program. To ensure the adequacy of education and health services, the head of each participating district (*Bupati)* signs a formal Memorandum of Understanding (MOU) agreeing to support the program. Each district is assigned a quota of PKH beneficiaries based on a comparative poverty-weighted formula.

(b) Selection of PKH participants (Targeting)

15. The selection of beneficiary families is carried out by BPS[12] using a three step process. Families are identified based on a series of characteristics for very poor households derived from household surveys and on their potential to fulfill conditions (pregnant women, children).[13] Eligibility is validated in the field; and a final list is drawn up by the central UPPKH, usually in consultation with the central PKH technical team and provincial and local PKH coordinating teams. Information about households on the final list is then entered onto a master data base that becomes the official list of PKH participant households. For the pilots, the process was somewhat modified: the initial data set was drawn from beneficiary households to the Direct Cash Aid (BLT)[14] and subsequently adjusted and complemented with households identified during the validation process.

16. While a range of targeting instruments may be used (see Attachment 6), the most common ones tend to be a combination of geographic targeting and scoring applicant households on the basis of characteristics that are fairly easily observed – proxy means-testing. The latter is used in the PKH. In many countries, especially ones with large informal economies where there is no alternative central database from which to confirm a household's actual income, it is the most straightforward, practical and reliable way to gage household poverty.

17. While the targeting methodology is straightforward, there is a perception among local officials involved with the PKH as well as among the general public that the program is non-transparent and sometimes badly targeted. Concerns about targeting have not been as pervasive as in the case of the BLT, but they have been voiced consistently in both case studies and in all the rapid assessments.

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[11] Poverty level, urban-rural balance, coastal/border regions, access, etc.)
[12] The Central Bureau of Statistics
[13] An underlying assumption is that poorer households are likely to underinvest in the human capital of their children.
[14] BLT was introduced in 2005 to mitigate the effects of a rise in prices of cooking oil.

18. And perception counts. It determines how well the program is accepted by the community and what kind of support it receives; it facilitates compliance and the work of *pendampings;* and it determines the nature of the complaints process – will it be one that emphasizes concerns about eligibility, or one where the focus is on matters of rights and obligations of beneficiaries.

19. A number of factors appear to have been present in shaping perceptions about the program:

(a) *Selection criteria*. The national household survey on the basis of which selection criteria have been identified may not be representative at the *kabupaten* (district) level.[15] And the greater the variance is from the mean in a given *kabupaten*, the more likely it is that the criteria will not adequately reflect the local poverty profile[16];

(b) *Targeting errors*. Errors of exclusion may be high;

(c) *Validation*. The household level screening process (the validation of eligible households) could have been stronger in instances where (i) enumerators are unfamiliar with local circumstances; (ii) recalls may be required but are not undertaken[17]; and (iii) geographical access to households may be difficult.

(d) *Socialization*. Socialization, i.e. the provision of information about the program, may not have been sufficient;

(e) *Transparency*. The selection process was non-transparent.

20. ***Selection criteria can be improved.*** The first factor is beyond the direct influence of the PKH, as it may require adjusting for regional variations in the sampling design, or introducing locally based targeting. In some instances – Sumba Barat is a case in point –

Example - Exceptions to the use of proxy means testing .

Brazil uses a self-reported simple means test, and Argentina uses a combination of categorical targeting and self-selection. Under self-selection, a program is open to anyone who meets the categorical criterion; however, the program is designed with other requirements that are assumed to encourage participation by the poorest families while discouraging the non-poor. In Argentina's Heads of Household Program, this involves at least four hours a day of eligible community work, or alternatively, participation in education and training activities. The programs in both Brazil and Argentina perform well on targeting. In *Bolsa Familia*, 73 percent of transfers reach the poorest quintile; iIn the Heads of Household Program, about half of all beneficiaries are from the bottom quintile. These numbers compare with 34 percent in the Mexican *Oportunidades* program and 56 percent in Chile's *Sol;idario* program.

Source: Background Paper on household targeting in OECD countries.

[15] There have also been concerns that the survey is out of date, and consequently criteria are no longer valid. This seems unlikely. The data is from 2004, and it would be surprising if poverty characteristics have changed in any significant way over the intervening period. Local poverty rates may of course have changed, for instance due to migration effects.

[16] Complaints about how representative the selection criteria are, will vary, depending on how well the the poverty profile in a given *kabupaten* corresponds to the criteria. This may be the reason why there was less concern about targeting errors in Kediri in East Jawa, as compared with Sumba Barat in NTT.

[17] "Recalls" are revisits to households that may not be at home during the the validation visit.

criteria have been selectively adjusted to better correspond to presumed local poverty characteristics. To the extent that a more nuanced set of criteria are desired, the following could be considered: (i) drawing on household surveys that are representative at the *kabupaten* level; (ii) drawing on household survey data that is representative at the provincial level; (iii) *ex ante* adjustment of weights; (iv) *ex ante* adjustment of district criteria by BPS by introducing one or two well established local poverty characteristics; or (iv) rigorous validation by BPS officials together with a local team that allows identification of "non-characteristic" very poor households for inclusion in instances where the quota otherwise cannot be filled. More generally, systems for determining targeting effectiveness could be improved for example through more frequent validation of the actual quintile distribution of PKH recipients against the statistically ideal distribution that would be observed if targeting were to be perfectly implemented.

Selection Problems in *Progresa*

The selection process in the Mexican PROGRESA program provides an instructive example of problems that can arise in targeting households for conditional cash benefits. The program uses a simple two-stage selection process – first, it identifies marginal rural communities using a conventional set of poverty correlates (adult literacy, access to basic utilities and supporting infrastructure, etc.); then, in each chosen community it undertakes a socio-economic survey to distinguish poor households from non-poor ones. While this methodology produced accurate results, both in selecting locations and identifying the poorest households, there were perceived problems with the selection process – both errors of exclusion and inclusion. Some were due to the collection process – enumerators did not follow up on absent households; and households overstated their resource situation so as not to appear poor. While individual respondents and focus groups agreed with targeting aimed at excluding non-poor households, they mostly perceived of themselves as all being poor, partly reflecting the emphasis on seeking out marginal communities. In addition, community members and service providers complained about not being associated with the selection process. In some instances, reactions were strong. Non-beneficiaries in some communities were reluctant to contribute toward school resources, arguing that beneficiary families should be relied upon more.

21. ***Focus on errors of inclusion rather than exclusion.*** The second factor – errors of exclusion - is bound to occur, especially in cash constrained benefit programs like the PKH. Inevitably, some deserving households will be left out. Instead, errors of inclusion – inclusion of households that should not receive the benefit – should be the main focus of concern, as every error of inclusion has a corresponding error of exclusion in a closed program of the PKH type. While the current selection process should give rise to relatively few errors of inclusion, this can be determined only by means of household surveys – either waiting for the next survey to be undertaken and analyzed, or by sampling the current beneficiary cohort through spot audits. To the extent that concern about targeting becomes strong, it may be worth considering undertaking spot audits in one or more of the pilot areas.

22. ***Supervise validation in cooperation with communities.*** The third factor – validation – has encountered all of the problems listed in point 19 (c) above, as well as selection bias. In large measure, this is an administrative problem, albeit an important one, since it influences credibility of the selection process at the village level. Formally, validation is undertaken by villagers, often the village secretary, under the supervision of BPS staff. In practice, this has not worked so well. Faced with difficult field conditions, the local enumerators were not sufficiently thorough, and in some cases personal bias was alleged. As a result, unjustifiable errors of inclusion and exclusion were generated. This can, however, be remedied – by means of more rigorous supervision and more thorough training of local enumerators; by broader local participation, for instance through village committees that review and comment on the list of all potential beneficiaries; and by a more information about the purpose of the PKH and the validation process so that there is a common basis for the activity in the community and among verifying teams.[18] Where it is deemed necessary, i.e. where error complaints are particularly high, validation can be accompanied by spot audits.

23. ***Make the selection process transparent.*** Transparency is essential, and non-transparency is an essential weakness of the PKH. Selection criteria are not made public, ostensibly to stop households from gaming the system. It is not unlikely that needy households, and sometimes not so needy households, will do so, given the opportunity. However, it is also an effective way of creating misperceptions and rumors and, ultimately, undermining much of the potential effectiveness of the program. And gaming can be effectively challenged – through the very transparency that it tries to avoid, by making selection criteria public, opening the validation process to public participation and scrutiny (for instance through community committees that work hand in hand with BPS staff), and by public listing of beneficiary households. These approaches have been applied successfully in other countries. In Indonesia, a parallel can be drawn to community-based approaches that expressly emphasize transparency and participation as linchpins to successful development[19]

The matter of targeting errors – some additional considerations

24. Concern has been expressed about targeting errors, in part because of the lack of transparency of the selection process, but also as a result of seemingly legitimate complaints from households that have been excluded from the PKH.

25. In very general terms, good targeting results are achieved when geographic targeting, means-testing and community involvement are combined. Performance may be enhanced or reduced depending on how well the methods are implemented. Performance may be further strengthened where extensive administrative systems exist that are suitable to the individual assessment of individual circumstances (present mainly in Europe and the Former Soviet Union).

