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Report No: 112703-ID

INTERNATIONAL BANK FOR RECONSTRUCTION AND DEVELOPMENT

PROGRAM APPRAISAL DOCUMENT

ON A

PROPOSED LOAN

IN THE AMOUNT OF US$200 MILLION

TO THE

REPUBLIC OF INDONESIA

FOR A

SOCIAL ASSISTANCE REFORM PROGRAM

April 18, 2017

Social Protection and Labor Global Practice
East Asia and Pacific Region

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CURRENCY EQUIVALENTS

Exchange Rate Effective April 11, 2017

Currency Unit = Indonesian Rupiah (IDR)
IDR 13,282 = US$1

FISCAL YEAR
January 1 – December 31

ABBREVIATIONS AND ACRONYMS

BADIKLIT	Training and Research Agency (*Badan Pendidikan Penelitian*)
BAPPENAS	National Development Planning Agency (*Badan Perencanaan Pembangunan Nasional*)
BI	Bank Indonesia
BPK	Audit Board of Indonesia (*Badan Pemeriksa Keuangan*)
BPKP	Financial and Development Supervisory Agency *(Badan Pengawasan Keuangan Dan Pembangunan)*
BPS	Central Bureau of Statistics (*Badan Pusat Statistik*)
CCT	Conditional Cash Transfer
CGS	Community Grievance System
CPF	Country Partnership Framework
CSV	Comma Separated Value
DFAT	Australian Department of Foreign Affairs and Trade
DG	Directorate General
DIPA	Budget Authorization Document (*Daftar Isian Pelaksanaan Anggaran*)
DLI	Disbursement-Linked Indicator
DLR	Disbursement-Linked Result
DMR	Digital Mark Reader
DPR	House of Representatives (*Dewan Perwakilan Rakyat*)
EA	Engagement Area
EFC	Error, Fraud, and Corruption
ESSA	Environmental and Social Systems Assessment
FDS	Family Development Session
FKP	Public Consultation Forum (*Forum Konsultasi Publik*)
FSA	Fiduciary Systems Assessment
G2P	Government-to-Person
GDP	Gross Domestic Product
GIZ	German Development Cooperation Agency (*Deutsche Gesellschaft für Internationale Zusammenarbeit*)
GRS	Grievance Redress System
GTA	Government Treasury Account
HIMBARA	Association of State-owned Banks (*Himpunan Bank Negara*)
HR	Human Resource
IG	Inspector General
IT	Information Technology

IVA	Independent Verification Agency
JKN-PBI	Recipient of Government paid health insurance premium (*Penerima Bantuan Iuran*) within the National Health Insurance Program (*Jaminan Kesehatan Nasional)*
JSK	Directorate of Social Assurance for Family (*Jaminan Sosial Keluarga*)
KKS	Family Welfare Card (*Kartu Keluarga Sejahtera*)
KPPN	Treasury Office
KUBE	Cooperative Business Group (*Kelompok Usaha Bersama*)
LM	Line Ministry
M&E	Monitoring and Evaluation
MoF	Ministry of Finance
MoSA	Ministry of Social Affairs
MoV	Ministry of Village, Development of Disadvantaged Regions and Transmigration
NIK	Single Identity Number (*Nomor Induk Kependudukan*)
PDO	Program Development Objective
Perpres	Presidential Regulation
PforR	Program-for-Results
PKH	Family Hope Program (*Program Keluarga Harapan*)
PIP	Smart Indonesia Scholarship Program (*Program Indonesia Pintar*)
PIS	National Health Insurance Program (*Program Indonesia Sehat*)
PMIS	Program Management Information System
PMU	Program Management Unit
PNPM	National Program for Community Empowerment (*Program Nasional Pemberdayaan Masyarakat*)
PPLS	Data Collection for Social Protection Programs (*Pendataan Program Perlindungan Sosial*)
PPK	Commitment Officer (*Pejabat Pembuat Komitmen*)
PSP	Payment Service Provider
PSE	Data Collection for Socioeconomic Trends (*Pendataan Sosial Ekonomi*)
PPSPM	Payment Officer
Rastra	Rice for the Poor Program (*Beras untuj Rakyat Sejahtera*)
RPJMN	National Medium-Term Development Plan (*Rencana Pembangunan Jangka Menengah Nasional*)
SA	Social Assistance
SAI	Government's Accounting and Reporting System
SB	Supporting Beam
SIM	Management Information System (*Sistem Informasi Manajemen*)
SISKADA	Integrated Social Registry
SLRT	Integrated Service and Referral System (*Sistem Layanan Rujukan Terpadu*)
SMS	Short Messaging Service
SOP	Standard Operational Procedure
SORT	Systematic Operations Risk Rating
SPM	Payment Order
TA	Technical Assistance

TNP2K	National Team for the Acceleration of Poverty Reduction (*Tim Nasional Percepatan Penanggulangan Kemiskinan*)
ToR	Terms of Reference
UDB	Unified Database
ULP	Central Procurement Unit (*Unit Layanan Pengadaan)*
UNICEF	United Nations Children's Fund
UPPKH	Implementation Unit of PKH (*Unit Pelaksana Program Keluarga Harapan*)

Regional Vice President:	Victoria Kwakwa
Global Practice Vice President:	Keith Hansen
Country Director:	Rodrigo Chaves
Senior Global Practice Director:	Michal Rutkowski
Practice Manager:	Jehan Arulpragasam
Task Team Leader(s):	Pablo Acosta/Changqing Sun

THE REPUBLIC OF INDONESIA

SOCIAL ASSISTANCE REFORM PROGRAM

TABLE OF CONTENTS

PAD DATA SHEET

Indonesia

Social Assistance Reform Program

PROGRAM APPRAISAL DOCUMENT

East Asia and the Pacific
Social Protection and Labor

Basic Information			
Date: April 18, 2017			
Country Director:	Rodrigo Chaves	Sectors:	Social Protection and Labor 60%; General Education Sector 20%; Health 20%
Practice Manager	Jehan Arulpragasam		
Global Practice Vice President:	Keith Hansen	Themes:	Social Safety Nets/Social Assistance & Social Care Services 40%; Social Protection and Labor Policy & Systems 20%; Education for all 20%; Nutrition and Food Security 20%.
Program ID:	P160665		
Team Leader(s):	Pablo Acosta Changqing Sun		

Program Implementation Period:	Start Date:	May 9, 2017	End Date:	June 30, 2021
Expected Financing Effectiveness Date:	July 1, 2017			
Expected Financing Closing Date:	June 30, 2021			

Program Financing Data

[X]	Loan	[ ]	Grant	[X]	Other	[ ]	Credit

For Loans/Credits/Others (US$, millions):			
Total Program Cost:	4,932	Total Bank Financing:	200
Total Cofinancing:		Financing Gap:	

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Financing Source	**Amount (US$, million)**
BORROWER	4,732
IBRD/IDA	200
Total	4,932

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Borrower: Republic of Indonesia

Contact:	Ayu Sukorini	Title:	Director of Loans and Grants, Directorate General of Budget Financing and Risk Management, Ministry of Finance
Telephone No.:	+62 21 3458289	Email:	ayu_sukorini@kemenkeu.go.id

Responsible Agency: Ministry of Social Affairs

Contact:	Harry Hikmat	Title:	Director General, Directorate General for Social Security and Protection
Telephone No.:	+62 812 10798374	Email:	h_hikmat@kemsos.go.id

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Expected Disbursements (in US$, millions)

Fiscal Year	2018	2019	2020	2021				
Annual	53	53.4	53.5	40.1				
Cumulative	53	106.4	159.9	200				

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Program Development Objective(s)

The Program Development Objectives (PDO) are to support the conditional cash transfer program coverage expansion, strengthen its delivery system, and improve its coordination with other complementary social programs.

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Compliance

Policy

Does the program depart from the CAS in content or in other significant respects?	Yes [ ]	No [X]

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Does the program require any waivers of Bank policies applicable to Program-for-Results operations?	Yes [ ]	No [X]
Have these been approved by Bank management?	Yes [ ]	No [ ]
Is approval for any policy waiver sought from the Board?	Yes [ ]	No [X]

Overall Risk Rating: Substantial

Legal Covenants

Name	Recurrent	Due Date	Frequency
Program Action Plan (Section I.C.2 of Schedule 2 to the Loan Agreement)	Yes		**Continuous**

Description of Covenant

Without limitation on the generality of Section I.A of this Schedule, the Borrower shall:

(a) undertake the actions set forth in the Program Action Plan in a manner satisfactory to the Bank;

(b) except as the Bank and the Borrower shall otherwise agree in writing, not assign, amend, abrogate, or waive, or permit to be assigned, amended, abrogated, or waived, the Program Action Plan, or any provision thereof; and

(c) maintain policies and procedures adequate to enable it to monitor and evaluate, in accordance with guidelines acceptable to the Bank, the implementation of the Program Action Plan.

Name	Recurrent	Due Date	Frequency
Mid-term Review (Section III.A.2 of Schedule 2 to the Loan Agreement)		June 30, 2019	

Description of Covenant

Not later than June 30, 2019, the Borrower shall, in conjunction with the Bank, carry out a mid-term review of the Program ("Mid-term Review"), covering the progress achieved in the implementation of the Program. To this end, the Borrower shall prepare and furnish to the Bank not less than three (3) months prior to the beginning of the Mid-term Review, a report integrating the results of the Program's monitoring and evaluation activities, on the progress achieved in the carrying out of the Program during the period preceding the date of such report, and setting out the measures recommended to ensure the efficient carrying out of the Program and the achievement of the objective of the Program during the period following such date. Following the Mid-term Review, the Borrower shall act promptly and diligently in order to take, or cause to be taken, any corrective action deemed necessary by the Bank to remedy any shortcoming noted in the carrying out of the Program in furtherance of the objective of the Program.

Conditions

Source of Fund	Name	Type
IBRD	Letter of Assignment (Section 4.01 of the Loan Agreement)	Effectiveness

Description of Condition

The Additional Condition of Effectiveness consists of the following, namely, that the Ministry of Finance has sent a Letter of Assignment to BPKP to carry out the verification of DLRs achievement for the Program.

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Team Composition

Bank Staff

Name	Title	Specialization	Unit
Pablo Ariel Acosta	Senior Economist	Co-TTL	GSP02
Changqing Sun	Senior Economist	Co-TTL	GSP02
Iene Muliati	Senior Social Protection Specialist	Institutional and Legal	GSP02
Juul Pinxten	Research Analyst	Monitoring and Evaluation, Economic Analysis	GSP02
Yasuhiko Matsuda	Senior Public Sector Specialist	Institutional and HR Development	GSP06
Kathy A. Lindert	Lead Economist	SP Delivery System, CCT Design	GSPDR
Tina George	Senior Public Sector Specialist	SP Delivery Systems, IT Development	GSPDR
Isaku Endo	Senior Financial Sector Specialist	Payment Systems	GFM02
Marco Schaefer	Social Protection Specialist	Institutional and HR Development	GSPGL

Ali Subandoro	Health Specialist	Health and Nutrition	GHN02
Lansong Zhang	Operation Analyst	Operational Support	GSP02
Fajar Argo Djati	Social Development Specialist	Social Safeguards	GSUID
Kian Siong	Environmental Specialist	Environmental Safeguards	GEN2A
Unggul Suprayitno	Senior FM Specialist	Financial Management	GGO20
Angelia Budi Nurwihapsari	Procurement Analyst	Procurement	GGO08
Ria Nuri Dharmawan	Counsel	Country Legal Systems	LEGES
Chau-Ching Shen	Senior Finance Officer	Disbursement	WFALN
Maria Jenny Puspitaswati	Executive Assistant	Operational and Administrative Support	EACIF
Non-Bank Staff			
Name	**Title**	**Specialization**	**Unit**
Susie Sugiarti	Consultant	Family Development Session and HR Development,	GSP02
Shonali Sen	Consultant	Institutional Analysis and Social Welfare/Care Services for Elderly & Disabled	GSP02
Usman Javaid	Consultant	IT and Information System	GSP02
Atin Parihatin	Consultant	Family Development Session, Monitoring and Evaluation	GSP02

I. STRATEGIC CONTEXT

A. Country Context

1. **Indonesia is the world's largest archipelagic state, the fourth most populous nation, and the tenth largest economy with regard to purchasing power parity**. It is a member of the Association of Southeast Asian Nations group of countries that have a combined population of 608.4 million and is also a member of the G-20. With more than 17,500 islands, of which 6,000 are inhabited, Indonesia has a population of over 250 million, with 300 distinct ethnic groups and over 700 languages and dialects. With a gross national income per capita of about US$3,440 (2015), Indonesia is currently classified as a lower-middle-income country and will transition to an upper-middle-income country with continued economic growth.

2. **Over the past decade, Indonesia has seen strong growth and job creation, supporting poverty reduction, but the end of the commodity boom has exposed structural weaknesses.**[1] Following the recovery from the Asian financial crisis, annual growth averaged 5.6 percent over the 2001–2012 period. As the external tailwinds of commodity prices and demand and global financing conditions have turned to headwinds, growth has slowed, down to 4.8 percent in 2015 and projected at 5.1 percent in 2016. The slowdown in growth and weakening of commodity prices has increased fiscal pressures significantly in 2015 and 2016.

3. **Indonesia's progress on poverty reduction contrasts sharply with its performance in sharing prosperity.** From 1999 to 2016, the national poverty rate more than halved to 10.8 percent, largely through sustained growth and job creation. Recently, however, the rate of poverty reduction has begun to stagnate, with a near zero decline in 2015. Lifting the 'hard core' poor permanently out of poverty will require greater focus and new programs. In 2016, the number of vulnerable (that is, those between the poverty line and 1.5 times the line) remains high, at 24 percent of the population, mainly due to a lack of productive employment and vulnerability to shocks. Together, the poor and vulnerable are 35 percent of the population. Inequality, as measured by the Gini coefficient, increased from 30 points in 2000 to 41 points by 2014, by far the fastest widening seen in the East Asia and Pacific Region.

4. **Despite progress made in human development, several challenges remain.** In education, adult literacy is at almost 95 percent. Gross enrollment has reached 100 percent, 83 percent, and 32 percent in primary, secondary, and tertiary education, respectively. The share of female enrollment exceeds that of males at each level.[2] But disparities in access among socioeconomic groups have persisted. About 23 percent of villages do not have any pre-primary education services. There are also severe disparities in education service provision between urban and rural areas and across provinces. Health outcomes and outputs in Indonesia have also improved in recent years. Life expectancy at birth has steadily increased to 69 years in 2014, up from 63 years in 1990. The under-five mortality rate has declined from 85 per 1,000 live births in 1990 to 27 in 2015. However, there is slow progress on maternal health and chronic malnutrition. Indonesia has one of the highest maternal mortality rates in the East Asia and Pacific Region

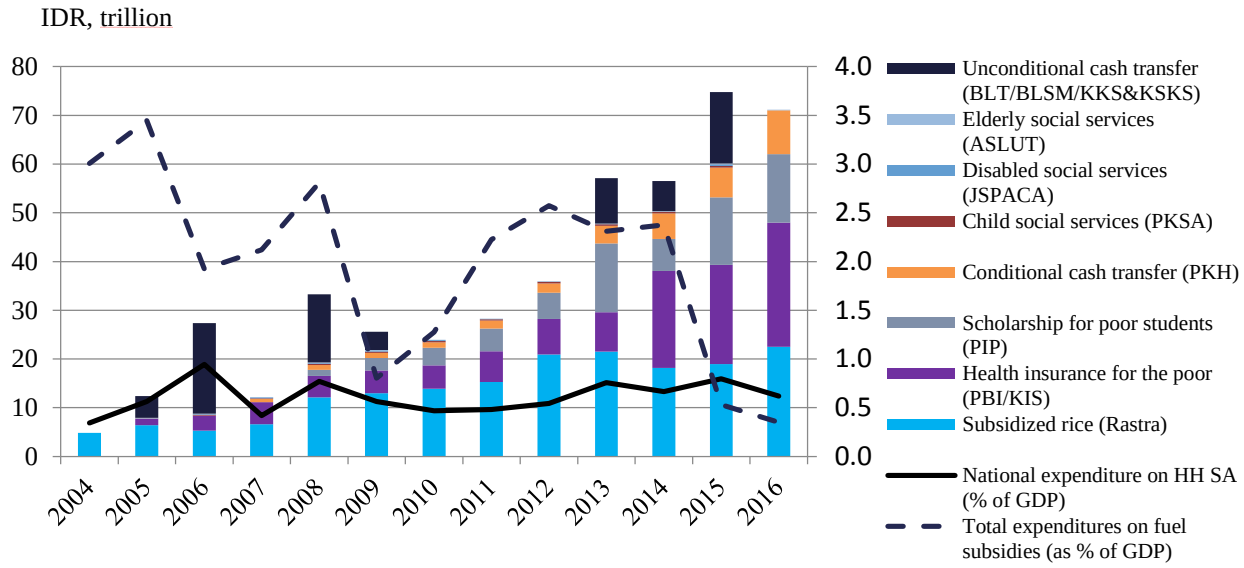
[1] World Bank. 2015. Indonesia - Systematic Country Diagnosis: Connecting the Bottom 40 percent to the Prosperity Generation.
[2] World Bank. 2016. Investing in Early Years: Indonesia Report.

