EVALUATION RESEARCH OF PROGRAM KELUARGA HARAPAN /FAMILY HOPE PROGRAM (INDONESIA CCT PROGRAM)

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The main problem faced by Indonesia at this time is the high rate of poverty. Since the independent day, the Indonesian government has been trying to address these problems with various poverty alleviation programs. But after the programs are evaluated in 2004 by National Development Planning Body (BAPPENAS), the result showed that the program implementation is not really effective.

In 2007, the Indonesian government launched a Conditional Cash Transfer (CCT) by Expected Family Program (PKH) in 7 provinces (Special Capital Region of Jakarta, West Java, East Java, West Sumatera, Gorontalo, North Sulawesi, and East Nusa Tenggara).

In 2012, after 5 years of CCT launched, an evaluation research need to be done to look at the program implementation, effectiveness and the program impact for the PKH target.
The Purpose of Evaluation Research

- knowing the description of PKH implementation
- knowing the effectiveness of PKH as seen from context, input, process, and product aspect
- identifying the supporting and barrier factors to the implementation of PKH
- Knowing impact of PKH towards the program targets
RESEARCH METHODS

- The location samples of the research were taken from 3 Provinces, namely North Sulawesi Province (Bitung City), West Sumatra Province (District of Pesisir Selatan) and East Nusa Tenggara Province (District of Timor Tengah Selatan).

- The reasons:
  1. Those locations are 3 out of 7 pilot project locations where Conditional Cash Transfer (CCT) program were conducted through the PKH so it is possible to get data required
  2. The number of very-poor household/the beneficiary at PKH in three locations is high. West Sumatra Province has 54,202 heads of family, North Sulawesi province has 23,319 heads of family and East Nusa Tenggara province has 66,027 heads of family. (Ministry of Social, 2011).
Sample

The respondent is the PKH target, 60 respondents of each location were determined by random sampling quota area technique. Other respondent participant at the research consisted of 6 post officers, 18 service unit operators of PKH, 20 program assistants, 19 health officers and 25 education officers, they were determined by purposive sampling. Therefore, the total of the respondent is 268 people.

The informant is stakeholder that involved directly or indirectly on PKH, 20 informants of each location, determined by purposive technique. Therefore, the total of the informant is 60 people.

- This research of evaluation used mixed-approach and CIPP model as formulated by Daniel L Stufflebeam (1976)

- **Technique of Data Gathering:**
  
  FGD, in-depth interview, questionnaire, observation, documentation.

- **Technique of Data Analysis:**
  
  a. **Quantitative Data:** The quantitative data is analyzed by descriptive statistic (to predict the implementation of PKH, to see the PKH effectiveness level, the supporting and inhibiting factor for PKH, and the effect of PKH target).
  
  b. **Qualitative Data:** Qualitative data is analyzed in interpretative descriptive (interpreting data in narrative term), related to the PKH implementation, the PKH effectiveness level, the pro & cons PKH factors, and the effect of PKH.
## Focus of evaluation

<table>
<thead>
<tr>
<th>No</th>
<th>Variable/Aspect</th>
<th>Focus/Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Context Evaluation</td>
<td>to evaluate the program background, the program aim and the environment support to PKH.</td>
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<tr>
<td>2</td>
<td>Input Evaluation</td>
<td>to evaluate human resources which are needed for PKH (the target accuracy), education and training program for human resources in PKH [manager/executive, assistant, operator, officer of health care providers, educational services providers officer, postman], the accuracy of accommodation, and the availability of facilities and infrastructure for PKH (public health center, midwifery centre, moving public health center, medicine, equipment, material health services for mothers / babies / children school age, school, education infrastructure in schools).</td>
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<tr>
<td>3</td>
<td>Process Evaluation</td>
<td>to evaluate the process of PKH implementation. Process evaluation focuses on the mechanism/procedures of PKH which involves as follow: (a) The mechanism for selecting participants PKH, (b) Pricing mechanisms replacement participants (inclusion and exclusion errors), (c) The mechanism of the initial meeting, (d) Payment mechanism, (e) The mechanism of formation of mother beneficiaries, (f) Verification commitment (on education and health components), (g) Mechanism of suspension and cancellation of participants PKH, (h) Data updating mechanism, (i) Complaints mechanism, (j) Evaluation of fulfillment of the obligations.</td>
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<tr>
<td>4</td>
<td>Product Evaluation</td>
<td>to evaluate result achievement/impact of PKH for the targets with reference to the objectives set., aid has been distributed to the target, ease of beneficiaries to access educational and healthy service, growing awareness to access education and health services.</td>
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ADVANTAGES OF METHODS

1. By using a combined approach involving the respondent as well as variety of related parties (various stakeholder) is expected to obtain comprehensive data.

