CASE STUDY OF PKH (CCT INDONESIA) IN SUMBA BARAT AND KEDIRI[1]

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ABSTRACT

Indonesia launched a pilot of conditional cash transfer (CCT) program called Program Keluarga Harapan (PKH) on 2007. Its beneficiaries are very poor households which have pregnant women and/or 0-15 years old children in it. PKH requires them to access education and health services as recompensation of the cash transfer.

PKH has been designed to be a better social protection system in Indonesia. Indonesia's government provides many protection for poor people, such as scholarship, health insurance, food (rice) stamp, and unconditional cash transfer, but they are not coordinated well and each of them has their own target. In the end Indonesia has several kinds of social protection but does not have a coordinated single system which integrate them. PKH is hoped to be a starting point for better system, at least to integrate all of those protection schemes and build better database of poor people who need to be protected.

Even though PKH is one of the best solutions for better social security system in Indonesia, it is also a complicated program. It needs very good preparation, and also quite long and expensive starting investment. Many sectors are involved in this program and good coordination will be needed among them. Good quality of data becomes priority, an exact targeting on the start and very good system for data updating during the program will be required. It also needs high quality human resources to operate this program.

Unfortunately, Indonesia almost has no time. Both of government and people need this program. Based on this condition, PKH was launched under a very fast preparation. Now, it has already more than one year after the launching. There are some positive progress related to education and health, but there are also problems. The very fast preparation has created a not so perfect implementation. The differences among pilot areas also contributes some specific problems.

According to that condition, we arranged a case study for PKH in district of Sumba Barat and Kediri on March and April 2008. It collected information through indepth interview and focus group discussion with almost all of PKH's stakeholders in those districts. From PKH's officers, local government, beneficiaries and non beneficiaries, leaders, medias and NGOs. We do hope that we can summarize the main problems and find the solutions. Also, if we can discover its achievements, it will the strength of this program which will be the reason to continue and develop PKH.

The paper then, tries to present the study result. It will be a summary of PKH's implementation in those two districts and some thoughts about possible solution for its problems.

***Keywords**: social protection, CCT, sectoral coordination*

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A. BACKGROUND

Indonesia launched a pilot of conditional cash transfer (CCT) program called Program Keluarga Harapan (PKH) on 2007. This program has been designed to be a triger for social security system in Indonesia. Not so different with other CCT programs, PKH gives cash transfer to very poor households which have pregnant mothers and/or under five children and/or children in school age[3]. This cash transfer requires them to access education and health services as recompensation.

For its first year, year of 2007, PKH Pilot Project covered about 388 thousand very poor households in 7 provinces. It has been scaled up for the next phase (2008) and reached about 620 thousand very poor households in 13 provinces. Eventhough it sounds big, but the overall amount of very poor households in Indonesia which meet PKH's criterias is about 3.06 million households spreading in 33 provinces (BPS, 2007). So until 2008, the this program has already covered about 20% of its potential beneficiaries.

PKH implementation in 2007 has shown both of achievements and problems. In remote area with limited education and health facilities, PKH did succeed encouraging its beneficiaries accessing the services. But its complicated mechanism and very fast preparation, that lead the program to face several problems, are the weakness of this program.

This case study of PKH tries to facilitate the need of deeper analysis of PKH's problems. It is a case study with discussion and in depth interview method which inventarizes the opinion of all PKH's stakeholders. A summary about what this study got and what the possible solution for the problems will be presented as the result.

B. THE BASIC CONCEPT AND DESIGN OF PKH

The designing process of PKH was leaded by Bappenas (National Development Planning Agency) on 2006. Like other CCT program, PKH was designed as a multisectors program which needs a strong cooperation between them. The executing process is Unit Pelaksana PKH - UPPKH (Executing Unit of PKH) under the Department of Social Affairs.

B. 1. The Purposes of PKH

The implementation of PKH has several puposes. The main purpose is, of course, to reduce poverty in Indonesia. Indonesia has a quite big, both of percentage and amount of poor people[4]. Many of them are very poor and has inherited their poverty from previous generation. It is like a vicious cycle and something has to be done to cut the cycle. PKH is expected to solve this problem. From one side, it is a cash transfer which can help the beneficiaries improving their live (increasing their

[3] 6-15 years old children and/or 16-18 years old children who still accessing basic education services).
[4] In March 2007, about three months before PKH implementation, 17.75 percent of the population, or about 39.3 million people in Indonesia (equivalent with 18 million households) live under national poverty line (BPS, 2007).

consumption, or furthermore starting micro business). In the other side it has conditionalities which try to improve the quality of the poor's next generation by requiring them to send the pregnants and children to access education and health facilities. In the long run, not only the transfer can help them improve their condition but also the transfer improve the next generation quality so they can cut the poverty cycle and bring their family out from poverty.

The second purpose, PKH is aimed as a start of better social protection system in Indonesia. Indonesia's government provide many social protection for poor people, such as basic education scholarship, health insurance for the poor, food (rice) stamp, and accidental support (related to shocks) like unconditional cash transfer, but they are not coordinated well each other especially for the targeting. For example, the basic education scholarship program has its own target defined by Department of National Education and the health insurance for the poor by Department of Health also has its own mechanism to choose their target. This happens in all of social protection program. In the end Indonesia has several kinds of social protection with no single data source. The target is same, the poor, but the poor's definitions are variously different between programs, with different criteria and method of selection. PKH is designed to be a starting point for better system. With PKH, Indonesia's government is starting to incorporate all of the various social protection programs into one and all-inclusive social protection program[5]. At least PKH implementation will lead to a better database of poor people, that can be used as a basic data for all kinds of social protection.

Before PKH, the Government of Indonesia provided protection only from supply side. The scholarship were given through the schools and the health insurance for the poor were given through health facilities. With this kind of scheme, people who do not have access to (or even never dare to accessing) public facilities will also can not access the protection. With integration of those programs with PKH, government now can provide the supply of public services and in the same time promote the demand for public services of poor people.

B. 2. The Executing and Controlling Agencies of PKH

The executing agency for this program is the Unit Pelaksana PKH - UPPKH (Executing Unit of PKH), under the Departemen Sosial (Department of Social Affairs). One central level executing unit called UPPKH Pusat is located in Jakarta (Indonesia's capital city) and it has their representatives, called UPPKH Kabupaten (district level UPPKH) under the Dinas Sosial (District Office of Social Affairs), in every district which implement PKH.