(190 per 100,000 live births in 2013). Births attended by skilled health staff, rates of immunization, and rates of access to improved sanitation facilities also remain behind the region's developing country average. And latest data from 2013 showed that 37 percent of under-five children were stunted, while 12 percent were wasted. Stunting affected all income groups but worsened among the poorest, it increased from 41 percent in 2007 to 48 percent in 2013.

B. Sectoral and Institutional Context

5. **The year 2005 marked Indonesia's shift to begin investing comprehensively in social assistance (SA) programs because of the creation of fiscal space through the phasing out of a regressive fuel subsidy.** In 2010, a main development priority of the reelected Government was poverty reduction, implying a redesign of Indonesian SA programs to achieve broad-based economic growth and fiscal sustainability with the aim to improve access to and quality of basic social services. Since then, spending on SA has kept its upward trend to reach 0.7 percent of gross domestic product (GDP) in 2015-6 (still below the world average, at 1.6 percent of GDP).[3]

Figure 1. Expenditures on Targeted SA and Fuel Subsidies, 2004–2016



Source: World Bank. Forthcoming. Indonesia Social Assistance Public Expenditure Review.

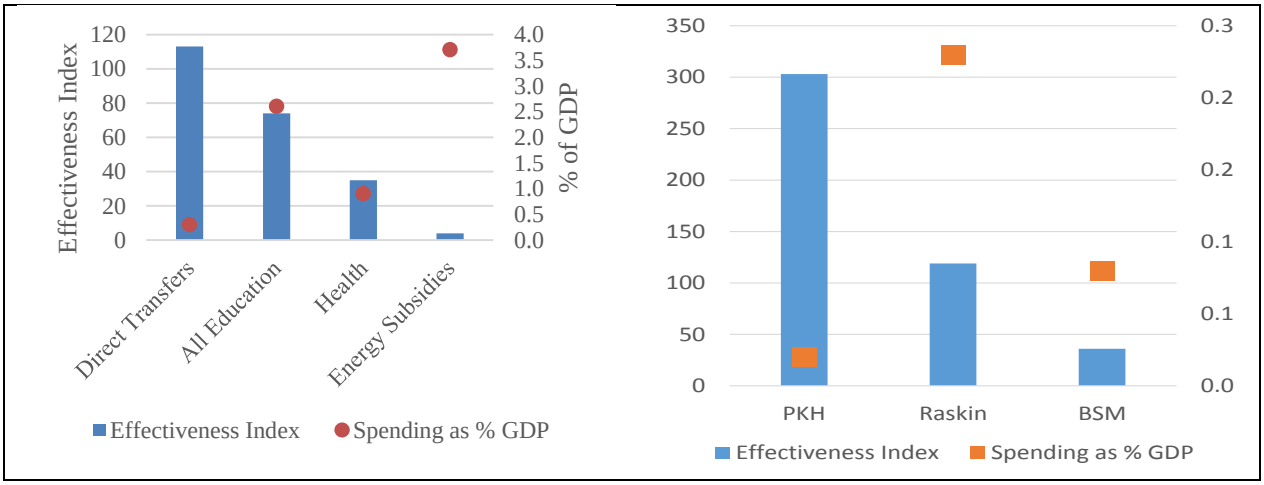
6. **Between 2010 and 2015, the Government executed several SA reforms, including the introduction of a new conditional cash transfer (CCT) program.** For example, standardized procedures for targeting and identifying potential beneficiaries, drawing on a new national registry of nearly 26 million poor and vulnerable households, were put in place. Also over this period, the national health insurance program (*Program Indonesia Sehat*, PIS, formerly called JKN-PBI) was also expanded to reach 92.4 million people in 2016, while the rice subsidy scheme for the poor (*Beras untuj Rakyat Sejahtera*, Rastra) reached 15.5 million households in

[3] World Bank. 2015. The State of Social Safety Nets 2015.

the same year. Several reductions in poorly targeted energy subsidies were achieved while the fiscal savings were reallocated to more effective purposes, including (a) a temporary, emergency, unconditional cash transfer (called *Bantuan Langsung Sementara Masyarakat*) targeted at poor and vulnerable households; (b) a family welfare card (*Kartu Keluarga Sejahtera,* KKS) giving beneficiaries access to multiple programs; and (c) benefit and coverage increases for the Smart Indonesia Scholarship Programs (*Program Indonesia Pintar*, PIPs) and the CCT program, Family Hope Program (*Program Keluarga Harapan*, PKH).

7. **Still, SA programs in Indonesia have limited poverty and inequality reduction impact based on current spending.** In 2012, less than one-quarter of total expenditures in the four permanent SA programs went to poor households while SA benefits eliminated only 16 percent of the poverty gap.[4] Direct transfers are the most effective at reducing poverty and inequality, yet total spending on direct transfers is dwarfed by that of energy subsidies. Among the SA programs, PKH is the most effective one with regard to its impact on poverty and inequality reduction.

Figure 2. Effectiveness Index and Spending in Selected Categories



Source: World Bank. 2016. "The Distributional Impact of Fiscal Policy in Indonesia."
Note: Effectiveness here is defined as how much a program reduces inequality, and therewith poverty, divided by the total budget spent. Direct transfers include PKH, Rastra, and PIP.

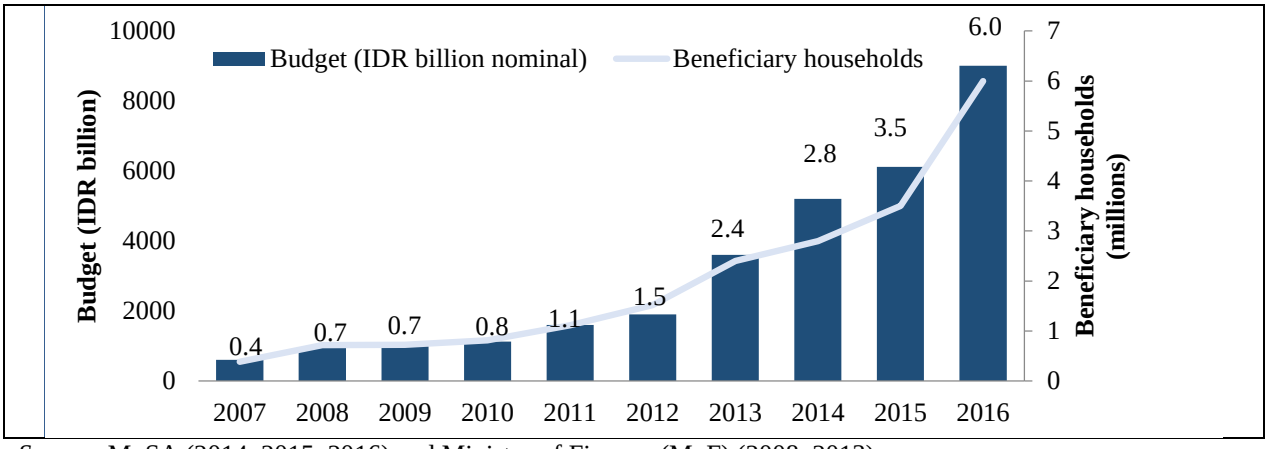
8. **The administration that took office in 2015 added a focus on reducing inequality and has identified SA, in particular the PKH program, as a means of reducing inequality in income and in opportunity.** The PKH program, implemented by the Ministry of Social Affairs (MoSA), was initiated in 2007, following reductions in the fuel subsidy. Initially it only included seven Indonesian provinces covering just under half a million families. Since then it has been expanding its coverage as part of a larger effort to build up a comprehensive social protection system to improve poor and vulnerable families' welfare and opportunity. PKH aims not only to help increase the beneficiaries' current consumption so as to alleviate poverty in the short run, but also to ensure their investment in the human capital of their children through education and health conditionalities. As PKH would encourage the beneficiary families to access and use basic

[4] World Bank (2017), Social Assistance Public Expenditure Review.

health, nutrition, and education services, it is expected to promote the future generation's opportunity and productivity in the long run.

9. **After reviewing the design, process, and systems of the PKH program, the Government decided in 2016 to expand its coverage to an impressive 6 million families, making it the third largest CCT in the world.** In the context of Indonesia's main SA programs, PKH has the highest effectiveness in terms of poverty and inequality reduction impact per IDR spent, but the lowest budget allocation.[5] Due to the potential highly effective impact of PKH with regard to poverty and inequality reduction per rupiah spent, the new administration had decided an impressive national scale-up in coverage, from 3.5 million families in 2015 to 6 million families (about 9 percent of the population) by the end of 2016. With the expansion, all except a few districts in Indonesia, including those of Papua, with the highest poverty rates in the country but previously not covered by PKH, are now covered. The ultimate goal of MoSA is to further expand the program by up to 15 million families by 2019 and reduce exclusion errors (poor families with children not covered; highly marginalized and remote regions with high presence of indigenous populations excluded). The program would come a long way from when it was first introduced in 2007 in seven Indonesian provinces covering just 382,000 very poor households.

Figure 3. PKH Coverage, Budgetary Support, 2007–2016



Source: MoSA (2014, 2015, 2016) and Ministry of Finance (MoF) (2008–2013).
Note: 2011–2013 data are realized budget; 2014, 2015, and 2016 data are budgeted totals.

10. **PKH's potential contribution to poverty and inequality reduction could be even higher when compared to other large CCT programs in the world.** With the expansion, all provinces in Indonesia, including Papua and West Papua, with the highest poverty rates in the country, are now covered. However, both its coverage of about 9 percent of the population and benefit level of 13 percent of beneficiary expenditure are still relatively low when compared to other large CCT programs. For example, the CCT programs in Mexico, Brazil, and the Philippines cover between 20 percent and 30 percent of the population and provide cash transfer benefits at 20 percent of consumption. Further coverage expansion will reduce exclusion errors, particularly among the vulnerable population who may easily fall below the poverty line due to

[5] World Bank. 2017 (forthcoming). Social Assistance Public Expenditure Review.

various shocks, and focus on the disadvantaged and remote regions with a high presence of indigenous populations.

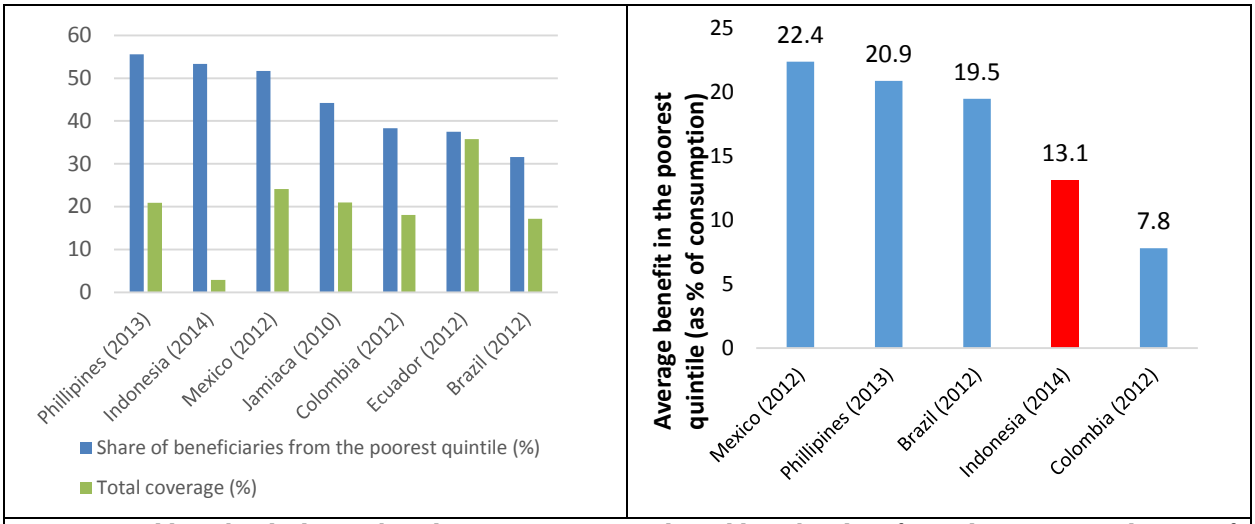
11. **PKH eligibility depends on both family resources and demographic composition.** To be eligible, a family must be included in the country's social registry (formerly called the Unified Database or UDB, and now called the Integrated Social Registry, or SISKADA) and ranked below a certain poverty cutoff point. They must also meet at least one of the following conditions: a family member is pregnant or lactating; the family has one or more children below 6 years of age; the family has children aged 7 years to 21 years attending primary or secondary school; or the family has children aged 16 years to 21 years who have not yet completed basic education. Furthermore, PKH beneficiary families must be in compliance with the relevant health and education conditionalities to receive the cash transfers, which are made only after verification of compliance with the conditionality. The mother is the main recipient in the majority of cases. Since November 2016, eligible families that have a severely disabled or an elderly person (70 years and older) living with them also receive additional transfers as long as they have not yet been covered by other SA programs (such as the old age assistance program).

12. **Robust impact evaluations have already shown positive impacts of PKH in increasing food expenditures, health-seeking behavior, and education for poor families and the communities in which they live.**[6] Two rounds of impact evaluation, using randomized-control trial techniques, have shown increases in participation in elementary and secondary school, transition from primary to junior secondary school, prenatal visits, and complete immunization for children. Similarly, a recent study showed that both worldwide and in Indonesia, CCTs do not increase recipients' purchasing of alcohol or cigarettes. Furthermore, it has been shown that cash transfers do not discourage work.[7]

[6] See World Bank. 2011. *Program Keluarga Harapan: Main Findings from the Impact Evaluation of Indonesia's Pilot Household Conditional Cash Transfer Program*. Washington, DC: World Bank;
TNP2K (National Team for the Acceleration of Poverty Reduction). 2015. *Evaluation Longer-Term Impact of Indonesia's CCT Program: Evidence from a Randomized Control Trial*. Jakarta: World Bank.

[7] Banerjee, Hanna, Kreindler, and Olken. 2015. "Debunking the Stereotype of the Lazy Welfare Recipient: Evidence from Cash Transfer Programs Worldwide." Working Paper No. 308.

Figure 4. PKH Targeting Performance and Coverage (left panel) and Benefit Level (right panel)



Source: World Bank calculations based on Susenas 2014 and World Bank Atlas of Social Protection Indicators of Resilience and Equity (www.worldbank.org/aspire). Both targeting performance (beneficiary incidence) and coverage are pre-transfer estimates, where data is available.

13. **PKH also has the potential to play a bigger role in Indonesia's fight against malnutrition.** The impact evaluations have shown that PKH is associated with important reduction in severe stunting among children of 3 percentage points, a significant milestone in a country with levels of malnutrition among the highest in the world. Indeed, in 2013, one-third of (almost 9 million) children in the country under age five were stunted. The prevalence of stunting among children from the poorest 20 percent is also higher as compared with countries with similar income level. The Government has pledged to take a multisectoral approach to address various binding constraints and bottlenecks in both the supply side (for example, service provisions of health, nutrition, water, and sanitation) and demand side (for example, awareness and knowledge in nutrition, and positive behavior changes). PKH could address the demand-side issues effectively by not only incentivizing beneficiary families to use existing health and nutrition services, but also promoting positive behavior changes (for example, exclusive breastfeeding) through monthly group-based learning meetings, called Family Development Sessions (FDSs). FDSs were originally designed as an instrument of graduation strategy to support PKH beneficiary families who are at the end of their six-year cycle. MoSA has decided to roll out FDSs to PKH beneficiary families regardless of their status in the six-year cycle. The FDS' structured learning modules are also to be upgraded incorporating the new findings from behavior research.