26. PKH performance can usefully be assessed drawing on those elements – are they present? Are they practiced with sufficient rigor? How do they interact? An additional consideration to keep in mind when looking at the targeting efficiency of the PKH is the

[18] In interviews, local authorities invariably indicated that they would have liked to have an input into the selection process.
[19] The Community CCT, which is being piloted in parallel to the household CCT, is an example of an intervention that rests completely on an integrated community approach.

observation that the PKH is a cash-constrained program: even under perfect targeting there are deserving households that will be left outside the program - errors of exclusion are inevitable. The number of legitimate households included will be a function of benefit levels and administrative costs.

27. The cash constraint has another implication. Errors of inclusion, i.e. including households that should not receive the benefit, especially non-poor households, takes on more meaning than might be the case in a more open-ended program. Every error of inclusion now has a corresponding error of exclusion – every "bad" household takes the place of a "good" household.

28. When considering targeting efficiency, it is important to keep in mind that targeting is a means towards an end. In this case, the end consists of helping to break an intergenerational poverty cycle by changing specific behaviors in families that are of high risk to perpetuate poverty. There are currently many such families, all deserving of support, some of them covered by the program, some not, and this forces a trade-off in targeting which should be kept in mind: (i) should more resources be spent on enhancing targeting accuracy at the cost of including fewer beneficiaries or providing lower benefits to more beneficiaries; or (ii) should those additional resources not be spent on targeting, but rather on higher benefits or more beneficiaries, some of whom may not be as high risk as the current target population, but where the positive inter-generational effects may well be the same. While this may show somewhat less progressive targeting outcomes than a "purer" transfer program, it is not to say that it would be bad policy.

29. That said, while there is little actual information on targeting performance, it would seem that the current selection process, when properly done, should have relatively few errors. Of course, that can only be determined by sampling the current cohort of beneficiary households, or through the periodic household surveys, which presumably include modules on consumption and sources of income. Since there is concern about targeting, the best way to dispel it may be to undertake sample surveys in one or more of the pilot areas.

3.2. Inter-agency coordination

29. The institutions to implement the PKH are in place, and their design is fundamentally sound:

(a) They aim at engaging all relevant public agencies at national and sub-national levels;
(b) Responsibilities of participating agencies are spelled out in a fair amount of detail;
(c) Coordination mechanisms are in place; and
(d) Essential support systems have been set up – to determine eligibility, for timely benefit payment, for data processing.

30. That said, there still is a great deal of uncertainty about program implementation at the provincial and district levels – among coordinating agencies and in the PKH structure.[20]

(a) *Fiscal-financial arrangements* – in particular, who bear responsibility for the operating costs for the program? And are funds allocated and available to spending units on time? The current practice of signing a Memorandum of

[20] The "PKH structure" is here defined as the district level UPPKH operators and the *pendampings*.

Understanding (MOU) whereby the *Bupati* agrees to support the program is too generally phrased. An MOU is necessary, but it needs to be more explicit – it should not only establish the *relationship* between central program authorities and sub-national authorities, but rather, it should delineate their *working relationship* in implementing the program. And that should specify the following in some detail:

a. the respective responsibilities in providing support, in terms of physical and human resources that will be provided to different activities to be carried out at district level (training sessions, selection activities, registration, benefit payment, monitoring and evaluation, verification, *pendamping*s, financial support for unspecified activities) and

b. the corresponding cost sharing arrangements, including salary and non-salary operating costs, and an allocation for incidentals, that will provide a minimum basis of financial capacity to undertake the activities.

(b) *Program coordination at the local level*. As emphasized in paragraph 13 above, strong coordination between all participating units is a necessary ingredient of successful implementation of any conditional cash transfer program. It will not function well, if at all, without that. This requires a sufficiently explicit Memorandum of Understanding. And it requires that coordinating and implementing units know their roles and have a good understanding about how to go about fulfilling them. At present, this is not yet apparent in the PKH – either among coordinating teams or, to a lesser extent, in the PKH structure itself.

a. At the provincial level, understanding of roles and responsibilities is still being sought – is it oversight, coordination, intermediation, something else? And the situation is aggravated when provincial coordinating teams are being bypassed in communications between the center and district authorities;[21]

b. At the district level, the district Bappeda[22] and the district office of the Ministry of Social Services (Dinas sosial), as Head and Secretary, respectively of the district coordinating team, tend to be well-informed about the program, which should be expected.

c. The situation is mixed concerning education and health service providers. In principle, service providers have access to information and guidance through the participation of local education and health offices in coordinating teams; and through training that was to be delivered by *pendampings*. In practice, this has not so far produced the necessary results, as little has been done by either education and health offices, or service providers, to plan for program implementation, either in terms of assessing needs or introducing compliance monitoring. [23]

[21] In both case studies, the provincial coordinating team had met only twice – for establishment and to meet the case study teams. Either they don't understand their function, or they don't have a meaningful one.

[22] The district planning office

[23] A common complaint among school and *puskesmas* (community health center) directors was that they had received little information about the PKH through formal channels, in most cases no such information had been received at all.

This has resulted in the virtual absence of compliance monitoring. Whatever monitoring is taking place, it is the result of individual initiatives, and it appears to be limited to schools.

A number of factors have given rise to the situation described in (b) above. They all can be summarized under the heading "discontinuities in information flows": (i) socialization of coordinating teams has been too rushed and too general; (ii) operational information flows from the center to provincial and district coordinating teams mainly has taken the form of communications between the central UPPKH and the district Dinas sosial, without much spillover to other units; (iii) communications between education and health offices on the one hand and schools and *puskesmases* (Community Health Centers) on the other appear not to have been sufficient, based on interviews with school principals and *puskesmas* directors; and (iv) written materials (PKH manuals) were sometimes not being distributed to service providers. (In Kediri, even the district health office had not received a copy of the PKH manual.)

d. In the PKH structure, training of UPPKH operators has mainly focused on providing general information of the PKH, with little attention being paid to the management information system and the use of application data. While more effort appears to have been put into preparing the *pendampings*, many were still unprepared to address more than basic questions relating to the PKH.

31. ***The PKH is a complex program***, and it will take time before everything operates smoothly: some conditional cash transfer programs that have been running for years still are working out problems of design and implementation. In a new program, the important thing is that all phases are based on careful preparation, monitoring, reporting and adjustment. The kind of concerns that were consistently voiced by interviewees and are reflected in the text above can be addressed and solved through careful preparation and monitoring of implementation. The requirements are simple:

(a) ***Don't rush things*** – most issues relating to program coordination at the local level can be resolved by more thorough preparation prior to start-up – programs invariably run into trouble in execution when insufficient time spent on preparation;

(b) ***Agree on a detailed Memorandum of Understanding*** about the responsibilities and commitments of all parties concerned at central, province and district levels in implementing the PKH, along the lines sketched out in paragraph. 30 above. It may not be sufficient to do this by an exchange of letters; rather, it should be based on a joint workshop that results in a jointly signed memorandum of understanding.

(c) ***Do initial socialization and training prior to startup*** that includes one or more interactive workshops. These workshops should be designed on the basis of interviews with key informants at provincial and district levels, and the workshops should aim at

a. ensuring that all entities involved in program coordination and implementation are clear about their roles (what to do) and their tasks (how to do them);

b. developing implementation action plans (indicative work programs) for each agency; and

c. ensuring that the proper arrangements are actually in place, not just agreed on, before launching a new program;

(d) ***Define the exact modalities for cooperation between Bappeda and Dinas sosial*** in program implementation; in practice at field level, they coordinate the program, coordination is a day-to-day activity, and it is dependent on how well these two agencies collaborate;

32. ***The role of the provincial level***, one step removed from the field, is fairly circumscribed, and currently many of the tasks envisaged for it presupposes that the program is fully underway. In both case studies, the provincial coordinating teams had met only twice. While it is not immediately obvious that a provincial-level coordinating team brings much value added to the PKH, at least at this, relatively early stage, this may change as the program takes on momentum and is scaled up. Then it can become an important facilitator in providing oversight and perspective on the program through upward reporting and downward feedback on program results,[24] as well as a depository for information and a mechanism for exchange of experiences between districts about PKH implementation. In the decentralized Brazilian *Bolsa Familia* program, where the district is the main level involved in direct implementation, states (the rough equivalent of the provincial level in Indonesia) play an important role in providing technical support and training to the districts; and in sensitizing district authorities to processes for implementing the program. This will of course require the building up of such capacity in the provinces.

Incentives in a Decentralized Program
The *Bolsa Escola* Program

In Brazil's *Bolsa Famila* program, eligibility determination is managed at the center based on a means test. But many aspects – recertification and monitoring of compliance – are managed by local authorities. The Social Development Ministry provides a performance-based financial incentive to municipalities to promote good implementation. Specifically, quality is monitored using a four-point decentralized management index (IGD), which covers key indicators of registration quality and compliance verification. IGD scores are calculated monthly. Based on these scores, the Ministry pays municipalities a cost subsidy. Municipalities with scores under a pre-specified limit do not qualify for a subsidy. Instead, they are monitored and receive technical assistance to improve performance

Institutional considerations – looking to the future

33. *The role of NGOs.* The PKH does not currently recognize the potential synergies that exist in collaborating with local NGOs. Tapping resources that exist in grassroots organizations can reap benefits – in encouraging compliance among beneficiary households; in making the program better understood in the community; in identifying barriers to service use among local populations; and in identifying and helping develop opportunities that will help households graduate out of the program. In some other

[24] The latter will of course only be possible once an MIS is in place that provides information on performance indicators; this is currently absent from the program.