2. Advantages of using CIPP models is able to evaluate the PKH as a comprehensive system, so that all the element in the PKH can be described, process that is implemented in PKH can be drawn, inter-connection or between the various element of PKH can be captured.

3. The recommendations that will be given are useful for improvement and development programs.
DISADVANTAGES OF METHODS & SOLUTIONS

1. It takes time and accuracy are sufficient to prepare the evaluation instrument
   • needs a long time period to measure/evaluate the PKH comprehensively

2. Took power competence and experienced researchers in the field of evaluations (needs an
   educated researcher to implement the CIPP model)
   Entered into a collaboration and involve the expert from the university as a consultant and member
   of the researcher team, thus the team performance is more effective and it transfers new
   knowledge for another team. do coaching for the same perceptions researcher team member

3. needs a relatively large cost to reach the target for the majority of respondent live dispersed
   in remote rural areas or with geographical conditional that are difficult to reach and lack of
   public transport facilities.
   To minimize the cost, the researcher lived in the study area during data gathering and make schedule
   for the meetings and the study area visits so the researcher had effective time-management.

4. Difficult in communicating with the natives for them poorly educated and do not master
   Indonesian language
   Involving local enumerator on data gathering
5. Needs a maturity in attitude because a researcher in location will face many very poor household to receive PKH but they don’t receive it because they are not registered (change of address, miss, or in certain case differ politically with enumerators or local goverment).

6. Difficult to measure the economic impact of CCT/PKH program is one of the strategy which is designed to help households with expenditure targeted at improving the human resourches for the shortime and improve the mindset and behaviour change that can brin home the poverty chain termination ladder in the long run.

Do approach to local people to handle social and political problem that arise as a result of programme has not been achieved yet to all very poor household in location.

Do coordination with Ministry of Social and local government to continue the PKH program and to monitor its progress while giving side-program such as empowerment program to help very-poor households’ economy in order to cut the poverty chain fast.
### SUPPORTING AND BARRIER FACTORS OF PKH IMPLEMENTATION

#### a. Supporting Factors

1. Supported by qualified human resources (educated, dedicated & competent ability in their field)

2. Mechanism of PKH implementation is obvious, thus it is easy to be understood and implemented by officer, assistant and the program target

3. There are good cooperation and coordination among officer, assistant and the program target.

4. Supported by local government, related institutions and some communities

5. Supported by socialization of mass media advertising
b. Barrier Factors

1) Not all of location has adequate education and health facilities infrastructure.

2) Bad geographically locations, while there is no public transportation facility.

3) Some equipments and facilities in the PKH secretariat were damaged, while the applied program cannot be found in the location. The limited equipments and high work-responsibility cause the operator’s work get obstructed when completing data entry or verification and sending the data to the head office.

4) Some of PKH officers have not had join training, such as education and health facilitator. Meanwhile other officers that have already had training are moved to other areas, thus it makes new officers have less understanding of their role and function.

5) Health Department and some Social Departments do not have data on the receiving PKH, which makes them cannot conduct monitoring and direct evaluation to subject.
a. **Positive Impact of PKH**

1) The enhancement of education service occurs for Elementary and Junior High School’s students from very-poor household that motivates them.

2) The change of very-poor household’s mindset for the importance of education, that motivates their children to be more diligent to get to school. It can increase the presence of children in school-age.

3) The change of attitude and participation in education section that potentially cuts drop out-chain of PKH participants’ children

4) The reduction of very-poor household school children that working and they re-register to back to school

5) The enhancement of health status of very-poor household’s members.

6) The change of very-poor household’s mindset for the importance of health living that makes them check their health status up regularly.

7) The enhancement of very-poor household number in visiting public health centers.

8) The repairement of health, nutrition and nutrient condition for very-poor household.
b. Negative Impact of PKH

1) Social jealousy happens because some very-poor households get assistency, while the others do not receive it, whereas they have the same requirements as cash transfer receiver.

2) In some cases, there are PKH fund assistency abuses conducted by the program target (out from education and health’s need).

3) The very-poor household depends on the assistance (cash transfer)

4) Individual officer can have a chance to abuse the assistance/cash transfer (NTT’s case)
1) Conditional Cash Transfer (PKH) implementation in Indonesia is well-targeted, it’s proved by very effective and positive impact in education and health service improvement for the program target.

2) PKH also has a positive impact in changing the mindset and behavior of the program target on the importance of education and health for their future so that it encourages an increase in their participation in education and health.
RECOMMENDATION

1) This program (PKH) should be continued for a wider target which is expected to break the chains of poverty that the main problem of the nation Indonesia.

2) In order to make the poverty affiliation program become more effective, PKH program need side-program such as empowerment program, so that very-poor households are able to maximize their potential.