14. **Still, several reforms are required to improve PKH implementation**. For instance, MoSA needs to establish a clear road map for identification and progressive inclusion of PKH beneficiaries, including in remote underserved areas (for example, Papua) and to new beneficiary groups (elderly, disabled). PKH's scale-up also requires a review of the program management information system (PMIS) to verify how it can effectively cope with expansion, including a potential review of its business processes, to ensure its capability and reliability to support expanded operational needs. MoSA also intends to pursue a rapid rollout of bank account-based card payment options (including savings accounts) for a more diversified financial inclusion strategy. Changes in program rules and scale-up will require an overhaul of the grievance redress

system (GRS). A massive scale-up and other potential program changes will require a thorough strategy on how to effectively communicate such innovations to the beneficiaries and the general public (including media). PKH's expansion will also demand a thorough strengthening of the institutional architecture of the program, which will be much harder to administer from the central level, and revise the current human resource (HR) strategy, in particular with relation to the role and functions of the program facilitators.

15. **As PKH is a key pillar of the comprehensive SA system, the efforts to strengthen the program will actually contribute to the development of the whole SA system.** While the Government has in place a collection of SA programs to achieve its poverty reduction goals, these programs reach only portions of all intended beneficiaries and are highly fragmented both internally and in relation to the rest of the system. In recognition of the great potential of better coordination between its suite of SA programs and implementation units, the MoSA leadership is also undertaking a review of its organizational structure, management models, and HR base, starting with a ministry-wide information management and information technology (IT) strategic plan. It has also started to pilot a payment integration model between PKH and the subsidized rice scheme Rastra (given current coverage gaps of Rastra among PKH families). And, MoSA is undertaking technology and HR upgrading to be able to manage the UDB, currently hosted by the National Team for the Acceleration of Poverty Reduction (*Tim Nasional Percepatan Penanggulangan Kemiskinan*, TNP2K) under the Vice President's Office until MoSA's capacity is strengthened. Government's aim is to eventually transform it into a dynamic social registry information system for SA interventions. An additional challenge is how central and local governments coordinate implementation of SA programs. In 2014, less than 30 percent of the CCT families in the poorest decile received PIP, PIS/JKN-PBI, and Rastra even though they were eligible for all three programs. Efforts at integration have been made; however, very little progress has been made regarding common standards and processes among programs. More recently, MoSA, in coordination with the National Development Planning Agency (*Badan Perencanaan Pembangunan Nasional*, BAPPENAS) is piloting an Integrated Service and Referral System (*Sistem Layanan Rujukan Terpadu*, SLRT) in 50 districts to promote better coordination, referral, and update of beneficiary information. Similarly, MoSA is piloting and aiming to scale up coverage for a new concept (called 'e-Warong') to integrate digital payments of benefits at the local level, including PKH, Rastra, and Cooperative Business Groups (*Kelompok Usaha Bersama*, KUBE)-PKH (for PKH beneficiaries) in several localities.

C. Relationship to the Country Partnership Framework (CPF) and Rationale for Use of Instrument

16. **The proposed Program is well aligned with the World Bank Group's twin goals of eliminating extreme poverty and increasing shared prosperity.** It supports the CPF for Indonesia FY16–FY20 (Report No. 99172), in particular under Engagement Area (EA) 4: Delivery of Social Services and Infrastructure; EA 6: Collecting More and Spending Better; and Supporting Beam (SB) II: Shared Prosperity, Equality, and Inclusion. The task also contributes to the achievement of the CPF objective indicators on (a) percentage of mothers and children receiving maternal and child health and nutrition services in community health center and its network in targeted areas (EA 4); (b) Central Government spending on health, capital expenditure, and SA (EA 6); (c) number of households benefiting from PKH, disaggregated by gender (SB II); and (iv) increase in the number of SA beneficiaries receiving payments digitally

(SB II). Moreover, with a strategic focus on delivery systems strengthening, promoting human capital, and increasing coordination across SA interventions, the Program is aligned with the World Bank's Social Protection and Labor Strategy 2012–2022.

17. **The World Bank is well positioned to support the Government of Indonesia through the Social Assistance Reform Program.** Through the last several years of engagement in the SA sector, the World Bank has established itself as a knowledge organization that is uniquely positioned to bring international good practice to bear. The World Bank has supported a range of analytical work that has strengthened the overall SA sector (through the Social Assistance Reform Technical Assistance, P117975, operating during FY09-FY16; and more recently through the ongoing Indonesia Social Assistance Strengthening Technical Assistance, P160590, while increasing the efficiency and effectiveness of individual programs. The World Bank-executed technical assistance (TA) package provides advice to PKH in the areas of identification/enrollment of beneficiaries, compliance verification, business processes and PMIS, payments, GRS, FDSs, communications/social marketing, monitoring and evaluation (M&E), and institutional reform and HR management, as well as to improve coordination with other SA programs. This TA has been valuable to strengthen MoSA's capacity to achieve better results for PKH. As such, it is closely aligned to this proposed Program-for-Results (PforR) and its results areas, and is critical to help MoSA achieve the intended results.

18. **Additionally, the World Bank's convening authority in the sector is well recognized, as is its commitment to support the Government-led, multi-donor processes.** In particular, the World Bank has an extensive track record in leveraging substantial expertise in expanding/reforming CCTs (for example, from many Latin American and Caribbean region countries; the Philippines, Kenya, Pakistan, and so on), and in fostering coordination between CCTs and other SA interventions, bringing the best available global knowledge to the Program. Moreover, the World Bank is among MoSA's major external partners, and MoSA sees value in having the World Bank's credibility and backing in reforming its SA program. In particular, the World Bank brings expertise to develop the instruments and tools required to operationalize the scale-up of large CCTs and monitor them adequately. The World Bank financing support can also allow deep engagement and dialogue with other central ministries such as the MoF and BAPPENAS on how best to support the SA agenda and its key flagship interventions.

19. **Adopting the World Bank's PforR instrument will ensure that the proposed operation effectively supports this Government-led agenda.** The PforR instrument seems appropriate for the proposed operation due to its focus on results for a mature program operating since 2007. More specifically, by linking disbursements to achievement of results that are tangible and verifiable, the PforR can be an effective instrument to shift focus toward policies and sector results and generate cross-sectoral consensus toward the reform, away from the financing of inputs as in Investment Project Financing. The PforR instrument would enable the World Bank's efforts to focus on technical inputs to key elements of the SA reform agenda and help build capacity within MoSA by complementing it with the existing World Bank-executed TA task. It also provides an instrument for Government to monitor progress of the reform against key milestones.

20. **The proposed PforR is also well aligned to a long-standing support of the World Bank to the social inclusion agenda, as well as efforts to improve the effectiveness of social**

spending. The World Bank has supported, through lending operations, a long-standing stream of projects aimed at rural and urban community development under the National Program for Community Empowerment (*Program Nasional Pemberdayaan Masyarakat,* PNPM) launched in 2008. For instance, the PNPM-Rural is now one of the world's largest community-based poverty reduction programs, implemented nationwide in over 60,000 villages, and it is supported by the ongoing Village Innovation Program (P128832). A pilot version of PNPM, called Generasi (ID-IF National Program Community Empowerment in Rural Areas Healthy and Bright Generation' Project, P132585), has also been supported by the World Bank to provide community-based, targeted CCTs for increased utilization of health and education services. Finally, the recent Indonesia Fiscal Reform Development Policy Loan (P156655, closed in December 2016) had a major focus on improving the impact of the Central Government's budget allocation by increasing resources, among others, to the SA sector.

II. PROGRAM DESCRIPTION

A. Government Program

21. **The integration of family-based SA schemes for poor and vulnerable families through CCTs is one of the key strategies in the National Medium-term Development Plan (*Rencana Pembangunan Jangka Menengah Nasional,* RPJMN) 2015–2019.**[8] The RPJMN recognizes the need to perfect the social protection system comprehensively for all citizens and to support special programs for the poor by improving targeting accuracy.[9] In it, under the section on 'Policy Directions and Development Strategies' (page 1–71), in the 'Organization of Comprehensive Social Protection' subsection, and 'Structuring of Regular and Temporary SA Based on Families and the Life Cycle through Productive and Prosperous Families' theme, the Government has determined the need to establish a comprehensive social protection system for all citizens and improve targeting accuracy of the SA programs for the poor. Its policy direction, in particular, discusses the need to "integrate several family-based SA schemes for poor and vulnerable families that have children, disabled, and elderly in the form of CCTs and/or through in-kind assistance to support nutrition."

22. **In turn, MoSA's Strategic Plan (Renstra)[10] for the period 2015–19 also put the focus on PKH as a key instrument for poverty alleviation.** PKH's legal framework is supported by several subsequent ministerial decrees.[11] In synchronization with the RPJMN, MoSA's Renstra 2015–2019 has established the following strategic objectives: (a) to contribute to reducing the number of poor people and vulnerable groups by at least one percentage point and support them in meeting their basic needs and improving their abilities and (b) to improve the HR capacity of the institution by increasing the quality of its social welfare activities and its facilitators. The first

[8] This RPJMN was published by the Presidential Decree No. 2 of 2015.
[9] The mandate of the Government of Indonesia in the area of social protection is stated in Law No. 11 of 2009 on Social Welfare, and Law No. 13 on 2011 on Management of Poor People. Those laws are then strengthened with the Government Regulation No. 39 of 2012 on Social Welfare Implementation and Government Regulation No. 63 of 2013 on the Implementation of Poor People Management through Area Approach, and Law No. 23 of 2014 on Local Government, and Government Regulation No. 38 of 2007 on Government Affairs Distribution between the Government, provincial government and city/district government.
[10] MoSA. 2015. "Rencana Strategis (Renstra) Kementerial Sosial RI, Tahun 2015–2019".
[11] The most recent one is number 12/LJS/09/2016.

objective is expected to be partially achieved by increasing PKH coverage to at least 6,000,000 in 2016 (already achieved) and up to 15,000,000 poor families by 2019, covering all 34 provinces, 426 districts, and 98 cities, as well as by expanding and integrating other SA interventions (see table 1).

Table 1. Selected MoSA Minimum Strategic Targets by 2019

Beneficiaries of CCT (PKH)	**6 million (min) to 15 million (max) families**
PKH participants who are beneficiaries of PIS/JKN-PBI	452,500 families
Poor and vulnerable people who are beneficiaries of welfare family saving program	16,030,897 people
Persons with severe disability who are beneficiaries of SA	24,500 people
Abandoned elderly who are beneficiaries of SA	33,000 people
Poor and vulnerable families that are beneficiary of sustainable business activity group (KUBE-PKH).	70,000 (rural), 326,411 (urban), and 135,000 (coastal, outer islands, and border areas) families

Source: Renstra 2015–2019.

23. **MoSA's Renstra and PKH's updated Operational Guidelines also highlight several areas of reform at both the ministerial and the program levels, to achieve the stated objectives of improved performance and impact of PKH.** For PKH to be a 'center of excellence' in poverty alleviation and foster 'social empowerment', MoSA's Renstra discusses the need for "integration, focus, program/activity segmentation, service targets, program/activity implementation supervision, synergy and synchronization, service and supervision standards, social welfare implementation HR quality and quantity, institutional quantity and quality, output-oriented service system mechanism, and the lack of integrated data base and service system" as key challenges to overcome during 2015–2019. It also recognizes that "parallel with the increase of budget target and PKH coverage from initially 3,000,000 to 6,000,000, and even up to 15,000,000 poor families in 2019, a new institution is needed to improve PKH implementation performance by putting into consideration a vast coverage area that consists of 34 provinces, 426 districts and 98 cities as well as 6,982 sub-districts." This last reference accounts for extending PKH coverage to provinces previously not served and despite having the highest poverty incidence (for example, Papua), now becoming a truly national program. The strengthening of PKH business processes, improving target accuracy, broadening target, and strengthening inter-program complementarity, as well as the inclusion of components (benefits) for people with severe disabilities and elderly, are also highlighted as critical agendas beyond 2016, in the recently updated (August 2016) program Operational Guidelines.[12]

24. **While multiyear budget planning is not the norm in Indonesia, to achieve these targets and results, MoSA undertook expenditure framework exercises that anticipated budgetary needs between IDR 61.7 trillion (RPJMN) and IDR 86.8 trillion (Renstra) for 2015–2019.** More detailed budget figures for PKH alone are presented in table 2. With a total of IDR 8.7 trillion (US$653 million) in 2016 second revised budget, PKH represents almost 70 percent of MoSA's budget. As seen in table 2, MoSA has been successfully implementing the PKH program based on its annual budgets and performance targets, with execution in excess of

[12] MoSA. 2016. "Pedoman Pelaksanaan Program Keluarga Harapan", updated September 2016.

95 percent of the planned budget. For 2017 its budget is expected to increase by 42 percent over the actual 2016 program spending to reach US$958 million (0.12 percent of Indonesia's GDP), in light of the planned expansion. A more detailed disaggregation of the planned 2017 budget shows that 88 percent of the expenditures are related to cash transfers to beneficiaries, with administrative costs around 12 percent, of which 64 percent correspond to salaries of facilitators and other contracted staff (around 25,000) (table 3). The ambitious system-strengthening agenda that lies ahead to successfully cope with the program expansion will likely require an increase in the administrative cost share allocation.

Table 2. PKH Expenditure Framework, 2016–2017

PKH Budget (IDR, billions)	2015 Planned	2015 Realized	2016 Planned	2016 Revised (2nd phase)	2016 Realized	2017 Planned
Total	6,385	6,266	9,998	8,683	8,964	12,748
Benefit transfer	5,580	5,580	8,708	7,621	7,965	11,340
as % of Total	87	89	87	88	89	88
Administration cost	805	686	1,290	1,011	999	1,408
as % of Total	13	11	13	12	11	12

Source: MoSA (2016–2017) and MoF Financial Note.

Table 3. PKH by Budget Category, 2017

Administration Cost by Activity Type	2016 Realized (%)	2017 Planned (%)
Compensation for staff (contracted)	66	64
Fee for payment services (PT Pos)	15	14
FDS training	0	10
Field implementation (IT, M&E, basic trainings, other operation cost)	19	12

Source: Renstra of MoSA 2015–19.

B. Program Development Objective/s (PDO) and Key Results

25. **The PDO are to support the conditional cash transfer program coverage expansion, strengthen its delivery system, and improve its coordination with other complementary social programs.**

26. **The progress toward achieving the PDO will be measured through five key results indicators:**

(a) Share of sub-districts with PKH beneficiary families having switched to cashless payment methods
(b) Share of PKH beneficiaries receiving other social assistance program benefits
(c) Share of children aged 7–18 years in PKH beneficiary families attending primary, junior, and senior secondary school at least 85 percent of the time
(d) Share of children aged 0–6 years in PKH beneficiary families who received basic health and nutrition services in accordance with protocol
(e) Total number of PKH beneficiary families

27. **These indicators reflect the three Results Areas that the proposed World Bank lending operation is expected to support:**

(a) **Results Area 1:** Strengthening the program delivery system to improve efficiency, transparency, and accountability
(b) **Results Area 2:** Improving access to basic social services and complementary social assistance programs for PKH beneficiaries
(c) **Results Area 3:** Expanding coverage and improving inclusivity of the conditional cash transfer program

28. The first indicator reflects the enhanced operational efficiency and transparency of PKH delivery system with regard to payments made to the program beneficiaries through modern electronic payment modalities (Results Area 1). The second to fourth indicators reflect the improved coordination between PKH and other complementary social programs, ensuring that PKH beneficiaries are also prioritized to receive other SA benefits and services, particularly PIP, Rastra, and PIS, as well as the effective use of health and education services through compliance with Program conditionality (Results Area 2). Finally, the fifth indicator reflects the progressive expansion of PKH program among the poor and vulnerable population, including previously excluded areas (Results Area 3).