Conditional Cash Transfer (CCT) programs (e.g. Mexico, Colombia) civil society organizations are involved at the local level, serving as a conduit between communities and program providers. In the PKH, the *pendampings* have in some instances expanded beyond the narrow confines of program facilitators (see paragraph 59 below) to play something of a similar role. That is good, and the opportunity should be sought to leverage that activity by actively involving civil society organizations. The PKH is just one element of a safety net, and opportunities for building up the social protection system should be sought in civil society as well as in public administration.

34. ***Program expansion.*** The PKH is a relatively decentralized program.[25] And it is still a modest program that includes only provinces and districts that have been carefully selected on the basis of their interest in and capacity to take on the program. It is unlikely that this strategy can be maintained as the program expands. Financial and administrative limitations will appear; and principal-agent problems will arise.[26] It cannot be assumed that local governments will automatically comply with expected behavior. Then, more elaborate arrangements may be necessary than currently is the case, including (i) the introduction of sets of contracts, such as the MOU described above, that specify the services to be provided and the payments to be made by every participant; and (ii) monitoring tools that not only focus on administrative indicators (i.e. registration and verification), but also assess quality.[27] The latter can be linked to other arrangements that also may reduce capacity constraints and principal-agent effects, such as (iii) straightforward capacity building of municipalities that score low on quality indicators; and (iv) performance based financial incentives to reimburse (in part) districts for the cost of implementing the PKH.

35. Some key questions to determine readiness to assume institutional responsibilities are set out in <u>Attachment</u> 7.

36. *Innovations.* The program is highly likely to generate local innovations. This was already observed during the rapid assessments: in Gresik in West Jawa, a *monitoring team*, headed by the local *Bappeda,* has been established to support the provincial coordinating team; and in Bandung, a *community UPPKH* has been established. An important function of these new entities is to address concerns expressed by *pendampings* and complaints from the public. More such initiatives are likely to turn up as program implementation proceeds, and local authorities start addressing local issues that relate to the PKH. An important future initiative should be to take advantage of such local developments by promoting knowledge-sharing across districts through periodic inter-province level meetings.

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[25] The PKH has many similarities with the Brazilian *Bolsa Escola* pogram. That program is managed locally, while control is at two levels – at the *federal* level, the number of beneficiaries claimed by municipal governments is checked for consistency against local aggregate indicators of affluence. In case of discrepancy, local governments will have to adjust the number of beneficiaries on the basis of income per capita rankings. At the *local* level, the responsibility for checking the veracity of self-reported incomes is left to municipalities

[26] The principal-agent problem arises when principals (such as a central government agency) employs agents (for instance a district government) to whom it delegates discretion. And principals and agents may not have exactly the same interests.

[27] In the Brazilian Bolsa Familia program, an outcome-based index of decentralized management is used that measures performance based on participation and compliance rates.

3.3. Socialization

37. Socialization is a key element of a successful conditional cash transfer program. It usually takes the form of a diversified information, education and communications strategy aimed at generating and maintaining support for the program in the community. It provides local authorities and participating agencies with sufficient information for them to be able to be effectively involved in program implementation; it informs beneficiary households of their rights and obligations under the program; it ensures that the program objectives and implementation modalities are sufficiently understood in the community; and it provides continuous information and education about the program during implementation. The Ministry of Communication and Information, DepKomInfo, and its regional equivalents are formally responsible for developing and implementing the strategy, either on their own, or by contracting other public or private entities.

38. ***Socialization in the PKH has been uneven***, based on findings on the ground:

(a) At the level of local authorities and key members of coordinating teams (Bappeda, Dinas sosial), the PKH is well understood in general terms, and it is supported. Knowledge about the PKH is less apparent among education and health authorities, and school and health center management and staff. In some instances, neither authorities (Kediri) nor facility managers (Kediri, Sumba) had received any information about the program through formal channels. While their willingness to support the PKH is evident, stronger socialization could improve implementation performance;

(b) Beneficiaries receive socialization when they are invited by the *pendamping* to First Assembly – the event (or events, there are often more than one, in order to reach as many beneficiary families as possible) - at which they first are informed that they are beneficiaries and what their rights and obligations are. It is also the first time that the community and community leaders have an opportunity to learn about the program. This process seems to work relatively well. The majority of interviewed beneficiaries understood why they were receiving benefits and what their obligations were. Likewise, the majority of interviewed non-beneficiaries understood the reasons for their exclusion.

(c) The community at large[28] was less well informed, and in few instances had they learned about the program directly through any PKH socialization effort. Such information as they had was mainly by word-of-mouth, from constituents and from clients.

Gaps in socialization

The following examples are drawn from field interviews:

- The DRPD learned about the PKH when there was a demonstration by non-beneficiaries
- NGOs learned of the existence of PKH by word-of-mouth from their clients
- Community leaders learned about the PKH when (i) the *pendamping* asked to use the community hall for First Assembly; (ii) non-beneficiaries complained
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[28] The "community at large" is here defined as the DPRD, the media, NGOs

39. ***Still, the socialization strategy, as it is described in the PKH manuals, is comprehensive***, and it has been designed and vetted by Depsos and DepKomInfo. It just needs to be effectively implemented. There may be a number of reasons for this:

(a) Initial socialization may have been adversely influenced by the relative rush with which the pilots were put in place; this may have been particularly awkward for coordinating agencies, who had little time to get ready to implement an unfamiliar and difficult social safety net program;

(b) According to national authorities, socialization was to be kept low-key initially, so as not to raise expectations about the program;

(c) A cutback of resources for the PKH forced a curtailment of socialization activities[29].

40. As a result, much of the burden of socialization fell on the *pendampings* – to inform the community, beneficiaries and non-beneficiaries, schools and health services. While this is part of their mandate, it was envisaged to be an effort that was to be supported and reinforced by a strong DepKomInfo-driven socialization program. This has not been the case so far, in large part for reasons of fiscal stringency and the desire to manage expectations. While these may be understandable reasons, they also raise unnecessary risks that yet may jeopardize the operational success of the pilots, and bring their justification into question. In the absence of rigorous socialization at the level of districts and sub-districts, where political authorities, much of the administration, and the population at large, remain uncertain and even ignorant about the program, confusion about the PKH, and its aims and justification, is likely, and it can gradually undermine support for it and raise the risk of subsequent failure in implementation.

41. Attention would need to be paid to socialization as the program is expanded:

(a) Strategies should be planned, tested, adequately resourced and implemented with a view to meeting the objectives of socialization – informing and educating prior to program start-up; and communicating progress and results during implementation. The present approach to socialization of providing general information on short notice, is unlikely to meet the aims of socialization;

(b) At the level of implementing agencies and individuals, socialization should not be limited to telling people just what to do; it should also tell them how to do it, then work with them to see that they know how to do it; and then test them;

(c) Messages should be tailored to the client both in terms of content and form of delivery – the authorities, participating agencies, political entities, the media, NGOs, beneficiaries, the community, etc.;[30]

(d) For it to be genuinely effective, socialization should preferably take the form of a continuous process of informing the community about the program, its contents, implementation and impact on beneficiaries; and

(e) The impact of socialization messages should be monitored and adjusted to maximize their effectiveness.

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[29] Program design envisages that socialization should be undertaken in all communities benefiting from the PKH. With the budget cut, this was no longer possible; for instance, in Sumba Barat socialization was undertaken in only 24 villages out of a total of 92.

[30] In discussions with media representatives about delivery methods to very poor households, radio and television were considered effective means of communication, in addition to face-to-face communication; as long as the messages were tailored to be easily understood.

(f) The officials in the Ministry of Social Services, and their district-level counterparts, who are responsible for overseeing and implementing the PKH, must take responsibility for the socialization strategy and work closely with implementing agencies to ensure that the right messages get communicated in the right way. Socialization is a marketing strategy; it requires joint efforts by the sales people (Ministry of Social Services) and the marketing agency (Ministry of Communications, or a private agent). In other countries, more often than not, the socialization (marketing) is contracted out to professional private marketing agencies.

42. While all these points already may be reflected in the design of the PKH, they also need to be put into practice.

3.4. Monitoring (verification) and compliance

43. In a conditional cash transfer system, monitoring consists of a series of elements: (i) creating awareness and encouraging compliance at the beneficiary level; (ii) monitoring compliance; (iii) reporting and data management; and (iv) the system of consequences for non-compliance.

44. In the PKH, the process of ***awareness-raising and encouragement of beneficiaries is well in hand.*** As noted in paragraph 38 (b) above, beneficiaries are aware of the program and their rights and obligations in it. This is reflected by the fact that, even in the absence of monitoring, schools and health centers report an increase in demand for their services. *Monitoring* of compliance is still not underway, and in the absence of monitoring, neither related *reporting and data management*, nor *consequences for non-compliance*, have been tested.

