Program Keluarga Harapan (PKH)

Family Hope Program

The Indonesian Conditional Cash Transfer Program

1. Background

What is Program Keluarga Harapan (PKH)/CCT?

- Social assistance with some conditionalities to the poorest households which have expecting or lactating mothers and children between 0-15 years old.
- PKH is designed to achieve compulsory basic education (9 years) and to achieve MDG's target.
- PKH will be conducted from 2007 to 2015.

Why PKH/CCT?

- Reducing current poverty and inequality
  - ✓ Via cash transfers to the poor – income effect
  - ✓ Redistribution and relief role
- Reducing future poverty and inequality
  - ✓ By linking transfers to incentives for investments in human capital (via health/education conditionalities) – price effect
  - ✓ Insurance effect
- Changing paradigm among the poor towards the health and education
- Reducing child labor
- Improving service quality (force the local government and sector to provide services to the poor – demand vs supply)
- Accelerating MDGs achievement (reduce poverty, promote gender issues, reduce child mortality rate, reduce maternal mortality rate, promote education for all)

Objectives of PKH/CCT

Health and Nutrition:

- To improve access of the poor to basic health care (especially for children and pregnant women).
- To improve nutrition condition of the poor children.

Education:

- To improve net enrollment in elementary and junior secondary school for the poor children.
- Target group especially for the children who are outside the school system.

In the long run:
•Improve quality of human resources
•Break poverty chain

Benefits of PKH

1. In the short term: provide income effect for poor households
2. In the long term:
   - Improving health and nutrition condition, education and income capacity of the children in the future (*price effect* of the poor children)
   - Provide insurance effect for the certainty of the future for the children of poor households
   - Provide price effect to the children of poor households → increase income capacity of the kids in the future
3. Induce change of attitude and investments by poor on human capital → overcome problems relate to *demand-side factors* because of:
   - Lack of information about rights, benefits, outcomes, and chances
   - High indirect costs (transportation, uniforms, books, shoes, etc)
   - Opportunity cost (many poor family prefer send their children to work instead going to school)

Benefits of PKH …*(Cont)*

4. Reduce child labor.
5. Exploit the complementarities among health, education, and nutrition.
   - Coordination: Promote coordination of poverty alleviation efforts among Gov't ministries (education, health, nutrition)
   - Synergy: simultaneous provision of health, education and nutrition benefits to all the beneficiaries.
6. Accelerate the achievement of MDGs (improving access to education, health, and gender development).

STAGES OF PROGRAM, 2007-2015 (plan)

Stages	2007	2008	2009	2010	2011	2012	2013	2014	2015
1st Stage	0.5	0.5	0.5	0.5	0.5	0.5	Exit*	Exit*	Exit*
2nd Stage		1.25	1.25	1.25	1.25	1.25	1.25	Exit*	Exit*
3rd Stage			2.25	2.25	2.25	2.25	2.25	2.25	Exit*
4th Stage				2.5	2.5	2.5	2.5	2.5	2.5
Total (mill. Poor HH)	0.5	1.75	4.0	6.5	6.5	6.5	6.0	4.75	2.5
Cost (billion Rp)	1,000	3,000	6,700	11,000	11,000	11,000	10,100	8,000	4,200

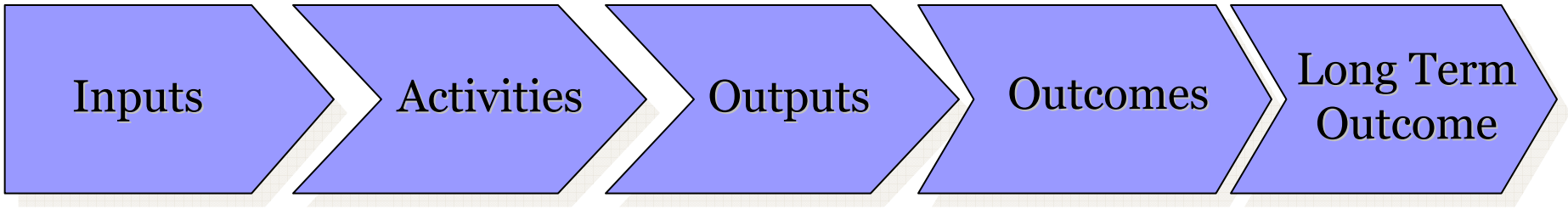
Notes:

1. It is assumed that the poor and very poor HH is 6.5 million which have children between 0 – 15 tahun (BPS)
2. Based on Latin America countries experiences, after 5-6 years beneficiaries would finish their school or receive another program.
3. Design of exit strategy will determine later and it will need coordination among sectors that involve in poverty reduction program (i.e. labor, industry, trade, agriculture, community empowerment, etc.)
4. The costs are calculated based on average annual benefit per poor HH (Rp 1.39 million) and it includes administration cost and supporting activities (survey, socialization, training, etc.)