3) It needs coordination and collaboration with other related institutions in implementing both PKH program and its development.
Follow up Evaluation Research for Program Keluarga Harapan (PKH)

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Ministry of Social Affairs of The Republic of Indonesia
Bonn, Germany April 2015
Poverty and Social Protection coverage 2015

Population: 246,846,191
GDP: $878,043,028,442
GDP Growth: 6.2%
Inflation: 4.2%
Poverty: 10.96% = about 27.7 million population

Universal Health Coverage
88.2 millions P (37%)

UCT/Rice for the Poor
15.5 millions HH (25%)

Poverty line
7 millions HH (10.96%)

CCT/PKH
3.5 millions HH (5%)

Poverty and Social Protection coverage 2015
Coverage and Resources PKH

- From 2007 to present, PKH still becomes a national priority programme in poverty elevation policy.
- In 2010-2014 Long-term Development there has been an increase of beneficiaries and budget allocation for PKH which surpassed planned target baseline.
- 2015 it sharply increased which reached 3.5 million targeted poorest households and IDR 6.4 trillion on budget (USD 7.6 billion).

### Area of Coverage

<table>
<thead>
<tr>
<th>Personnel</th>
<th>Total</th>
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<tbody>
<tr>
<td>Province</td>
<td>34</td>
</tr>
<tr>
<td>Regency</td>
<td>443</td>
</tr>
<tr>
<td>Sub-District</td>
<td>5.271</td>
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### Human Resource

<table>
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<tr>
<th>Personnel</th>
<th>Total</th>
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<tbody>
<tr>
<td>Assistant</td>
<td>14.594</td>
</tr>
<tr>
<td>Operator</td>
<td>2000</td>
</tr>
<tr>
<td>Area Coordinator</td>
<td>47</td>
</tr>
<tr>
<td>Management</td>
<td>40</td>
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### Budget

<table>
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<tr>
<th>Year</th>
<th>Targeted Baseline</th>
<th>Strategic Baseline</th>
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<tbody>
<tr>
<td>2010</td>
<td>USD 0.989 b</td>
<td>USD 3,500,000 b</td>
</tr>
<tr>
<td>2011</td>
<td>USD 1.282 b</td>
<td>USD 3,000,000 b</td>
</tr>
<tr>
<td>2012</td>
<td>USD 1.867 b</td>
<td>USD 2,871,827 b</td>
</tr>
<tr>
<td>2013</td>
<td>USD 3,536 b</td>
<td>USD 2,326,537 b</td>
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<tr>
<td>2014</td>
<td>USD 5,548 b</td>
<td>USD 1,866,000 b</td>
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<tr>
<td>2015</td>
<td>USD 6.471 b</td>
<td>USD 1,516,000 b</td>
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**Efectivity of PKH**

**Health**  
*World Bank, 2010*  
- Increase of pre-natal examination rate by 9-13%  
- Increase of post-natal examination rate by 21%  
- Increase of child weighing rate by 22%  
- Increase of number of child who received complete vaccination by 11%  

**Education**  
*World Bank, 2010*  
- Increase of school hours by 0.7 hour per week for Secondary School Students  
- Increase school hours by 20 min per week for Primary School  
*TNPK, 2014*  
- Decrease of drop out rate at Primary School by 1.2%  
- Increase of school participation/enrolment rate at Secondary School level by 5%  

**Spillover**  
*Worldbank, 2010*  
- Increase of pre-natal examination among neighbours who don’t receive PKH by 4%  
- Increase of child weighing among neighbours who don’t receive PKH by 7%  
- Almost 8% of PKH participants’ neighbour perform childbirth through support of medical workers  

**Household Consumption**  
*World Bank, 2010*  
- Increase of consumption almost by 10% of average monthly expense  
- Indicators of nutritious food consumption (meat, fish, egg, milk) increased by 0.75%  

**Child Labour/Worker**  
*World Bank, 2010*  
- Reduce incident of child labour/worker by 0.6%  
*TN2PK, 2014*  
- Reduce of child labour prevalence by 3.9%
Empirical Study of PKH Effectivity

- PKH has successfully increased the number of Posyandu (integrated services post) visit to observe child’s growth and development as well as immunisation activities (TNP2K).

- PKH has effectively boosted increase of HDI particularly on MDGs targeted achievement (Bappenas).

- PKH has resulted positive effects on households in performing childbirth with health/medical worker and health facility, (Margaret Triyana, March 2013).

- PKH has encouraged community to alter their mindset to raise.
- PKH is the most effective programme to directly reduce poverty and inequality compared to other poverty alleviation programmes.
- PKH is the most effective programme of APBN spending per rupiah in order to reduce Gini coefficient compared to other poverty alleviation programmes.
- The impact of PKH towards Per Capita Expenditure (PCE) is considerably significant.
- Budget percentage of PKH towards GDP is the smallest compared to other countries that conduct CCT such as Argentina, Bolivia, Brazil, Mexico, Peru, Uruguay, Armenia, Sri Lanka (0.2% GDP).
THANK YOU