45. ***Monitoring needs to be made operational.*** In practice, while three payments already have been made, the verification system is not yet functioning properly in the case study districts. There are some exceptions in selected schools, but these are based on individual initiatives taken by school officials, often at the encouragement of *pendampings*. (*Pendampings* are the day-to-day operational link between the program and the service providers.) As of yet, there are no *formal* field-level arrangements for verification in place. Local authorities are legitimately concerned about this state of affairs and aware of the potential risks – an erosion of adherence to compliance, and exposure to criticism that the program is just another government hand-out.

46. Three reasons primarily may have contributed to this state of affairs: (i) priority has been placed on disbursing all benefit moneys allocated in the 2007 budget before they are retracted prior to the following fiscal year; (ii) socialization of education and health services has been ineffectual; and (iii) field-level agency coordination has not worked.

47. Internationally, getting compliance monitoring to work well has not been easy, especially in the early stages of a program. Programs have been plagued by difficulties in coordinating with line ministries and local education and health authorities; and in data collection in schools and health centers. The reason is simple: conditional cash transfer programs are demand-driven schemes to induce households to make more intensive use of existing education and health services; and support by service providers – provision of services and monitoring compliance - is almost taken for granted. Judging from the case studies, this is also true for the PKH.

48. The remedies are obvious – (i) a more explicit relationship with the line ministries that sets out the opportunities and challenges of the program – in terms of service provision and education and health outcomes; (ii) stronger guidance to local health authorities from the line ministries emphasizing the priority attached to the PKH as part of an overall education or health sector strategy; and (iii) in the context of the coordinating teams, proactive collaboration with local education and health directorates to develop action plans for implementing the program at facility levels, including workshops that focus on verification and reporting logistics. (Here, the day-to-day operational link between *pendampings* and service providers is a good start, although the absence of essential support in terms of points (i) to (iii) above is still missing.) Such action plans will also have to focus on resourcing – for service delivery and for compliance monitoring. Already, as schools and health centers report an increase in demand for services, supply constraints are starting to show up, especially in schools in terms of teachers, classrooms, teaching materials and equipment.[31] And experience in Colombia and Mexico has shown that compliance monitoring can generate substantial time costs for school and health facility officials in terms of collecting, filling out and returning forms for processing. If they become excessive, support for the PKH among schools and health centers may wane.

Logistics management of forms and data entry.

In Colombia, an external firm was contracted to handle all logistics related to forms - transporting them from the program's offices in the municipalities, picking them up after having been filled out by the health and education officers, and transporting them back to the offices in Bogotá – and data entry for the calculation of the payments. This system allowed the program to avoid implementing an entire personal logistics system, and logistical costs turned out to be lower than if they had been done with the use of public resources

49. ***Are supply constraints likely to become a compliance issue?***[32] In the PKH, there has been little focus on complementary efforts directed at strengthening the supply of services (physical access, quality); nor do there appear to have been any needs assessments to try to anticipate the supply-side implications of a potential increase in the demand for education and health services. Instead, ready access to physical facilities has been a criterion for selecting pilot districts. This is unlikely to be a feasible strategy when the program is expanded. Even now, supply constraints are starting to show up – in terms of availability of teachers, overcrowded classrooms, insufficient teaching materials and classroom equipment. These observations were made by school directors in both Sumba and Kediri. While health services also reported an increase in people seeking services, supply constraints there seem to be less severe. In part, this may reflect already high participation rates, especially in Kediri, as well as the fact that resource needs in the health sector usually are estimated on a catchment population basis. Bottlenecks, when they appear in health, then initially are more likely to reflect supply-line constraints.

[31] It is not unusual that demand for services increases with the introduction of a conditional cash transfer program, even when the conditionalities are not yet applied – the appearance of a conditionality often suffices to prompt families to increase use and intensity of use of services.
[32] An underlying assumption of the PKH is that the required behaviors are feasible – that there is physical access to the service, that service quality (including capacity) is sufficient, and that the service is affordable to the household, at least when the household receives the benefit.

50. Maintaining a conditional cash transfer system that requires compliance places the responsibility for facilitating compliance squarely with the program authorities. Since the compliance is mandatory for participants, access to services is essential. The PKH does address the issue of *financial barriers* by reducing direct and indirect costs to beneficiaries of using education and health services; and *physical access* has been a criterion in selecting pilot districts. Still, *non-financial supply-side barriers* – in addition to physical access, maintaining and improving the quality of services can be expected to pose increasing challenges as the program expands; while household and community attitudes will play a bigger roll on the demand side as the program seeks to reach marginal households. A recent PKH-related study by SMERU[33] looks at supply and demand barriers to the use of Mother and Child Health (MCH) services, as perceived by households. On the supply side, low quality of services, especially for poor patients, are cited[34]; on the demand side, insufficient coverage by the Askeskin health assistance program, as well as negative perceptions about modern health care; and embarrassment about one's own personal circumstances, are mentioned as barriers to attendance. Surveys of the school system point to quality barriers that touch on the quality and availability of teachers; the relevance of the curriculum; and the scarcity of secondary schools in peri-urban and rural areas.

51. While it is reasonable to assume that the majority of beneficiaries who respond positively to the PKH do so because financial barriers to access are reduced, and trade-offs between school and work come to favor continued schooling, a hardcore of households are likely to remain hold-outs, unless non-financial barriers are addressed; or, alternatively, other safety net strategies are applied that better cater to such households.

52. As the demand for services is likely to continue to increase, supply-side constraints, especially in education, are likely to become increasingly important in determining education outcomes. This is an issue to be tackled earlier rather than later. Experience in a number of Latin American countries point to the time and resource intensive nature of acquiring the extra resources to maintain or raise education standards. In many instances, improvements in education outcomes have been due to student interest and better nutritional status, rather than better education services. [35]

3.5. Information Management

53. Information management under the PKH consists of (i) hardware, software and staffing; and (ii) data collection and manipulation. The IT system is in place, and routine data collection on participant households, their benefits, and on complaints, is being inputted into the system. Training of district level UPPKH operators has focused on the PKH, with less emphasis being placed on managing the system. That knowledge has been acquired by the operators themselves.

[33] Program Keluarga Harapan dan PNPM-Generasi: Qualitative Study and Preliminary Findings (SMERU Research Institute)

[34] Complaints about the quality of health services usually focus on the process of service delivery, including such matters as courtesy or consideration with which poor users are treated, or the amount of time they have to wait for a service. However, quality also includes the state of physical facilities, appropriate staffing, availability of drugs and medical supplies, etc.

[35] The experience at the secondary level is somewhat different. Interest in school among older children, especially boys, tends to weaken and drop-out rates increase, as competing interests arise – the desire to help out at home or just simply perceived low returns to secondary education. This is not a phenomenon unique to the Latin American experience, but worldwide, causing increasing focus on means to retain boys in school.

54. While the data base on beneficiary households has been established and is being maintained on a regular basis, changes are still recognized in the system with a lag, and this tends to have adverse effects on benefit delivery (see para. 57). Where the system still is not working is on developing and allowing the analysis of data on program outputs and results monitoring. That element of the management information system is under development, and is expected to be put in place in the near future. At the current state of the PKH, this is not a severe deficiency.

55. As the program expands, and when the management information system is fully operational, presumably the lags that currently appear in the reporting and adjusting of beneficiary lists will disappear. Instead, the emphasis of concern will shift to the training of the operators, which may have to be more comprehensive to ensure that the information in the system is up-to-date and available in a timely manner.

3.6. Pendampings (Facilitators)

56. ***The potentially strongest element of the PKH*** is its network of field-level facilitators – *pendampings*. They have a key role in mobilizing beneficiary households, informing them of their rights and obligations, encouraging them to adopt and maintain PKH practices, monitoring eligibility and ensuring that the household data base is kept current. They are an important link in enrolling schools and health services into the verification process. Each *pendamping* supports some 200 to 250 households. Most *pendampings* have secondary education, and in most instances they come from the environment in which they are working.

57. A number of factors currently limit the effectiveness of the *pendamping*s.

(a) While the *pendampings* have received basic training in the PKH, their understanding of the program is still evolving – they are able to explain the rudiments of beneficiary rights and obligations, but in most instances their knowledge is still insufficient to deal with specific questions of benefit amounts, selection and eligibility, or handle complaints;

(b) Their situation has not yet been formalized in terms of contractual arrangements, and salaries are still paid irregularly; there are no structured work programs; and they have insufficient operating budgets to get around easily;

(c) The number of families covered by *pendamping*s – an average of 250 families – may be too large for effective interaction in instances where families do not form easily reachable clusters.

58. Contractual and salary issues reflect temporary budget problems at the national level; while insufficient operating costs are a result of unclear assignment of program costs. The former will presumably sort themselves out, while the latter relate directly to the MOU issue discussed in para. 25 above. The *pendamping* function needs to be better defined: a predictable working environment needs to be created, with predictable work programs, performance management and feedback; in-house training and workshops on PKH themes, on building relationships with households and stakeholders such as schools and health centers, as well as issues that may be identified as problems by the *pendamping*s themselves in their daily work. Regarding coverage, Depsos has correctly identified this problem, and in appropriate cases already reduced the *pendamping*/family ratio by increasing the number of *pendamping*s. While necessary, this action has also

exacerbated the temporary shortage of budget resources, as the number of *pendamping*s have increased.