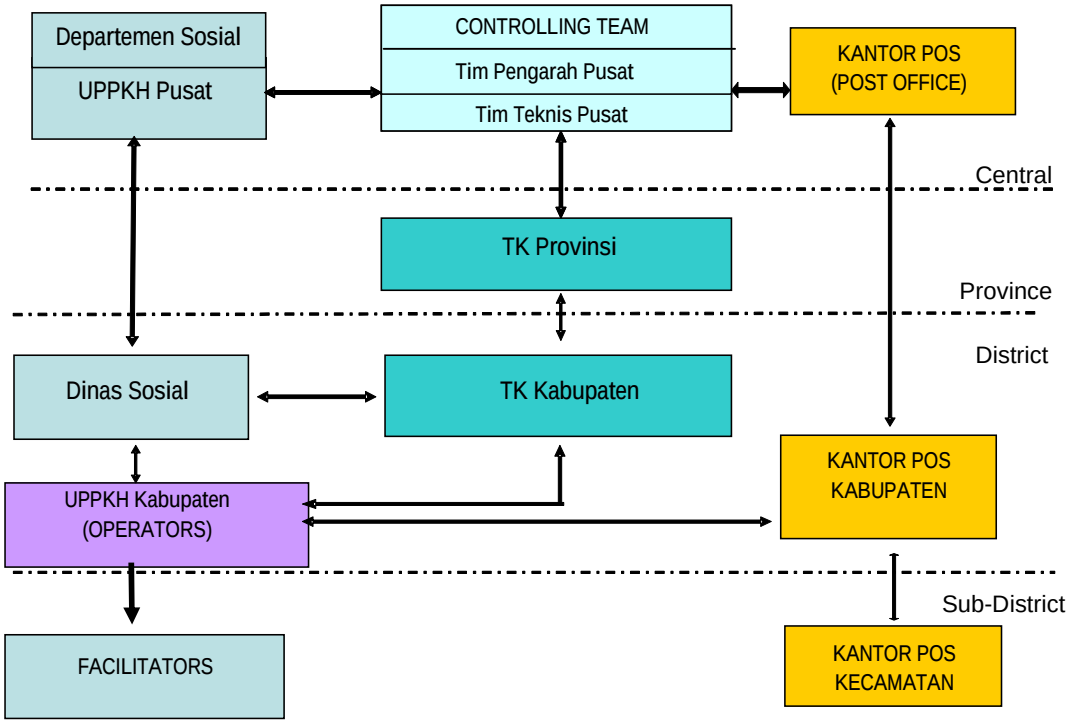
UPPKH Kabupaten consists of four Operators. The Operators are responsible to manage the office of UPPKH Kabupaten, one person as general coordinator, one person as MIS manager, one person is responsible for complaint management (from PKH's stakeholders), and another one is responsible for the general office administration.

[5] The design of PKH includes other social protection programs to be synchronized with PKH implementation, especially for basic education scholarship and health insurance for the poor program. PKH's beneficiaries should be facilitated to be beneficiaries for those two programs.

The Operators are also managing the Facilitators who hold their responsibility in sub district level and directly related to the beneficiaries. The Facilitators are responsible to facilitate the beneficiaries participating in PKH. For example preparing the beneficiaries to receive the cash transfer, building a network between beneficiaries through forming several groups between them and helping beneficiaries to be able to access health and education facilities. The amount of Facilitators depends on the number of beneficiaries and the difficulties of social, cultural and geographical condition.

In the central level, UPPKH Pusat is controlled by Controlling Team which consist of Tim Pengarah Pusat (Steering Committee) and Tim Teknis Pusat (Technical Team). The Tim Pengarah Pusat consists of institutions, they are ministries and agencies in social, education, health and communication[6]. Bappenas (National Development Planning Agency) and BPS (Statistics Beurau) are also part of it[7]. The Tim Teknis Pusat, in the other way, consists of personal functionaries from institutions in Tim Pengarah Pusat who specifically manage the technical procedure and monitor the implementation.

Figure 1. PKH Organizational Chart from Central until Sub District Level (Bappenas, 2007)



[6] Coordinating Ministry of Social Welfare, Department of Social Affairs, Department of National Education, Department of Religious Affairs, Department of Health, Department of Communication.
[7] Bappenas led the designing process and BPS was responsible for data collection process.

In the local level, UPPKH Kabupaten is controlled by at least two institutions called Tim Koordinasi – TK (Coordinating Team), TK Provinsi (in province level) and TK Kabupaten (in district level). Except controlling UPPKH Kabupaten, the TK Provinsi and TK Kabupaten also have to coordinate with the Tim Pengarah Pusat and Tim Teknis Pusat. TK Provinsi and TK Kabupaten consist of the same sectors with steering committee in central level, but the institutions or functionaries are those who are in province or district level (it is ussually called Province Office/District Office/Office)[8].

Beside to controll UPPKH, Tim Pengarah Pusat, Tim Teknis Pusat and Tim Koordinasi have a great rule to make sure that every sectors are coordinated well supporting PKH implementation. Sufficient health and education services, good socialization of PKH, continuing improvement of its design, and good quality of data collection and updating, are also the main duties of these teams.

Last but not least, there is PT Pos Indonesia/Kantor Pos (Post Office) who is responsible for the payment process. PT Pos Indonesia have representatives in all districts (Kantor Pos Kabupaten) and most of sub districts (Kantor Pos Kecamatan) in Indonesia. Their capability and accountability to deliver cash transfer has been proven when they have to deliver BLT (unconditional cash transfer) to 19.1 million poor households in 2005.

B. 3. The Target of PKH

The target of PKH is chronically poor people or the first group of poor people in Indonesia. Poor people in Indonesia are devided into three different groups by the government. The first group, which are being PKH's target, is for very poor people who are in deep poverty or quite far from the national poverty line[9]. This group consists of people who need help to access the public services from both of supply and demand side. PKH is suitable for this group because it provides encouragement (the cash transfer) for them to access the services and also fulfill their needs by strengthening the capacity of the supply side.

Beside that, PKH is still a pilot project before it is ready to be scaled up. The government need to choose the right target to maximize the limited budget and provide a good evidence of the program effectiveness. For this condition, of course the poorest one (group 1) will be targeted[10]. The first group itself has about 3.6

[8] Bappeda (Local Development Planning Agency), Province/District Office of Social Affairs, Province/District Office of Education, Province/District Office of Religious Affairs, Province/District Office of Health, Province/District Office of Communication.

[9] Group 1 and 2 are officially poor, under definition of 'below the poverty line'. Those groups become government main target for social protection and empowerment based program. Group 3 is considered as non poor, but they are vulnerable in surroundings of poverty line. Government still provides program for group 3, but only for empowerment based program. Total of those three clusters is about 19.1 million households (BPS, 2007).

