

Report on Findings of Impact Evaluation of Program Keluarga Harapan (PKH)

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List of Abbreviations

Abbreviation	Description
ANC	Ante Natal Care, is a health service provided by professionals to women during pregnancy
ATM	Automated Teller Machine
BCG	Bacille Calmette-Guerin, is a vaccine for tuberculosis (TB) disease
BDT	Basis Data Terpadu, Unified Beneficiary Database
BPJS	<i>Badan Penyelenggara Jaminan Sosial</i> , Social Insurance Administration Organization), administrator of the Indonesian national health insurance <i>Jaminan Kesehatan Nasional</i> or JKN for short
CBI	Complete Basic Immunization, is a basic immunization given to babies, age between 0-12 months, in a complete manner.
DPT-HB1-2-3	Diphtheria-Tetanus toxoids-Pertusis-Hepatitis B, where the vaccine for Hepatitis B is combined with the vaccine DTP and given to toddlers starting from 18 months age in three separate cycles
e-commerce	Electronic commerce, refers to the buying and selling of goods or services using the internet, and the transfer of money and data to execute these transactions
e-PKH	Electronic-PKH, an android-based HP application with the e-PKH new initiative validation system involving all PKH facilitators

e-Warung KUBE	<i>Elektronik Warung Kelompok Usaha Bersama</i> , established by MoSA from among selected PKH beneficiaries in one sub-district
Fintech	Financial technology, is the technology and innovation that aims to compete with traditional financial methods in the delivery of financial services.
HBO	Hepatitis B vaccine given to a just born babies within 24 hour.
HPV	Human Papiloma Virus, a common sexually transmitted infection
IDR	Indonesia Rupiah
KK	<i>Kartu Keluarga</i> , Family Register/certificate
KKS	<i>Kartu Keluarga Sejahtera</i> , a Combo Card for beneficiaries to receive social assistance from the government
Lansia	<i>Lanjut Usia</i> , an Indonesian terminology for elderly
MIS	<i>Management Information System</i>
MoSA	Ministry of Social Affairs, <i>Indonesia</i>
MR	Measles Rubella vaccine
OTP	One-Time-Password, a password that is valid for only one login session or transaction on a computer system or other digital device
PCV	Pneumococcal Conjugate vaccine to prevent pneumococcal infections
PIN	Personal Identification Number
PKH	<i>Program Keluarga Harapan</i> , Family Welfare Programme, a conditional cash transfer program by Government of Indonesia, targeting poor women.
PNC	Post Natal Care, the care given to the mother and her new born baby immediately after the birth and for the first six weeks of life. In Indonesian term called as masa Nifas
P2K2	<i>Pertemuan Peningkatan Kemampuan Keluarga, Family Development Session</i> . The session happens in frequent basis for groups of PKH beneficiaries to increase knowledge and understanding about the importance of education, health, and financial planning of their families
Puskesmas	<i>Pusat Kesehatan Masyarakat</i> , government-mandated community health clinics in sub-district level
Riskesdas	<i>Riset Kesehatan Dasar, Basic Health Survey</i> , one of the national scale research that is community based and has been carried out periodically by the Indonesian Ministry of Health Research and Development Agency
RCT	Randomized Control Trial, an experimental form of impact evaluation in which both the population receiving the program or policy intervention and the ones who are not is chosen at random from an eligible population.
QR code	Quick Response Code) is the trademark for a type of matrix barcode (or two-dimensional barcode)

Contents

BACKGROUND OF PKH AND OBJECTIVES OF THE STUDY	8
ABOUT THE PKH PROGRAM	8
LEARNINGS FROM PAST EVALUATIONS OF PKH PROGRAM	9
OBJECTIVES OF THE EVALUATION.....	10
RESEARCH METHODOLOGY	11
PKH INDICATORS ANALYZED	11
METHODOLOGY FOR QUANTITATIVE RESEARCH	13
LIMITATIONS OF THE STUDY	14
SAMPLING FOR QUANTITATIVE HOUSEHOLD SURVEY	15
INTERPRETATION OF RESULTS	15
METHODOLOGY FOR QUALITATIVE RESEARCH.....	15
RESULTS AND DISCUSSIONS	16
IMPACT ON HOUSEHOLD EXPENDITURES	16
IMPACT ON HEALTH OUTCOMES	17
IMPACT ON EDUCATION OUTCOMES.....	21
IMPACT ON SOCIAL WELFARE OF ELDERLY AND DISABLED	22
CONCLUSION AND RECOMMENDATIONS	23
CONCLUSION	23
RECOMMENDATIONS	25
REFERENCES	26
ANNEXURES	28
ANNEX I - SAMPLING METHODOLOGY	28
ANNEX II - QUANTITATIVE DATA ANALYSIS	32
ANNEX III : SURVEY TOOL.....	33

Table of Figures

Table 1: Summary of PKH Impact across different Outcomes Indicators.....	7
Table 2: PKH commitment indicators analyzed in this study	11
Table 3: Impact on family expenditures	17
Table 4: Impact on maternal health outcomes	18
Table 5: Impact on child immunization outcomes.....	18
Table 6: Impact on child immunization (1-5 years)	19
Table 7: Impact on child health monitoring outcomes.....	20
Table 8: Impact on other health outcomes.....	20
Table 9: Impact on education outcomes.....	21
Table 10: Impact on elderly	22
Table 11: Sample spread across provinces.....	Error! Bookmark not defined.

Executive summary

MSC, on the request of Ministry of Social Affairs (MoSA) Indonesia, conducted an impact evaluation of the Program Keluarga Harapan (PKH), a conditional cash transfer program managed by MoSA, this report presents the key findings of the study. PKH program's primary objective is to reduce the expenditure burden of poor families, and changing people's behavior in accessing health, education and social welfare services. The program started as a pilot in 2007 covering around half a million families. By 2018, the program was implemented in all the provinces of Indonesia covering around 10 million families. The last evaluation of the PKH program was done in 2013. This is the first evaluation of the program after it has been scaled up nationally.

Methodology

The evaluation adopted a modified Regression Discontinuity Design (modified RDD) method and compares the results of treatment and comparison groups. The respondents were selected from the Unified Beneficiary Database (UDB) managed by MoSA. The treatment group consists of PKH beneficiaries with percentile scores of 11 to 20 as per the UDB while the comparison group consists of non-PKH beneficiaries with the same percentile scores. The sample size consisted of 1467 beneficiaries and 1437 non-beneficiaries selected from 15 provinces across Indonesia.

Results and Findings

This study finds a significant positive difference on the monthly family expenditure (3.84% higher), more specifically on the monthly non-food expenditure (11.80% higher) of the beneficiary families (treatment group) compared to the non-beneficiary families (comparison group).

On health indicators, we find significant positive difference of the PKH program on assisted deliveries at government facilities or at mid-wife's facilities (12.10% higher for beneficiaries), delivery assisted by doctors or midwives (13.80% higher for beneficiaries), administration of on-time complete basic immunization of children (17.00% higher), and regular weight monitoring of children (0-11 months) (20.60% higher). The difference is positive but not significant on some indicators like making at least 4 visits for Ante Natal Care and Post Natal Care by PKH beneficiaries.

This study finds no significant difference in drop-outs between beneficiaries and non-beneficiaries. However, the level of drop outs in both the treatment and comparison groups is quite low. While we did not find any significant difference in child labor or school attendance, a significant difference is observed in special achievement at schools among children of PKH beneficiaries as compared to non-beneficiaries (2.28 % higher).

We find that elderly PKH beneficiaries are 8.87% more likely to visit a health care facility to get their health check-ups done as compared to non-beneficiaries. This study did not find enough severely disabled people in the sample to make a conclusive analysis on their participation in day care services or regular health check-ups at health care facilities. The summary of the impact indicators is presented in Table 1.

Conclusion and Recommendations

This study shows that PKH continues to have a positive impact on a number of health and welfare indicators for the beneficiary households. However, we feel that the impact on outcomes can be further improved by improving the compliance monitoring of beneficiaries especially on indicators like: ANC and PNC visits for both mothers and babies, children height and development monitoring. This should be complemented by applying penalties for non-compliance. MoSA should also focus its efforts to improve




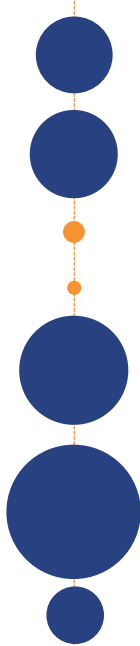


awareness on the benefits of PKH outcome indicators (especially on ANC, PNC, health monitoring visits) among the beneficiaries through intensive family development sessions. MoSA may also relook at the commitments for elderly and people with severe disability since the supply side infrastructure to meet these commitments is not ready in some regions.

MoSA can also coordinate with the Ministry of Health to ensure the services such as child height and development monitoring are provided pro-actively in all government health centers. Similarly, closer integration of databases across MoSA, Ministry of Health and Ministry of Education can bring in more efficiencies and better monitoring of the PKH program.

Summary of the PKH Impact Indicators

Table 1 represents the impact of the PKH program across different health and education indicators. The size of the bubble represents the quantum of impact while the color indicates whether the impact is positive or negative

Table 1: Summary of PKH Impact across different Outcomes Indicators

Family Expenditure 	Per capita total monthly expenditure	
	Per capita monthly food expenditure	
	Per capita monthly non-food expenditure	
Health 	Delivery at government health facility	
	Delivery assisted by doctor or midwife	
	ANC Visits for mothers: 4 visits and above	
	PNC Visits for mother (1-42 days): 4 visits and above	
	Complete basic immunization for children	
	Regular weight check-ups for children (0-11 months)	
	Regular health check-ups for elderly	
Education 	School drop-out	
	Academic/extracurricular achievement of children	

Positive
 Negative
 Insignificant

Background of PKH and Objectives of the Study

About the PKH program

Government of Indonesia launched the *Program Keluarga Harapan* (PKH/Family Hope Program) as a conditional cash transfer program for the poorest segments of the society in 2007. PKH is envisaged to provide welfare to the poor families by aiding household consumption in the short term while in the medium term create changes in beneficiaries' behavior in accessing health, education and social welfare services to produce a healthier and smarter generation.

Through PKH, beneficiaries are encouraged to utilize basic public services such as government health facilities and health services offered in these facilities such as immunization, infant health checks, public schools, elderly/disability care centers, including accessing various other social protection programs that are complementary. PKH is seen as a fulcrum for poverty reduction that synergizes various national protection and social protection programs.

The government of Indonesia has expanded the outreach of PKH program over the years and till 2018 the program is now available in all 34 of Indonesia's provinces with a coverage of 10 million families in 2018. At the time of launch in 2007, the program was given out in only seven provinces to just under half a million families.

Program Eligibility and Conditions

To be eligible for PKH, families must be in the bottom 15 percentile as per the UDB database of the government of Indonesia. In addition, families must have at least one family member who is: a pregnant/lactating mother, a pre-school age child (under 6 years old) or school-age child (up to Senior High School), an elderly or a person with a severe disability. The conditions to receive the PKH benefit amount are as follows:

- Pregnant/lactating mother should visit Puskesmas (Pusat Kesehatan Masyarakat/Community Health Center) 4 times
- Infants (0-12 months) must take complete basic vaccination at *Posyandu* (Pos Pelayanan Terpadu/Integrated Health Post) or Puskesmas
- Pre-school age (1-6 years) children must be brought to *Posyandu* (Pos Pelayanan Terpadu/Integrated Health Post) or Puskesmas for growth monitoring and nutrition supplementation and complementary vaccination
- School-age children must have monthly attendance rate of at least 85% at schools
- Elderly and severely disabled persons must participate in social welfare activities and also visit local government health centers for regular health checkups.