C. PforR Program

29. **The proposed PforR is consistent with the Government's program, supporting PKH CCT's strengthening, coordination with other services and SA programs, and expansion of coverage to improve inclusiveness.** It focuses on three results areas and a complete results chain illustration is provided in figure 5.

(a) **Results Area 1: Strengthening the Program delivery system to improve efficiency, transparency, and accountability.** *Ultimate Outcomes: (i) improved efficiency of PKH implementation; (ii) improved transparency of PKH implementation; and (iii) improved accountability of PKH implementation.* This results area aims to address a number of gaps and inadequacies in the building blocks of PKH delivery system to ensure smooth expansion and enhance the program results. The key Program activities to reach the intended ultimate outcomes cover simplification of business processes, upgrading of information management system, rollout of electronic payment modalities, strengthening of GRS and M&E systems, and development of a PKH communication strategy, HR management plan, and error, fraud, and corruption (EFC) detection and control mechanisms. While many of these activities are ongoing, previous efforts were clearly made under different policy and operational environments than those existing today. Therefore, the existing mechanisms and tools are inadequate to support the administration's current needs. For example, the existing PMIS was not designed to manage millions of beneficiary families and its performance, capability, and reliability have become so inadequate that many administration tasks cannot be carried out effectively, hampering efficiency, transparency, and accountability of the program. A comprehensive gap analysis is much needed to develop an action plan for the minimum required protocols and standards of data integrity, security, and operational soundness. Also, to build in-house capacity to manage the systems and system development, an industry-standard IT system audit is planned to ensure

that the upgraded PMIS continues to be assessed and improved accordingly. The PforR will build on the experience accumulated from the inception of PKH and learn from the good practices of other social programs both inside and outside of Indonesia.

(b) **Results Area 2: Improving access to basic social services and complementary social assistance programs for PKH beneficiaries.** *Ultimate Outcomes: (i) improved access for PKH beneficiary families to social protection programs; (ii) improved educational outcomes of PKH beneficiary children; (iii) improved nutrition status of PKH beneficiaries, particularly children.* The ultimate goal of PKH is to improve the educational and health/nutrition outcomes of children. For that, it is critical that beneficiaries have the appropriate knowledge on good feeding and hygiene practices and child development, and have access to the needed basic education and health services. The revision of modules and training of facilitators to implement the improved FDS to a larger number of families can contribute towards increasing beneficiary knowledge and help achieve these critical outcomes. Equally important is that the poorest families, i.e. PKH target group, can also be ensured effective enrollment in all the complementary social assistance programs they are entitled to, including the large-scale ones as Rastra, PIS, and PIP programs, to maximize their chances to exit poverty in a more sustained way. For that, a pre-requisite is that these families are appropriately identified, which will also require registration and verification of Single Identity Number (*Nomor Induk Kependudukan* or NIK).

(c) **Results Area 3: Expanding coverage and improving inclusivity of the conditional cash transfer program.** *Ultimate Outcomes: (i) progressive expansion of PKH coverage until 2020 based on policy targets, including previously excluded geographical areas; and (ii) increased consumption among PKH beneficiaries.* The expansion of PKH is needed to ensure that most of the poorest families in the country are effectively covered, minimizing exclusion gaps. The program has already expanded in December 2016 to reach 6,000,000 beneficiary families, including 42 new districts, with which the program will achieve the coverage of all districts for the first time. More importantly, the majority of the new districts are in Papua and West Papua provinces, which suffer from high poverty but have been underserved by PKH and other public services. The program has also expanded to cover poor families with severe disabled and elderly members. This results area aims to support further gradual coverage expansion, particularly after its delivery system is strengthened, and continuing prioritizing the underserved areas in the Papua region and less connected sub-districts in other regions. Ultimately objective is that PKH consumption among beneficiary families is increased, focusing on ensured program coverage among most needed population groups.

Figure 5. PforR Results Chain

Activities	Outputs	Intermediate Outcomes	Outcomes
Results Area 1: Strengthening the program delivery system to improve efficiency, transparency, and accountability			
Assess, design, and develop PKH PMIS architecture	**PKH PMIS Enhancement Plan implemented**	Upgraded/integrated PMIS deployed to support operation	Improved efficiency of Program implementation
Review and re-engineer PKH business processes	PKH Operation Manuals revamped	**Increase in the share of PKH families' conditionality verified and recorded in PKH PMIS***	
Develop a rollout strategy to transition toward cashless payments	Decisions on cashless modalities made and implemented	**Increase in PKH recipients paid through cashless methods* (PDO Indicator i)**	
Assess, design, and develop an M&E system	Improved operational M&E system implemented	Improved evidence-based management decisions	Improved transparency of Program implementation
Assess, design, and pilot a GRS system	**Implementation of an enhanced GRS after evaluation of pilot**	Complaints recorded and redressed within one month	
Develop a communication strategy for the central and local government levels	Improved communication strategy implemented	Increase awareness among stakeholders	
Assess and revamp HR development and management plan, including redefinition of roles and responsibilities of internal units	HR competency and performance monitoring system developed and roles for internal units defined	HR competency enhanced and coordination among units improved	Improved accountability of Program implementation
Develop systems for EFC detection and control	EFC systems implemented	EFC managed properly	
Results Area 2: Improving access to basic social services and complementary social assistance programs for PKH beneficiaries			
Identify PKH beneficiaries eligible but excluded for other basic social services (Rastra, PIS, and PIP)	**Increase in PKH beneficiaries whose ID numbers have been verified ***	**Increase in PKH beneficiary families receiving other SA programs (Rastra, PIS, and PIP) * (PDO Indicator ii)**	Improved access for PKH beneficiary families to social protection programs
Development of an FDS implementation strategy and training of PKH facilitators to implement FDSs	**Number of PKH mother groups that have received FDSs from trained facilitators ***	Increase in use of education services for PKH families (**PDO Indicator iii**)	Improved educational outcomes of PKH beneficiary children

Review and revise health and nutrition module of FDSs and delivery modality		Increase in use of health and nutrition services for PKH families (**PDO Indicator iv**)	Improved nutrition status of PKH beneficiaries, particularly children
Results Area 3: Expanding coverage and improving inclusivity of the conditional cash transfer program			
Prepare the potential new beneficiaries list using the most recent targeting data	New eligible beneficiaries informed, validated, and registered	**Total number of PKH beneficiary families*** (**PDO Indicator v**)	Progressive expansion of coverage until 2020 based on policy targets, including previously excluded geographical areas
Assess and adapt PKH parameters and procedures for areas with implementation challenges	Share of PKH beneficiaries in previously underserved provinces	**Ratio of number of PKH beneficiary families to number of the targeted families in areas categorized by the Ministry of Social Affairs as remote and border areas ***	Increased consumption among PKH beneficiaries
Identify existing PKH beneficiaries eligible for disabled/elderly benefits	Adjusting identified PKH beneficiaries to add disabled/elderly benefits	Eligible PKH beneficiaries receive disabled/elderly benefits	

Note: DLIs are in bold. * indicates scalable DLI.

30. **It is estimated that the PforR financing will represent 4.2 percent of the total PKH budget over the fiscal years 2017 through 2020.** There are three major expenditures for the program: (a) CCTs, (b) consultants/facilitators, and (c) fees for CCT transfer. This calculation is made under the assumption that benefit levels remain the same as in 2017 and by calculating a constant ratio of 11 percent for administrative costs.

Table 4. Program Financing, FY17–FY20 (US$, millions)

Source	Amount	% of Total
Government	4,732	95.8
IBRD/IDA	200	4.2
Total Program Financing	**4,932**	**100.0**

Note: The Government's contribution is calculated based on expansion coverage targets in DLI 8 for the period 2017–2020, and assuming constant share of administrative costs of 11% as in the 2016 realized budget.

31. **PKH has benefited from strong support from a range of development partners.** Aside from the World Bank, the German Development Cooperation Agency (*Deutsche Gesellschaft für Internationale Zusammenarbeit* GIZ), United Nations Children's Fund (UNICEF), and the Australian Department of Foreign Affairs and Trade (DFAT) have been supporting MoSA over several years to implement the CCT program, including early PMIS development and business process reviews. GIZ has specifically supported the assessment of PKH HR management and its operational modality in remote areas. UNICEF has played a critical role in supporting the development of FDS modules for health and nutrition. DFAT has been a key instrumental partner for the World Bank, providing most of the funding for the first World Bank-executed TA package to MoSA (Social Assistance Reform Technical Assistance, P117975), and continues to finance the ongoing TA assistance (Indonesia Social Assistance Strengthening Technical Assistance, P160590) that will support this PforR operation. Others

development partners, such as the Asian Development Bank and the World Food Programme, are also exploring ways to support the SA reform agenda. The World Bank has been and will continue coordinating with them to ensure synergy and avoid duplication of activities.

D. Disbursement-Linked Indicators and Verification Protocols

32. **The World Bank will disburse funds for US$200 million over four years through nine disbursement-linked indicators (DLIs) for the Program.** These are the following and identified in annex 3, along with the Program's results monitoring framework provided in annex 2:

- DLI 1: PKH PMIS enhancements implemented
- DLI 2: Share of sub-districts with PKH beneficiary families having switched to cashless payment methods
- DLI 3: An enhanced GRS rolled out after evaluation of pilot
- DLI 4: Share of PKH beneficiary families, for which verification of their respective conditionality is recorded in PKH PMIS
- DLI 5: Share of PKH beneficiaries receiving other social assistance program benefits
- DLI 6: Share of PKH beneficiary families whose NIK numbers have been verified
- DLI 7: Number of PKH mother groups that have received FDS from trained facilitators
- DLI 8: Total number of PKH beneficiary families
- DLI 9: Ratio of number of PKH beneficiary families to number of the targeted families in areas categorized by the Ministry of Social Affairs as remote and border areas

33. **The three main criteria for selecting these DLIs are that** (a) the desired results are within control of the implementing agency, MoSA; (b) the DLIs are achievable in the Program period; and (c) the DLIs are verifiable. The DLIs are designed combining both scalability (financing proportional to the progress toward achievement) and floating (disbursements made when they are met) features.

34. **The Program will triangulate DLIs' evidence from multiple sources.** An independent verification agency (IVA) will verify all DLI evidence submitted by MoSA. The Financial and Development Supervisory Agency (*Badan Pengawasan Keuangan Dan Pembangunan*, or BPKP), a government agency reporting directly to the President and mandated to carry out duties in auditing, evaluation and supervision, will be assigned by MoF to carry out the verification task (formal assignment of BPKP to carry out the verification of DLRs achievement is a condition of effectiveness of this loan). BPKP has already been assigned as IVA in an ongoing loan operation in Indonesia (Local Government and Decentralization Project, P111577), performing so far according to plan. Verification data will be drawn from, among others, the PMIS module and random sample surveys. In addition, external sources of verification include, but will not be limited to, operational reviews (spot checks and process evaluations) and validation reports by

payment service providers (PSPs). The calendar year for verification will be from January 1 to December 31 each year. The verification protocols are provided in Annex 3.

E. Capacity Building and Institutional Strengthening

35. **Capacity building and institutional strengthening are critical elements of the PforR and will be delivered as part of the Program Action Plan (annex 8).** PKH had been implemented by a program implementation unit largely staffed by consultants and attached to one subdirectorate within MoSA. The current MoSA leadership has begun to mainstream and transfer the responsibilities of PKH implementation to regular civil servants of a whole directorate. This reform is timely in light of the expanded coverage and changes in the program design for PKH, which will increase the implementation workload. Therefore, MoSA's strategy includes an ambitious HR recruiting and training plan, strengthening IT support, and fostering linkages with other partners in (local governments, health, and education sectors). Additional budget funding would be required for MoSA to carry out its capacity upgrading.

36. **Similarly, the World Bank will support the implementation of the PforR through a complementary TA package under the Indonesia Social Assistance Strengthening task (P160590).** The TA supports MoSA with just-in-time advice in improving PKH's key operational building blocks, including the areas of identification/enrollment of beneficiaries, compliance verification, business processes and PMIS, payments, GRS, nutrition-sensitive FDSs, M&E, and institutional reform and HR management. It also supports MoSA in developing a ministry-wide information management and IT strategic plan, with a view to foster better coordination and complementarity across the SA programs it implements. The TA is partially funded by the Australian DFAT though a Trust Fund established with the World Bank.

III. PROGRAM IMPLEMENTATION

A. Institutional and Implementation Arrangements

37. **The Program is implemented by MoSA in collaboration with other line ministries (LMs) and local governments.** The policy decision body is the National Coordination Team, which is advised by the Coordinating Minister of Human Development and Cultural Affairs, chaired by the Minister of Social Affairs and consists of echelon 1 level (top rank civil servant) officers from the following ministries/agencies: MoSA, BAPPENAS, Ministry of Health, Ministry of Education and Culture, MoF, Ministry of Religious Affairs, Ministry of Communication and Information, Ministry of Manpower, Ministry of Home Affairs, Ministry of Village, Development of Disadvantaged Regions and Transmigration (MoV), Ministry of Women Empowerment and Child Protection, and Central Bureau of Statistics (*Badan Pusat Statistik,* BPS). The policies are operationalized by a Technical Coordination Team which consists of director-level officers from those ministries/agencies. There is an equivalent PKH Technical Coordination Team at the provincial, district/city, and sub-district levels and these local teams are responsible for implementation coordination.

38. **Within MoSA, the Directorate of Family Social Security (*Jaminan Sosial Keluarga*, JSK) under the Directorate General (DG) of Social Security and Protection, is responsible for implementing PKH.** PKH program management structure has been reformed recently. In

October 2015, MoSA issued a ministerial decree[13] to reorganize the entire directorate of JSK with the central implementation unit of PKH (*Unit Pelaksana Program Keluarga Harapan*, UPPKH). The reorganized JSK has four subdirectorates (subdit) and all are involved in PKH implementation. Both the civil servants and contracted 'experts' are re-mapped to various teams under the four subdirectorates.

39. **The institutional arrangement for PKH implementation at the subnational level has mirrored the organizational arrangement at the central level.** At each subnational level, previously a local UPPKH consisting of contracted personnel carries out virtually all the program implementation functions, while formally being supervised by the Social Affairs Office (*Dinas Social*) of each subnational government. Going forward, the Social Affairs Offices are responsible for PKH implementation with support of contracted personnel.

40. **Since its inception, thousands of PKH facilitators have been mobilized to carry out myriad of core and supporting functions.** Such functions range from conducting socialization; advocacy; running initial meetings and eligible beneficiary validation; assisting beneficiaries in withdrawing cash; updating, verifying, and entering data; organizing and leading FDS; handling complaints and case management; recording and reporting beneficiaries' compliance to conditionalities; reporting on payment reconciliation; distributing PKH cards to participants; and preparing weekly activity reports. PKH facilitators are recruited nation-wide through a competitive selection. The ratio of facilitators to PKH families is usually 1:200-250, but this ratio is lower for islands or areas that are difficult to reach. These facilitators carry out the day-to-day responsibilities to ensure that the program is implemented on the ground.

41. **As a CCT program, PKH depends critically on availability of health and education services.** Although the availability of standard health and education services in Indonesia is considered quite reasonable, it is likely that certain services that PKH families require to meet program conditionality might not be available. Service gaps are more likely in certain geographic (mostly rural and remote) areas. The Coordinating Ministry for Human Development and Cultural Affairs is a key institution in supporting coordination and availability of essential human development services. The district PKH Technical Coordination Teams can address supply-side constraints as they emerge.

B. Results Monitoring and Evaluation

42. **MoSA will be responsible for monitoring results and activities under the Program by using its M&E systems**. MoSA has a dedicated M&E team, uses various data sources, and will be responsible for tracking progress against result indicators and the DLIs. Concurrently, it will work to further strengthen its M&E, including the quality of administrative data collection, and the security and operational soundness of the PMIS. The M&E team in the JSK is supported by provincial coordinators who oversee 514 district coordinators. Regional and local staff assist in updating indicators on the FDS implementation, training of facilitators, and the rollout of the GRS. The remaining indicators which are measured by outputs (completion of a communication

[13] Ministerial Decree, October 2015.

strategy and HR competency and performance monitoring system implemented) are to be monitored by the World Bank team together with the IVA.