[10] There are 14 criterias for poor households in Indonesia. To become PKH participant (or considered as very poor household - group 1), a household should suffer for at least 13 of the set of criterias. Those criterias are general and implemented nationally but they can be localized by adding different weight to each criteria. The complete criterias can be seen in appendix.

million very poor households in it and only about 11% of them were selected for the PKH pilot target in 2007.

Goverment then selected several provinces which have high prevalence of poverty to be the place of the pilot project. For example, Jawa Timur was chosen because it has biggest number of poor people in Indonesia, and Nusa Tenggara Timur was also chosen because it has highest proportion of poor people. The local government of those areas, which become PKH target, had to sign an agreement to support this program. Especially to support the service providers in that area, so the encouragment to the poorest to access services (through PKH) will be facilitated well also from the supply side.

Last, the very poor households in chosen areas (which signed the agreement with the central government) have to meet the certain set of criteria. As said before, PKH's target is the next generation of very poor households. So the beneficiaries should be poor households which have pregnant mother and/or 0-15 years old children (or 16-18 years old children who has not completed their basic education). They are considered as new generation, or at least prospective new generation, and should access health and education services properly to improve their quality.

Based on the design of PKH which placed the next generation as the target, PKH requires the mothers to accept and be responsible for the cash. The great role of mother in Indonesia in shaping children and family's future became the reason for this decision. This design is trying to enable mothers to hold some decision power in the family, especially to be able to send the children accessing health and education services.

B. 4. The Benefit and Conditionalities

PKH beneficiaries get cash transfer as benefit. The amount of cash transfer is different depends on the structure of the households. BPS did the data collection. The Facilitators, on the next step, conducted a validation process before the first payment to know whether the BPS' data is correct or not. Then the transfer would be done based on Facilitators' validation result.

The cash transfer will be counted per household per year which will be splitted into three parts and paid on every 4 months. Has been informed before, that the mothers will represent their household to take the benefit, even the PKH card has mother's name on it.

Eventhough the benefit is differentiated by households charactheristics, every household will get IDR 200.000 (US$ 18.2) per year as lump sum. For additional, based on households' structure, they will get:

- IDR 800.000 (US$ 72.7) per year for pregnant mother and or 0-6 children. This benefit will be the same no matter how many 0-6 children they have, in order to avoid poor people get encouraged to make more child.
- IDR 400.000 (US$ 36.4) per year per 7-12 years old children. This is purposed to support their need in elementary school.

- IDR 800.000 (US$ 72.7) per year per 13-15 years old children. The concept is same with above, but this is for children who are lower middle school students.

So the minimum amount of the benefit, if the household only have one child in elementary school age (7-12 years old), is IDR 600.000 (US$ 54.5) per year. And eventhough the upper limit could be infinite (if the household has so many children in the targeted age), the government have limited it and set the maximum transfer is IDR 2.200.000 (US$ 200) per year per household[11].

Since PKH is conditional cash transfer program, the beneficiaries are its participants who have to obey its rules and do their obligation. The rules are (Bappenas et. al., 2007):

- For pregnant or lactating mothers
  - Four antenatal care visits and taking iron tablet during pregnancy
  - Birth assisted by a trained professional
  - Two postnatal care visits for lactating mothers
- For 0-6 years old children:
  - Complete childhood immunization and Vitamin A capsules twice a year
  - Monthly growth monitoring for infant 0-11 months and quarterly for children 1-6 years
- For target households with 6-15 years old children (or 16-18 years old children but not yet completed primary and secondary school), the rules are:
  - Enrollment and attendance of a minimum of 85 percent of school-days for primary school children.
  - Enrollment and attendance of a minimum of 85 percent of school-days for junior secondary school children.
  - Poor household with children aged 16 -18 years who have not completed 9 years basic education can be eligible if the children are enrolled in an education program to complete 9 years equivalent.

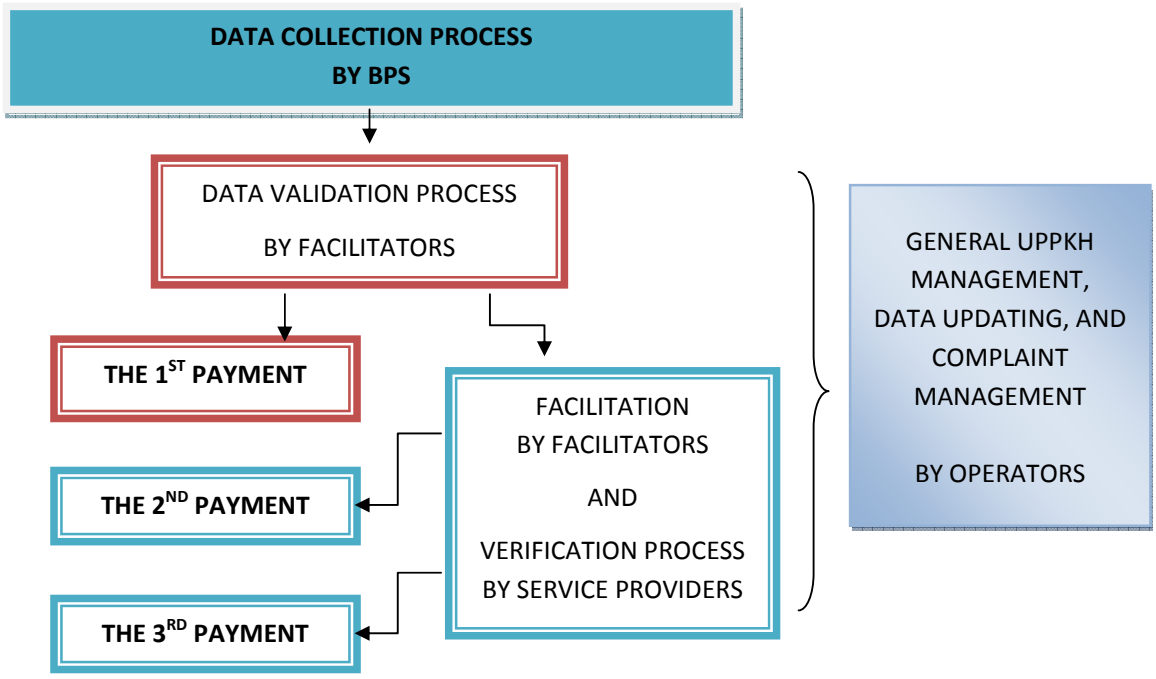
Those rules are aimed to encourage the beneficiaries to access at least minimum services in health and education for their children or prospective children. Through the conditionalities, the poor will do some efforts to improve the quality of their next generation, so they can escape from the poverty cycle.