PKH program process

PKH program has built a network of facilitators (front line staff) who are tasked with doing compliance checks of the beneficiaries on the program conditions. In addition, facilitators are also responsible to conduct Family development sessions (FDS) through monthly group meetings of beneficiaries wherein

awareness and advice is given to beneficiaries on a series of topics including: benefits of complying with PKH conditions, managing household finances and general nurturing and caring for children. For the identification of the beneficiaries the PKH program uses the Unified Beneficiary Database (UDB) which has been created as a repository of all beneficiaries of all the social protection programs in Indonesia.

The program facilitators visit the beneficiaries, local health centers and local schools to check on the compliance of beneficiaries. The data is filled manually every month in pre-designed forms and submitted to the regional MoSA team to be filled into the MIS of the program. The benefit amount is paid to the beneficiaries once a quarter, based on their performance in meeting the conditions in the preceding 3 months. Till 2016, the benefit amount was paid in cash through the Indonesian post office network. From 2017 onwards the benefit amount is transferred directly to the bank accounts of the beneficiaries. Four government owned banks (Bank BRI, Bank Mandiri, Bank BNI and Bank BTN) are involved in the distribution of the PKH amount through their ATM networks, branchless banking (Laku Pandai) agent network and bank branches.

The program has also undergone other changes over the years. When the program was launched in 2007, the benefit amount varied from IDR 600,000 to IDR 2.2 million per family per year as per the number of eligibility conditions that each family fulfilled. In 2016, this was changed and each family received a fixed amount of either IDR 1.8 million (for mothers and children) or IDR 2 million (in case of elderly and disabled). This has been changed back to a non-fixed method from January 2019. PKH will consist of Fixed Assistance (*Bantuan Tetap*) and Component Assistance (*Bantuan Komponen*) and each family can now get benefit ranging from IDR 2 million to 10 million per year based on the number of specified conditions.

Learnings from past evaluations of PKH program

World Bank and TNP2K did a comprehensive Randomized Control Trial (RCT) of the PKH program over a six year period. The baseline data was collected in 2007 followed by a mid-line in 2010 and an end-line in 2013. The evaluation found that PKH was effective in improving the overall welfare of beneficiary households. The average monthly expenditure increased by 4.8 % and they used this additional income to increase non -food expenditure (12.2 % increase in monthly family non-food expenditure) especially on education costs (15.4 % increase in monthly education expenses). There were no significant improvement in monthly food and health expenditure. PKH was also found to have a positive impact on helping beneficiaries improve their health seeking behavior. These include mothers from beneficiary households completing four ante natal visits (treatment group 7.1 % more likely to make visits than comparison group), deliveries in health facilities, deliveries assisted by medical staff (midwives or doctors), completing the recommended two post-natal visits, weight monitoring for children (0- 5 year olds), complete basic immunization (7.7 % more likely to get on-schedule and complete immunization), treated their children for diarrhea. However, beneficiary did not demonstrate increased usage of recommended vitamins (vitamin A for children). The evaluation also showed that PKH had little impact on changing education behaviors. For children from beneficiary households who were already in school, the program helped to increase the time they spent in school.

The last phase of the RCT data collection done by TNP2K in 2013, was analyzed by Cahyadi et. all (2018) in their paper. This paper mentioned that PKH continued to have large static incentive effects on many

of the targeted indicators, including childbirth assisted by a skilled birth attendant (doctor or midwife), delivery at health facility, complete basic immunization, school enrolment for children age of 7 - 15, and child labor (wage labor for 13-15 year olds). As long term impacts on outcomes that may require cumulative investments, this survey was able to observe large reductions in stunting (reduction of stunting 2.7% among treatment group) and some evidence of increased high school completion rates.

Nazara and Rahayu (2013) in their research paper mention that Bappenas made an early attempt in 2009 to measure the behavior PKH faced a challenge of improving women's position in the households and community. Generally, mothers are monitored for compliance with the conditions imposed by conditional cash transfer, thereby reinforcing women's role as primary care givers for children. At the same time there is also an adverse gender impact associated with the provision of funds to women since women's role is largely confined to 'servicing the needs of others', especially their children. This research also argues that PKH can empower women, but it has potential risk of becoming a burden for women in chronically poor households due to the number of conditions they must fulfil, and make women return to their original roles that are only concerned with domestic affairs. While our current study did not focus on the impact of women due to PKH, this is a potential future area of research. SMERU's baseline study of PKH found that associated school expenses such as transportation, books, students' exercise sheets, school equipment, uniforms and snack money are a burden for parents in sending their children to school. Financial difficulties in meeting the cost of school education have contributed to a high school dropout rate, and low higher education rate.

Research by Hadna, Agus and Dyah (2016), investigated the influence of PKH in Indonesia, on the academic performance of poor students in elementary and junior high school. The academic performance of students who received PKH assistance were measured through three parameters, namely student enrolment (participation), student attendance, and students' grades in class subjects. PKH has a positive effect in terms of increase in the primary school student attendance rate and the junior high school student enrolment rate (13-15 years). However, PKH has showed no significant relationship with the enrolment rate of primary school and attendance rate among junior high school students. At the junior high school level, grades in three subjects, namely Bahasa Indonesia, English, and Mathematics, show a significant increase that can be attributed to PKH. Despite the above positive impacts, PKH has not helped alleviate some key problems that parents perceive as equally important in improving the quality of education service including high rates of teacher absenteeism and poor quality school facilities. These two factors are perceived as undermining the quality of students' academic performance. The public perceives these factors as causes for concern, and as such urgent resolution is required if the government is serious in its efforts to enhance students' academic performance.

Objectives of the Evaluation

Government of Indonesia has changed the payment method for PKH from cash to account transfer in 2016 and increased the number of beneficiaries up to 10 million by the end of 2018. After the RCT end-line study by TNP2K/World Bank in 2013, there has been no other large scale program evaluation or impact evaluation conducted on the PKH program. The Ministry wanted an update on the impact on key welfare, health and education indicators and also understand the feedback of the new bank account transfer process from the beneficiaries. With this background, MoSA requested MSC to do an impact evaluation of the outcomes of PKH and also to look at effectiveness of key operational processes.

In consultation with MoSA, MSC identified the following core objectives of the study:

- To evaluate the implementation of PKH digitalization, especially from the perspective of beneficiaries (Keluarga Penerima Manfaat/ KPM) and identify important operational issues - if any
- To provide an overview of beneficiaries behaviors on health seeking, education and social welfare
- To measure the outcomes of PKH program on indicators related to health, education and social welfare in terms of behavior change

This report focusses on the objectives 2 and 3 above. The operations and process evaluation results are compiled in a separate report. (Please see the link to the report here).

Research Methodology

The evaluation used a mixed-methods approach to provide an assessment of the impact of the PKH on its beneficiaries across a range of impact areas and their indicators as listed in Table 2. The indicators of the area of impact and methods employed in the evaluation were finalized in coordination with MoSA during the inception phase of the evaluation.

PKH Indicators Analyzed

Table 2: PKH commitment indicators analyzed in this study

Area of Impact	Indicator
Consumption expenditures	<ul style="list-style-type: none"> • Total monthly expenditure • Per adult equivalent expenditure on food • Per adult equivalent expenditure on non-food • Per adult equivalent expenditure on education • Per adult equivalent expenditure on health • Per adult equivalent expenditure on alcohol • Per adult equivalent expenditure on cigarette
Health seeking behavior of pregnant women and lactating mothers	<ul style="list-style-type: none"> • Percentage of Ante Natal Care (ANC) visit to health facility: 4 visits and above • Percentage of Post Natal Care (PNC) visit for mothers (within 1 - 42 days after delivery): 4 visits and above • Percentage of Post Natal Visit (ANC) for baby (1 - 30 days): 3 visits and above • Percentage of babies delivered in a government health facility or in a mid-wife's facility • Percentage of assisted delivery by a doctor or midwife
Health seeking behavior for babies (0 - 11 months)	<ul style="list-style-type: none"> • Percentage of Post Natal Care (PNC) visits for baby (1 - 30 days): 4 visit above • Percentage of children who received complete basic immunization • Percentage of children who received weight check every month • Percentage of children who received height check every month • Percentage of children who undertake development monitoring check two times per year

	<ul style="list-style-type: none"> Percentage of children who received vitamin A supplement one time per year for baby of age 6 - 11 months
Health seeking behavior of children (1 until ≤ 6 years old)	<ul style="list-style-type: none"> Children of age 1 until ≤ 5 years old: <ul style="list-style-type: none"> Percentage of children who received complementary immunization Percentage of children who received weight check every month Percentage of children who received height check two times per year Percentage of children who received vitamin A supplement two times per year Children of age 5 until ≤ 6 years old: <ul style="list-style-type: none"> Percentage of children who got their weight, height, and development monitoring checked minimum two times per year
Education behavior for school age children (6 - 21 years old)	<ul style="list-style-type: none"> Percentage of children who dropped out from school before completion of 12 years of education Percentage of children with special academic/extracurricular achievement
Social welfare for elderly (above 60 years old) and severe disability	<ul style="list-style-type: none"> Percentage of elderly who participate in day care services Percentage of elderly who visit government facility to get their health checks done

The principal evaluation questions were analyzed using a household survey targeted at beneficiary households and non-beneficiary households with poverty scores just close to the program's eligibility threshold. The comparison between beneficiary and non-beneficiary households with poverty scores close to the program's eligibility threshold provides impact of the PKH program on key outcomes. This was supplemented by a qualitative research that included in-depth interviews with beneficiaries and PKH facilitators. The qualitative data collected from beneficiaries and facilitators not only help to explain the findings of quantitative survey but also provide information on potential impacts that are difficult to gauge using quantitative survey.

Eligibility Criteria used by PKH

PKH targets families classified as extremely poor by National statistics agency of Indonesia (Badan Pusat Statistik (BPS)) using both economic and asset-based poverty measurements. An extremely poor household is defined by BPS as one whose living conditions are inadequate, whereby a large portion of their income is used for basic staple food consumption and they are unable to afford medical treatment except at the community health clinics or other public health facilities subsidized by the government. They are also unable to buy clothing once a year, cannot afford to send their children to school or can afford schooling for their children only until junior high school.