C. Disbursement Arrangements

43. **The World Bank will disburse US$200 million through the nine DLIs under the Program.** The time frame for achieving each DLI takes into account the Government's need for budget predictability and flow of funds. There is no restriction on early achievement of the DLIs: payment will be disbursed as and when targets are achieved. All releases of DLI amounts will be done after a verification of DLI evidence by an IVA according to the agreed verification protocols at negotiations.

44. **The Program will follow a regular biannual implementation review jointly with PKH management, which will include projections for achievement of DLI targets.** The World Bank will also provide annual feedback to the MoF on expected disbursements against DLIs for the following fiscal year, coinciding with the Government's regular cycle of estimating budgetary ceilings for ministries and attached departments.

IV. ASSESSMENT SUMMARY

A. Technical

45. **The World Bank's technical assessment of the sector confirms that the proposed operation is strategically relevant to the Government's development objectives.** The RPJMN recognizes the need to support special programs for the poor such as PKH and integrate family-based SA schemes for poor and vulnerable families that have children, disabled, and elderly. PKH is one of the key programs comprising Indonesia's social safety net and warrants sustained government intervention for several reasons. A comprehensive SA system is an important prerequisite for sustained and inclusive economic growth. Generally, it reduces poverty by providing direct income support, through cash transfers such as PKH and PIP, and protects against economic shocks by fostering access to social insurance through PIS, fee waiver to access Indonesia's public health insurance scheme, while increasing overall employment and employability of poor and vulnerable households by providing skills training and promoting access to the labor market. Direct transfers to poor and vulnerable households through programs such as PKH and PIP in particular, can make government-driven policy reform more palatable, thereby encouraging robust economic growth.

46. **The World Bank has an important track record in supporting the evolution of PKH, as well as substantial expertise supporting CCTs around the world.** The World Bank has been supporting MoSA since 2010 when it contributed to the development of MoSA's first management information system (*Sistem Informasi Manajemen*, SIM). Since then, the World Bank has also developed most of the FDS modules and advised in their implementation and operation design, including M&E of its implementation as it was piloted in 2015. More recently, in response to the requests from MoSA, the World Bank team has been providing technical inputs across all of the program's operation payments, targeting, HR development, and the institutional set up. The World Bank has been supporting CCT programs in over 40 countries, 22 with lending operations, including in Mexico, Brazil, Colombia, Kenya, and the Philippines.

47. **The PforR is expected to have positive impacts on the Government's effectiveness in delivering the CCT as one of the core pillars of Indonesia's social safety nets to protect and enable those who do not have the capability to participate in the economic growth process.** By supporting the CCT's implementation, the Program is expected to benefit over 6 million poor families in Indonesia who will receive non-reimbursable contributions aimed at increasing household consumption and human capital investments and increasing beneficiaries' health and education and, ultimately, productivity. International experience with cash transfers, both conditional and unconditional, have shown that these household-level interventions lead to significant effects on household consumption, reduced child labor, school enrollment, and health behaviors.

48. **Indeed, PKH's main aim is to encourage positive change in health, nutrition, and education behaviors of poor families by tying cash disbursement to the fulfillment of program conditionality; evidence from impact evaluations confirms this success.** [14] The evaluations show that PKH had significantly increased the likelihood of receiving prenatal and postnatal care, of newborn delivery at a facility or attended by a professional, and of immunizations and growth monitoring checkups for children below school age. Positive impacts were also registered in reducing severe stunting (height for age), increasing enrollment for elementary school and junior high school, and continuing to secondary school after graduation from primary school.

49. **Beyond the microeconomic effects of conditionality, the provision of cash transfers in Indonesia that represents an average value of 14 percent of poor household expenditure, itself serves to support the costs of access to health and education services, while also increasing the consumption of poor families.** Essentially, increased consumption leads to lower rates of poverty while the steady provision of cash also reduces income uncertainty and so helps to protect against economic and social shocks. Evaluation results confirm that beneficiary household expenditure increased as a result of the program and they also spent more than non-beneficiaries on food as well as on protein.

50. **In addition, PKH has consistently revealed higher levels of targeting accuracy than other programs.** In 2014, the bottom 20 percent received over half of the benefits available; and the bottom 30 percent received over two-thirds of the benefits available, while exclusion errors were also the lowest among the main SA programs.[15] This puts PKH on par with similar programs such as Brazils' *Bolsa Familia* and the Philippines' *Pantawid Pamilya* which had CCT benefits accruing to 57 percent and 52 percent of the poorest 20 percent of households, respectively.[16] While the poverty headcount rate fell by about 2 percentage points between 2010 and 2014, the share of PKH benefits accounted for by the poor group increased by approximately

[14] This section draws upon evidence from two impact evaluations: World Bank (2011); TNP2K (2016), and several other sources, Kabeer et al. 2012. "What are the Economic Impacts of Conditional Cash Transfer Programmes? A Systematic Review of the Evidence"; World Bank. 2016. "Social Assistance Public Expenditure Review Update"; World Bank. 2016. "The Distributional Impact of Fiscal Policy in Indonesia"; and World Bank. 2016. "The Benefit Incidence of Indonesia's Main Social Assistance Programs".

[15] Notably, the program has a very small size and target level so exclusion errors are expected to be minimal; that said, relative to program size, incidence is still the highest among Indonesia's main SA programs.

[16] World Bank Atlas of Social Protection Indicators of Resilience and Equity Database.

8 percentage points. This trajectory indicates that as the micro-level poverty situation changes—many households exit poverty year to year, while fewer enter—PKH has continued to add significant numbers of the poor households that remain.

51. **By providing cash to poor households, PKH contributes significantly to poverty reduction.** The observed reduction in the poverty headcount of about 0.3 percentage points in early 2016 has in part (almost 30 percent) been attributed to expansion of PKH from 2.8 million to 3.5 million households.[17] In addition, simulations of the expansion of PKH from 3.5 million to 6 million households using the latest available Susenas data (2014 September) predict a reduction in the poverty head count of about 0.8 percentage points, while other conditions remain the same. Inequality was also simulated to fall slightly by 0.25 Gini points.[18]

52. **Additionally, the World Bank's fiscal incidence analysis based on 2012 survey and expenditure data further support the claim that PKH is an effective tool to reduce poverty and inequality in the short term.** The analysis shows that PKH has the highest effectiveness in reducing inequality and poverty of all main SA programs, as well as compared to subsidies and in-kind transfers on health and education.[19] Yet, to date, PKH has received lower budget than other, less effective, programs. For instance, Rastra cost about IDR 22.5 trillion in 2016, while PKH cost only less than half of that.[20]

B. Fiduciary

53. **The Fiduciary Systems Assessment (FSA) has concluded that, subject to the implementation of the Program Action Plan to mitigate the identified risks, the overall fiduciary framework is adequate to support Program implementation and to achieve the desired results.** The FSA confirmed that the program has satisfactory arrangements to identify and capture program expenditures by organization, function, program, and activities using the Government budget classification and chart of accounts. The Government has existing fiduciary controls that will be used for the Program. As part of the Government program, PKH uses the Government's accounting and reporting system (SAI) to record the program expenditures, as well as expenditures item. The application may produce the financial reports on a regular basis, quarterly, by semester, as well as annually. However, the Program entails a rapid expansion of the CCT program in a short span across the country and in the scope of beneficiaries. The design of the CCT is very complex given the release of grants to beneficiaries in scattered areas and challenging locations. In addition, review of MoSA's 2015 audited financial statements showed that the auditors rendered a disclaimer opinion to the financial statements with significant observations on the CCT program. MoSA has carried out follow-up actions on the audit findings and recommendations. The Inspector General (IG) of the ministry monitors the status of follow-up action and reports to the Audit Board of Indonesia (*Badan Pemeriksa Keuangan*, BPK) regularly.

[17] Indonesia Economic Quarterly October 2016. Pressures Easing. World Bank, Indonesia.
[18] Susenas 2014 data and World Bank staff calculations and internal documentation.
[19] Jellema, Wai-Poi, and Afkar. 2015. The Distributional Impact of Fiscal Policy in Indonesia and Ministry of Finance and World Bank. 2015. *Taxes and Public Spending in Indonesia: Who Pays and Who Benefits*.
[20] Indonesia MoF, Financial Note. 2016.

54. **Procurement spend is only a small fraction of the total Program expenditure, while the bulk of the Program funds are meant for the cash transfers which do not fall in the purview of procurement.** Similarly, the recruitment of facilitators under the Program, to be carried out by MoSA following the applicable procedures for recruitment of staff, also does not fall under the purview of procurement. Procurement under the Program is limited to only a small number of contracts for goods and services (other than consultant services) being procured annually by MoSA, the most notable being the contract of the service provider for distribution of the cash fund; however, none of the contracts under the Program are envisaged to be of large value exceeding the Operational Procurement Review Committee threshold. These contracts are procured through competitive procurement methods under Presidential Regulation (*Perpres*) No. 54/2010 on Government Procurement and using the national e-procurement system, which are aimed to support economy, efficiency, and transparency in the procurement processes. Based on the information provided by MoSA, the procurement processes under these contracts were found to have been carried out on time.

55. **Like most CCT programs, PKH faces particular implementation challenges from a governance and anticorruption perspective.** It is large in scope, with nearly 6 million beneficiaries by the end of 2016 and a high volume of financial transactions. It is politically high-profile and engages multiple government actors at the national and subnational levels. And by targeting the poorest of the poor, program locations are often in remote and inaccessible areas, exacerbating implementation challenges and increasing risk. However, the Program already considers several measures to mitigate these challenges and promote transparency and accountability. For instance, the Program supports strengthening of the M&E system and the GRS, to resolve and track complaints including targeting errors, payment irregularities, and fraud and corruption. Beneficiaries are also identified through an objective targeting mechanism (UDB). MoSA is revamping its communications strategy (including through the FDS) to improve awareness of program rules and beneficiary rights and responsibilities as active members of the program. These aspects and needs are incorporated in the Program Operations Manual. The World Bank has also shared the 'Guidelines on Preventing and Combating Fraud and Corruption in Program-for Results Financing' with MoSA, which applies to the entire Program.

56. **Based on fiduciary assessment, the following areas are considered for compliance/institutional strengthening as part of the Program Action Plan:** (a) enhance the SIM to include information on payment realization; (b) take follow-up actions on the BPK audit findings and recommendation; (c) conduct internal audit of the Program by the IG, MoSA; (d) enforce timely submission of payment realization reports by facilitators (including confirmation that beneficiaries have received the fund) during transition to PMIS to improve internal controls.

C. Environmental and Social Effects

57. **There are no infrastructure and other physical activities that are supported and/or financed through PKH.** Therefore, the program will not generate potential environmental impacts that may result in the loss, degradation or conversion of natural habitats, pollution, and/or changes in land or resource use. While the program supports the demand for health and education services, it is not expected to induce significant expansion of health and education services that would lead to construction of new facilities.

58. **However, the program has social risks associated with exclusion from the program and low understanding of the aim and scope of the program.** These are mostly related to inadequate outreach and socialization, which could foster perceptions of unfairness and suspicion particularly among households that do not receive PKH benefits. These issues were addressed in the publicly consulted Environmental and Social Systems Assessment (ESSA) by focusing attention on how the poor and marginalized communities are identified, surveyed, and eventually enrolled in the program. Specifically, the ESSA took into account issues around targeting, gender, timing and means of cash transfers, power dynamics at the community level, the role of facilitators, cadres, and service providers with regard to access to the program, and, lastly, existing complaint handling mechanisms. The assessment was done both at the national and subnational levels, covering several districts (Medan, Serang, Lebak, and Serdang Bedagai) that have been participating in PKH and also new districts that were recently included for the program expansion.

59. **The social risks for PKH are Moderate.** The program fosters inclusion by expanding to mostly cover the most disadvantaged population groups (for example, the disabled and indigenous populations). Social risks are mainly associated with the program's capacity to correctly target poor beneficiaries, engage with communities and make use of appropriate communication channels, roll out a more responsive GRS and create enabling environments to help PKH households use cash transfers to improve their overall welfare, health, and education outcomes.

60. **Among the main social risks is the limited capacity to resolve complaints at the local level given the highly centralized implementation approach.** The existing GRS should be strengthened to raise the program's accountability and transparency as well as address dissatisfaction and perceived unfairness or exclusion from the program. There is no decentralized grievance redress mechanism that the district and provincial governments can use to manage grievances or inform complainants about the status of their complaints. In addition, the current system does not provide space for the communities to voice their complaints in an anonymous manner. The program needs to revamp its GRS by taking into account accessibility and opportunity costs for complainants to file complaints, enabling local governments to assist in addressing complaints, connecting more closely with the targeting mechanism, and strengthening socialization.

61. **Supply-side readiness is a critical factor that affects the extent to which social inclusion within PKH can be sustained.** The assessment suggests that enforcing stringent conditionalities for households to stay eligible can be challenging in areas where there are serious supply-side issues and, therefore, attempts to make conditionalities and verification protocols more contextual become critical to promote social inclusion for communities in underserved areas. In some remote locations, such as small islands, forests, or highland areas, verification of compliance to conditionalities can be very much compromised by the lack of basic services. Issues around supply-side readiness are likely to increase as PKH is beginning to include remote, unserved areas and is looking toward greater inclusion of the elderly and people with severe disabilities. The PKH operational procedures related to conditionalities and verification need to be assessed and adapted for areas with supply-side constraints.

62. **Lack of legal identity documentation was acknowledged to be an emerging issue as PKH is moving toward an electronic payment system and seeking complementarity with other SA programs where ownership of a NIK is a technical requirement.** Such an issue may disproportionately affect people who are not formally registered and transient populations, including nomadic communities and temporary and migrant workers. The constraints that have contributed to the gap in NIK ownership are likely more severe in the new PKH areas, particularly in Eastern Indonesia where access is limited. Closing the gap would require a stronger collaboration with sub-national governments, particularly with the civil registration authority, to ensure that relevant village governments are equipped to register PKH beneficiaries.

63. **No systematic differences were found on school enrollment and immunization by gender.** Data from Susenas 2014 shows that the enrollment rates for primary and secondary schools between male and female children from PKH families are very similar. So are the shares of under-six children who have received full immunizations between the boys and girls from PKH families. On the other hand, female empowerment has been considered as one key element within PKH and payments are directly transferred to mothers or adult female members who act as caregivers for PKH families.

64. **The ESSA identifies several avenues that could have the potential to empower women, including**

(a) Tailoring outreach and socialization materials by taking into account literacy levels, prevalent languages/dialects, frequency, timing, and so on to ensure that they are inclusive, accessible, and socially and culturally appropriate;
(b) Accommodating practical lessons in the FDS contents, particularly for women across age groups and backgrounds. The FDS needs to strengthen its function to support mother groups;
(c) Incorporating more explicit gender perspective and gender equality guidelines in the manual for facilitators; and
(d) Strengthening partnership with nongovernmental organizations, civil society organizations, and other organizations that are concerned with gender issues.

65. **Communities and individuals who believe that they are adversely affected as a result of a Bank supported PforR operation, as defined by the applicable policy and procedures, may submit complaints to the existing program grievance redress mechanism or the WB's GRS.** The GRS ensures that complaints received are promptly reviewed in order to address pertinent concerns. Affected communities and individuals may submit their complaint to the WB's independent Inspection Panel which determines whether harm occurred, or could occur, as a result of WB noncompliance with its policies and procedures. Complaints may be submitted at any time after concerns have been brought directly to the World Bank's attention, and Bank Management has been given an opportunity to respond. For information on how to submit complaints to the World Bank's corporate GRS, please visit http://www.worldbank.org/GRS. For information on how to submit complaints to the World Bank Inspection Panel, please visit www.inspectionpanel.org.

D. Risk Assessment

66. **The overall risk rating for the Program is Substantial.** The main contributors to the overall rating are fiduciary, technical, and implementation capacity as described in the following paragraphs.

67. **The political and governance risk is Moderate and mostly associated with the potential change of the government in 2019.** The Program's alignment with the priorities of the RPJMN and its focus on mitigating poverty and inequality increases the likelihood of the continued support from the new government in 2019; however, this is not guaranteed. For instance, the new government may decide to focus on other priorities away from the delivery of cash transfers. Overall, the likelihood of materialization of this risk is moderate but if it materializes, the impact will be high.

