

Conditional Cash Transfers: Lessons from Indonesia's Program Keluarga Harapan

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Presentation Outline

1. A brief history of the PKH: from fuel to Istanbul
2. The devil is in the (design) details
3. Implementation case studies in 2 districts
4. Lessons and recommendations

1. Indonesia's CCT story

- October 2005: government removes universal fuel subsidy, knows this will be immensely unpopular
- Mitigation plan: compensate the poor for major increases in fuel prices
- Unconditional cash transfer for 15.5m households (28% of the population)
- \$10/month per household, quarterly payments through post office

From UCT to CCT...

- Even before 1st UCT payment, government was considering eventual shift to CCTs
- 3rd international CCT conference, Istanbul 2006
- Visited the original CCT program: Mexico's *Oportunidades*
- Weighed the pros and cons of CCTs

...in 7 simple steps

1. Refine targeting method
2. Determine conditions in health, education, nutrition (based on human capital bottlenecks)
3. Make sure supply side is ready
4. Set benefit levels
5. Explain program to stakeholders (develop manuals)
6. Develop management information system
7. Establish strong M&E component

Design details: conditions

Health & Nutrition	<p>4 pre-natal care visits for pregnant women</p> <p>Iron tablets for pregnant women</p> <p>Delivery assisted by trained health professional</p> <p>2 post-natal care visits</p> <p>Complete immunization of children < 6</p> <p>Monthly growth monitoring for children < 1, quarterly for 1-6 years</p> <p>Vitamin A every 6 months for < 5 years</p>
Education	<p>All children aged 6-12 years enrolled in primary school</p> <p>All children aged 13-15 in junior secondary school</p> <p>Minimum attendance rate of 85% for all</p>

More design details: benefits

Annual Benefits:	IDR	USD
Fixed transfer amount	200,000	20
Additional amount for poor families who have:		
Children < 6 years	800,000	80
Pregnant/lactating mother	800,000	80
Primary school children	400,000	40
Junior secondary school children	800,000	80
Average transfer per poor family	1,390,000	139
Minimum transfer per poor family	600,000	60
Maximum transfer per poor family	2,200,000	220

Other details

- Benefits paid to mother or another adult woman in the household
- Beneficiaries may participate for maximum 6 years
- Recertification of eligibility every 3 years
- Payments through post office
- Ministry of Social Affairs (DepSos) is the implementing agency
- Program planned to run through 2015 (link to MDGs)

The PKH Pilot

- **2007**: 388,000 poor households in 7 provinces
- **2008**: 580,000 poor households in 13 provinces
- **2009**: 720,000 poor households in 13 provinces

Case studies in implementation

- March-April 2008 in 2 districts: **Kediri**, East Java and **Sumba Barat**, East Nusa Tenggara
- Focus on core program elements:
 - beneficiary selection
 - inter-agency coordination
 - “socialization”
 - monitoring & verification
 - field-level facilitation
 - management information system
 - payment mechanism

Case studies in implementation: findings

- **Beneficiary selection:** concern about targeting errors (inclusion) and transparency of the selection process
- **Inter-agency coordination:** financial arrangements not well defined, discontinuities in information flow (not enough published info)
- **Socialization:** uneven, too rushed - largely bypassed service providers, media, general public
- **Monitoring & verification:** still only *ad hoc*

More findings:

- **Field-level facilitators:** *Pendampings* need more training, number of families covered by one person is high (esp. in remote areas)
- **Management information system:** not ready
- **Payment mechanism:** payments sometimes irregular, long queues, inflation can erode benefits if not adjusted

Lessons

- Problems are mostly ones of execution rather than design
- Most issues can be resolved with more preparation prior to start up
- Issues are remarkably similar to ones encountered in other countries
- It will take time until everything runs smoothly

General recommendations:

Ensure that...

- requisite knowledge and skills have been acquired (and coordination is strong)
- financial resources are available/clearly defined
- program is understood and supported by community at large
- timetables are realistic

Specific recommendations:

- Consider introducing form of inflation adjustment (e.g. Mexico)
- Focus more on errors of inclusion than exclusion
- Make selection process more transparent by making it participatory
- Strengthen socialization strategies
- Collaborate with local NGOs to serve as conduit between communities and program providers

Challenges in 2009...

- Verification still an issue, payments made without checking conditionalities
- Payments made 3 times/year instead of quarterly
- Socialization is not as strong as it could be (training to providers only started in 2009)
- Coordination at provincial & *kabupaten* levels and between sector units at all levels is lacking
- Complaints/grievance mechanism needs strengthening

The good news...

- Field-level facilitation functioning very well
- MIS now in place, preliminary data starting to show some positive impacts
 - **Gorontalo**: fully immunized children 65% in treatment v 56% in control
 - **North Sulawesi**: enrollment in 1st year SMP up by 4.2% (4.8% in treatment v 3.5% in control)
 - **West Java**: fully immunized children 23% before, 35% after
 - **Jakarta**: malnutrition in children 0-3 years: 25% before, 21% after

Thank you!
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Indonesia's human capital bottlenecks

- Sharp increase in drop-out rates between elementary and junior secondary school
- High maternal and infant mortality rates
- High malnutrition rates, particularly in rural areas

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CCTs: the good...

- **Proven benefits:** Rigorous impact evaluation studies show impressive outcomes in LAC.
- **Flexibility:** Gov'ts can adapt CCT programs to specific local circumstances.
- **Political attractiveness:** Conditionality makes recipients responsible/accountable. Significant impact on MDGs, sustainable long-term poverty reduction.
- **Improved targeting of scarce resources:** Gov'ts can reallocate from less effective public spending.
- **Benefits of cash:** Lower transaction costs, families can make own decisions on how to spend, no price distortions.
- **Empowerment:** payments to mothers gives them more control over resources (with positive results for children).

CCTs: the not-so-good

- **CCTs are complex:** design elements include targeting, analysis of human capital bottlenecks, conditionalities, supply capacity, supply gaps...
- **Institutional arrangements can be challenging:** who manages the program, what level of decentralized management, need to establish strong inter-agency coordination...
- **Implementation capacity is key:** need to establish information system to run program and monitor compliance, develop M&E system for impact evaluation, build capacity at district and village levels...

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