There is a verification process to measure whether the beneficiaries did their obligation or not[12], Ideally it is managed before the first payment and should be continued during the program. In every payment period, the payment amount will depend on the verification result. This process also became a solution for some inclusive error. For example, some cases show that beneficiaries do not really have pregnant mother, or even any child to be eligible for this program. The verification result will show that there are no data about them accessing public and health facilities so their name can be deleted from beneficiaries list.

[11] With assumption 1 US$ = IDR 11,000.

[12] The verification process is done by facilitators and service providers. Facilitators have verification form for each beneficiary and service providers have the list of beneficiearies attendance (especially for schools) and have the record of services given to them (health facilities). The facilitators and service providers will be cooperating to fill the verification form.

Figure 2. General Mechanism of PKH Implementation (District Level)



For those who failed to meet the conditions (as result of the verification process), will get some penalties. The first penalty is to cut their benefit in the next payment. If they still do not obey the rules, their benefit will be cut again on the next payment period, and if there are three periods in which the beneficiaries can not fill the conditions, the benefit will be stopped and the beneficiaries will be dropped from PKH participants list.

PKH was designed to be a strict and complicated program with many conditions in it. Poor people with lack of intellectual capacity could be bothered by its complicated rules. Moreover, in 2005, Indonesia was hit by oil price hike and government launched a one year unconditional cash transfer program called bantuan langsung tunai (BLT). This BLT was much more simple, without any rules, which is preferred by poor people than PKH.

The designers did realize that condition could create problems in PKH implementation. But PKH still have to go on. PKH has different purpose than BLT, those are to improve the quality of poor people's next generation and build a better social protection system. It *needs* conditionalities which have to be filled by the poor and poor people have to understand that this obligation (and complicatedness) is important for them and will change their condition.

C. METHODOLOGY AND STUDY LOCATION

As said before, this case study tried to inventarize problems behind PKH implementation. Based on that purpose we did interview and discussion with almost

all of PKH's stakeholders. The study tried to find both of general and specific information and opinion from beneficiaries, non beneficiaries (also the very poor one), community public figure, NGOs and also medias. Moreover, those information will be compared by also interviewing PKH executor (UPPKH Kabupaten: the Operators and Facilitators), government (TK Kabupaten and TK Provinsi), service providers (elementary schools, junior high schools and health facilities), and also parlemen as elite politician. Most of the information were gotten from interview and discussion because this program is new and there are no data yet which are directly related to the program implementation.

Table 1. Respondents of Sumba Barat and Kediri PKH Case Study

PKH's Organization	TK Kabupaten, UPPKH Kabupaten, Operators and Facilitators
Government	Office District of Social Affairs, Office District of Education, Office District of Health, Office District of Communication, Post Office
Services Providers	Elementary School, Junior High School, Sub District Health Service Center
General Public	PKH Beneficiaries, Non Beneficiaries (Very Poor Households), Local Public Figures, NGOs, Medias
Others	Local House of Representatives

The study team consists of elements from development planning agency (national and local), office of social affairs as executing agency (national and local) and international organization. The team was responsible to design the case study including arrange the questions. With that composition, the team would be able to build a set of questions which explore PKH implementation from many point of views, from basic concept, technical implementation until general and international experiences and thoughts.

Moreover, the team was also expected to be able to answer or cover questions and complaints from the respondents. That is so important for the respondents to know more about PKH, and it would be very good for them to get right information from the right persons. That is why in the end of the field study, there was always a small discussion involving representatitives of respondents just to disseminate the early summary, conlusion and reccomendation from the study.

Since this study is only a small case study, it only took two areas which represent the poorest area and the better one. The areas are the District of Sumba Barat in Province of Nusa Tenggara Timur (NTT) and Kediri in Province of Jawa Timur.

D. THE RESULT OF PKH CASE STUDY IN SUMBA BARAT AND KEDIRI

The condition in the study areas, Sumba Barat and Kediri, is quite different. The District of Sumba Barat is one of the poorest district in Indonesia which has more than 45% of its population poor (BPS, 2007). It is in the west side of Sumba Island, a quite remote island, as a part of the Province of NTT. Sumba Barat is always considered as a left behind district with many of its indicators show low performance, especially related to poverty and the access of the poor to health and education facilities. The main issue in Sumba Barat is the high disparity of public facilities availability between government area (Sub District of Waikabubak) and other 16 sub districts (Sumba Barat has 17 sub districts). The number of poor people in Sumba Barat is not as much as in Kediri, but the *very poor* take a quite big proportion of it.

The District of Kediri, in the other side is much better than Sumba Barat. It is in the south side of the Province of Jawa Timur, Java Island. Eventhough it is one of the poorest areas in Java, it has appropriate public facilities and infrastructures (Java is the most developed area in Indonesia) and there is almost no disparity problem in public facilities availability there. The number of poor people is high, but the very poor only take a small percentage of it. The human resources quality is better and they support PKH very well.

Table 2. Selected Key Indicators of Sumba Barat and Kediri

	Sumba Barat	Kediri
Sub Districts Number	17 kecamatan	25 kecamatan
Population Number (2006)	410,007	1,445,695
% Poverty (2006)	45.18%	19.28%
Education Indicators		
15+ Literacy Rate (2006)	71.58%	90.69%
Pupil-Teacher Ratio (2006):		
Elementary School	1 : 36	1 : 18
Junior High School	1 : 15	1 : 14
School Participation Rate (2006):		
7-12	82.28%	97.43%
13-15	75.16%	89.18%
DO Rate:		
Elementary School	2.8% (2007)	2.2% (2002)
Junior High School	n.a.	6.8% (2002)
Health Indicators		
Birth Attendance by Paramedic (2006)	24.6%	93.4%
Infant Immunization (2006):		
BCG	77.39%	95.58%
DPT	73.76%	89.59%

	Sumba Barat	Kediri
Polio	75.4%	92.92%
Malnutrition	19.76% (2005)	n.a.
Maternal Mortality	514.25/100,000 (2005)	n.a.
Infant Mortality	53.5/1000 (2005)	39.71/1000 (2000)
PKH's Data		
PKH Beneficiaries in 2007 (HHs):		
BPS Data	21,131	9,852
Validated Data by Facilitators	20,775	9,402
Number of Facilitators	75	31
Number of Sub Districts Implementing PKH	8	9

Resources: Data dan Informasi Kemiskinan 2005-2006, Buku 2: Kabupaten
Kabupaten Sumba Barat dalam Angka 2005
Kabupaten Kediri dalam Angka 2007
Provinsi Jawa Timur dalam Angka
UPPKH Kabupaten Sumba Barat, UPPKH Kabupaten Kediri
Dinas Pendidikan Kabupaten Sumba Barat, Dinas Pendidikan Kabupaten Kediri
Dinas Kesehatan Kabupaten Sumba Barat, Dinas Kesehatan Kabupaten Kediri

The result of PKH's case study in those two districts showed that PKH still needs many improvement in its implementation. There are problems during its execution. Some of them are general problem which happened also in other areas and some others are quite specific. But in the other way, something has to be realized, that this year is the first and pilot year of PKH implementation. It needs more than one year to develop a very good system of social protection.