68. **Macroeconomic risk is Substantial.** The Government's budget for the social protection sector has been steadily increasing. However, fiscal risk remains. Revenue collection has recently been declining, owing mainly to lower commodity prices and domestic demand, as well as several revenue policy and administration changes. At the same time, total expenditure increased in 2016. The ambitious tax amnesty goal has increased the risk of additional, potentially large expenditure cuts in the coming future. On the other hand, the President and Government have identified PKH as a priority social program.

69. **The risk related to sector strategies and policies is Moderate.** SA is well captured and prioritized at the national level in sectoral policies and strategies. The PDO and results are fully aligned with the related national policies and sector-specific strategies. There is a strong interest from the Government in increasing the effectiveness of all main SA programs, particularly in the light of the fiscal management challenges and the ambitious poverty and inequality reduction targets. Because PKH program is recognized as the most effective SA program for both poverty and inequality reduction and boosting human capital, further coverage expansion is considered a strong policy option going forward.

70. **The technical design related risk is Substantial.** The Program supports an expansion of the CCT program that includes new areas, including remote and hard to reach regions (for example, Papua region), and expansion to new components (elderly and disabled), at a time when its delivery systems (technological, HR) are in need of strengthening. The risk is mitigated by the fact that several ongoing experiences in the country, as well as abroad, will provide lessons for the design.

71. **The implementation capacity risk is Substantial.** MoSA has been implementing SA interventions for a long time. However, PKH has been implemented by a program implementation unit largely staffed by consultants and attached to one subdirectorate within MoSA. The current MoSA leadership has begun to mainstream and transfer the responsibilities of PKH implementation to regular civil servants of a whole directorate, which will enhance sustainability of efficient PKH implementation over time. Changes in institutional leadership may jeopardize these efforts. The new design package within PKH which will increase the implementation workload, could also pose implementation risks by further overwhelming MoSA's implementation capacity. These risks will be mitigated by ensuring that staff will be

appropriately trained, IT support strengthened, and linkages with experienced partners in this area (local governments, health and education sectors) will be fostered.

72. **Fiduciary risks are Substantial.** The Government has existing fiduciary controls that will be used for the Program. However, the Program entails a rapid expansion of the CCT program in a short span across the country and in the scope of beneficiaries. The design of the CCT program is very complex given the release of grants to beneficiaries in scattered areas and challenging locations. In addition, the external auditors have expressed a disclaimer on the 2015 financial statements of MoSA stating that the flow of funds could not be traced adequately to the end beneficiaries and that reasonable assurance was lacking on the ending balance in post office accounts. The main risks are

(a) Lack of an automated system to record and reconcile data of payments to beneficiaries;
(b) Inadequate follow up on external audit findings;
(c) Need to improve the program's internal controls;
(d) Addressing interim mitigation measures until PMIS implementation;
(e) Absence of complaint-handling mechanism could be a deterrent to bidder's participation in bidding;
(f) Risk of noncompliance to the World Bank's list of debarred/temporarily suspended firms;
(g) Interference or errors in the payment process; and
(h) Detection risks.

73. The proposed mitigation measures are

(a) Implementation of a PMIS to capture detailed data at the beneficiary level;
(b) Monitoring of implementation of external auditor recommendations with the support of IG of MoSA;
(c) Instituting periodic internal audit of the program;
(d) Enforcing timely submission of payment realization reports by facilitators, including confirmation of receipt of payments by beneficiaries;
(e) Development of a procurement complaint-handling mechanism by MoSA, consistent with Government regulations;
(f) Putting in place a mechanism by MoSA to ensure that its head offices (*Unit Layanan Pengadaan*, ULPs), for each procurement process, checks and records in the file that the recommended firm is not on the World Bank's list of debarred and temporarily suspended firms; and
(g) PT Pos's internal audit unit and MoSA's IG have selected verification of payments to beneficiaries during the audit assignment.

74. **Environmental and social risks are Moderate.** The Program does not produce any outputs that may have negative environmental consequences. The CCT program will also operate in remote areas (for example, Papua region), which will impose several implementation challenges and will require a potentially different approach (on payments, compliance verifications, and GRS). In general, social risks may be exacerbated in light of operational implementation challenges on targeting, communication, and availability of supply services,

which can be under stress for an expanded program, and contribute to diminish social cohesion in communities of intervention. MoSA is working to improve PKH delivery mechanism, including adapting it to local condition realities in challenging remote areas through a modified scheme.

75. **The stakeholder risk is Moderate.** The World Bank enjoys a strong and constructive relationship with MoSA. Other development partners have also been supportive. However, remaining challenges include the inadequate coordination with local governments of uneven capacity and governance structures, as well as with other social delivery sectors (health and education), essential to guarantee the supply of services to make a meaningful impact on human development indicators. This risk can be mitigated by MoSA's commitment to strengthen coordination with other sectors, and involvement in this role by the Coordinating Ministry for Human Development and Cultural Affairs.

E. Program Action Plan

76. **A number of actions are identified to be taken by MoSA to ensure the achievement of the agreed results.** These are detailed in annex 8. Progress toward these actions will be monitored during the World Bank implementation support missions. Following the completion of each action, World Bank team will continue to monitor the enforcement and/or application of relevant actions.

Annex 1: Detailed Program Description

A. The SA Sector in Indonesia

1. **The Government of Indonesia had begun investing comprehensively in SA programs in 2005 because of the creation of fiscal space through the phasing out of a regressive fuel subsidy**. In 2010, a redesign of Indonesian SA programs was initiated to accelerate poverty reduction and improve access to and quality of basic social services. As stated in the country's RPJMN (2015–2019), the Government is determined to establish a comprehensive social protection system for all citizens and improve targeting accuracy of the SA programs for the poor. Its policy direction also discusses the need to (a) integrate several family-based SA schemes for poor and vulnerable families that have children, disabled, and elderly, in the form of CCT and/or through in-kind assistance to support nutrition; (b) transform the rice subsidy for the poor in a phased manner so that it becomes a more nutrition-focused program; and (c) structure temporary SA at the central and local level by raising the coordination and sharing of authority between ministries/institutions that implement temporary SA.

2. **Indonesia's targeting system is called UDB[21] and has been developed since 2005 in response to the emerging need to scale up SA programs.** In 2005, to establish a registry of poor and vulnerable households for a new unconditional cash transfer program introduced to mitigate the effects of universal fuel subsidy reforms, the BPS conducted a survey called Data Collection for Socioeconomic Trends (*Pendataan Sosial Ekonomi*, PSE). The final output of PSE-2005 was a registry with basic information of 19 million households, which belonged to the three bottom deciles of all households in Indonesia. In 2008, a new survey of poor households known as Data Collection for Social Protection Programs (*Pendataan Program Perlindungan Sosial*, PPLS) was conducted and covered approximately the same number of poor households as the PSE-2005.[22]

3. **Since 2012, all major SA programs have adopted UDB as their targeting system, including many local government institutions that have requested UDB data to facilitate the implementation of local poverty reduction programs.[23]** Rastra and PKH began using the UDB in 2012 and the PIS, and the poor student scholarship program, PIP, joined in 2013. However, only PKH has fully adopted the UDB standard for use in quota generation, eligibility determination, and beneficiary identification, and only PKH has implemented a bidirectional updating procedure that works in concert with the UDB. Due in part to its low coverage and use of bidirectional updating, out of all the main household targeted SA programs, PKH shows the best targeting performance in the years after adopting the UDB. The latest available Susenas

[21] TNP2K (National Team for the Acceleration of Poverty Reduction). 2015. Indonesia's Unified Database for Social Protection Programmes. Management Standards.
[22] World Bank. 2012. Indonesia Social Assistance Public Expenditure Review. *Note:* The same households surveyed in 2005 were resurveyed in 2008.
[23] TNP2K (National Team for the Acceleration of Poverty Reduction). 2014. An Evaluation of the Use of the Unified Database for Social Protection Programmes by Local Governments in Indonesia.

survey data estimates that over 70 percent of the total program beneficiaries are found in the poorest 40 percent of the population.[24]

B. PKH Program

4. **PKH plays a major role in the comprehensive social protection system for family-based SAs.** It was initiated in 2007 as a pilot in seven provinces to just 382,000 beneficiary families and has been expanding its coverage as a part of a larger effort to build up this comprehensive social protection system to improve poor and vulnerable families' welfare and opportunity. PKH aims not only to help increase the beneficiaries' current consumption so as to alleviate poverty in the short run, but also to ensure their investment in the human capital of their children through education and health conditionalities (also sometimes called 'co-responsibilities'). As PKH will encourage the beneficiary families to access and use basic health, nutrition, and education services, it is expected to promote future generations' opportunity and productivity in the long run.[25]

5. **One of the first steps that the new administration took was to review the design, process, and systems of PKH, implemented by MoSA.** It had decided to scale up in coverage, from 3.5 million families in 2015 (5 percent of the population) to the new target of 6 million families nationally (9 percent of the population) by the end of 2016. With the expansion, all provinces in Indonesia, including Papua, with the highest poverty rates in the country but previously not covered by PKH, will be covered. As the new areas often have implementation challenges, the program needs to modify and adapt its implementation guidelines and arrangements according to the local context. While the coverage after expansion is still lower than that of similar large CCT programs in other countries (in Mexico, Brazil, and the Philippines CCTs cover between 20 percent and 30 percent of the population), the program has come a long way from when it was first introduced in July 2007.

Table 1.1. PKH Operation Scale, 2007–2016

Year	Number of Provinces	Number of Districts	Number of Sub-districts	Field Staff	Regional Coordinators
2007	7	48	337	1,556	2
2008	13	70	637	2,738	7
2009	13	70	781	3,370	11
2010	20	88	946	4,565	18
2011	25	119	1,387	5,446	28
2012	33	169	2,001	7,450	37
2013	33	336	3,417	10,590	54
2014	34	430	4,870	14,068	46
2015	34	472	6,080,	16,665	43
2016	34	514	6,435	26,168	57

Source: MoSA.

[24] World Bank. 2017. Indonesia Social Assistance Expenditure Review Update.
[25] World Bank. 2012. PKH Conditional Cash Transfer – Social Assistance Program and Public Expenditure Review 6.

6. **PKH eligibility depends on both family resources and demographic composition.** To be eligible, a family must be included in the country's targeting database, the UDB, and ranked below a certain cutoff point, which is determined by the program coverage target. They must meet at least one of the following conditions: a family member is pregnant or lactating; at least one child is aged below 6 years; at least one child aged 7 to 21 years attending primary school, junior secondary school, or senior secondary school; or at least one child age 16 to 21 years who has not yet completed basic education. Furthermore, PKH beneficiary families must be in compliance with the relevant health and education conditionalities to receive the cash transfers, which are made only after verification of compliance with the conditionalities. Mothers are the main recipient in the majority of cases. Starting in November 2016, eligible families that have a severely disabled or an elderly person (70 years and older) living with them will also be receiving additional transfers as long as they have not yet been covered by other SA programs (such as the old age assistance program).[26]

Table 1.2. PKH Eligibility and Conditionality

Households with…	...must accomplish at least these conditionalities to continue receiving PKH
Pregnant or lactating women	1. Complete four antenatal care visits and take iron tablets during pregnancy 2. Be assisted by a trained professional during the birth 3. Lactating mothers must complete two postnatal care visits
Children ages 0–6 years	4. Ensure that the children have complete childhood immunization and take Vitamin A capsules twice a year 5. Take children for growth monitoring checkups (monthly for infants 0–11 months and quarterly for children 1–6 years)
Children ages 7–21 years	6. Enroll their children in primary school and ensure attendance for at least 85% of school days 7. Enroll junior secondary school children and ensure attendance for at least 85% of school days
Children ages 16–21 years with incomplete education	8. Enroll their children in an education program to complete nine years of basic education

Source: Adapted from World Bank (2012) and MoSA (2015).

7. **Verifying beneficiary families' compliance with their responsibilities in health and education, which triggers continued PKH transfers, is done jointly with service providers.** PKH facilitators will visit nearby schools, health centers, and hospitals every month to confirm that mothers and children from PKH beneficiary families have presented themselves and are acquiring or attending the services required. At some facilities and in some regions, PKH facilitators will join local service provider staff to verify attendance. Verification forms are then submitted to the district/provincial offices to be entered in PKH PMIS.

8. **PKH benefits represented an approximately 10 percentage point share of beneficiaries' average expenditures before they were increased in 2013**. Then PKH benefit levels were raised in early 2015 and again in 2016, with the maximum (minimum) annual transfer per household at IDR 3.7 million (IDR 800,000) or approximately US$284 (US$61). At these transfer magnitudes, on average a PKH beneficiary family receives transfers worth about 13 percent of their regular expenditures. For a PKH beneficiary family with four members (a

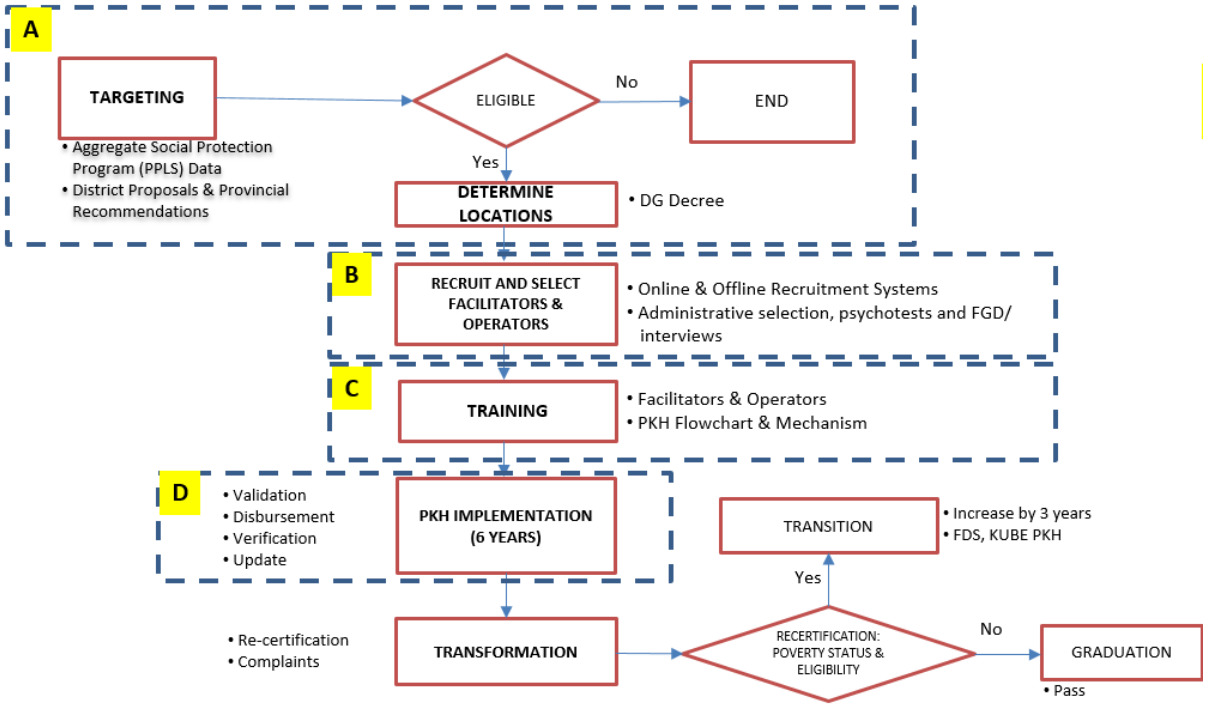
[26] MoSA. 2016. "Pedoman Pelaksanaan Program Keluarga Harapan", updated September 2016.

couple, one under-five child, and one child attending primary school), the total annual PKH benefit is IDR 2.2 million in 2016, which is equivalent to 12.6 percent and 13.3 percent of the official urban and rural poverty lines, respectively. In comparison, an average PKH transfer is about five times the average out-of-pocket costs of a regular outpatient visit or one and a quarter times the average cost of one year of schooling. In other words, PKH transfers, on average, can finance multiple health facility visits or only one year of education.

9. **The beneficiary families would receive PKH transfers for six years as long as they comply with the conditionality and remain eligible**. In addition to the required education and health care service attendance, PKH mothers attend monthly meetings organized by program facilitators and receive guidance on fulfilling PKH conditionalities. If any beneficiary families are determined to be poor at the end of the six-year cycle, an additional three years can be granted and complemented by other livelihood support programs such as KUBE-PKH, as well as training with the FDS modules, which are designed to raise beneficiary families' knowledge and life skills.