To create the initial beneficiary roster at the start of the program, BPS first surveyed poor and extremely poor households which were drawn from the 2005 BLT beneficiaries list (known as PPLS05). Approximately 30 to 40 % of BLT beneficiaries were not included in the resulting roster. To minimize exclusion errors they also conducted "sweepings" in targeted sub-districts, which involved interviewing poor households

with the intent to identify newly poor households that were excluded in PPLS05. However, the sweeping exercise was limited and resulted in the addition of approximately 5 % of households to the PPLS05 list. The agency then applied a proxy-means test (PMT) to all poor households to identify the extremely poor households targeted by PKH. The PMT consists of 29 variables including housing characteristics, educational attainment, fuel sources, type of employment and access to health and education services. From this pool of households, BPS used health and education survey data to demographically screen households on the roster and identified eligible household that met program criteria:

- Households with pregnant and/or lactating women
- Households with children aged 0-15 years
- Households with children aged 16-18 years who have not yet completed 9 years of basic education

BPS delivered the list of eligible and poor households to the implementing agency (i.e., Ministry of Social Affairs) responsible for finalizing and approving the PKH beneficiary list. To carry out this responsibility, the PKH Implementation Unit (UPPKH) conducted a series of assemblies to review the data with the potential PKH candidate households and approved the final PKH beneficiary list. Originally the program was designed to only include “very poor” households. Additional resources became available later to include a small percentage of households that were identified as “poor”. Not all eligible poor households, however, were included in the pilot program. A cut-off point was established and PKH benefits were then rationed to eligible poor households who were closer to the bottom end of the consumption distribution. This method was replaced for subsequent expansion of the program by adopting the Unified Beneficiary Database (UDB). The UDB also uses a proxy means test that analyses household conditions like housing, asset ownership, expenditure etc. and gives a percentile score to each family in the bottom 40% of the population. Periodic surveys are done to validate the existing data and update the UDB.

Methodology for Quantitative Research

The gold standard for evaluating the impact of social programs is a Randomized Control Trial (RCT). However, RCT was not possible in this evaluation as the program is being implemented nationally for some years now and random assignment of households to treatment and control group was not possible at this stage. Therefore, we adopted a quasi-experimental approach and compared the outcomes of program beneficiaries with those of non-beneficiaries. A key challenge of quasi-experimental designs is the identification of a suitable counterfactual or comparison group against which to compare the results of treatment group. We employed a modified version of Regression Discontinuity Design (RDD) to meet this challenge.

This study uses the percentile scores data compiled by Unified Beneficiary Database of the Government of Indonesia. PKH beneficiaries have their program eligibility determined by a percentile score (that indicates poverty level) such that support is offered only to lowest 15 % households. We assumed a continuous relationship between the eligibility score and the outcome variable and used the eligibility cut-off to define valid treatment and comparison groups. This evaluation compares households falling in 11th to 15th percentile of poverty score (treatment group) with households falling in 16th to 20th percentile of poverty score (comparison group). For indicators on which the PKH does not have an impact, we expect no difference between households in treatment and control groups. Alternatively, for

indicators on which the PKH has an impact, we expect a difference between households in treatment and control groups.

This study compares the means and proportions of treatment and comparison groups to see the difference between the two groups. To account for household size and composition, all monetary variables (expenditure and income) were compared across two groups after conversion into per adult equivalence.¹ To test the significance of the difference between two groups, we applied a t-test or z-test. To further, isolate the impact of PKH on key outcome indicators, we ran a regression analysis taking the outcome indicator as dependent variable and type of household (beneficiary vs. non-beneficiary) as independent variable. All household level characteristics, head of family or mothers (whichever was more relevant) education and employment status, location (districts) were used as control variables in regression.

When the dependent variable was continuous (e.g., expenditure), we used Ordinary Least Squares (OLS) regression to estimate Log-Level models; where coefficient of independent variables can be interpreted as average percentage change in dependent variable. Where the dependent variable was dichotomous in nature (e.g., delivered a baby in government hospital or otherwise), we applied a logit regression and present the marginal effects which can be interpreted as percentage change in likelihood of dependent variable.

Limitations of the Study

The quantitative approach adopted in the evaluation has the following limitations:

- **Underestimation of impact:** The design assumed that a sharp eligibility cut-off is followed while providing PKH support which means that actual treatment status should perfectly match the eligibility of a family i.e. a family that is determined as eligible for PKH should actually become a beneficiary and a family that is determined as ineligible for the PKH should not become a beneficiary. However, we find in Unified Beneficiary Database, that it is not the case. Quite a few families falling in lowest 15% on poverty score have not received the program. Similarly, quite a few families falling above the cut-off received the program.² This fuzziness could result in underestimation of the program impact.
- **Weak external validity:** Since beneficiary and non-beneficiary households in a small band around the program eligibility cut-off are compared (i.e., 11th to 20th percentile), the estimate of impact is a Local Average Treatment Effect (LATE). This means that whilst the design adopted in the evaluation has strong internal validity, it has weaker external validity, in terms of its applicability to families further away from the eligibility threshold.

¹ A weight of 1 was assigned to each adult (18 years or above of age) and a weight of 0.8 was assigned to each child (less than 18 years of age) to compute adult equivalence i.e., $AE = \text{No. of Adult Members} + 0.8 * \text{No. of Children}$.

² This is pertinent to mention here that, during the field work, we did not find a single household that was listed as beneficiary in the database and was not receiving the program. Similarly, we did not find a single household who was listed as non-beneficiary in the data base and was receiving the program. This boost the confidence in database available in ministry.

Sampling for Quantitative Household Survey

A complex multi-stage stratified random sampling approach was adopted to collect the sample of 1,400 beneficiary and 1,400 non-beneficiary families. This sample size is large enough to detect a difference of 8 percentage points between the two groups with 95% confidence and 80% power of test. In order to gauge a difference of 8 percentage points between the treatment and comparison groups, a basic sample size of 608 households in each group was required. After making continuity correction and adjusting it for non-response rate of 10%, the sample size increased to 696 households from each group. As cluster sampling approach was used for the selection of families instead of simple random sampling, an additional family from the same cluster will add less new information than would a completely independent selection. To adjust the sample for effect of clustering, the required sample was raised by two times to 1400 households from each intervention and comparison group.

In the first stage of sampling, from 3 specified geographic regions, 15 provinces were selected using simple random sampling. These selected provinces are North Sumatera, West Sumatera, Kepulauan Riau, West Kalimantan, East Kalimantan, DKI Jakarta, Banten, West Java, Central Java, East Java, North Sulawesi, Maluku, North Maluku, East Nusa Tenggara, and Papua. In the second stage of sampling, from each selected province, two districts were selected again with simple random sampling. In the third stage, from each selected district, two sub-districts were selected. From the 60 sampled sub-districts, a list of 233 villages was created with at least 6 beneficiary and 6 non-beneficiary families in each village and survey was conducted in all such villages at the fourth-stage of sampling. In the last stage, from each sampled village, equal number of beneficiary (treatment group) and non-beneficiary (comparison group) families were selected randomly. (Please see Annex 1 for detailed methodology and sampling)

Interpretation of Results

The results of the quantitative household survey are presented in the Results and Discussion section. The format for presenting the results is illustrated in table 3. The following estimates are presented:

- Mean values of the outcome indicator for treatment and comparison group in case of continuous variable (for example, expenditure or income) and proportion of favorable outcome or outcome indicator for treatment and comparison group in case of binary variable (for example, delivery at government facility).
- In the case of a continuous dependent variable, we estimated Log-Level model using OLS.³ In Log-Level model, we presented coefficients multiplied by 100 which can be interpreted as average percentage change in dependent variable with unit change in independent variable.
- In the case of a dichotomous dependent variable, marginal effects estimated from Logit regression are presented. These are isolated impacts of PKH after controlling for other variables.
- We used (*) to show the statistical significance of results.

³ In Log-Level models, we take natural log of dependent variable and independent variables are used in their original form.

Table 3: Format for presenting the results

Indicator	Treatment Sample (Mean or proportion)	Comparison Sample (Mean or proportion)	Impact (%)
Indicator 1	83.33	78.40	2.91**

Statistically significant at *** $p < 0.01$, ** $p < 0.05$, * $p < 0.1$

Methodology for Qualitative Research

To complement the findings of the quantitative household survey, the evaluation also conducted In-Depth Interviews (IDI) with beneficiaries and PKH facilitators. The objectives of the IDIs were to understand the PKH beneficiaries' behavior and perceptions on the health, education and welfare conditions and to understand PKH facilitator's view on PKH program processes and beneficiaries' behavior. 24 IDIs (18 with beneficiaries and 6 with PKH facilitators) were conducted in six provinces. The six provinces selected for IDIs were Kepulauan Riau, West Kalimantan, Banten, East Java, Maluku, and East Nusa Tenggara. Two PKH Akses sub-districts were chosen from Kepulauan Riau and Maluku. Akses are regions which have major challenges in geographical outreach, and availability of infrastructure and human resources. In these regions the benefit amount per family is more than that of non-Akses regions at a flat IDR 2 million per family per year.

The beneficiaries were selected based on criteria of key PKH components and included a mix of beneficiaries such as lactating women, families with children under 3 years of age, school age children, and elderly. PKH facilitators for IDIs were chosen from the list of PKH facilitators in the selected sub-district for quantitative study. We included a combination of experienced and newly joined PKH facilitators.

Results and Discussions

Impact on Household Expenditures

The PKH cash transfers can be used in a variety of ways including consumption on food, non-food items as well as debt payments and savings. In terms of family's average monthly expenditure on food and non-food items per adult-equivalence, PKH has significant positive impact. After controlling for other household level characteristics, PKH beneficiaries' monthly expenses per adult equivalence are 3.84% higher than non- beneficiaries.

Study did not find any significant impact of PKH on average monthly food expenditures per adult-equivalence of beneficiaries. However, the PKH beneficiaries' monthly expenses per adult-equivalence on rice are around 4.00% higher than non- beneficiaries. The negative difference is observed on beneficiaries' monthly expenses per adult-equivalence on other staples (8.00%) and processed meat (8.80%). There are some concerns within government stakeholders that the PKH cash transfers are used by beneficiaries to buy alcohol and tobacco. The study did find that beneficiaries consume more cigarettes than non-beneficiaries, however the results are not significantly different.

When it comes to non-food expenditures, PKH beneficiaries spend 11.80% higher on non-food expenditures than non-beneficiaries. On other non-food expenses, no impact of PKH is observed.

Table 4: Impact on family expenditures

Indicator	Treatment Sample	Comparison Sample	Impact (%)
Average family expenditure per adult equivalent	511.49	565.32	3.84**
Average family food expenditure per adult equivalent	306.69	349.52	2.67
Average family non-food expenditure per adult equivalent	259.3	251.88	11.8***
Average family food expenditure per adult equivalence on			
Grains : Rice	76.4	85.51	3.95**
Grains : Others staples	6.36	7.99	-7.99*
Alcoholic beverages	0.29	0.18	-51.8
Cigarette	54.2	60.64	-5.36
Tobacco, betel, areca nut	1.25	1.92	7.5
Average family non-food expenditure per adult equivalence on			
Health expenditure.	6.47	10.82	-15.5
Education expenditure- Up to high school	74.91	35.39	0.633
Education expenditure- Above high school	7.08	6.23	-19.1

Statistically significant at *** $p < 0.01$, ** $p < 0.05$, * $p < 0.1$

Impact on Health Outcomes

PKH cash transfer has significant positive impact on delivery at government facility and deliveries assisted by doctor or midwife. After controlling for other household and personal level characteristics, PKH beneficiaries are 12.10% more likely to deliver a child in a government health facility compared to non-beneficiaries. Similarly PKH beneficiaries are 13.8 % more likely to be assisted by doctors or midwives during deliveries as compared to non-beneficiaries.