This part will show several problems faced by PKH implementation. The problems will be separated into some main categories to make it easier to understand.

D. 1. Problems in Selection Process and the Set of Beneficiaries Criterias

PKH is a cash transfer program. Eventhough it has complicated rules, poor people would rather to see it as money transfer from government than a set of conditionalities they have to obey. They all will want to be the beneficiaries to get the money. That is why a good selection process is very important to set the targeted households. The criterias, as the selection guide, must be well designed and represent both of the general conditions of very poor people and the specific conditions based on the specific characteristics in their community, culture or area.

Many of the PKH's stakeholders in Sumba Barat and Kediri feel that the PKH selection result is not good. This opinion came from almost every part. They said the result does not represent the real condition with so many exclusion and inclusion error in the data. Especially poor people who are not included as beneficiaries, they said that some of benefited households are not very poor and do not really need the cash transfer. They feel excluded, they need the benefit more

than those some beneficiaries and ask the government to include them as PKH participants.

Even the government (especially the District Office of Social Affairs) sometimes find this exclusion and inclusion error in the field. They found it when they came to monitor the payment process. Facing this problem, many of them place this as BPS fault, but some of them also impose this problem to the program design, especially the criterias.

- *The Causes of Selection Error*

Every data must has error in it. It is normal and happened in almost all data collection/selection process. It grew into a big problem because this error are poor people, a part of a massive number of Indonesian population. For this context, one percent error of the selection process means missplacing of 4.000 households or about 18.000 poor people. Based on the stakeholders' opinion and as conclusions of some discussion, the exclusion and inclusion error can be resulted from:

- *Absolute Criterias*. The criterias are absolute. They consist of 14 criterias and, and very poor households have at least meet 12 of them. But sometimes, there is almost no significant difference between the households which meet 11 and 12 criterias. This condition, technically, will separate them into beneficiaries and non beneficiaries group. But in the reality, it creates big question and dissatisfaction, especially for the non beneficiaries.
- *Too General Criterias*. Some communities have their own specific cultures[13] and sometimes their culture *is* one or several of those criterias for poor households. For example, Sumba Barat has specific culture to live together with their poultry in a house under the leaves roof. That condition is common even for a rich person in there, but generally it is one of the criterias of poor household. This too general criterias sometimes misslead the selection of the beneficiaries which will create the error.
- *Moral Hazard of the Enumerators*. BPS placed its people as selection coordinators. The coordinators have enumerators in village level. At least two enumerators were recruited in every village to complete the data. The normal error can happen in data collection process, but the enumerators may have their own preference (encouraged by some incentives) to place some households in beneficiaries list or, in the contrary, to exclude some of them. The coordinators will never know and the enumerators can get the incentives.
- *Geographical and Cultural Restriction*. Outside Java usually have limited infrastucture and sometimes the geographical condition is extreme. For example, some villages in Sumba Barat consist of some smaller communities spread in several areas in the village. They ussually live and build community in top of a hill (Sumba Barat consists of hills). So a village is formed by some communities live on top of several hills. The enumerators might try to visit

[13] The set of criterias looks suitable for Javanese only. It can be understood because 60% of Indonesian population are Javanese and more than 50% of poor people are in Java (BPS, 2007). This condition is proven when there is almost no complaint from PKH stakeholders in Kediri (which is in Java) about the criterias.

them all but maybe they could not find anyone, because the villagers usually are farmers who work in valley. Imagining the enumerators climbed hills and sometimes found empty houses makes it is sensible for them to do some mistakes.

- *Solution for the Problems*

The inclusion error problem can be solved by the PKH's design itself. PKH has been designed to have validation process. The beneficiaries selection process is managed by BPS and after that, the validation process is managed by the facilitators to make sure that the beneficiaries are really eligible for the program. They will exclude the inclusion error who accidentally selected. In case there is an error in validation process, the verification process and data updating during the program will also be able to remove the inclusion error.

The exclusion error, in the other way, is more difficult to handle. There is no mechanism to include them, even the facilitators does not have any right to include them[14]. The most possible solution is to list the excluded non beneficiaries, verify the households on the list (by BPS and Facilitators) and then add the eligible one for the next phase of PKH. This is still a pilot, so there is a possibility to scale up or improve the amount of beneficiaries by fixing the error.

Beside that, the selection process also needs to be improved. The first one is to improve the quality and integrity of enumerators. At least BPS has to avoid the possibility for the enumerators to include anyone they want to the list. The easiest thing is by adding the amount of coordinators and enumerators, so they have a smaller concern area and are possible to controll each other.

The second is to improve the set of criterias[15]. Many parts suggest to add local criteria to avoid adverse selection. It can be done but may be too complicated. It might be too specific and need a long decission process. Another idea, which offered by BPS, is to add weight in the existing criterias (the 'too general' one). Some criterias will be weighted more in some specific areas to meet the local/cultural condition[16]. Of course this option can not perfectly facilitate the need of local criterias, but at least it requires shorther process than the other one.

The best option is to combinate both of those ideas. BPS can do the second option first (weighting the general criterias) while they are preparing to arrange a set of local criteria. But of course arranging local criteria is not an easy thing and it needs to deal with many parts of the community.

[14] This is to decrease possibility for the facilitators to include their relatives or anyone to the beneficiaries list.

[15] The neighbor of Sumba Barat, Sumba Timur has arranged a set of local criterias for poor people. It was arranged by local BPS, local government and also community figures who sat together discussing the specific things of poverty in Sumba Timur. Eventhough it needed great effort to do, it is very good and quite accurate, at least the set of criteria and result are accepted well by the Sumba Timur community.