10. **PKH implementation workflow has five broad steps:** (a) determine where and who the expansion should cover; (b) recruit additional facilitators and operators required for the additional beneficiaries; (c) train the newly recruited facilitators and operators before they start; (d) implement PKH; and (e) determine if the beneficiaries are ready to 'graduate' (exit) from the program and provide additional support, if needed. In addition, PKH also has put in place an M&E system and a community grievance system (CGS) to ensure feedback and learning.

Figure 1.1. PKH Workflow



Source: MoSA (2016).

11. **PKH's PMIS is composed of multiple software applications, which are used at different stages of the program implementation cycle for the purpose of data collection, data validation, data processing, data update, eligibility determination, beneficiary selection, payment calculation, payment list generation, grievance redressal, and reconciliation.** The core PMIS application is the online SIM application, which is web-based and was designed and developed using JAVA, in 2007. It runs on PKH main database hosted on Oracle 11g. The application has been modified with some minor revisions, but the required major modification to accommodate recent program changes could not proceed due to lack of application architecture documentation. To support data entry of an improved validation process, a new application called Offline Validation Application was built using VB.NET and an MS Access Database and introduced in 2015. The UPPKH/JSK IT team has been able to modify this application several times. All other tasks of data extraction, data sharing, and data upload are done either manually using scripts or through custom built small applications in VB.NET.

12. **The five main business processes supported by PKH PMIS are**

(a) **Validation.** Before any selected poor family can become a PKH beneficiary, the responsible facilitator needs to validate the family's eligibility by checking its actual situation against the targeting data. The facilitators use a validation form to collect this information and then update the information in the Offline Validation Application. The initial targeting data for each district is extracted from PKH database and is placed in the form of text files on FTP servers. The data is then downloaded and loaded into the Offline Validation Application. The facilitators, using a laptop, make any changes in this data based on the validation forms, on which data has been captured. The validated data is brought to district operators who further export and merge this data into a comma separated value (CSV) file. The file is then shared with UPPKH/JSK through email for further loading into PKH database.

(b) **Verification**. All PKH families must comply with their responsibilities and their receipt of program benefits is contingent on the verified compliance of their conditionality. The facilitators use the verification forms to collect school attendance and health facility visit data of PKH beneficiary families. There are two types of verification forms—one is like a typical data collection instrument and verification data is manually provided on the form; and another is a digital mark reader (DMR) form, which uses machine readable marks to represent information. As noncompliance is of a small percentage, facilitators only collect data for PKH beneficiary family members who did not attend school or did not make the required visits to health facilities. After the verification forms are signed and stamped by the providers, the forms are brought back to district operators who either enter data using the verification module of the online SIM application, or scan the DMR forms using the dedicated DMR scanners and send the resultant CSV files to the UPPKH/JSK team for further processing. Among 514 district offices, 113 use the manual verification form and the rest use the DMR forms.

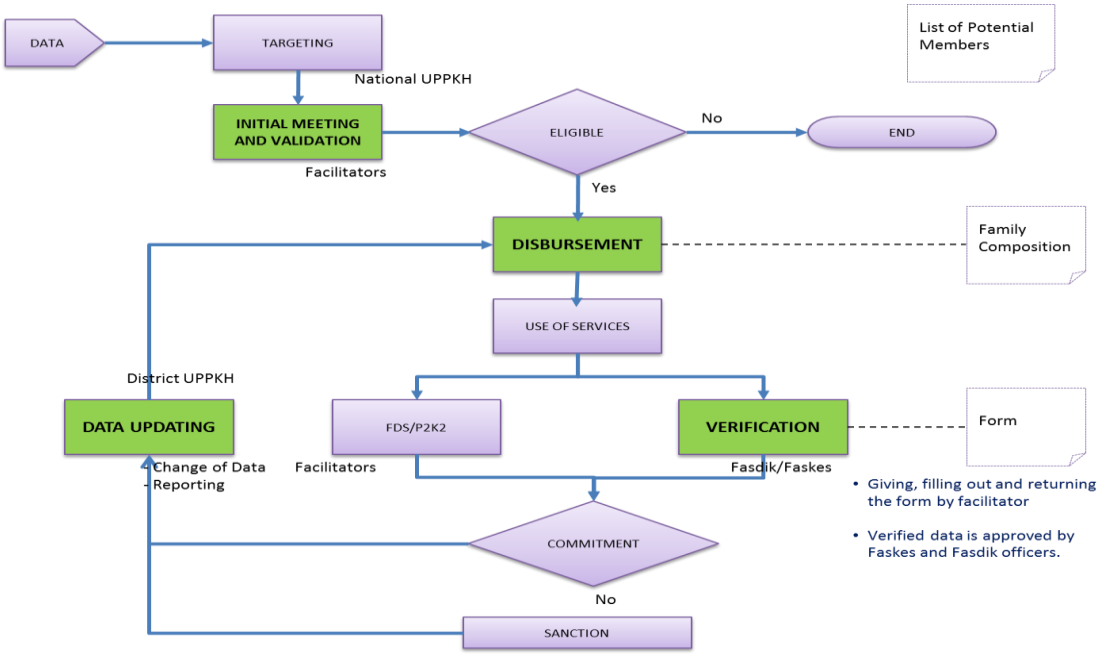
(c) **Final closing and payment list generation**. For each payment cycle after verification data is entered, district operators must use the Final Closing module of

the Online SIM Application to review the beneficiary data and 'close' the database to proceed to the next step that involves payment calculation and payment list generation. Internally, the process calculates payment based on verified conditionality compliance for each PKH family and the rules in case of not meeting the threshold of conditionality. The UPPKH/JSK payment team uses the Payment module of the Online SIM Application to extract payment-related information into a CSV file and shares it with the PSPs (PT Pos and partner banks) for their processing. The payment team in parallel also calculates the total funds to be distributed to each district and the report is submitted to the treasury team. After each payment transfer, facilitators entry realization data to the system.

(d) **Data updating.** PKH beneficiary families' situations often change over time. As some of these changes are relevant for determination of their benefits and responsibilities under the program, it is important to update beneficiary data accurately and on time. For example, both a new birth and a new pregnancy will very likely lead to increased need for health and nutrition services as well as an increased benefit level. Other important changes to be updated relate to the name and address, children's school enrollment status (for example, graduation or dropout), marriage status of PKH mothers, and receipt of other complementary services. The recorded change data will be input into the Online SIM Application.

(e) **Recertification.** After five years of consecutively receiving program benefits, PKH families will be recertified during the sixth year if they are still eligible for the program. Those that are still deemed poor will be given another three years of transition period before cash benefit ceases. Others who have managed to change their situation by growing out of poverty will graduate from the program and the cash benefits will stop immediately. This module also deals with complaints received from the families who are supposed to graduate. Some of them may consider they are still poor and should continue to receive cash benefit. Complaints will be clarified by local community leaders before they are approved.

Figure 1.2. PKH Information Flowchart



Source: PKH Implementation Guidelines.

13. **While both banks and post offices have been involved in the delivery of PKH cash transfers, PT Pos is the longest running and largest PSP for the program as of now.** It delivers payments through 4,261 post offices (almost all online) and carries out community-based delivery for those beneficiaries who are too far from the nearest branch (offline mechanism). However, delivery of payments by PT Pos is in cash, not digital. Because PT Pos has a wider nationwide network of branches in comparison to commercial banks in Indonesia, it is uniquely positioned to deliver SA payments. When PKH was launched in 2007, PT Pos delivered payments to 388,000 beneficiaries in urban areas through its national remittance service Wesel Pos. In 2013, PT Pos switched from Wesel Pos to Giro Pos, an account-based money transfer system, because it was the cheaper option of its two payment mechanisms. PT Pos plans to launch a simple savings product (SimpulPOS) after modernizing its disbursement channel.

14. **The FDS originated from a group-based learning approach introduced in PKH in 2012.** A group of PKH mothers or grandmothers who live close by and, possibly, share similar education and health characteristics would elect a leader among themselves. Then facilitators would organize monthly meetings with group leaders and then with each group to disseminate new information on PKH, discuss day-to-day problems faced by the beneficiaries, and provide a venue to share thoughts. Later, the Government wanted to transform these monthly group-based learning meetings into the FDSs with structured training modules to provide knowledge and training on life skills to PKH mothers and promote positive behaviors that can help lift their families out of poverty. At the time, the FDSs were prepared as an instrument to prepare PKH beneficiary families at the end of their six-year cycle to graduate from the program.

15. **With the technical support of the World Bank and UNICEF, four modules and seventeen sessions were developed, building on consultations with PKH beneficiaries and**

other key informants at the community and lessons from other countries (for example, the approach taken in the Philippines' CCT). The World Bank supported the development of the Education and Economy modules, while UNICEF supported the development of Health and Child Protection modules. Each module consists of step-by-step guides for activities and discussions on specific practices, delivered in an interactive-participatory learning process.

(a) Education (4 sessions) and Economy (3 sessions) modules are equipped with smart books (*Buku Pintar*), brochures, flipcharts, films, and posters. In addition, tutorial videos were made for the FDS trainers and facilitators as training refreshment.

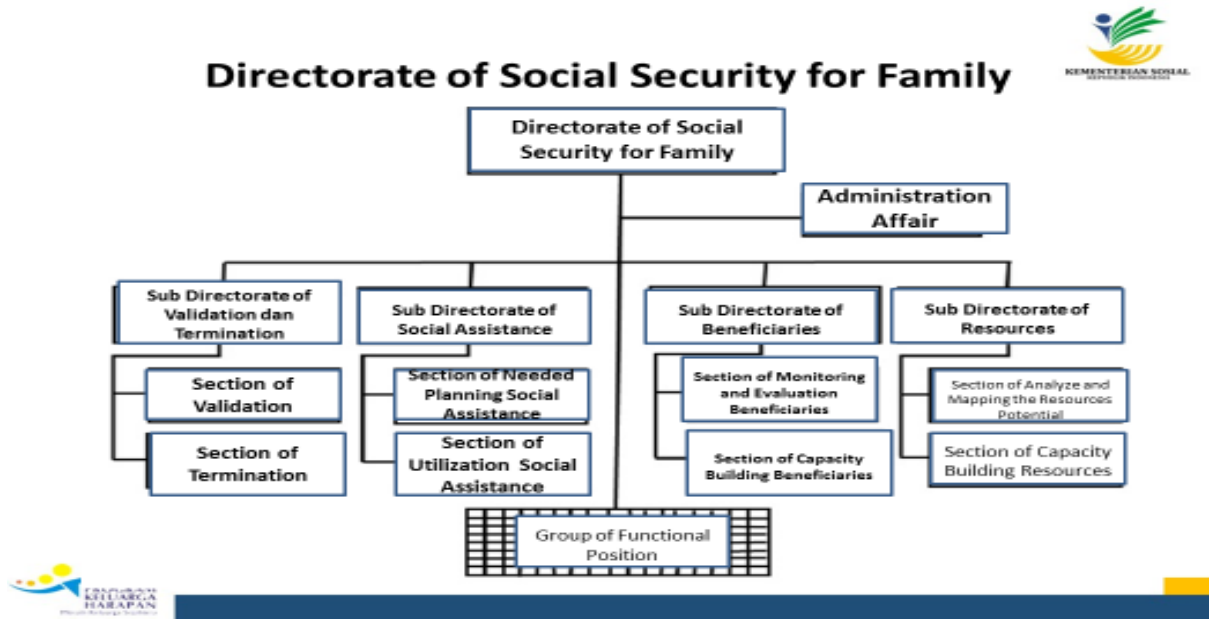
(b) Health and Nutrition (8 sessions) and Child Protection (2 sessions) modules are equipped with handbooks (*Buku Prestasi*), films, and games tools.

(c) In 2016, following the introduction of two new components on elderly and severely disabled, the MoSA Training Center developed the respective FDS modules—Elderly (1 session) and Disability (1 session).

16. **Based on a recertification process, any PKH family determined to be poor after six years of the program is granted an additional three years of transfers complemented by additional livelihood and income support from programs like KUBE.** KUBE is a livelihood development and empowerment program implemented by MoSA since 1983. It encourages the creation of group-based microbusinesses through the provision of capital to groups of seven to ten people from poor households (a onetime grant of IDR 20 million or approximately US$2,000) as well as entrepreneurship and business trainings. It has been linked to PKH since 2013 to encourage eligible PKH beneficiary families to set up a sustainable business as a group and graduate from PKH. In 2013, 1,000 KUBE-PKH groups were formed, across eight districts in five provinces, making use of existing PKH facilitators who received extra training to manage PKH beneficiaries' progress in receiving the KUBE grant. In 2015, around 20,000 KUBE-PKH groups were formed and are to receive the KUBE grant. A new development to the existing KUBE program is that PKH facilitators receive continued web-based trainings to better facilitate beneficiaries with the creation of business proposals and are tasked with managing a KUBE-PKH business database and PMIS to monitor the development of KUBE-PKH businesses.

17. **The institutional arrangements for PKH involve three layers, all of which are important for achieving the desired results of PKH.** First, as MoSA is responsible for planning, setting operation rules, and managing overall implementation, the central management unit's internal organizational structure and institutional capacity are critical. Second, there are a large number of subnational implementation teams involved in carrying out various tasks and hence the adequacy of their capacity and clarity of their roles and responsibilities affect the actual implementation on the ground. Lastly, inter-sectoral coordination at both the central and local levels is essential to ensure that the program is smoothly implemented and the beneficiaries have complementary access to basic services which are necessary for achieving the program objectives.

Figure 1.3. Directorate of Social Assurance for Family Organizational Chart



Source: MoSA.

18. **MoSA, through the JSK under the DG of Social Security and Protection, is the agency responsible for setting policies and implementing PKH.** The PKH program management structure has been reformed recently. In October 2015, MoSA issued a ministerial decree[27] to reorganize the institutional arrangement for PKH implementation and made the entire JSK directorate fully in charge of the program. In the structure that prevailed before the 2015 reorganization, a subdirectorate (Subdit) within the JSK oversaw PKH implementation with a lean administrative structure with most of the actual program management delegated to a team of about two dozen contracted 'experts' under the central UPPKH. UPPKH consisted of functional units handling the SIM, data, and disbursement, implementation, monitoring and grievance handling, and administrative support. Other than the subdirector and the two section heads, no civil servant was directly involved in managing PKH.

19. **Each subdirectorate has two sections under it to carry out the following in their respective areas of responsibility: policy formulation and implementation; drafting norms, standards, procedures, and criteria; providing technical guidance and supervision; and M&E and reporting.** The JSK is headed by a Director; each subdirectorate is headed by a subdirector and staffed with two section heads (echelon 2–4) and around two civil servants in each section.

20. **While PKH is a national government program, its implementation relies heavily on the nationwide network of field staff.** The institutional arrangement for PKH implementation at the subnational level has mirrored the organizational arrangement at the central level. Previously at each subnational level, a local UPPKH, consisting of contracted personnel, virtually carries out all the program implementation functions, while formally being supervised by the Social

[27] Ministerial Decree, October 2015.