59. The *pendamping*s continue to impress – throughout the rapid assessments and in the case studies they have been a positive force. They may prove to be an important resource for Depsos in the future, not only for PKH implementation, but more broadly as a support element for poor households and communities. Consequently, there are short-term and longer term considerations to the *pendamping* function:

(a) In the short term, the focus should be on their work on the PKH – monitoring and encouraging their client households to meet their conditional undertakings. And the focus of their managers should be on being alert to their needs – resource needs and training needs. This has not yet been the case - operating costs are not being met, nor are there any explicit arrangements for work planning or on-the-job training;

(b) In the longer term, the current heavy workload of the *pendamping*s is likely to diminish. As adherence to program conditions become routine, their work will mainly focus on the "red flags", those relatively few client families that have difficulty meeting the conditions regularly. This should create an opportunity to use *pendamping*s in more of a social care and empowerment function. They may develop established relationships with their client families, much along the lines of caseworkers in social care. With some training, they should be able to provide basic advice on social issues to their "cases'. Likewise, with some training they should be able to provide impetus for household and community empowerment – working together with beneficiary families to seek opportunities that would help mitigate poverty. There are already signs of this occurring, even at this early stage of the program. In several instances, *pendampings* were working with beneficiary families to leverage their benefits into productive uses. To the extent that the program is intended to have a "graduation" element to it, it is unlikely that any graduation will occur, unless these kinds of initiatives are taken advantage of. This will increasingly require that *pendampings* develop the ability to pay attention to such opportunities; and it will require that program managers seek synergies with other formal national and sub-national poverty programs, as well as activities of grassroots organizations.

3.7. The payment mechanism

60. Benefit payments are supposed to occur every three months on fixed days[36]; they are conducted by the Indonesian postal service (PT Pos) through its offices and through mobile units. So far, while delivery has proceeded smoothly, payments have suffered from the following: (i) payments did not always correspond to benefit award; (ii) payments have been irregular; and (iii) and people have spent a long time waiting for payment.

[36] In most countries, payments are made bi-monthly (for instance Colombia, Jamaica, Mexico, Nicaragua). Less frequent payments, as in the case of Indonesia, have the advantage of generating lower operating costs than if frequency were higher, and it reduces travel costs for beneficiaries.

61. These factors generate welfare costs to the beneficiary: the disadvantages of uncertain cash flow can be high when they reduce cash-in-hand in beneficiary households;[37] and waiting time can generate significant opportunity costs.

62. ***Making correct payments in a predictable way so far has proven to be difficult***: (i) in some instances the rush to launch the program has led to only minimum benefit amounts being paid out to a limited number of households ("photo ops"); (ii) in other cases, the updating of beneficiary lists has been late; this was the case in both case study districts; as a result, there is a risk that the wrong amounts or newly ineligible households will be paid;[38] and (iii) second and third payment were made either jointly or in rapid succession ("lumpy payment").

63. When the pressure to make a first payment at any cost subsides, or is resisted, this problem should disappear by itself, as should the issue of lumpy payments. The updating of beneficiary lists at present needs the approval of the Ministry of Social Services (Depsos). In principle, Depsos has almost a month to give its approval and provide the approved lists to PT Pos, so timely updating should be feasible. Over time, consideration might be given to decentralizing list approval to the district level, and accompanying it with occasional random sample audits. (In a sense, regular monitoring is already done by the *pendampings*, but an audit might have the additional advantage of confirming that *pendampings* are carrying out the updating conscientiously.

64. ***Excessive waiting times*** are usually incurred when fixed payment dates are not set or maintained, and/or individual payment schedules are not used. In the PKH, fixed payment dates are set, but in both case study areas beneficiaries (and non-beneficiaries) started lining up some four hours before the payment event, which itself was completed in about an hour. This does not necessarily argue for introducing a queuing system *per se*. It may well be that over time beneficiaries will turn up only when payments start, as they will realize that the process will not stop until everyone has gotten her benefit and the right amount. It is, however, worth monitoring, especially as the program expands, to reduce the likelihood of such a problem arising.

3.8. The payment amount

65. At an average of IDR 1,390,000, the current benefit averages some 27 percent of the national poverty line. It also averages some 16 percent of the annual household income of very poor households. The benefit therefore is a significant addition to the income of very poor households. However, with close to double-digit inflation (and possibly double-digit inflation in commodities that form a large share of spending in poor and very poor households, some consideration may have to be given to maintaining the real value of the cash benefit over time. At the same time, care should be taken to assess the impact of such implicit debt on the fiscal situation.

66. In some programs, the nominal value of the cash benefit is adjusted annually, or every six months to adjust for changes in the cost of living (most Former Soviet Union countries, Mexico). In some other programs, adjustments are triggered when inflation exceeds a certain rate, for instance over the period of a quarter.

[37] If one assumes that the poor have high discount rates, i.e. the value of cash now is high compared to cash later, the welfare loss to poor households from payment delays can be significant.
[38] In some instances, *pendampings* have intervened to withhold payments to ineligible households.

3.9. Graduation

67. Households exit from the program based on changes in family status, which is reviewed regularly by *pendamping*s; during recertification that is performed every three years; or after they have been six years in the program. If they still are very poor at that point, they will be transferred to other programs that may facilitate their exit from poverty.

68. Ideally, the household income/consumption level will exceed the cut-off point at graduation. Presumably this happens in one of three ways (or a combination of ways): (i) through the effects of general economic growth on households; (ii) a rise in the sensitivity of poor households to growth; and (iii) changes in relative incomes. In fact, the last item by itself has little impact on changes in poverty.

69. The PKH is assumed to have a positive influence on the sensitivity of poor households to growth by raising incomes and increasing earnings opportunities. Over the long term, the education and health initiatives will do this for the next generaiton. In the shorter term, the cash transfers may encourage families to invest at least part of their benefits in productive activities, as is currently already happening on a small scale in Kediri.[39]

70. When this is not possible, alternatives must be sought. These may include building links to (i) other social assistance programs and social care services that focus on helping vulnerable beneficiary families overcome specific risks; and (ii) employment-related services – training, placement, public works, public service - that aim at raising the productivity of household members, generating income and raising their risk tolerance.

71. While graduation arguably measures how successful a conditional cash transfer program is, success is not only dependent on access to a CCT, but on insertion into the wider economy along lines sketched out above. This is already occurring, albeit modestly, in some older programs. Chile has set up a bridging program to help insert very poor families into the wider economy through the coordinated use of layers of social safety net programs. The Brazilian *Bolsa Familia* collaborates with local development interventions and micro-credit and business development schemes. Ultimately, the challenge is how to design mechanisms that avoid creating new dependencies and instead encourage and facilitate graduation.[40]

3.10. The longer term

72. The PKH should not simply be viewed as a conditional cash transfer program, but as an important element in a longer term strategy aimed at building a viable social safety net that balances protection and opportunity – a safety net that helps the poor and vulnerable cope with current poverty; while at the same time promoting movement out

[39] The PKH also has a temporary positive effect on the depth and severity of poverty, i.e. as long as the families continue to receive the program benefit(assuming it exceeds any income foregone and costs incurred as a result of participating in the program.

[40] Most programs have three-year re-certification/graduation mechanisms combined with some phasing-out period (for instance Mexico, Paraguay and El Salvador). While these programs offer graduation support, it is not obvious that these rules fit well with a primary objective of human capital accumulation, in particular if they do not sufficiently cover education and health care cycles.

of poverty by encouraging human capital formation and enhancing economic opportunities among the poor. [41]

73. At present, the formal Indonesian safety net mainly consists of initially temporary and now quasi-permanent targeted food and health subsidies, and scholarships for education. The gradually diminishing fuel subsidy is also an element of this safety net, albeit in the form of a universal benefit. Targeted cash assistance has been of a purely temporary nature.

74. While the elements of a safety net may be there, they hardly can be characterized as a well-thought out and comprehensive strategy that offers both protection and promotion. Here, the PKH is a good beginning. It is an instrument that offers poverty relief and builds human capital. However, it still is quite limited, and even at full implementation, it only covers a subset of the poor – very poor families with pregnant mothers and children.

75. A safety net usually consists of a series of complementary interventions that address the needs of various poverty profiles, ultimately ensuring that as few people as possible fall through the cracks. A coherent longer term strategy would therefore build on an expansion of the PKH and include: a cash benefit for the very poor who are unlikely to be able to benefit from economic growth; well-targeted subsidies in education and health; community development initiatives (and possibly temporary public works schemes) that build socio-economic infrastructure that can have a positive impact on human development and economic opportunity; and direct pro-active micro- and small business promoting initiatives. An important constraining factor for any expansion will be the budgetary implications. Policy decisions – choices of who to protect and who to promote? – will be difficult. Should the priority be places on families with children, the working poor, the elderly, or some balance between these groups? The choices will in turn determine the appropriate instruments.

[41] The Mexican PROGRESA program forms part of an overall strategy for poverty alleviation in the country, working in conjunction with other programs that aim at developing employment and income opportunities and facilitating the formation of physical capital.