[16] For example: It is common to have a house with leaves roof in Sumba Barat and even rich people prefer to have leaves as roof, so in Sumba Barat, the roof criteria will be weighted lower than other criteria.

D. 2. Problems on the Coordination Process

The coordination process, between institutions in TK (Coordinating Team), especially TK Kabupaten, plays a vital role in PKH implementation. It was said before that the team is responsible for every supporting part of PKH implementation. District Office of Health will make sure that the health facilities are ready to serve the prospective additional clients, District Office of Education and District Office of Religious Affairs will support schools infrastructure and teachers for prospective additional students and District Office of Communication will do socialization to the community. Low coordination among the team members will not optimize the PKH execution.

Unfortunately, the low coordination happened in both of Sumba Barat and Kediri. There is not so many multisectoral program in Indonesia which requires a good inter-sector coordination process and PKH is one of their first experiences. Many institutions included in the TK rather to think that this program is the Department of Social Affairs' program and they are placed in TK not to play a vital role. Or in many cases, they do not think either PKH or Department of Social Affairs are important (will be explained later) and then choose to not manage their role well. This condition, of course, created some impacts in PKH execution:

- *Insufficient Facilities in Health and Education Services*. Especially in Sumba Barat, PKH succeed to bring pregnant mohers, under seven children, and 7-15 children, from poor people, to go back accessing schools and health facilities. This increasing number of clients sometimes is so enormous and exceeding 100%. It is a good achievement, but in the other way, many schools and health facilities stated that they need more support to do the services. For example, an elementary school in the Village of Pu Weri, Sumba Barat has to serve 78-82 children in each of its six classes during PKH implementation (started from November 2007) and a village health facilities in Sub District of Loli, also in Sumba Barat, is starting afraid that they can not provide enough iron tablet for the clients. Those service providers experienced a huge increasing number of their clients while they were not ready yet. They do not know about PKH, even they know it from their clients[17]. This means the coordination process has been failed and the information about PKH was not disseminated well to the service providers.
- *Unreadiness of Health and Education Services Providers to do the Verification Process.* Because of incomplete coordination process, not only the facilities were not ready to serve its clients, the officers are also unready to do their role in verification process. Actually, the verification process is not complicated, but it needs socialization. The District Office of Health Affairs and the District Office of Education should cooperate with UPPKH Kabupaten to disseminate information and technical skill to conduct the verification process. The reality is there was no sufficient coordination so only the Facilitators had to do extra work. They came to each officers and teach

[17] This problem does not occur in Java. Even though Kediri also faced a problem in coordination, but schools and health facilities in Kediri did not experience a significant increasing number of clients. Maybe it is because Kediri already has very good health and education facilities where poor people can easily access them, so the encouragement of PKH did not give significant effect like in Sumba Barat.

them how to manage verification process. The further impact then, it could hamper the payment process due to the extra time it needed. As said before, the payment process, after the first one, depends on the result of verification process.

- *Low Level of Socialization which is Causing Unstability*. Socialization plays a vital role, especially to give the right information of PKH to the community (beneficiaries and non beneficiaries) and local government (in sub district and village level). Lack of socialization will encourage community to find more information by themselves. It most likely will happen because PKH is a cash transfer program which is quite sensitive program. The first place to ask about government policy will be the nearest local government in village or sub district level[18]. Wrong or incomplete information, which is provided by uninformed village government, may lead to an unstable condition. This condition happened in Sumba Barat, when beneficiaries and non beneficiaries finally did a strike in house of representatives, because they are not satisfied with PKH. They were unsatisfied with the selection process and the criterias. The strike should not happened if the socialization was optimally done, where the community could get clear explanation about PKH's design.

- *The Causes of Low Coordination*

Knowing the impacts, coordination process can be considered as the most important process in PKH implementation. It is not technical work, but the continuity of all technical works depend solely on it. Based on the interview and discussion, there are some problems causing this imperfect coordination:

- *Low Internal Department/Office Information Dissemination.* It is common in government institutions, especially in local level, to not disseminate the information someone got. It is rather a culture than intentionally. They just feel it is not too important so everyone has to know and choose to keep it by themselves. It may be problem if:
  - The Head of Office or the decission maker in the Office prefered to not coming to a PKH coordination meeting by themselves and only sent their representatives. It even could be worse if they sent different person/representatives in several PKH meetings which are actually related each other. The information will be not disseminated and not integrated either, because the attendances are different person who do not know well about the program.
  - Rotation for the district officers is a common thing. Some officers could be assigned to work in new place or different office. They would bring the information with them, without disseminate it, and the new officers will join the team without knowing anything.
  - The district is split and also the Officers are[19]. Quite similar with the rotation, the officers who are moved will go with all of the information and leave nothing.

[18] There are facilitators of PKH in every sub districts. But the facilitators are usually young and the community would not be satisfied by their explanation. The community would rather to ask it directly to village or sub district officers who does not really know either.

[19] This one is very common in Indonesia for last 6-7 years. It is called 'pemekaran', when a district splits into two or more districts. The Districts of Sumba Barat recently split into three new districts,

- *Inferior Position of Department/Office of Social Affairs.* The Department of Social Affairs is inferior institutions compared to others. It does not have big program before PKH and considered as weak department[20]. The new role of it, to be executing agency of PKH, placed Department of Social Affairs on the important place together, or even higher than other institutions especially which are included in TK. But in district level this condition does not change yet. Province/District Office of Social Affairs is still judged as a weak one. Eventhough Local Planning Agency is the leader of TKs, but as Office of Social Affairs is the main associate, other offices rather choose to not seriously cooperating with the team. In several coordination meetings, other offices often sent only the representatives who do not really know about PKH. This thing surely disturbed the coordination process.
- *Inactiveness of TK After the Real Implementation.* Another thing causing bad coordination is, after PKH entered validation process, TK Provinsi and TK Kabupaten felt that this is the end of their duty and they start to give all of its resposibility to UPPKH Kabupaten. They thought their job is only coordinating PKH during the preparation process, and after that it will be more technical job which is the responsibility of UPPKH Kabupaten. Of course this is wrong, the first year of PKH implementation even could be the most important time to find what is going wrong and it needs TK's role to fix the problem. The reality then, so many problems were fixed by UPPKH Kabupaten or for the crucial problem, UPPKH Kabupaten will ask UPPKH Pusat for help without informing TK Provinsi or TK Kabupaten. This is also wrong, because TK Kabupaten is responsible to know about UPPKH Kabupaten's problems and has duty to solve PKH problem together with UPPKH Kabupaten, so if the problem is crucial and needs to be solved by all of the sectors, the TK Kabupaten would be able to facilitate it. Moreover, if the problem is bigger than TK and UPPKH Kabupaten ability, they can include the TK Provinsi before finally ask to UPPKH Pusat or Tim Pengarah Pusat.