This study did not find significant difference between beneficiaries and non-beneficiaries on the Ante Natal Care (ANC) and Post Natal Care (PNC) behaviors. PNC visits both by mothers and babies are less frequent as compared to ANC visits. People believe that ANC visits are more critical because they are not sure about the well-being of the baby as they cannot physically see the condition of the baby before delivery. The Integrated Health Post cadre (Kader Posyandu) play a critical role in encouraging pregnant women, and mothers of infants and toddlers to attend monthly health check-ups. Kader Posyandu has a

big role to support Posyandu in providing health information to community, motivate community to come to Posyandu for health check and implement a clean and healthy life style. (Ministry of Health, 2012)

Table 5: Impact on maternal health outcomes

Indicator	Treatment Sample	Comparison Sample	Impact (%)
Proportion of women who had 4 or more ANC visits before delivery	83.33	78.40	2.91
Proportion of women who delivered their children in a Government health facility	56.57	43.05	12.1***
Proportion of delivery assisted by doctor or midwife	94.86	81.43	0.138***
Proportion of women who did 3 or more health check-ups for their child within one month of delivery	24.53	21.60	2.35

Statistically significant at *** $p < 0.01$, ** $p < 0.05$, * $p < 0.1$

PKH has positive significant impact on complete basic immunization (Refer to Table 6). Children belonging to PKH beneficiary families are 17.00% more likely to receive complete basic immunization compared to children belonging to non-beneficiary families. PKH program also show significant positive impact on the beneficiaries in the uptake of HB-0, Polio 3, Polio 4 and Measles vaccinations. Beneficiaries generally believe immunization is good for their babies and we feel this positive perception is due to the counselling given by midwives/Kader Posyandu during ANC and PNC visits.

The major reason for missing vaccination is children being sick on the scheduled vaccination date. Only few respondents (mostly non-beneficiaries) mentioned about ill-effects of vaccination and vaccines not being halal as the reasons for not getting their children vaccinated. None of the PKH beneficiaries mentioned halal as being an issue for not doing vaccinations.

Table 6: Impact on child immunization outcomes

Indicator	Treatment Sample	Comparison Sample	Impact (%)
Proportion of children who received complete basic immunization	71.13	49.06	17.0***
Proportion of children who received HB0 vaccination	91.55	82.08	11.4**
Proportion of children who received BCG vaccination	95.77	93.40	4.32
Proportion of children who received DPT-HB1 vaccination	90.85	86.79	4.28
Proportion of children who received DPT-HB2 vaccination	84.51	75.47	4.96
Proportion of children who received DPT-HB3 vaccination	80.28	69.81	5.75
Proportion of children who received Polio1 vaccination	90.85	83.02	5.03

Proportion of children who received Polio2 vaccination	84.51	74.53	6.89
Proportion of children who received Polio3 vaccination	79.58	65.09	10.3*
Proportion of children who received Polio4 vaccination	77.46	62.26	11.7**
Proportion of children who received Measles vaccination	82.39	65.09	16.4***

Statistically significant at *** $p < 0.01$, ** $p < 0.05$, * $p < 0.1$

Table 7 presents the coverage of complementary immunization among children in the age group of one to five years old. For children above one year old, the coverage of Measles-Rubella (MR) and Hepatitis-A vaccination was better among PKH-beneficiaries compared to non-beneficiaries. Qualitative interviews show that higher proportion of coverage for MR vaccination is due to the intense campaign on MR immunization run by the Government of Indonesia in 2018.

Table 7: Impact on child immunization (1-5 years)

Indicator	Treatment Sample	Comparison Sample	Impact (%)
Proportion of children (1-5 years) who received MR vaccination	70.57	61.31	7.74*
Proportion of children (1-5 years) who received Pneumococcus vaccination	39.36	38.10	1.03
Proportion of children (1-5 years) who received Hepatitis A vaccination	63.12	55.36	5.23
Proportion of children (1-5 years) who received Varicella vaccination	36.17	36.31	-2.59
Proportion of children (1-5 years) who received Influenza vaccination	39.72	35.71	1.17
Proportion of children (1-5 years) who received HPV vaccination	30.14	27.98	-0.442

We did not find any difference on most of the indicators related to child growth and development monitoring across all age groups (0-11 months, 1-5 years and 5-6 years). The only significant positive impact is on regular weight monitoring of children belonging to 0-11 month's age group. Among PKH beneficiaries, the compliance for regular child growth monitoring was better among children less than one year old compared to children between 1-6 years old. A common practice of parents' in Indonesia is to focus on checking their children's weight because they believe weight shows the child's health condition rather than height and development monitoring. As long as their children have a proper weight according to their age, parents are assured that their children are healthy.

Table 8: Impact on child health monitoring outcomes

Indicator	Treatment Sample	Comparison Sample	Impact (%)
Proportion of children (0-11 months old) whose weight is regularly monitored	96.30	78.38	20.9**
Proportion of children (0-11 months old) whose height is regularly monitored	74.07	59.46	14.9
Proportion of children (0-11 months old) who received child development monitoring process regularly	51.85	48.65	-2.00
Proportion of children (1-5 years old) whose weight is regularly monitored	85.70	84.20	1.71
Proportion of children (1-5 years old) whose height is regularly monitored	71.83	69.81	0.390
Proportion of children (1-5 years old) who received child development monitoring process regularly	47.62	45.91	-4.35
Proportion of children (5-6 years old) whose weight is regularly monitored	59.30	62.90	-3.64
Proportion of children (5-6 years old) whose height is regularly monitored	53.44	47.41	6.51
Proportion of children (5-6 years old) who received child development monitoring process regularly	32.80	26.72	6.30

Statistically significant at *** $p < 0.01$, ** $p < 0.05$, * $p < 0.1$

This study also finds significant positive impact of PKH on other health indicators that are not directly related to the program. PKH beneficiaries are 8.40% more likely to use modern methods of contraception compared to non-beneficiaries. The beneficiaries realize the importance of family planning even though it is not mandated by PKH. Some beneficiaries mentioned that they are already overwhelmed with the education expenses of their existing children, and they do not want to add more children to increase the burden of expenditure.

PKH beneficiaries are 5.80% more likely to have national health insurance card (BPJS/Badan Penyelenggara Jaminan Sosial card) compared to non-beneficiaries. PKH facilitators play a positive role in this as they help beneficiaries in registering their family members for BPJS.

Table 9: Impact on other health outcomes

Indicator	Treatment Sample	Comparison Sample	Impact (%)
Proportion of couples using any of the modern methods of contraceptives	47.50	25.90	8.41***
Proportion of families having BPJS card	88.10	82.70	5.78***

Statistically significant at *** $p < 0.01$, ** $p < 0.05$, * $p < 0.1$

Impact on Education Outcomes

This study does not find any significant impacts of PKH program on school drop-out rates. Only 0.95 % of beneficiaries' children and 0.76 % of non-beneficiaries have dropped out showing very few actual drop outs happening. 78% children of PKH beneficiaries who are of school going age attend school regularly. The proportion is same for children of non-beneficiaries. The main reasons for children not going to school regularly among both groups are illness to children and unwillingness to go to school. One interesting finding is that children of PKH beneficiaries are 2.30% more likely to have academic/extracurricular achievement compared to children of non-beneficiaries. There are no special programs directed towards beneficiary children by MoSA. So we cannot conclude the reason for the positive difference. A more focused study on PKH beneficiaries children's might help to explain this phenomenon.

Table 10: Impact on education outcomes

Indicator	Treatment Sample	Comparison Sample	Impact (%)
School drop-out rate	0.95	0.76	0.10
Academic/extracurricular achievement	10.36	8.01	2.28**

Statistically significant at *** $p < 0.01$, ** $p < 0.05$, * $p < 0.1$

Impact on Social Welfare of Elderly and Disabled

We find that the elderly PKH beneficiaries are 8.87 % more likely to visit a health center to get health check-ups. However, the number of elderly going for medical checks ups is quite low (only 35%) of the beneficiaries go for health checks. Typically elderly go for health checks only after the incidence of any health issue. Also, some elderly feel embarrassed to go for health checks at Posyandu's where they have to wait with babies and pregnant women. This study is not able to conclude anything on the impact of PKH on beneficiaries who are severely disabled since the sample was very low.

Table 11: Impact on elderly

Indicator	Treatment Sample	Comparison Sample	Impact (%)
Visits of Elderly for health check ups	35	26	8.87***

Statistically significant at *** $p < 0.01$, ** $p < 0.05$, * $p < 0.1$

Conclusion and Recommendation

Conclusion

The PKH program has completed 12 years of its existence and it continues to create a positive impact on key welfare, health and education indicators of the poor segments of the society.

Welfare Indicators

On monthly family expenditure we do find conclusive evidence that PKH has resulted in a significant increase in non-food expenditure (11.20 %). This is in line with the RCT results of World Bank and TNP2K. However, the impact on monthly expenditure on education is not significant while the RCT results showed a significant increase of 15.10% for the treatment group as compared to Comparison group. There are two potential reasons to explain this phenomenon. First, since this study only targeted respondents who are between 11 to 20 percentile and hence quite similar in terms of socio-economic profile, the impact within this small segment might be muted and the impact might be more for beneficiaries with percentile scores of less than 10. The second factor is the launch of the Program Indonesia Pintar (PIP) in 2014. This program provides cash transfer to the bottom 40% of the population to take care of education related expenses including school fees, buying school equipment, dresses etc. Since both the treatment and control group are eligible for PIP it might explain some part of the low impact in education expenditure among PKH beneficiaries.

While our study shows that there is a positive but not a significant impact on the food expenditure of the families which is in line with the TNP2K/World Bank RCT. However, our study does show a positive impact on purchase of rice which is a staple for majority of Indonesians. One cause of concern is the finding on the expenditure of tobacco and cigarettes which our study shows is higher (though not significant) than non-beneficiaries.

Health Indicators

Our study finds significantly higher use by PKH beneficiaries (treatment group) of government health facilities and/or trained mid-wives' facilities for deliveries as compared with non-beneficiaries (control group). Similarly, presence/supervision of a qualified doctor, nurse or trained mid-wife was significantly higher for deliveries of treatment group as compared with the control group.

On health indicators such as ante natal and post natal care visits to health centres there is an insignificant difference between treatment and control, especially on meeting the standard of minimum 4 visits. Majority of both the beneficiaries and non-beneficiaries are diligent in doing ante natal visits of a minimum of 4 times since there is a genuine concern for families to know the well-being of the unborn child. Post natal checks has shown some interesting behavior, there is a significant difference in post natal visits by mothers in the treatment group who make at least 1 visit to the health center which shows that PKH does nudge mothers to make more post natal visits as compared to non-beneficiaries. In general, post natal visits are made by mothers only when they see the child is not doing well. They feel there is no need to make the effort or spend time to make a health check-up visit when the child is doing fine.

On child development monitoring, weight checks for babies (0-11 months old) are significantly higher for the treatment group than the control group. Height checks and development monitoring are not done regularly and there is no significant difference on these parameters across both groups. This might be partly due to supply side issues since not all *Posyandus* do these checks regularly unless specifically asked for. Similarly, height monitoring for babies requires special equipment which might not be available in all the *Posyandus*. The practice to monitor child development (including height, weight and other development) reduces for children in the age group of 1- 5 years. This is similar to doing post natal checks, people visit health centers only if they feel the child is sick or if there are any visible issues in the development of child.