Annex - Some considerations about the economics of CCT-type programs

A conditional cash transfer program usually is a high profile program, and significant resources are put into it. But are the benefits always commensurate with the costs?

This Annex looks briefly at some aspects of the economics of conditional cash transfer programs. Its purpose is not to provide ready-made answers, but rather to provide a better understanding of the kinds of considerations that come into play when justifying the use of limited resources. In particular, it looks at considerations of cost and program efficiency.

Starting point

The PKH provides a benefit that averages 27 percent of the national poverty line. While this is a generous benefit, it is somewhat mitigated by the fact that it supports two objectives – poverty relief and increased use of education and health services; and the latter places additional costs on the beneficiary households – in terms of cash expenditures and in terms of welfare costs.

Consideration: leakages

For ease of analysis, program costs can be grouped in two kinds of costs: (i) benefit transfer costs; and (ii) efficiency costs.

1. **Benefit transfer costs**

The main PKH-related costs consist of:

(a) *Administrative costs* – all salary and non-salary operating costs financed out of the PKH budget;

(b) *Social costs* – costs incurred by other departments , such as time devoted to PKH by other department staff and local public and private entities and service providers to implement the program; incremental investment costs by service providers; incremental non-salary operating costs of service providers;

(c) *Private costs* – costs incurred by beneficiaries, such as financial costs, time costs for travel, waiting time, school attendance)

Regarding *private costs*:

- For many households, the program may in fact have negligible implications for total costs incurred, since they are likely to already be applying conditionalities prior to the PKH; it is only the private costs incurred by families that have changed their behavior as a result of the program, that may need to be taken into account;
- The opportunity cost of time is likely to be zero; it can be assumed that households will be able to substitute between activities so that only the most unproductive tasks are left undone.

Indicators for benefit transfer costs (examples):

- The cost (the sum of items 1-3 above) of transferring a unit of funds to beneficiaries – the cost-transfer ratio
- The cost of generating an additional year of education
- The cost of a percentage point increase in full immunization coverage

Note: the cost-transfer ratio will tend to decline over time in line with a decline in average fixed costs (start-up costs).

1. **Efficiency costs**

Efficiency costs arise due to leakages that might arise in (i) targeting of households and (ii) calibration of the benefit. Other inefficiency costs relate to (iii) the adverse welfare effects of the conditionality; and (iv) substitution between the formal and informal safety net.

Targeting and calibration

(a) *Targeting* of households relates to payments to households that are already highly likely to apply conditionalities (i.e. paying people for what they are already doing)

(b) *Calibration* relates to providing a benefit that is sufficient to meet the opportunity cost of the change in behavior among households who are not already applying the conditionalities (i.e. ensuring a high uptake while minimizing costs).

Can better *targeting* and *calibration* of transfers more efficiently increase participation, i.e. greater participation at lower cost?

In situations where enrollment and attendance are already high, predictive models drawing on baseline surveys and focusing on characteristics of marginal (non-participating) households in order to prioritize beneficiary households, have shown that significant efficiency gains can be had.[42]

However, a number of considerations and qualifications need to be made:

1. In all conditional cash transfer programs, the majority of households are already adhering to the conditionalities prior to the program; but
    a. The program has two purposes – poverty relief and conditionality; in already participating households, the benefit provides poverty relief; in others, it provides both;
    b. It would be awkward to penalize performing households and award non-performing households
2. Much of the focus of conditionality is on *continuity* – ensuring that households maintain schedules. The efficiency costs of targeting and calibration must be measured against the educational (and ultimately economic) benefits to very poor households of earlier enrollment, more regular attendance, lower drop-out rates and higher pass-through into secondary education; and in health, the benefits that come with maintaining check-up and vaccination schedules.

The welfare effects of the conditionality

The conditional cash transfer has two important effects – it raises incomes and it manipulates relative prices.

While the longer term effects of the conditionalities may enhance the income-earning potential of the next generation (and while there may be a positive spillover effect onto the

[42] De Janvry and Sadoulet – Making Conditional Cash Transfer Progams More Efficient: Designing for Maximum Effect of the Conditionality. The World Bank Economic Review, Vol. 20, No. 1, 2006

current generation), the value of the cash benefit to very poor families is reduced (assuming a fixed budget allocation for the program):

1. to all participating families since it comes with a tied spending obligation – an obligatory minimum must be spent on education and health services;
2. to families who already comply - in the form of a lower benefit than might be the case without the higher level of administrative costs that are required to compel non-complying families to comply;
3. to eligible non-beneficiary families who are left out because of limitations on how many families the benefit budget can cover because of the larger administrative budget.

<u>The substitution effect between formal and informal safety nets</u>

Informal safety nets (gotong-royong) play an important role in community-level support systems. What will the effect of cash transfers – conditional or otherwise – be on these systems? The international experience is that the introduction of formal systems tends to have a damaging effect on these informal safety nets, thus reducing the value of the formal benefit to the household, often significantly so. Field level observations during the case study and recent discussions in the press indicate that this is a strong possibility.

While it does not mean that formal structures should not be put into place, their design should be sensitive to informal arrangements; at least they must recognize that the net value of program benefits may be less as a result of such adverse reactions.

Attachment 1

Case study methodology

The purpose of the case studies was to review if and how key administrative processes[43] required to implement the PKH are working. In particular, it would identify key issues in implementation as perceived by the following: provincial and district coordinating teams, district and sub-district implementation units, service providers, beneficiaries, non-beneficiaries, other stakeholders (DPRD, media, NGOs, community leaders).

While only two case studies were undertaken, they should nevertheless provide a representative picture of the early stages of PKH implementation – the procedures are relatively standard. The case study districts that were chosen provide an opportunity to identify difficulties in a fairly developed environment – Kediri – and one less developed – Sumba Barat.

Case study methods included focus group discussions and semi-structured interviews based on questionnaires. Focus group discussions were held with the provincial and district coordinating teams, *pendamping*s, district UPPKH teams and NGOs. Semi-structured interviews were held separately with individual members of the coordinating teams, with beneficiaries and non-beneficiaries picked at random in the communities, community leaders and representatives of the DRPDs, the media

An outline for the case study questionnaire is annexed

[43] Key administrative processes are beneficiary selection, organization, socialization, service provision, verification, payment, appeal, information management

Annex

Draft questions for the Case Study

Beneficiary selection

Questions to – TK Provinsi (Provincial level)*, TK K/K* (District level)*, UPPKH K/K* (PKH program policy and supervision units at district level)*, Pendampings*

a. Your understanding of the method of selection, the criteria used, the results

b. What information/feedback did you receive about the beneficiary selection process

c. Province and district-level participation in the selection process – political authorities, TK Provinsi, TK K/K, UPPKH K/K, pendampings, community leaders

d. Your perception of the results of the selection process

e. Should it have been done differently? How? Why?

2. District-level establishment and implementation process

a. **General observations**

Questions to TP Pusat, TT Pusat, UPPKH Pusat

i. What is your perception of the implementation to date
   1. implementation schedule
   2. administrative processes
   3. positive/negative surprises

ii. In light of the experience to date, what adjustments would you make, if any

Questions to TK Provinsi

i. What is your perception of the implementation to date
   1. implementation schedule
   2. administrative processes
   3. positive/negative surprises

ii. In light of experience to date, what do you see as your main role in program implementation
   1. Are your day-to-day contacts with the program adequate
   2. Are the coordination, collaboration arrangements with central authorities, district coordinating and implementing units adequate
   3. What measures would strengthen the program

Questions to TK K/K

i. Views on the legal establishment of the PKH at the K/K level, the recruitments of staff/consultants, pendampings, offices, equipment, materials, manuals
   1. Adequacy, timeliness
   2. If done again, what improvements, if any, could be made in the process

ii. Are the arrangements adequate for collaboration and coordination between the program and district authorities, the TK K/K and the UPPKH K/K, the PKH and other poverty programs

iii. In light of experience, are there any adjustments that should be made in the following:

1. The process of establishment of the TK K/K?
2. Composition, role or duties of the TK K/K?

Questions to UPPKH K/K, in addition to the above ones with UPPKH K/K focus:

i. Is the current staffing of the UPPKH K/K with permanent staff and data entry personnel complete?

ii. Is it adequate to carry out current tasks in a timely way? In the future?

iii. Does it have the necessary facilities, materials and equipment to carry out its tasks adequately?

iv. Have adequate budgets been allocated to allow for wages, salaries, operating costs of the UPPKH K/K? From where?

v. Are the budgets available on time?

vi. Other observations/suggestions on the UPPKH K/K – its functions?

b. **Administrative processes**

i. **Socialization**

Questions to Depkominfo

1. General description of socialization program implementation in district
   - Themes
   - Target groups
   - Strategies and activities per target group
   - Activities implemented
   - Timing of initial socialization in relation to the launching of the PKH
   - Suggestions for the future
2. Measurement of the impact of socialization messages on the various target groups *[listed in ii to vi below]*

Questions to TK Provinsi, TK K/K, UPPKH K/K, Pendampings, district service providers (education, health, PT Pos:

3. Timing of initial socialization in relation to launching of the PKH
4. Description of socialization you received
   - Initial socialization
   - Any follow-up socialization during implementation
5. Relevance of the socialization to your duties
6. Adequacy of the socialization to your duties
7. Are there improvements that could be made

Questions to DPRD, media, strategic groups (NGOs):

1. Timing of initial socialization in relation to launching of the PKH
2. Description of socialization you received
   - Initial socialization
   - Any follow-up socialization during implementation
3. Adequacy of the socialization
4. Suggestions for improving PKH socialization – themes, channels of communication, timing
5. Your views of the PKH – positive, negative; suggestions on improving PKH

Questions to community leaders

1. Timing of initial socialization in relation to launching of the PKH
2. Description of socialization you received
   - Initial socialization
   - Any follow-up socialization during implementation
3. Adequacy of the socialization
4. Suggestions for improving PKH socialization – themes, channels of communication, timing
5. Your views of the PKH – positive, negative, suggestions to improve PKH

Questions to beneficiaries

1. Timing of initial socialization in relation to first assembly
2. Description of socialization you received
   - Initial socialization
   - Any follow-up socialization during implementation
3. Adequacy of the socialization
4. Suggestions for improving PKH socialization

Questions to the general public (proxy: focus group of non-beneficiaries)

1. How have you learned about the PKH
2. Do you feel that you understand the PKH – not at all, average, well
3. What do you see as the main features of the PKH
4. What is your opinion of the PKH
5. Should it be changed? How?

ii. **Training of UPPKH units and service providers**

Questions to UPPKH K/K, Pendampings, service providers (education, health, PT Pos) SIM/IT training

1. District training strategy in anticipation of PKH launch
2. Contents
3. Timeliness
4. Adequacy of training in light of implementation experience

5. Adequacy of training materials
6. General observations

Question to IT, MIS staff, consultants

1. One-time training, training per module

iii. **Information management**

Questions to UPPKH K/K

1. The following is installed and working at the level of the UPPKH K/K:
   - All necessary hardware
   - All software modules
2. Staff (permanent and consultant) is in place, have had appropriate training and are operating the SIM
3. Has a budget been allocated for salaries and operating expenses? Is it available? Is it sufficient?
4. Does the SIM include routine data collection on participants – beneficiary data, education and health compliance, service providers, complaints
5. Is data collected for all indicators included in the PKH monitoring system
6. Is data collected on PKH financing – spending and sources of financing related to the administration of PKH
7. What challenges, if any, are there in the data collection process and manipulation process
8. Are you able to fulfill your reporting obligations in a timely way
   - Are there problems related to the reporting process
9. Are the reports relevant to your work? Could the reporting be improved? Do you get feedback on the reporting? Is it meaningful to your work?

ii. **School participation**

Questions to TK Provinsi, TK K/K, UPPKH K/K, school authorities

1. Are all schools in the district participating in the program, i.e. providing access according to BOS, verifying attendance and reporting absences in a timely way
2. What initiatives have been taken to ensure their participation
   - Formal arrangements
   - Socialization
   - Training of school principals and staff in program objectives and strategy, conditions, compliance verification and reporting
3. Perception of effectiveness of the above initiatives
4. Have the additional resource needs – human, material, financial - of schools been estimated to anticipate any increase in demand for education services by PKH participants
5. Have additional budgets been allocated to meet estimated additional needs? By whom?

6. Have arrangements been put in place that ensure that beneficiary family children have access according to BOS
7. Are there school-related expenses (excluding travel) that beneficiary families need to meet
8. Are attendance verification and reporting systems in place

Questions separately for schools:

1. Do school authorities believe that they sufficiently understand the program
   - Was the socialization sufficient
   - Was the training sufficient
2. Are there formal agreements with the district school system on the implementation of the PKH in schools
   - If there are, do they provide sufficient guidance for schools to implement the program
   - Have the formal agreements, socialization, training, collaboration with KT and UPPKH been sufficient to offer clear guidance on how to implement the program in schools
3. Are the resources – human, material, financial - schools have at their disposal adequate to properly fulfill their obligations under the program
   - If not, how will additional resource requirements be met
4. Are there problems that arise with the registration, attendance verification and reporting on beneficiary household children
5. How does the school handle non-compliance (lapses in attendance)
6. Are there improvements that could be made

Questions for Pendampings separately

1. Are there problems that arise with the registration, attendance verification and reporting on beneficiary households children
2. How do schools handle non-compliance (lapses in attendance)
3. Are arrangements in place to ensure that beneficiary children have access according to BOS
4. Are there school-related expenses (other than travel) that beneficiary families need to meet
5. Are there improvements that could be made

iii. **Health**

Questions for TK Pusat, TK K/K, UPPKH K/K, Health authorities

1. Are all puskesmas in the district participating in the program
2. What preparations have been made for their participation
3. What formal initiatives have been taken to ensure their participation
   - Formal agreements
   - Initial socialization

- Training of health providers in program objectives and strategy, conditions, compliance verification and reporting

4. Perception of the effectiveness of the above initiatives
5. Have the additional needs of the district health system been estimated to anticipate any increase in demand for program-type health services due to PKH participants
6. Have additional budgets been allocated to meet estimated additional needs? By whom?
7. Are verification and reporting systems in place
8. Have arrangements been put in place to ensure that all beneficiary children and pregnant beneficiary mothers have Askeskin aid? If not, how are additional costs being met
9. Are there compliance-related expenses (excluding travel) that beneficiary families need to meet

Questions separately for puskesmas managers:

1. Are there formal agreements with the district health system on the implementation of the PKH in puskesmas
2. If there are any, do the formal agreements provide sufficient guidance to implement the PKH at puskesmas levels
3. Are puskesmas managers and service providers satisfied that they sufficiently understand the program
    - Was the socialization sufficient
    - Was the training sufficient
1. Are the resources – human, material, financial – that puskesmas have at their disposal adequate to properly fulfill their obligations under the program
    - If not, how will additional resource requirements be met
5. Are there problems that arise with registration, verification that conditionalities are being fulfilled, and reporting
6. How does the puskesmas handle non-compliance
7. Are there improvements that could be made

Questions separately for pendampings:

1. Are there problems that arise with the registration, verification that conditionalities are being fulfilled, and reporting
2. How do puskesmas handle non-compliance
3. Are there compliance-related expenses (except travel) that beneficiary families need to meet
4. Are there improvements that could be made

iv. **The Assembly process**

[use existing Assembly questions for UPPKH K/K, Pendampings]

v. **Benefit delivery**

Questions for UPPKH K/K, PT Pos

1. Do the current verification, compliance recording and reporting systems allow for accurate benefit disbursement in a timely way
2. Were there any inaccuracies in first or second payment? Any delays?
3. Are there means to ensure that pre-payment beneficiary lists can be drawn up in a way that ensures timely and correct payment

Questions separately to beneficiaries

1. Have you received your benefit payments on time? In the correct amount?
2. Is the location for benefit payment convenient? If not, how could it be more convenient?

vi. **The appeals process**

Questions to UPPKH K/K,

[Also: analysis of the number of complaints; submitted directly to UPPKH K/K, through the Pendampings, the Pt Pos; kinds of complaints; how handled]

1. What kind of complaints do you handle at the UPPKH K/K level; what kind do you routinely send on
2. Is the feedback – on complaints you handle, and ones sent on – handled promptly? How promptly?
3. Can the complaints process be improved

Questions to Pendampings

1. Do you find that complaints that are handled by UPPKH K/K and higher instances, are handled promptly
2. Do you handle any complaints
3. Can the complaints process be improved

Questions to beneficiaries

1. Do you understand the complaints process
2. Have you used it? If you have used it, what has been the channel?
3. Did you get a response? If it was a rejection of your request, was a clear reason given for it?
4. Can the complaints process be improved?

3. The Pendamping function

Questions to Pendampings

a. Taking into account the tasks that you are performing, was your training adequate, and are the PKH manuals useful

i. What would further improve your performance

b. Is the number of households you monitor sufficient, too many, could be more

c. What is your view of the groups "mothers"? Do they facilitate your work?

d. How is the working relationship with the UPKKH K/K? Suggestions for strengthening it?

   i. What are the main elements?
   ii. Should there be other elements?
   iii. Reporting arrangements:
      1. Reporting
      2. Feedback – do you get feedback and is it useful
      3. Suggestions for improvements
   iv. Do you have adequate material resources – facilities, equipment, materials?
   v. Are you paid for your services? On a regular basis? By whom?

e. What are the main advantages and disadvantages of the PKH? How could it be improved?