- *Solution for the Problems*

Coordination problems are very distracting and can be dangerous for next PKH implementation. There are some options which can solve the problems. The first one is to empower the role of TK Provinsi and TK Kabupaten by maximize the role of Local Planning Agency as TK's leader. Local Planning Agency, in the contrary with Office of Social Affairs, is honored as strong and influencing institution. Every institution appreciates Local Planning Agency. With a good leadership from Local Planning Agency, the problem can be minimalized and the team members can be directed to support PKH optimally. The main thing to do then, is to convince Local Planning Agency, about its important role and intensively improving their capacity and knowledge related to PKH[21]. It would be better if the knowledge which is

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while one of them keep the old name and government system (the Sumba Barat). The splitting was worsening the coordination problem and disturbing PKH implementation especially in the new districts.

[20] Department of Social Affairs' Budget increased about 30% because of PKH.

[21] It should covers the whole concept and the expected role from institutions in TKs. So the Planning Agency will hold the big map of PKH implementation and can lead where the TK should go to improve it.

shared is more about PKH's basic concept and design, so Local Planning Agency will be able to identify the problems and find out what policy needed for those problems. This thing was never thought before. The ongoing process of PKH excluded Planning Agency from its role unintentionally and only left Office of Social Affairs trying to hold everything, which did not work.

The second is, which can be implemented individually or together with the first one, to remind and controll the TK Provinsi and TK Kabupaten strictly by Tim Pengarah Pusat. Every district had signed an agreement to support PKH. Supporting PKH means the district has to provide appropriate services in education and health together with PKH implementation. So the TKs, especially the TK Kabupaten as district representative, has to play their role in order to coordinate the service providers to supply the services. Bad coordination process, causing insufficient services and unoptimized PKH implementation, can be considered as not fulfilling the agreement and there will be a punishment for that.

D. 3. Problems on PKH's Management and Information System (MIS)

This problem can be the biggest problem in PKH implementation. MIS is the main tool to process the result of validation, data updating and verification process, so the data can be used as the basic data for the payment process. The failure of MIS development will cause the inaccurate list of beneficiaries, the payment process will only depend on unvalidated data from initial data collection by BPS.

Unfortunately this thing happened on the whole first year of the pilot of PKH. This was general problem and not only PKH's problem in Sumba Barat and Kediri. The MIS was totally failed and the data processing was totally distracted. As the temporary solution of this problem, the unvalidated data from BPS was used to conduct the first payment, so the non eligible beneficiaries were included in the first payment process.

For the second and third payment, the Operators were asked to do the data processing manually (without using the specific PKH application) to entry the validation result. The second and third payment succeed to use the validated data. But the manual method has several weakness so it only can be used to entry validation and data updating result. The data entry for verification result, as the main spirit of PKH, was not done at all. The payment process only based on validated and updated data related to household's structure and not based on beneficiaries' submission of their responsible. For this early time, maybe the beneficiaries would not know about this condition. But if the MIS is not being developed soon, the beneficiaries will know that it is fine to just accept the money without obeying the conditionalities and the program will achieve nothing.

- *The Causes of MIS Problems*

Several conditions can be the causes of the failure of the development of PKH's MIS. The first one is the low capacity of UPPKH Pusat officers so the progress of MIS development was so slowly. The UPPKH Pusat officers are dominated with Departemen Sosial officers who do not have IT background. So they would use the IT consultant and depended solely to the consultant's work result. If there is any

technical problem related to MIS, the UPPKH officers theirselves can not solve the problem. In this first year implementation, the problem did occur. The MIS was totally failed to work and until this study is done there is no solution yet for this problem except to do it manually.

The second one is not really the MIS problem but more on the support on MIS' operational, that is the lack of electricity in some of remote areas in Eastern Indonesia. In Sumba Barat, it is common to see that the electricity only works for about 15 hours per day. Usually they get the electricity off on the morning, middle of afternoon or end of afternoon, or even on the whole day. This condition makes the Operators can not maximize their effort, even to do manual data processing.

- *Solution for the Problems*

The problem of MIS is more difficult one to solve. It needs not only the physical infrastructures but also the sufficient capacity of the executors. The recent solution for the problem of electricity resource in Eastern Indonesia has been done by providing the generator set (alternative electricity resource) for each UPPKH Kabupaten. But the operational of generator set is costly which most of UPPKH Kabupaten in Eastern Indonesia can not afford. For this while the proposal to bear the generator set's operational cost on UPPKH Pusat's budget is still in progress.

For the low capacity of UPPKH Pusat officers, there should be a technical assistance for them to rule the MIS. The decision to hire IT consultants just to build the system did not work, because after the consultants left, the UPPKH Pusat officers can neither maintain the system nor solve its problems. The capacity building and technical asistance should be done. It will help them maintaining the MIS and also develop their capacity to continue this duty.

It is proven that the PKH's implementation, on its pilot, still have many problems. But in the other side it reached several achievements especially to bring poor people accessing health and education services and to build a new point of view that health and education is very important to help them escaping poverty. Some of Facilitators in Sumba Barat already stated that the beneficiaries are starting to understand the purpose of this programs.

Like blessing in disguise, in some sub districts in Sumba Barat and Kediri, the non beneficiaries also start to annually accessing helath and education services. The Facilitators who are responsible to those areas said that some of them has already understood the importance of having the services, but some others just try to attract PKH's officers so they can be the next beneficiaries of PKH. But overall the officers of health and education facilities in PKH areas in Sumba Barat and Kediri said that they served bigger amount of clients since the implementation of PKH.