On immunization for children we find significant positive impact for on schedule complete basic immunization for the treatment group as compared with control group. This is again in line with the RCT results in 2013. For complementary basic immunization too we find significantly higher difference for the treatment as compared to the control showing that PKH has created a positive impact for children's immunization. We also found that issues of culture and religion are not playing a major role to reduce access to children's immunization at least in our study sample and geographic regions.

The study did find some positive spillover effects in terms of increase usage of family planning and increased coverage of BPJS among the treatment group as compared with the control group. These effects are due to the positive role being played by the PKH facilitators through family development sessions and being the go to persons in the field for any health related queries. We found instances of facilitators helping families to fill the BPJS registration forms for family members and also guiding the families on how to enroll new family members into BPJS.

Education Indicators

The study did not find any significant difference in drop outs between the beneficiaries and non-beneficiaries. The low levels of drop outs can be due to a combination of social assistance programs like PKH, PIP and improvement of public education services.

The study did not seek to measure the attendance of the children in terms of percentage of schools days of attendance. We did ask beneficiaries if in the last one month did the children skip school and this was not significantly different for beneficiaries and non-beneficiaries children. Also this study did not measure the school transition rates.

The study however finds a significant positive difference in terms of the special achievement of beneficiaries' children in school as compared to non-beneficiaries. As explained in earlier section, a more focused study on the education behavior of beneficiary children can throw some light on the reasons for this positive impact.

Social Welfare of Elderly and Disabled

Our study finds that elderly beneficiaries of PKH visit government health centers for check-ups more frequently than non-beneficiaries. However, there is a general reluctance for elderly people to visit health centers especially if they feel they are not sick. Also some elderly beneficiaries are not

comfortable to visit government health centers as they are embarrassed in front of women. Other social welfare activities are not happening in most places so the participation of the elderly PKH beneficiaries is not significantly different from non-beneficiaries. Also, the PKH program guidelines have not clearly articulated the sort of health checks that the elderly need to do at the health care facility.

The number of sample of beneficiaries or non-beneficiaries with severe disability was very low to make any conclusive analysis. However, one of the key commitment indicators for elderly and disabled is to participate in day care services. The supply side infrastructure for the day care is not available in a number of regions. In the absence of such infrastructure, having these PKH indicators may not lead to positive outcomes.

Recommendations

While there are a number of positive impact outcomes due to PKH, we feel that there a number of potential improvements which can be considered by MoSA to enhance the achievements of the program.

Strengthening compliance monitoring, imposing sanctions while also improving awareness on some commitment indicators

As mentioned earlier, the compliance of beneficiaries is low on indicators such as 4 visits for ANC, 3 visits for PNC, Child health and development monitoring. MoSA can adopt a twin strategy of ensuring stricter compliance, effectively using sanctions on these indicators while at the same time increasing efforts to improve the awareness of the beneficiaries on the importance of making these the specified number of visits to the health center. MoSA can also look deeper into identifying and quantifying any supply side issues prevailing in the local posyandus that may be preventing the access to these services.

Digitizing field data collection to expedite data collection and more accurate analysis

Digitizing the compliance data collection through initiatives like e-PKH will help in timely data collection, compilation and analysis. Ensuring faster analysis of this data and establishing sound communication protocols to transparently communicate the findings of the, needs to be looked into as well so that corrective decisions can be taken quickly by MoSA.

Exploring opportunities to integrate data with that of Ministry of Health and Ministry of Education

PKH facilitators collect data on compliance with health and education conditions by visiting the local primary health centers or the local schools. There is a duplication of effort here, since the data that MoSA requires is already being captured by other government agencies. Digitizing of the data entry by the government health centers and schools and integration of the databases of the line ministries of education and health with that of MoSA to track the shared indicators can bring in greater efficiencies and more effective MIS for the PKH program. This will require a lot of cooperation and sharing of resources between the different line ministries but such an initiative will complement the digital governance efforts of the government of Indonesia.

Relooking at PKH impact indicators

For elderly and disabled, one of the key commitment indicators is getting regular health checks at a health care facility and to participate in the day care activities. For the health checks, it is left open as to what will be the purpose or specific health checks that needs to be done at the health center. This opens room for ambiguity. Similarly, in a number of regions the day care infrastructure is not present. MoSA can relook at the indicators for disabled and elderly and re-frame the conditions to make them less ambiguous. MoSA can also explore on adding additional health indicators which are key public health focus of Ministry of Health such as use of family planning, BPJS enrolment for all family members etc. as part of the core commitment indicators.

Areas for further study

As mentioned earlier, this study gives a snapshot of the impact of PKH program on the beneficiaries using a loosely defined comparison group. A longitudinal study with the same set of respondents will allow us to collect stronger evidence to establish attribution between PKH and improvements in program outcome indicators.

The other important area for research is to understand the effects of other complementary social assistance programs, such as *Program Indonesia Pintar (PIP)* and *Program Indonesia Sehat (PIS)* to better understand the causal effects of each program on the beneficiary families. This will need a much larger sample to detect the distinct and often confounding effects of various programs.

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Annexures

Annex I - Sampling Methodology

To evaluate the impact of the PKH on its beneficiaries across a range of impact areas, the evaluation used a survey of 1400 household each from treatment group (beneficiaries) and comparison group (non-beneficiaries) selected through multi-stage stratified random sampling from 15 provinces across the country. PKH beneficiaries have their program eligibility determined by a poverty score. Using Unified Beneficiary Database of the Government of Indonesia, evaluation defines treatment group as households whose poverty score falls within 11th to 20th percentile of poverty scores and at least one member of those households is receiving support from PKH. Similarly, evaluation defines comparison group as households whose poverty score falls within 11th to 20th percentile of poverty scores and not a single member of those households is receiving support from PKH.

Selection of sampling units at different stages

At the first stage of sampling, from different regions, 15 provinces were selected using simple random sampling. At the second stage of sampling, from each selected province, two districts were selected with simple random sampling. At the third stage, from each selected district, two sub-districts were selected with simple random sampling. Within each sampled sub-district, a list of villages with at least 6 beneficiary and 6 non-beneficiary households was generated. From the list of eligible villages, all villages were selected in the sample at the fourth-stage of sampling. In the last stage, from each sampled villages, 6 households of each type (beneficiary or treatment group, and non-beneficiary or comparison group) were selected randomly.

Sample size

In impact evaluation studies, we look for a sample size that can detect the effect of program on treatment group. There are two ways to approach that sample size. First, start from a plausible effect size, and figure out how big a sample is needed in order to be able to detect this effect with reasonable confidence and power. Second, start from the sample size that is affordable and figure out what would be the smallest true effect (known as the minimum detectable effect for a given design) that could be detected with reasonable confidence and power. In this study, we adopted the second approach. We tried for a number of option and concluded that with a sample of 1400 households from each treatment and comparison group, a difference of 8 percentage points can be detected in the value of key indicator for treatment and comparison groups with 95% confidence and 80% power of test. The following formula is used in calculation of sample size for treatment and comparison group:

$$n = \frac{\left[Z_{1-\frac{\alpha}{2}} \sqrt{2\bar{\pi}(1-\bar{\pi})} + Z_{1-\beta} \sqrt{\pi_c(1-\pi_c) + \pi_t(1-\pi_t)} \right]^2}{(\pi_c - \pi_t)^2}$$

Where $\bar{\pi}$ is the combined value of the key indicator in both groups. π_c and π_t represents values of key indicator in comparison and treatment group respectively. The α and β show the level of confidence and power of the test respectively. In order to gauge a difference of 8 percentage points in the value of key

indicator for treatment and comparison groups with 95% confidence and 80% power of test, a basic sample size of 608 households in each group was required⁴. After making continuity correction and adjusting the sample for 10% non-response, the sample size increased to 696 households from each group. As cluster sampling approach was used for the selection of households instead of simple random sampling, an additional household from the same cluster will add less new information than would a completely independent selection. To adjust the sample for the design effect (deff) of clustering, the required sample was raised by two times to 1400 households from each treatment and comparison group.

From database to sampling frame

In the Unified Beneficiary Database of the Government of Indonesia, we found there are 745531 individual records or persons listed from 678 different villages. Using address, we identified 59063 unique dwellings, of which 28198 dwelling have at least one individual receiving PKH. The remaining 30865 (59063 - 28198) dwellings, had not a single individual receiving PKH. Out of 678 villages, there were 440 villages with at least 6 households of each type (beneficiary and non-beneficiary).

By looking at the percentile value of poverty scores, we separated individual records whose percentile values lies between 11th to 20th. This left us with 167487 individual records or persons listed from 667 different villages. Using address, we identified 22766 unique dwellings, of which 12250 dwelling have at least one individual receiving PKH and this is the potential treatment group⁵. The remaining 10516 dwellings, had not a single individual receiving PKH, and this is the potential comparison group. Out of 667 villages, in 233 villages from 13 provinces we were able to find at least 6 households of each type (beneficiary and control). All of these 233 eligible villages were selected in our sample and from each of 233 villages, 6 household of each type were enumerated. For 2 provinces, where we were unable to find any village with at least 6 households of each type, we purposively selected 4 villages from each province. From each sampled village in these two provinces, we enumerated maximum equal number (less than six) of households of each type (treatment and comparison). This way we ended up enumerating 241 villages and 1444 households of each type⁶. The distribution of sample by provinces, districts, and sub-districts is given in table 10.

⁴ We assumed $\pi_c = 0.5$ and $\pi_t = 0.58$ as no data on key indicators was given by MoSA.

⁵ One dwelling may have more than one household. If a dwelling with more than one household get selected in our sample, we will interview only one household.

⁶ In achieved sample, we enumerated 1466 beneficiary households and 1437 non-beneficiary households.