4. Beneficiary/non-beneficiary household analysis

a. Understanding of the program and beneficiary selection criteria – beneficiaries, non-beneficiaries

b. Beneficiary/non-beneficiary attitudes

   i. Overall satisfaction with the program – beneficiaries
      1. In particular benefit, benefit delivery, conditionality, service provision
      2. Have you had reson to use the complaints process? Opinion?
   ii. Positive aspects of the program – beneficiaries, non-beneficiaries
   iii. Concerns – beneficiaries, non-beneficiaries
      1. especially, are there expenses related to meeting the conditions on education and health
   iv. Adequacy of benefit

c. Satisfaction with support services - beneficiaries:

   i. "mother' arrangements, pendampings, complaints process, payment process, health and education services
   ii. Reasons for dissatisfaction with the program – beneficiaries, non-beneficiaries[44]
   iii. Suggestions for improving services

[44] This would draw on the appeals data base as well as interviews and discussions

Attachment 2

PKH Protocols

Health and nutrition

Child age 0-6 years
Infant age of 0-11 months: (i) complete immunization protocol (BCG, DPT, Polio, measles, Hepatitis B); (ii) weighed every month

Infant age of 6-11 months: Vitamin A minimum twice a year (February, August)
Infant age of 12-59 months: (i) complementary immunization; (ii) weighed every 3 months

Children age of 5-6 years: (i) measured for weight; or (ii) participate in early childhood education program (PAUD) when there is PAUD facility at the closest location/integrated services post

Pregnant and lactating mothers
Pregnant mother (i) undergoes pregnancy examinations at any public health facility up to 4 (four) times and (ii) obtains Fe (Iron) tablet supplements.

Professionally assisted delivery
The health conditions of post-delivery mothers checked at least twice (2) prior to the baby reaching age 28 days

Education

Children 6-15 should be enrolled at SD/MI (Elementary chool) or SMP/MTS (Junior High School) and comply with attendance requirements at least 85 percent of school days per month

Children 15-18 who have not completed elementary school, should (i) be enrolled in the nearest school, (ii) participate in an equalization education program in accordance with current legislation; or (iii) undertake remedial classes;

Attachment 3

PKH Benefits

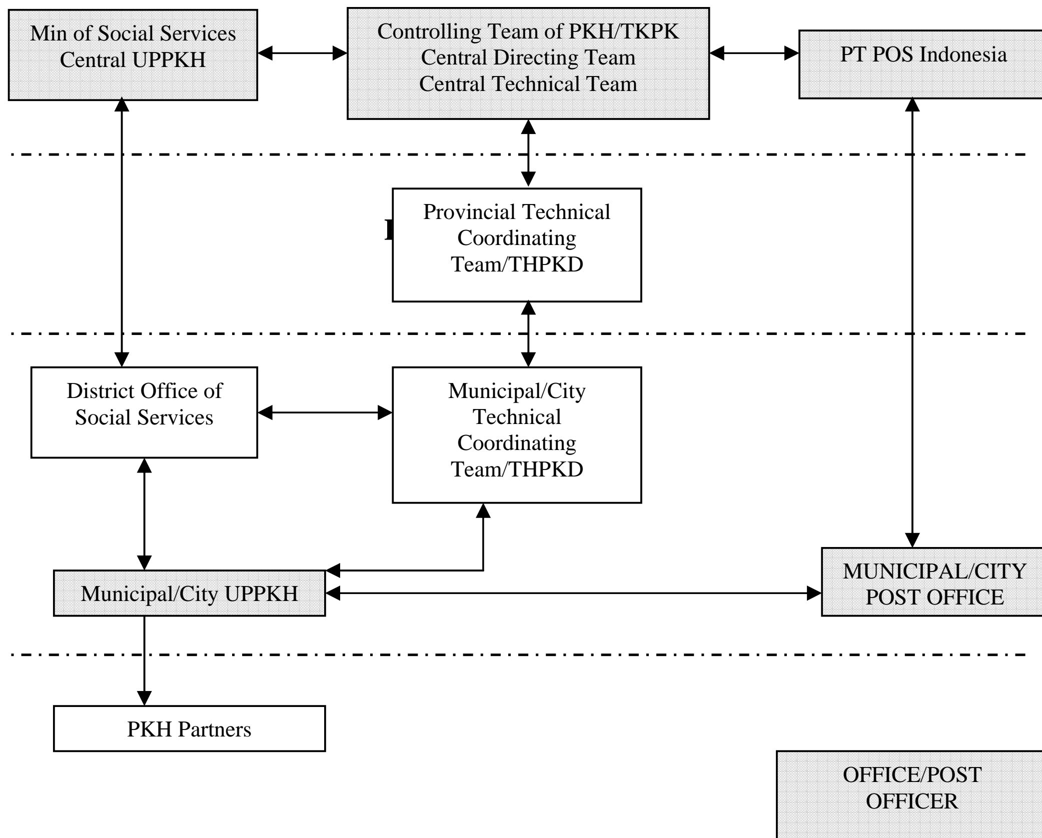
Benefits	Benefits/household/year IDR
Basic benefit	200,000
Benefits for Households (HHs) with 1. Children under age 6 and/or pregnant and lactating mother 2. Each Elementary school-age child (SD/MI) 3. Each Junior High school-age child (SMP/MTS)	 800,000 400,000 80,000
Average benefit per HH	1,390,000
Minimum benefit per HH	600,000
Maximum benefit per HH	2,200,000

When beneficiary households are unable to meet the conditions, benefits are decreased as follows::

a. After one month of delinquency, the benefit will decrease by IDR 50,000
b. After two months, the benefit will decrease by IDR 100,000
c. After three months of delinquency in a row, benefits are withheld for the payment period.

Attachment 4

Organization structure of the PKH



Attachment 5

PKH – Responsibilities at the center and districts

Function	Center	Local
Management		
• Overall program	Depsos	
• Local coordination & mgmt		Tim koordinasi, Dinas sosial
Database management		
• Selection	Depsos	*BPS*
• Updates	Depsos	*Pendampings*
• National mgmt	Depsos	
• Eligibility	Depsos	
Payments		
• Authorization	Depsos	
• Payments		PTPos
Conditionalities		
• Compliance oversight		District education, health authorities
• Recording		Schools, health centers
• Consolidation		PTPos
• Penalties	Depsos	
Monitoring		
• Ongoing program monitoring	Depsos	Dinas sosial
• Complaints process	Depsos	District UPPKH

Attachment 6

Conditional Cash Transfers and Targeting

The International Experience

Several methods have been used internationally to target benefits to the poor.

Geographic targeting. Combining population census with socio-economic survey data allows the construction of a poverty map. The poverty map can be used to target poor localities. For example, in the CCT program *Progresa* in Mexico, a poverty map is used to select the poorest villages in rural areas and the individuals are selected based on a proxy means test. Every child in the village then receives the CCT as long as the conditions are met.

Expert evaluation. In some countries, social workers or other informed local sources such as teachers, decide who is poor enough to be eligible for social assistance. In Jamaica, social workers until very recently decided who benefits from the Poor Relief program, but they have now adopted a scoring formula (see below) which will free social workers from home inspection and allow them to provide social services and counseling to clients.

Scoring formula. Scoring formulas (also called proxy means-testing or combined indicator targeting) are a technique whereby the household's living standards are estimated based on a series of indicators that are found to be correlated with poverty in that country. The indicators are typically things like the number of children and elderly in the household, the housing material and amenities (such as water and electricity), number of rooms, and often, consumer durable goods (refrigerators, cars) and in agricultural areas, household holdings of livestock and land. Such scoring formulas have been widely used in Latin America, Russia and in other former Soviet Union countries. Scoring formula are best derived from quantitative household survey data, and can be differentiated by urban/rural or major geo-economic zones of a country.

Self-targeting. Self-targeting is when a government provides a benefit that is so low that only the poor are interested in receiving the benefit. Positive examples include a food subsidy for a low-quality food product that only the poor consume, or a public works program where the wage is kept so low (lower than the minimum wage) that only the poor are willing to work for it. Negative examples include the creation of difficult bureaucratic procedures that require so much time and difficulties that only the desperate will try to obtain the benefit.

Income-testing. In the USA and several European countries, income-testing is used to verify household income and eligibility for social assistance. Income-testing is cost-efficient only when there is a culture of tax declarations for both individuals and companies and computer systems which can verify and check the income declaration. For example, in the USA, social assistance applicants must provide their most recent tax declaration and their social security (identification) number. Computer checks are then run

on the identification number to verify the declared income. Income-testing does not work well in countries where there are large informal or subsistence agricultural sectors, since it is very difficult to verify informal income. Sending an inspector to the home of each applicant is extremely expensive administratively is normally only done for a random sample of applicants or in special cases where there is evidence of fraud.

Attachment 7

Suggested institutional analysis to ensure clear responsibilities should answer a series of relevant questions.

- Are institutions and responsibilities mapped clearly, or are there potential overlaps or voids?
- Are assigned responsibilities aligned with incentives? If not, how to address the gap?
- Do institutions have adequate technical and managerial capacity to fulfill their roles?
- Are accountability and feedback mechanisms adequate for solving problems?
- Are institutions insulated from political influence and manipulation?
- Do the roles envisaged for each actor pose potential conflicts of interests?
- Are there mechanisms to reinforce accountability—for example, crosschecking data used to identify beneficiaries with local or country knowledge; and mutual accountability mechanisms that allow beneficiaries to hold service providers accountable while service providers confirm beneficiary compliance with conditionalities?[45]

Source: Operational Innovations in Latin America and the Caribbean

[45] The effectiveness of mutual accountability is enhanced through citizen oversight committees in Colombia and trained community promoters in Mexico. Similar practices are being employed in newer conditional cash transfer programs outside Latin America.

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