Location Criteria for PKH

- Criteria for selecting region:
  - Region's commitment at the National Developmen Planning Meeting
  - Multi dimension of poverty: number and percentage of the poor, malnutrition rate and transition rate.
  - Supply side readiness for health and education.
  - Selection of district and sub district based on poverty data and random selection.
- In 2007: 348 sub districts in 49 districts at 7 provinces
  - West Sumatera, DKI Jakarta, West Java, East Java, North Sulawesi, Gorontalo, and East Nusa Tenggara (NTT).
- Additional Location In 2008: 22 districts at 6 provinces
  - Nanggroe Aceh Darussalam, North Sumatera, Banten, Yogyakarta, Kalimantan Selatan, and West Nusa Tenggara (NTB).

2. Results Chain



- Budget
- Staffing

- Supply side assessment
- Screening, targeting household (data collection, validation
- Dissemination of the program (IEC)
- Verification (compliance with conditionalities)
- Training of facilitators
- M&E
- MIS
- Institutional coordination

- Cash Transfer Delivered

- Improved health and nutrition of poor children
- More mothers seeking pre-natal care
- Increased school enrolment and attendance
- Reduced drop-out

- Poverty reduction
- Reduced maternal mortality
- Increased educational attainment

3. Primary Research Questions

Does cash transfer

1. improve health of children 0-5/ 6-14 years old?
2. increase pre and post natal care utilization?
3. decrease malnutrition of children 0-5 years old?
4. increase school enrollment?
5. increase school attendance?
6. increase school survival rate?
7. increase consumption per capita?

4. Outcome Indicators

1. Number of pre & post natal check-ups
2. % of women getting a check-up in the first trimerster
3. % of women assisted by trained health worker during delivery
4. % of children fully immunized
5. % of children with low birth weight (LBW)
6. % of malnourished children
7. % of children who comply with growth monitoring protocol
8. Enrollment rate
9. Attendance rate
10. Drop out rate
11. Consumption/capita

5. Method and Sample/Data

Randomized Control

CCT Implementation			
	2007	**2008**	**Total**
Provinces	7	6	13
Districts	48	22	70
Sub-Districts	337	292	629
Villages	4.311	3.953	8.264
Households	392.813	244.951	637.764

IE Sampel Data (2007 location)		
	Treatments	**Control**
Provinces	6	6 (Same Provinces)
Districts	24	24 (Same Districts)
Sub-Districts (Random)	196	196 (Different Sub-Districts)
Villages	5	5
Households (Random)	5 Hh/Villages	5 Hh/Villages

Quesionair Baseline Survey 2007

- There are 13 set of quesionairs
- Consisting of :
  1) Exam test of Indonesian Language:
     - Children, age of 7-12 years old
     - Children, age of 713-15 years old
  2) Exam test of Basic Math:
     - Children, age of 7-12 years old
     - Children, age of 713-15 years old
  3) Book 1A (quesionair for Households)
  4) Book 1B (quesionair for marrige women, age 16-49 year old)
  5) Book 1C (quesionair for children age of 6-15 year old)
  6) Book 1D (quesionair for baby 0-36 months)
  7) Book 2 (quesionair village characteristics)
  8) Book 3 (quesionair for Sub-districts health services)
  9) Book 4 (quesionair for staff health service /nurse)
  10) Book 5 (quesionair for school)
  11) Book for Verification

6. Timeframe and Fund

- Baseline survey is executed in early 2007 (CCT begin in the second quarter of 2007)
  - Implemented by an Independent institution, funded by the World Bank
  - Designing quesionair and survey done in 6 months
  - Draft Final report done in March 2008
  - It cost about US$500.000
- First Impact Evaluation is executed at the end of 2008
  - Using the same quesionair
  - Exactly the same data and areas, but smaller number of villages (2 villages per Sub-districts) due to lack of Fund
  - Implemented by an independent institution, funded by the Government of Indonesia
  - It cost about US$100.000

6. Timeframe and Fund

- Follow up survey will done in early 2010
- It will be done by the World Bank and the Government of Indonesia
- IE Fund is not determine yet (approximately about US$ 900.000). It will be combined with other survey for different purposes

Terima Kasih

Thank You