Province	Kota/Kabupaten	In database				In Sampling Frame				No. of villages selected in sample
		Dwelling with at least one PKH beneficiary	Dwelling with no PKH beneficiary	Total number of villages	Eligible Villages (with at least 6 HH of each type)	Dwelling with at least one PKH beneficiary	Dwelling with no PKH beneficiary	Total number of villages	Eligible Villages (with at least 6 HH of each type)	
BANTEN	LEBAK	605	305	24	21	237	47	24	0	2*
	PANDEGLANG	656	140	25	10	262	50	25	0	2*
	Sub-Total	1261	445	49	31	499	97	49	0	4
DKI JAKARTA	KOTA JAKARTA SELATAN	1572	2807	12	12	186	762	12	10	10
	KOTA JAKARTA TIMUR	1824	4100	13	13	702	2168	13	13	13
	Sub-Total	3396	6907	25	25	888	2930	25	23	23
JAWA BARAT	BOGOR	1209	484	22	20	813	175	22	15	15
	SUMEDANG	1525	455	25	25	846	164	25	13	13
	Sub-Total	2734	939	47	45	1659	339	47	28	28
JAWA TENGAH	DEMAK	2003	1412	31	31	883	1028	31	30	30
	SEMARANG	1277	494	34	32	767	192	34	16	16
	Sub-Total	3280	1906	65	63	1650	1220	65	46	46
JAWA TIMUR	BOJONEGORO	1027	333	37	29	721	133	37	8	8
	PROBOLINGGO	1161	1218	27	27	318	493	27	16	16
	Sub-Total	2188	1551	64	56	1039	626	64	24	24
KALIMANTAN BARAT	KOTA PONTIANAK	2226	1318	11	11	1077	902	11	11	11
	LANDAK	399	286	35	10	184	205	35	7	7
	Sub-Total	2625	1604	46	21	1261	1107	46	18	18
KALIMANTAN TIMUR	KOTA BALIKPAPAN	882	2167	11	10	452	189	11	10	10
	KUTAI KARTANEGARA	607	272	22	15	319	145	22	10	10
	Sub-Total	1489	2439	33	25	771	334	33	20	20
	KARIMUN	368	268	9	9	189	38	9	3	3

KEPULAUAN RIAU	KOTA B A T A M	2084	4765	14	10	319 ⁷	709	14	7	7
	Sub-Total	2452	5033	23	19	508	747	23	10	10
MALUKU	MALUKU TENGAH	460	71	18	2	271	30	18	1	1
	SERAM BAGIAN BARAT	258	94	13	4	168	20	13	1	1
	Sub-Total	718	165	31	6	439	50	31	2	2
MALUKU UTARA	HALMAHERA BARAT	471	757	64	22	82	110	57	0	2*
	HALMAHERA UTARA	336	332	20	13	71	40	18	0	2*
	Sub-Total	807	1089	84	35	153	150	75	0	4
NUSA TENGGARA TIMUR	ALOR	366	178	15	13	96	191	15	5	5
	MANGGARAI	564	472	33	9	328	246	33	1	1
	Sub-Total	930	650	48	22	424	437	48	6	6
PAPUA	JAYAPURA	119	25	19	0	36	6	17	0	0
	KEEROM	357	270	19	10	62	242	19	5	5
	Sub-Total	476	295	38	10	98	248	36	5	5
SULAWESI UTARA	KOTA MANADO	814	415	14	14	435	132	14	11	11
	MINAHASA	232	89	22	3	95	26	22	0	0
	Sub-Total	1046	504	36	17	530	158	36	11	11
SUMATERA BARAT	KOTA PADANG	1598	1915	27	27	823	252	27	16	16
	PESISIR SELATAN	454	164	19	10	121	127	19	5	5
	Sub-Total	2052	2079	46	37	944	379	46	21	21
SUMATERA UTARA	KOTA MEDAN	2211	4909	21	18	1098	1615	21	18	18
	LANGKAT	533	350	22	10	289	79	22	1	1
	Sub-Total	2744	5259	43	28	1387	1694	43	19	19
Total		28198	30865	678	440	12250	10516	667	233	241

* Villages with less than six households of each type.

⁷ In achieved sample, we enumerated 1466 beneficiary households and 1437 non-beneficiary households.

Annex II - Quantitative Data Analysis

In analysis a sturdy local randomization between treatment and comparison groups is assumed as only households falling within 11th to 20th percentile of poverty scores were selected from both groups. After the household survey data were checked for accuracy and completeness, survey responses were coded against the definitions of the desired outcomes and other variables. The data was first analyzed using descriptive statistics related to outcomes to show the presence of any impact of PKH. Descriptive data were tested for significance using t-test for difference between means and z-tests for difference between proportions. Regression analysis was then applied for each outcome of interest to show the impact of PKH on outcome variables, while controlling for geographic (province), personal (head or mother's age, educational attainments, and employment status etc.), and household level characteristics (household size).

When we were dealing with monetary outcome indicators (for example, food expenditure per adult equivalence), we used Ordinary Least Squares (OLS) Regression to estimate Log-Level function. In Log-Level function, we take the Log of dependent variable and use independent variables in their actual form. The estimated coefficients can be interpreted as average percentage change in dependent variable with change in independent variables. Following model is an example of Log-Level model:

$$\ln(\text{Exp on food per capita}) = \beta_0 + \beta_1(\text{PKH Beneficiary}) + \beta_2 X_{2i} + \dots$$

In the above model, β_0 is the intercept, $\beta_1 * 100$ is the impact of PKH, and β_2 is coefficient of other control variables. For example, if $\beta_1 = 0.115$, this can be interpreted as per capita food expenditures of PKH beneficiary households are 11.5 % more than non-beneficiaries on average keeping other things constant.

When we were dealing with dichotomous outcome indicators (for example, delivery at government hospital), we used Logistic regression (logit). Logistic regression measures the relationship between the dichotomous dependent variable and one or more independent variables by estimating probabilities using a logistic function. The interpretation of coefficients in Logistic regression is tricky, therefore, we presented the impact of PKH in terms of marginal effects. Marginal effects measure the expected instantaneous change in the dependent variable as a function of a change in a certain independent variable while keeping all the other covariates constant and can be interpreted as the effect of the regressors on the dependent variable. For example, if the dependent variable is whether your last child got immunization or not. And the marginal effect of PKH program is 0.09. This can be interpreted as, PKH beneficiaries are 9% more likely than non-beneficiaries to get their child immunized.

Annex III: Survey Tool

Greetings

We are (names of interviewers) from an organisation called MicroSave. It is a research organisation which helps governments improve the delivery of government benefits especially for Program Keluarga Harapan. We try to ensure that government hears voices and ideas from the beneficiaries like you. We are holding peopleal interviews to understand the demand side evaluation for Program Keluarga Harapan. We appreciate your time and our interview will need around 60 minutes of your time. The details of the interview and your name(s) will be kept confidential - so please feel free to express your views/opinions.

A. For All Respondents

Are you willing to participate in this interview?

Yes → go to B

b. No → [Stop the interview!](#)

[Politely say thank you to the respondents for their time and leave the respondent location.](#)

Screening Question

B. For All Respondents

What kind of Social Program have you received in last one year? (Multiple Response possible)

Kartu Merah Putih for Program Keluarga Harapan (PKH)

Kartu Merah Putih for Rastra

Kartu Merah Putih for Bantuan Pangan Non Tunai (BPNT)

Kartu Indonesia Sehat for Program Indonesia Sehat

Kartu Indonesia Pintar for Program Indonesia Pintar

Decent House Subsidy

KUBE

Electric Subsidy 450 VA

3kg of LPG/Cooking Gas Subsidy

Kredit Usaha Rakyat (KUR)

Land Certificate

Supplementary Nutrititious Food

Government Scholarship

None

Others (please specify) : _____

Yes

No

C. For Non PKH Beneficiary

Do you know about Program Keluarga Harapan?

General Information of Respondent - For All Respondents

No.	Question	Responses
D.	City of Residential	
E.	Type of Locality	Rural Urban
F.	Village Name	
G.	Sub District Name	
H.	Date of Survey	____ / ____ / ____ (DD/MM/YYYY format)
I.	Time of Survey	____ / ____ (HH/MM format)
J.	Detail address of the respondent home	

Individual Information of Respondent - For All Respondents

NO.	Question	Responses
K.	Respondent's name	
L.	Contact number	

M. Marital status

- a. Single
- b. Married with no children
- c. Married with children
- d. Widow with no children
- e. Widow with children

Social Economic Information of Family Member - For All Respondents

Fill 1.a with respondent name and data, following with other family members data

No. (1)	Name (2)	Relationship to Family Head (3)	Gender (4)	Age (5)	Main Livelihood (6)	Type of Disability (if Any) (7)	School Participation (8)	School Grade (9)
1.a.	(Respondent Name)	(Respondent Data)	(Respondent Data)	(Respondent Data)	(Respondent Data)	(Respondent Data)	(Respondent Data)	(Respondent Data)
1.b.								
1.c.								
1.d.								
1.e.								
1.f.								
1.g.								
1.h.								
1.i.								
1.j.								

Response Options for Q.1

(3) Family Head Wife/Husband Children Son/Daughter in Law Parents/Parents in Law Maid Others	(4) Male Female	(6) Underage children School age but not going to school and not working Student - Not working Student - Working Unemployeee Entrepreneur Entrepreneur and helped by temporary/unpaid workers Entrepreneur and helped by permanent/paid workers Labor/private workers/ employees Government employee Casual labor in agriculture Casual labor non-agriculture Family worker/unpaid	(7) No disability Physically disabled Blind Deaf Blind & deaf Speech impaired Deaf & speech impaired Blind & physically disabled Blind, deaf & speech impaired Deaf, speech impaired, & physically disabled Deaf, speech impaired, blind, & physically disabled Mental disorder Former mental disorders Physically and mentally disabled	(8) No/Never been to school Not going to school anymore Primary School Equal to Primary School Islamic Primary School Junior High School Equal to Junior High School Islamic Senior Junior School Senior High School Equal to Senior High School Islamic Senior High School College	(9) Primary School 1 st grade 2 nd grade 3 rd grade 4 th grade 5 th grade 6 th grade Junior High School 7 th grade 8 th grade 9 th grade Senior High School 10 th grade 11 th grade 12 th grade
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Family Expenditure - For All Respondents

What is the average expenditure of your family per month to buy daily necessities (i.e. food, electricity / water / telephone / handphone, gasoline, gas or kerosene costs, school fees, pocket money, monthly rental fees) - exclude luxury items (i.e. TVs, motorbikes, washing machines, household furniture, household appliances), any installments, rent if paid annually, or non-permanent expenses?
 What is your average monthly expenditure on food alone?

Expenditure for Food in The Past One Week (IDR)

Non FodExpenditure (IDR) Pengeluaran Bukan Makanan (Rupiah)

Rice, exclude own produce/given by government or other people
 Others staples (maize, cassava, sweet potato, potato, yam, sago, etc.), exclude own produce/given by government or other people
 Fish/others seafood (Fresh/unprocessed)
 Fish/ others seafood (Salted/preserved/semi-processed - termasuk kalengan, bakso, nugget)
 Beef meat/chicken meat/others (Fresh/unprocessed)
 Beef meat/chicken meat/others (Salted/preserved/semi-processed)
 Eggs
 Milk (fresh, evaporated, powder, etc) - exclude condensed milk
 Vegetables (raw)
 Tofu and tempe (raw)
 Beverage supplements [sugar, brown sugar, tea, coffee, chocolate powder, syrup, etc.]
 Noodle and Pasta (Instant noodle, noodle, vermicelli, macaroni/dried noodle)

Ready to eat (bread, biscuit, cake, porridge, meatball, salad, fritters, ice cream, etc.)
 Alcoholic beverages (beer, palm wine, other)
 Cigarette (clove cigarette, white cigarette)
 Tobacco, betel, areca nut

Non Food Expenditure (IDR)

Past 1 month (IDR)

Past 12 months (IDR)

Housing and household equipment
 a. House lease, rent, etc.
 b. If you do not pay house rent (company / family owned), how much is the rent expectation amount
 Electricity bill, telephone bill, gas, kerosene, water, firewood etc.

d. House landline telephone bill, cellular phone voucher, data package voucher, public phone, telephone kiosk, postal goods etc.

e. Various goods and service

*Toiletries: bath/washing soap, cosmetics, shampoo, toothpaste, tissue, sanitary napkins, etc.

*Baby products: diapers, cotton bud, wet tissue, etc.

*Laundry: washing detergent, softener, clothes whitener, camphor, laundry service, etc. *Others: newspaper, magazine, tabloid, etc.

f. Health expenditure (hospital, public clinic, doctor practice, healer, surgery, medicine etc.)

g. Education expenditure - UP TO HIGH SCHOOL (pocket money, registration fee, monthly educational fee, re-registration fee, boy/girl scout, craft, course, stationary, etc.)

h. Education expenditure - ABOVE HIGH SCHOOL (pocket money, registration fee, monthly educational fee, re-registration fee, boy/girl scout, craft, course, stationary, etc.)