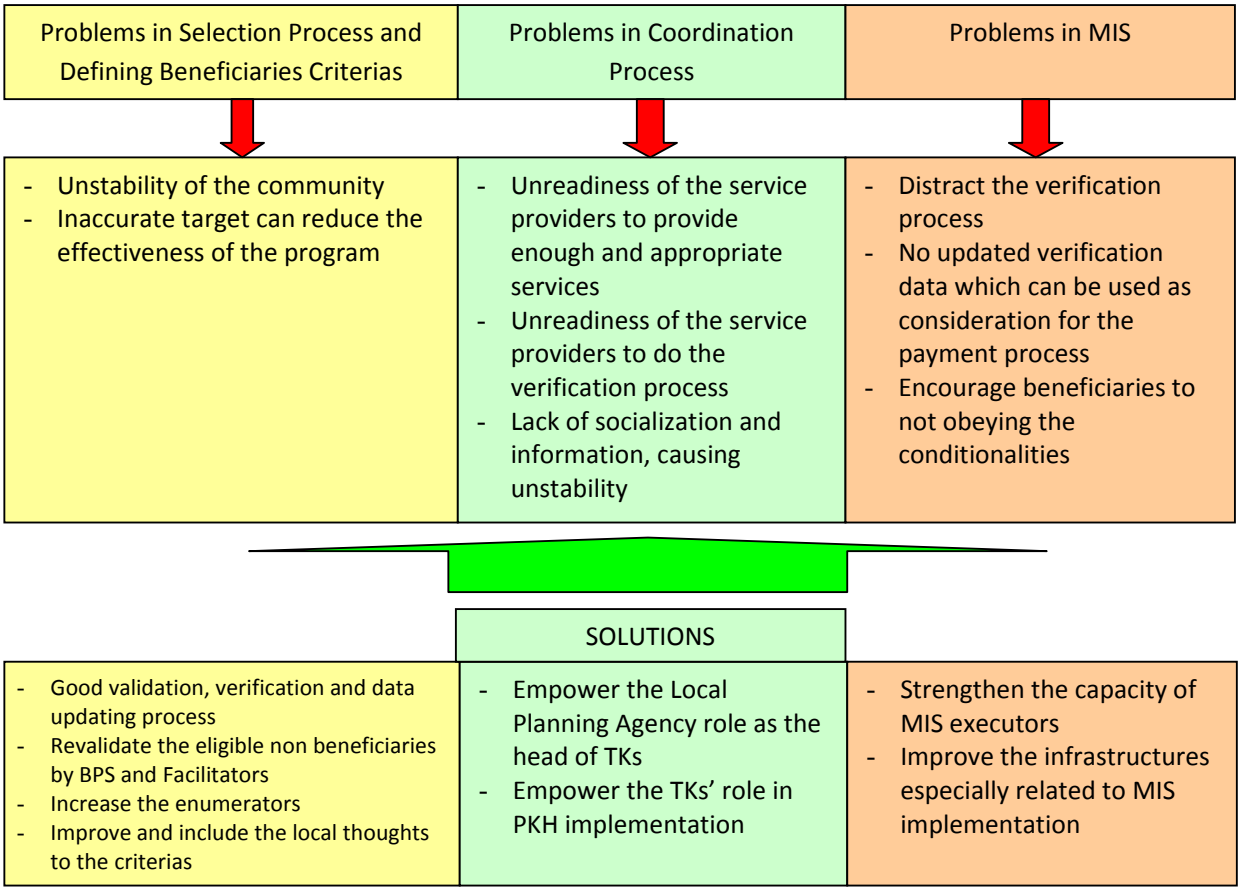
This conditions prove that PKH has a chance to be improved into a much better program. It does need some modification in its design and much more improvement in its implementation and those things will be the responsibility of all PKH's officers in central and local level.

E. CONCLUSIONS AND RECCOMENDATIONS

The study shows that PKH implementation in Sumba Barat and Kediri has problems in their three main elements: problems in Selection Process, Coordination Process and MIS. As consequences, those problems created barriers in other elements of PKH implementation and reduce the effectiveness of the PKH execution. Some other important elements to support the program are not effectively done, like the payment, socialization, verification and data updating process.

Moreover, those problems creates some distractions in the field implementation. Lousy selection process did create an instability in the communities in receiving the program. Low sectoral coordination caused unreadiness in almost all service providers of public education and health. The most difficult one, the failure of MIS development to support the verification and data updating process made the payment process of PKH is no longer based on conditionalities fulfillment. It seems turn into *unconditional* cash transfer and encourage the beneficiaries to no longer following the rules.

Figure 3. The Map of PKH's Problems and the Possible Solutions



Like said before, there are some possible specific solutions for each problem. Generally the solutions can be divided into three different areas:

1. *The improvement of PKH targeting design*.

   Improvement in targeting design includes the improvement in selection process and beneficiaries' set of criterias. The improvement is purposed to reduce the inclusion and exclusion errors. It can be done by improving the number and quality of enumerators in each area. In less developed Eastern Indonesia like Sumba Barat this solution will help to reduce the exclusion error due to its hard geographical condition, and generally in most areas the additional enumerators will reduce the enumerators' moral hazard and possibility of beneficiaries adverse selection by them.

   Next and further step is to build a pro-local set of beneficiaries criterias, especially for certain areas with specific culture like Sumba Barat. Better selection process will create a controllable and conducive community which will support PKH execution and improve the effectiveness of the program.

2. *The improvement of human resources quality for PKH executors in both of central and local levels*.

   The improvement of human resources quality is aimed to improve the quality of the execution of PKH in each element. The study has proven that the lack of human resources quality of PKH executors in Sumba Barat and Kediri has created substantial problems. In the whole massive plan this step will include all executors of PKH: the member of Tim Pengarah Pusat, TK Provinsi, TK Kabupaten, UPPKH Pusat (especially the MIS element), UPPKH Kabupaten and service providers' officers. But for the first step the capacity building, through some trainings and technical assistance, can be done to UPPKH Pusat, especially to improve the quality of MIS management. The next phase of capacity building can set TK Kabupaten, to empower them, and service providers' officers as its target to improve the PKH implementation through strong sectoral coordination.

3. *The improvement of supporting infrastructures in PKH implementation especially in local levels.*

   This part will be the most difficult one especially because the very different infrastructures condition between PKH areas, especially in Sumba Barat and most areas in Eastern Indonesia. The main problem is electricity and the most possible way now is to provide a substitution of electricity resource. But not only to provide the installation, the operational cost of the installation has to be considered. The UPPKH Pusat should arrange the budget allocation for this or UPPKH Pusat can arrange an agreement to share the cost with the local government[22].

[22] The budget allocation of each UPPKH Kabupaten are decided by UPPKH Pusat. The UPPKH Kabupaten make the annual proposal and then UPPKH Pusat will evaluate the proposal and give its approval. The UPPKH Kabupaten budget is totally separated from local government budget. The local government are suppose to give additional safeguarding budget, but there is no written agreement/commitment for this so the local government's support are variously different between the areas.

Those set of solutions are the best one for now, even though some of them are temporarily. The program must go on and already prospected to be scaled up. This program brings Indonesia's dream to have a good and comprehensive social protection scheme, and to realize that dream the improvement

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