Installment payments for:

Vehicle

Household Equipments (Electronic/non-electronic such bed, frying pan, cupboard, etc)

Cash Loan (formal/informal) for all purpose i.e consumption smoothening, working capital

Health insurance

k. Party and ceremony excluding food (wedding, circumcision, birthday, religious holiday, traditional ceremony etc.)

In the past month, to meet daily expenditure (food and non-food consumptions), is the family (Multiple responses)

- Use family daily income
- Use savings (in bank/house)
- Use supporting funds from government/other parties
- Sell assets
- Borrow from family
- Borrow from friend/neighbor
- Borrow from loan shark
- Borrow from bank
- Borrow from cooperatives
- Pawn goods

Family Income - For All Respondents

- | | | |
|----|--|---|
| 7. | Who has the biggest source of family income (including PKH/other G2P program) (Single response only) | Father
Mother
Children
Other family members (please specify): __ |
| 8. | Amount of total income per month WITHOUT ANY SOCIAL ASSISTANCE FROM THE GOVERNMENT (please specify) | IDR _____ per month |
| 9. | Assets owned by the family (Multiple responses) | Smartphone
Feature phone |

- Bicycle
- Rickshaw/pedicab/small vehicle
- Motorcycle
- Refrigerator
- Gas container size 12 kg & up
- Moveable electronic goods (e.g. TV, laptop)
- Gold/jewelry
- Fixed asset (house)
- Fixed asset (land)
- Livestock

C. Family Health Profile Data - For All Respondents

10. Where did the delivery of your children happen? (number of children ask in here will be correlate with the information in Q.1)
- Child # : Government health facility/Private health facility/Midwife/Others (please specify)*:
 _____/I do not know
 Did you receive PKH at that time? Yes/No
- Child # : Government health facility/Private health facility/Midwife/Others (please specify)*:
 _____/I do not know
 Did you receive PKH at that time? Yes/No
- *)Choose the exact place name
11. Who assisted the birth process? (number of children ask in here will be correlate with the information in Q.1)
- Child # : Doctor/Midwife/Nurse only/Other Paramedic/ Traditional healer/Traditional healer assisted by midwife /Family/Others (please specify)*: _____/I do not remember
- Child # : Doctor/Midwife/Nurse only/Other Paramedic/Traditional healer/Traditional healer assisted by midwife/Family/Others (please specify)*: _____/I do not remember
- *)Choose the right medical staff
12. Do you have Mother and Children Health book ? Yes
 No
13. Do you use any form of Family Planning? Yes → go to Q.14
 No → go to Q.15
14. If yes, which type of device?
 Women/tubectomy
 Men/vasectomy
 Injection
 IUD
 Implant/Norplant
 Birth control pill
 Condom/rubber
 Intravaginal/tissue for women
 Female condom
 Traditional method (by marking calendar, breastfeeding, interrupted intercourse, etc)
15. What is reason of not using family planning? (Single response only)
 Fertility reason (barren, menopause, want child)
 Against my tradition/religion
 Do not know family planning device/method
 Afraid of family planning side effects
 Have no worry to add child because government will help me

- I do not know
 Refuse to answer
 Others (please specify) : _____
16. Are you 4 months pregnant or above?
 Yes, for Q.17 - Q.20 refer to current pregnancy
 No, for Q.17 - Q.20 refer to youngest children
 I'm less than 4 months pregnant and this is my first pregnancy, for Q.17 - Q.20 refer to current pregnancy, and continue to Q.31 directly
17. For Ante Natal Visits (ANC), did you go to a healthcare facility for health check up on your current pregnancy/while you were pregnant with your last child?
 Yes → go to Q.18
 No → go to Q.20
18. How many times did you visit the health care facility for your current pregnancy/last child?
 1
 2
 3
 4
 > 4
19. Your first ANC visit was in the First Trimester of your current pregnancy/last child?
 Yes
 No
 I do not know
20. Did you receive following vaccination during pregnancy?
 TT 1 (Tetanus Toxoid 1) : Yes/No/Not yet/I do not know
 TT 2 (Tetanus Toxoid 2) : Yes/No/Not yet/I do not know
 Flu vaccine : Yes/No/Not yet/I do not know
 TDAP (Tetanus Diphteria Pertussis) : Yes/No/Not yet/I do not know
21. How many times do you go to Puskesmas /health facility after delivery of your most recent child within first 42 days?
 0 (Tidak pernah)
 1
 2
 3
 4
 > 4
22. For your last child, how many times did you do their health check in the first month of their age?
 0 (Tidak pernah)
 1
 2
 3
 4
 > 4
23. Did your last child get following immunization within age of 0 - 23 months?
 HB0 : Yes/No/Not yet/I don't know
 BCG : Yes/No/Not yet/I don't know
 DPT-HB1 : Yes/No/Not yet/I don't know
 DPT-HB2 : Yes/No/Not yet/I don't know
 DPTHB3 : Yes/No/Not yet/I don't know
 Polio1 : Yes/No/Not yet/I don't know
 Polio2 : Yes/No/Not yet/I don't know
 Polio3 : Yes/No/Not yet/I don't know
 Polio4 : Yes/No/Not yet/I don't know
 Measles: Yes/No/Not yet/I don't know
 Not given at all → Go to Q.24
24. Why you did not vaccinate your last children? (Multiple Responses)
 Responses any "No", "Not Yet", or "Not given at all" go to Q.24
 Otherwise, go to Q.25
 Not yet reach the eligible age for that immunization
 My children was ill during vaccination schedule
 I can not afford vaccine

- Puskesmas/health facility is too far from my house
 There was no vaccines stock when I came to
 Puskesmas/health facility
 I heard/believe vaccine is bad for my child's health (rumors)
 My other child experienced negative effect of vaccine
 It is cultural beliefs in here that we do not need vaccination
 Vaccine has religious issue (I.e: halal, fetus cells, etc)
 No need for vaccine because there is no disease
 Others (please specify): _____
25. Did your last child get exclusive breastfeeding within age of 0 - 6 months?
 Yes
 No
 I do not know
26. How often do you weigh your child?
 Baby 0 - 11 months Children 1- <5 years old Children 5 - <6 years old
 Monthly
 2x a year
 Irregular
 Never
 I don't know
27. How often do you had height check for your child?
 Baby 0 - 11 months Children 1- <5 years old Children 5 - <6 years old
 Monthly
 2 times per year
 Irregular
 Never
 I don't know
28. How often do you had child development monitoring process?
 Baby 0 - 11 months Children 1- <5 years old Children 5 - <6 years old
 Monthly
 2 times per year
 Irregular
 Never
 I don't know
29. Did your children within age of 1 - <5 years old children get complementary immunization as following?
 Measles Rubella/MR : Yes/No/Not yet/ I don't know
 Pneumokokus/PCV : Yes/No/Not yet/ I don't know
 Hepatitis A : Yes/No/Not yet/ I don't know
 Varisela : Yes/No/Not yet/ I don't know
 Influenza : Yes/No/Not yet/ I don't know
 Human Papiloma Virus/HPV : Yes/No/Not yet/ I don't know
 I do not know
30. How often did you give your children vitamin A supplement?
 Baby 0 - 11 months Children 1- <5 years old
 1 time per year
 2 times per year
 Irregular
 Never
 I don't know
31. Does anyone in your family smoke? Yes
 No

32. Do all family members have BPJS card? Yes → go to Q.34
No → go to Q.33
33. If no, why? (Multiple responses)
We never have illness
We do not think it is important
There is no health facility nearby
We do not understand how to register ourselves
We do not receive information on BPJS
We do not have required documents to get BPJS card
We are concern if there will be any cost for it
I do not know
Other reasons (please specify): _____
34. What is the main source for drinking water? (Single response only)
Branded and sealed gallon water
Refill gallon water
Piped water/with meter
Terrestrial well/pump
Protected/covered well
Protected spring
River
Rainwater
Others (please specify) : _____
35. What is the type of latrines used by your family?
Goose neck
Squat toilet
Pit toilet
None
I do not know
36. Where is the final disposal spot of your latrine? (Single response only)
Septic tank
Pond/paddy field/river/lake/sea
Ground hole
Beach/field/garden
I don't know
Others (specify): _____
37. Where do you usually seek healthcare services? (Single response only)
Government healthcare facility → go to Q.38
Private healthcare facility → go to Q.38
Traditional medicine practitioner/healer → go to Q.40
38. Asked for the formal health facility only
How far do you have to travel to access healthcare services? (Single response only)
_____ kms
39. Asked for the formal health facility only
How much do you spend on the transportation cost to health facility?
IDR _____

Children Education Profile Data - For All Respondents

40. What are the conditions that your children face for not attending school regularly? (Multiple response possible)
Children has been fully occupied by a regular housework
Children has been fully occupied by a job
School location is too far/difficult to reach
Teachers are not regularly present
Transportation cost to reach school is expensive

- | | | |
|-----|---|--|
| 41. | Did your children ever dropped out of school during education of Primary School until Senior High School? | The children do not want to go to school
My children never skip school
Others (please specify): _____
Yes → Go to Q.42
No → Go to Q.44 |
| 42. | In which level, they were dropped out? (Single response) | Primary School, in grade (please specify): _____
Junior High School, in grade (please specify): _____
Senior High School, in grade (please specify): _____ |
| 43. | What were the reasons for drop out? (Multiple responses) | My family cannot afford their education anymore
My child did not pass the next grade exam
My child was expelled by the school because of behavior problems
My child did not want to go to school
My child works to support the family financially
Current level of education is sufficient
School is too far
Higher level of education not available
Illness/ health issues with child
Others (please specify): _____ |
| 44. | Does your children have academic/extracurricular achievement? (Multiple responses) | a. Yes
Academic
Sport
Art
Others (please specify) _____
b. No |

Elderly and Severe Disability Profile Data - For All Respondents

- | | | |
|-----|---|---|
| 45. | Is there any day care/social activities facility for elderly (above 60 years old) and severe disability in your village? | a. Yes
b. No
c. I do not know |
| 46. | Did family member with severe disability in your family have health checks by medical staff (by going to health facility or home care)? | Yes
No |
| 47. | Did elderly member in your family have health checks by medical staff (by going to health facility or home care)? | Yes
No |
| 48. | What type of social activities for elderly/disabled utilize? (Multiple response possible) | Addition of elderly food nutrition
Nurturing and caring
Our elderly/disables family never join any day care activities
Others: _____ |

PKH Operational Assessment - Only For PKH Beneficiaries

- | | | |
|-----|---|---|
| 49. | Based on your understanding, who provide PKH to community? (Single response only) | Central Government in Jakarta
Local Government (Governor/Mayor/District Head)
Bank
I don't know
Others (pls specify): _____ |
| 50. | Which year did you start receiving PKH beneficiaries? | Year of _____ |

51. How much is the total amount of PKH transferred into your account in 2018? IDR _____
I don't know
52. How much is the total amount of PKH transferred into your account 2019?
a. IDR _____
b. I don't know
c. I have not received the fund
53. How do you collect your PKH fund? (Multiple responses possible)?
Bank branch
ATM of Bank
Bank agents
e-warung KUBE
Bank staffs who visit the community
Others (pls specify): _____
54. Why do you choose to select that point of disbursement? (Multiple responses possible)
Closest to my place
Cheaper price
I can buy/utilize other services available in the location
Better services
Community leader/PKH Facilitator/ MoSA/ staff advised me
Friends/another beneficiary advised me
I don't choose, there is no other option
Others (please specify): _____
55. Who goes to the disbursement location for withdrawing PKH fund? (Single response only)
Myself (beneficiary)
Head of the family
Myself (beneficiary) accompanied by my husband/family member
Family member
Community Leader/Kelurahan staff
PKH Facilitator/Kader/MoSA staff
Other beneficiaries
56. How do you/ other people who you assigned usually get to disbursement location? (Single response only)
By walk
By public transport (ojek/gojek/rickshaw)
By public transport - others (angkot/bus/boat)
Rent full transport (angkot), shared with others
By my own vehicle (motorbike, bike, car, boat)
Doorstep → Go directly to Q.58 - response c
57. Usually how much time you take to reach the disbursement location? (Please mention) minutes
58. How much you spend for the transportation cost to go to disbursement location (for back and forth)? (including gasoline or costs of "ojek").
IDR _____
I have no transportation cost
Delivery fee: IDR _____
59. Do you withdraw entire amount you received from the last PKH disbursement in one go (within one week after transferred)?
Yes → go to Q.60
No → go to Q.61
60. If yes, what is the reason? (Multiple responses possible)
PKH facilitator/Bank/ Bank agen/ e-warung KUBE told me to utilise it in one go
Disbursement place is not open everyday
I need the cash as soon as possible
I am afraid the fund will be gone/taken back
I don't know, I though it should be withdrawn one go
Other reasons (please specify): _____
Continue to Q.62
61. If no, what is the reason? (Multiple responses possible)
PKH facilitator/Bank/ Bank agen doesn't allow
No availability or not enough cash stock to withdraw at that time

I want to utilize PKH fund as per my needs
 I want to save for future
 Other reasons (please specify): _____

- 62. Do you have to pay any fee for the last PKH disbursement?
 Yes → go to Q.63
 No → go to Q.64
- 63. If yes, then how much?
 Disbursement service: IDR _____
 Paying for documentation: IDR _____
 Retribution fee: IDR _____
 Other (please specify): _____, IDR _____
- 64. What type of problem you have ever faced for receiving of PKH fund? (Multiple response possible)
 Issues with PKH amount (e.g. zero balance)
 Can't access the account/system failure/network issue
 Forget my PIN
 Disbursement place is closed
 Disbursement place is too far from my place
 My KKS card lost/damage
 The queing was so long
 No cash in agent/ATM
 None
 Others (please specify): _____
- 65. What channel have you used to address any complaint? (Multiple response)
 a. PKH facilitator
 b. PKH call center
 c. SMS center PKH
 d. Through email pengaduan@pkh.kemsos.go.id
 e. Social media PKH
 f. Through LAPOR.go.id
 g. Never raised any complaint
- 66. Which one do you prefer using KKS or Post Office disbursement? (Single response)
 Never disbursed through post office before
 Prefer KKS card
 Prefer Post office
- 67. How do you rate PKH process using KKS card on the following parameters:

	Extremely Easy	Moderately Easy	Neutral	Moderately Difficult	Extremely Difficult
How easy/difficult for you to reach disbursement location?					
How easy/difficult of transaction process at disbursement location?					

	Extremely Satisfied	Moderately Satisfied	Neutral	Moderately Unsatisfied	Extremely Unsatisfied
How satisfied/unsatisfied are you on timely/regularity of receiving PKH payment into your account?					
Refer to Q.65 How satisfied/unsatisfied are you on contact center responsiveness to handle complaints? (Add Not Applicable - N/A for respondents who never used contact center)					
How satisfied/unsatisfied are you towards PKH Facilitator?					

PKH Sanction - Only For PKH Beneficiaries

- 68. Were you ever sanctioned for PKH payment?
 Yes → go to Q.69
 No → go to Q.71
- 69. What was the mode of sanction? (Multiple responses)
 I don't know → go to Q.71
 Deduction in amount
 Amount got postponed for next cycle
 PKH payment stopped completely
 Others (please specify): _____

70. What is the reasons of getting sanctioned? (Multiple response possible)
- a. I did not meet the health condition - tick the suitable responses
 - Ante Natal Visit
 - Assisted Labor in Health Facility
 - Post Natal Visit
 - Vitamin A Supplement
 - Complete Basic Vaccination
 - Complementary Vaccination
 - Weight check
 - Height check
 - Development monitoring check
 - b. I did not meet education condition:
 - My children did not go to school > 3 days without information
 - c. I did not meet social welfare conditions:
 - For elderly: health check by visiting health facility or having home visit
 - For severe disability: health check by visiting health facility or having home visit
 - d. Others (please specify): _____
 - e. I don't know

Family Development Sessions (FDS) - Only For PKH Beneficiaries

71. Have you received any socialization (FDS) from PKH Facilitator every month, for the last 6 months?
- Yes → go to Q.72
 - No → go to Q.73
-
72. What type of topic had you received from group meeting/P2K2/FDS? (Multiple responses)
- Nutrition and Health Module
 - Modul Child Care and Education Module
 - Child Protection Module
 - Family Financial Management Module
 - Social Welfare Module
-
73. I use PKH funds for the following purposes: (Multiple responses)
- Paying my children school enrolment/ re-registration fee
 - Paying my children school tuition fee
 - Paying my children extracurricular activities fee in school
 - Buying school appliances (stationary, uniform, books, etc)
 - Paying transportation money for my children going to school
 - Paying transportation cost to Puskesmas
 - Paying medical services in Puskesmas
 - Buying vitamin and health supplement for my family (including my children)
 - Buying additional food items for my family (including my children)
 - Paying loan instalments
 - Paying home bills (electricity, water, gas, etc)
 - Additional venture capital for my/my family business
 - Others non-food expenditure (please specify): ____
-
74. Do you have any suggestion for improvement? (Multiple response possible)
- PKH Fund should be transferred regularly every month
 - PKH Fund should be transferred once as lumpsum upfront

75. Do you have any suggestion for improvement of PKH Facilitator? (Multiple response possible)
- Flexibility to choose point of health/education/day care services where I can get the service
 - Closer point of services location
 - Reduce system error
 - Better and faster time to solve the problem
 - Reduce queuing time to disburse the fund
 - Others (please specify): _____
 - Everything is fine, no need improvement
 - Facilitator should visit more oftenly
 - Facilitator should be able to speak in local language
 - Facilitator should be friendlier
 - Facilitator should be more informative related to PKH and others
 - Others (please specify)
 - Everything is fine, no need improvement

Financial Inclusion

76. Only for PKH beneficiaries
- Which of the following statements best describes the account that you use to receive payments from the government (KKS and or/ KIP/KJP* - if any)? (Multiple responses possible)
- *KIP: Kartu Indonesia Pintar from Program Indonesia Pintar
KJP : Kartu Jakarta Pintar from Provincial Government of Jakarta
77. Only for PKH beneficiaries
- Have you ever used the KKS account for financial transaction such saving, transfer/send money, receive money, bill payment, or purchase?
78. Only for PKH beneficiaries
- If yes, why? (Multiple responses)
79. Only for PKH beneficiaries
- If no, why? (Multiple responses)
- I had an account before, but my KKS account was opened so I could receive payments from the government
This was my first account, and it was opened so I could receive payments from the government
-
- Yes → go to Q.78
- Saving
 - Transfer/sending money
 - Receive money
 - Bill payment
 - Purchase
- No → go to Q.79
-
- It is easy and convenient to use
 - Safer than cash transaction
 - I can easily do transaction from nearby (Bank/Cooperative) agent/branch
 - I can do transaction in any amount I have
 - Advised by PKH Facilitator
 - Influenced by my friends/neighbours/agent
 - There is no (or at least smaller) charges to do transaction
 - I don't have other options to do transaction
 - Others (please specify): _____
-
- I don't know that I can use my KKS card for any transaction
 - I don't have enough money
 - I don't know how to do/use it
 - I'm not sure about the account safety (include trust issue with the agent)
 - I don't like it because all the issues I had with this KKS account during reimbursement
 - I prefer for cash transaction
 - I already have another saving account

I don't need any financial transaction from this account

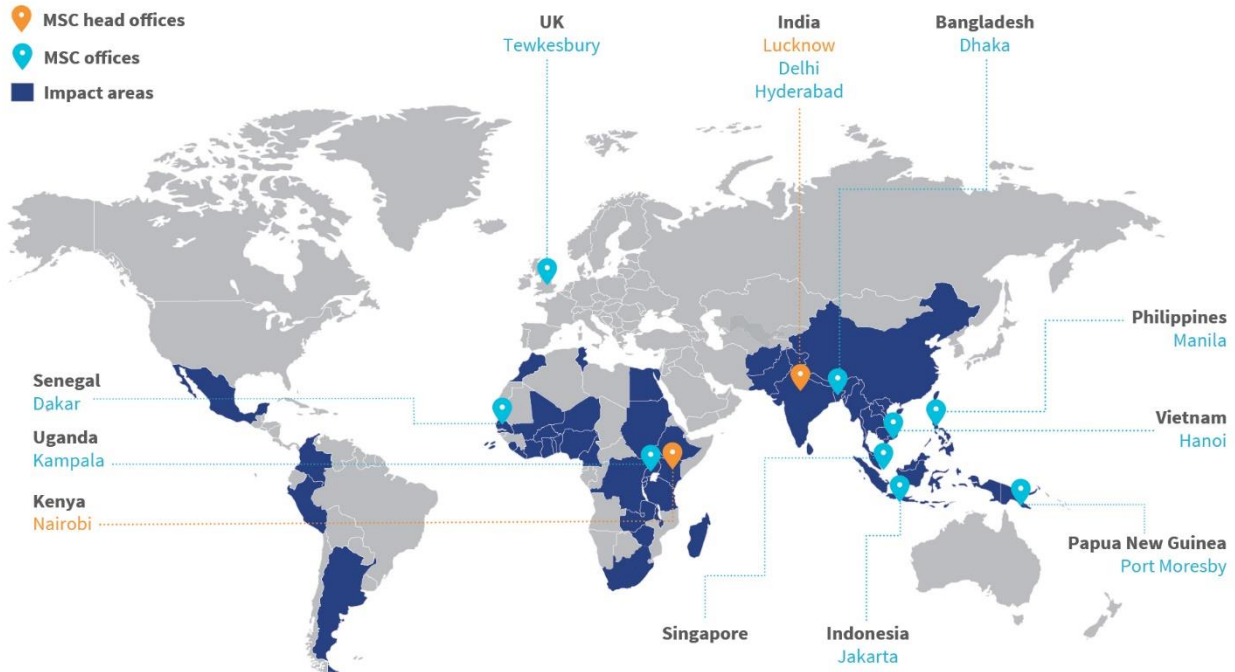
Other reasons (please specify): _____

80 For All Respondents

In your family, do you have any formal account beside any account from government social assistance? (i.e.: account from bank, cooperative, and BPR)

	Head of Family	Husband/Wife	Children < 15 years old	Children > 15 - 21 years old	Other family members	None
Bank						
Rural Bank						
Cooperatives						

Say Thank You To The Respondent



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