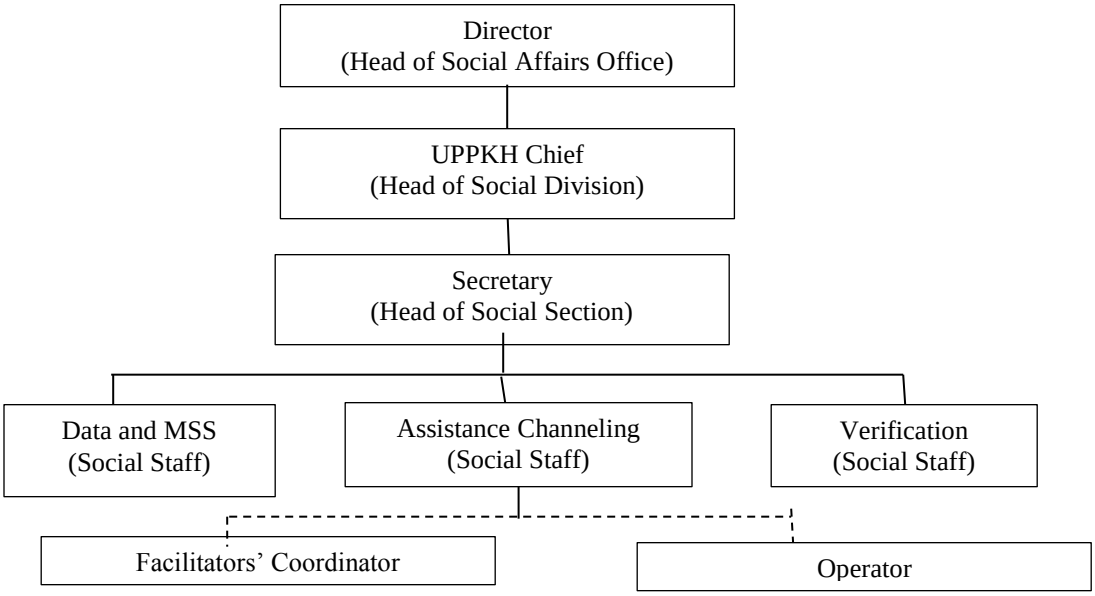
Affairs Office (*Dinas Social*) of each subnational government. Going forward, the Social Affairs Offices are responsible for PKH implementation with support of contracted personnel. The number of field staff to be deployed follows predefined ratios and the geographic characteristics of the areas to be served.

21. **At province level there are 'provincial coordinators' and 'provincial operators'.** Provincial coordinators are recruited to coordinate PKH activities at the provincial level, supervise district/city coordinators, and ensure that local education and health services are available and functioning. Responsibilities of provincial operators include (a) scanning paper forms of beneficiary compliance with PKH conditionality and (b) entering weekly activity reports of facilitators into the PMIS. The provincial PKH unit is formally led by eight members from the Social Affairs Department, including the department head as Advisor, the head of Social Division of the Social Affairs Department as Chairman, the head of the section responsible for PKH at the Social Affairs Department as secretary. The other five members are staff from the Social Affairs Department responsible for data, CGS, assistance distribution, verification, and M&E.

22. **Similarly, at district and city there are also coordinators and operators. Coordinators are contracted to coordinate PKH implementation at the district/city level.** They are required to supervise the facilitators at the sub-district level, monitor and assist service facilities to ensure steady supply of services, and oversee and assist sub-district-based administration and PMIS teams. Operators are contracted to input data, including uploading data of validated PKH families entered by the facilitators, to the PKH PMIS. Each district is also supposed to constitute five PKH-dedicated working groups: the data team, the health and education services team, the fund allocation team, the verification team, and the M&E team. The district PKH office is also responsible for supervising and liaising with the sub-district PKH implementation staff.

23. **At sub-district level there are facilitators who interact directly with PKH beneficiaries/families.** If there is more than one facilitator in a sub-district, then one of them is assigned to be a 'facilitator coordinator' for that sub-district.

Figure 1.4. Structure of District/City UPPKH



24. **Mirroring the reorganization at the central level, MoSA has recently issued an instruction to the provinces and the districts to eliminate the subnational UPPKH and incorporate the responsibilities of managing PKH implementation fully into their respective Social Affairs Offices.** But, it is unclear if this formal restructuring will result in a tangible change in the ways in which the subnational Social Affairs Offices will approach PKH implementation. Given the oft-reported lack of ownership by provincial and district governments to fully support PKH and the staffing constraints at the provincial and district Social Affairs Offices, it is likely that actual implementation will continue to depend on the contractual staff, whether they are nominally placed under the core structure of the Social Affairs Offices or in a separate program management unit (PMU).

25. **Like any CCT, PKH also depends critically on the proper implementation of health and education services.** Although availability of these services is generally considered quite reasonable in Indonesia, it is possible that certain services that PKH families require to meet program conditionality might not be available in certain locations. Service gaps are more likely in certain geographic (mostly rural and remote) areas. For example, while 62 percent of *puskesmas*[28] nationally report having stocks of Vitamin A, availability varies widely from above 80 percent in East Java and DI Yogyakarta, to under 50 percent in nine provinces, including just 28 percent in Bengkulu.[29]

[28] Health services for PKH families can be accessed at any public health facility which includes *puskesmas* and its network of *posyandu*, *pustu*, *polindes*, and *puslinglity* facilities. However, PKH beneficiaries are more likely to use front-line facilities, especially *posyandu*, which is a community-managed integrated health service post. No health professional is permanently posted at *posyandu*. Services are offered on the basis of regular visits by designated health professionals (midwives).

[29] Indonesia: National Medium-term Development Plan (RPJMN), 2015–2019, Health Sector Review: Service Delivery and Supply-side Readiness. June, 2014.

26. **Formal structures for inter-institutional coordination for PKH exist at both the national and the subnational levels.** At the national level, PKH' National Coordination Team, advised by the Coordinating Minister of Human Development and Cultural Affairs, and chaired by the Minister of Social Affairs, has been set up for the purpose of high-level policy coordination. It consists of echelon 1 level (top rank civil servant) officers from the following ministries/agencies: MoSA, Health, Education and Culture, MoF, BAPPENAS, Religious Affairs, Communication and IT, Home Affairs, Manpower, MoV, Women's Empowerment and Child Protection, and BPS.

27. **PKH policies are operationalized by a 'National Technical Coordination Team', chaired by the DG of Social Security and Protection, with the Director of JSK as Secretary.** It consists of echelon 2 and/or echelon 3 (Director level) officers assigned by the member ministries and agencies of the National Directive/Coordination Team. The technical team is supposed to act as a bridge between the National Directive/Coordination Team, JSK, and the field-level PKH implementation teams. Its responsibility is to review operational plans, coordinate sectoral activities, establish an inter-sectoral team with the mandate to select PKH participants, and monitor program implementation progress. There is an equivalent PKH Technical Coordination Team at provincial, district/city, and sub-district levels.

C. Proposed PforR

28. **The proposed PforR supports the Government's main PKH CCT program areas.** It focuses on three results areas, and a complete results chain illustration is provided below.

(a) **Results Area 1: Strengthening the Program delivery system to improve efficiency, transparency, and accountability.** This results area aims to address a number of gaps and inadequacies in the building blocks of PKH delivery system to ensure smooth expansion and enhance the program results. Program activities cover business process simplification, information management system upgrading, electronic payment modalities rollout, GRS implementation, M&E system strengthening, communication strategy development, HR management, and EFC detection and control mechanisms development. While most of these activities are not completely new, many previous efforts clearly were made under different policy and operation environments than those of today. Therefore, the existing mechanisms and tools are inadequate to support the administration needs. For example, the existing PMIS was not designed to manage multiple millions of beneficiary families and its performance, capability, and reliability have become so inadequate that many administration tasks cannot be carried out effectively. A comprehensive gap analysis is much needed for developing an Enhancement Action Plan in reference of the minimum required protocols and standards of data integrity, security and operational soundness. Also to build in-house capacity to manage the systems and system development, an industry-standard IT system audit is planned to ensure that the upgraded PMIS continues to be assessed and improved accordingly. The PforR will build on the experience accumulated from the inception of PKH and learn from the good practices of other social programs both inside and outside of Indonesia.

(b) **Results Area 2: Improving access to basic social services and complementary social assistance programs for PKH beneficiaries.** PKH beneficiary families need to have better access to other social services that are complementary to the cash benefit provided with regard to achieving human development potential. This results area will facilitate the enrollment of PKH families into the Rastra, PIS, and PIP programs, as well as the access to other services. Furthermore, it will strengthen both the content and delivery modality of FDSs to be more effective in reducing malnutrition, particularly through knowledge and behavior change related to good feeding and hygiene practices.

(c) **Results Area 3: Expanding coverage and improving inclusivity of the conditional cash transfer program.** The expansion of PKH has taken advantage of both the updated UDB and a vetting process involving verification and validation with local governments. The program has expanded in December 2016 to reach 6,000,000 beneficiary families, including 42 new districts, with which the program will achieve the coverage of all districts for the first time. More importantly, the majority of the new districts are in Papua and West Papua provinces, which suffer from high poverty but have been underserved by PKH and other public services. This results area aims to support the coverage expansion, particularly to the underserved areas in the Papua region and less connected sub-districts in other regions. As PKH is the most effective SA program with regard to poverty and inequality reduction in the short run and will also contribute to beneficiary families' capability and productivity in the long run, it will be expanded further, particularly after its delivery system is strengthened.

29. **These results areas' aims are consistent with the Government's strategy to improve PKH performance and coordination with other complementary interventions.** Several reforms lie ahead to improve PKH implementation that this PforR will support. For instance, in the short term, MoSA needs to establish a clear road map for identification and progressive inclusion of PKH beneficiaries, including in remote underserved areas (for example, Papua) and to new beneficiary groups (elderly, disabled). A rapid scale-up of PKH will also require a review of the PMIS to verify how it can effectively cope with expansion, including a potential review of its business processes, to ensure its capability and reliability to support expanded operational needs. MoSA also intends to pursue a rapid rollout of card payment options (including savings accounts) for a more diversified financial inclusion strategy and increase frequency to bimonthly payments, which will also require support. Changes in the program rules and scale-up will require an overhaul of the GRS, starting with an assessment and recommendations on how to improve it. With regard to M&E, a process evaluation to gauge the effectiveness and efficiency of the program's scale-up, as well as rigorously evaluating additional impacts of the new components and changes to its design is envisaged. Similarly, MoSA has decided to expand implementation of the FDS, but before scaling it up MoSA needs to take stock and evaluate its implementation aspects. A massive scale-up and other potential program changes will require a thorough strategy on how to effectively communicate such innovations to the beneficiaries and the general public (including media). PKH expansion will also demand a thorough strengthening of the institutional architecture of the program, which will be much harder to administer from the central level, and revision of the current HR strategy in particular with relation to the role and functions of the program facilitators. An additional challenge is how the central and local

governments can coordinate and control implementation and monitoring of SA programs. This is not currently happening: in 2014, less than 30 percent of CCT families in the poorest decile received PIP, PIS, and Rastra even though they were eligible for all three programs. Efforts at integration have been made, but very little progress has been made regarding common standards and processes among programs. More recently, MoSA, in coordination with BAPPENAS, is piloting 'single window services' (SLRT) in 50 districts to promote better coordination, referral, and update of beneficiary information. Similarly, MoSA is piloting and aiming to scale up coverage for a new concept (called 'e-Warong') to integrate digital payments of benefits at the local level, including PKH, Rastra, and KUBE-PKH in several localities.

30. **The Results Framework will be monitored using PKH's own M&E capacity.** In particular, the PMIS will be an important instrument to assess quantitative indicators at the level of the families receiving the program such as compliance to conditionality, receipt of transfer, and complementarity of PKH with other SA programs. In addition, the M&E team, supported by three regional coordinators, oversees 514 district coordinators and so indicators on FDS implementation, complete training of facilitators, and the rollout of the GRS is best tracked this way. The remaining indicators, which are measured through observation of whether the indicator is completed or not (completion of a communication strategy and HR competency and performance monitoring system implemented), are to be monitored by the World Bank team together with the IVA.

31. **It is estimated that the PforR financing will represent 4.2 percent of the total PKH budget over the fiscal years 2017 and 2020.** This calculation is made under the assumption that benefit levels remain the same as in 2017 and by calculating a constant ratio of 11 percent for administrative costs.

Annex 2: Results Framework Matrix

Results Areas Supported by PforR	PDO/Outcome Indicators & Intermediate Results (IR) Indicators	PDO/IR	DLI #	Unit of Measurement	Baseline (2016)	Target Values			
						2017	2018	2019	2020
Results Area 1: Strengthening the Program delivery system to improve efficiency, transparency, and accountability	PKH PMIS enhancements implemented	IR	1	Yes/No	No	Enhancement Action Plan developed	Enhancement Action Plan implemented satisfactorily	PKH PMIS audited and additional enhancements recommended	Audit report recommended enhancements implemented
	Production of operation monitoring statistical reports for all districts regularly generated and disclosed to related stakeholders	IR		Yes/No	No	Operation monitoring report re-designed	Operation monitoring report disclosed	Operation monitoring report further modified	Operation monitoring report disclosed
	Share of sub-districts with PKH beneficiary families having switched to cashless payment methods	PDO	2	%	15	27	39	56	73

Results Areas Supported by PforR	PDO/Outcome Indicators & Intermediate Results (IR) Indicators	PDO/IR	DLI #	Unit of Measurement	Baseline (2016)	Target Values			
						2017	2018	2019	2020
	PKH uses digital platforms and mass media to regularly disclose information about program performance and the program manages to carry out social promotion	IR		Yes/No	No	Program communication strategy developed	Communication through digital platform and mass media commenced at national level	Communication through digital platform and mass media expanded at subnational level	Communication through digital platform and mass media regularly disclosed at subnational level
	HR capacity building plan and performance monitoring system implemented for program implementers at the subnational level	IR		Yes/No	No	HR strategy on capacity building and performance monitoring developed	HR capacity building plan implemented	HR performance monitoring mechanism implemented	HR strategy revised after review of implementation lessons
	An enhanced GRS rolled out after evaluation of pilot	IR	3	Yes/No	No	Enhanced design developed	Pilot implemented and evaluated	Enhanced GRS rolled out	Grievance analysis produced
	Error, fraud, and corruption detection systems implemented	IR		Yes/No	No	EFC detection framework developed	EFC detection systems piloted	EFC detection systems rolled out	EFC detection systems modified

Results Areas Supported by PforR	PDO/Outcome Indicators & Intermediate Results (IR) Indicators	PDO/IR	DLI #	Unit of Measurement	Baseline (2016)	Target Values			
						2017	2018	2019	2020
	Share of PKH beneficiary families, for which verification of their respective conditionality is recorded in PKH PMIS	IR	4	%	40	50	70	85	90
Results Area 2: Improving access to basic social services and complementary social assistance programs for PKH beneficiaries	Share of PKH beneficiaries receiving other social assistance program benefits	PDO	5	%	13.6	40	70	85	95
	Share of PKH beneficiary families whose NIK numbers have been verified	IR	6	%	73.5	80	90	93	95
	Share of children aged 7–18 years in PKH beneficiary families attending primary, junior, and senior secondary school at least 85% of the time	PDO		%	81.1	85	90	95	95

Results Areas Supported by PforR	PDO/Outcome Indicators & Intermediate Results (IR) Indicators	PDO/IR	DLI #	Unit of Measurement	Baseline (2016)	Target Values			
						2017	2018	2019	2020
	Share of children aged 0–6 years in PKH beneficiary families who received basic health and nutrition services in accordance with protocol	PDO		%	79.7	85	90	90	90
	Number of PKH mother groups that have received FDS from trained facilitators	IR	7	Number	7,357	32,000	56,000	81,000	106,000
Results Area 3: Expanding coverage and improving	Total number of PKH beneficiary families	PDO	8	Number	5,980,000	6,000,000	6,000,000	8,000,000	10,000,000

Results Areas Supported by PforR	PDO/Outcome Indicators & Intermediate Results (IR) Indicators	PDO/IR	DLI #	Unit of Measurement	Baseline (2016)	Target Values			
						2017	2018	2019	2020
inclusivity of the conditional cash transfer program	Ratio of number of PKH beneficiary families to number of the targeted families in areas categorized by the Ministry of Social Affairs as remote and border areas	IR	9	%	48	60	70	80	85
	Number of PKH beneficiary families that also receive benefits for severely disabled or elderly family members	IR		Number	496,540	498,000	581,000	747,000	966,000

Indicator Description

Indicator Name		Description	Frequency	Data Source/Methodology	Responsibility for Data Collection
1	PKH PMIS enhancements implemented	This indicator measures various improvements in the data integrity, security, and operational soundness of PKH PMIS. It reflects the information system development cycle, including (a) a time bound Enhancement Action Plan developed based on comprehensive gap analysis in reference to the minimum required protocols and standards of data integrity, security, and operational soundness; (b)	Annually	PMIS enhancement plan and system audit report	MoSA

Indicator Name		Description	Frequency	Data Source/Methodology	Responsibility for Data Collection
		the Enhancement Action Plan satisfactorily implemented and the upgraded PKH PMIS operational, which include payment realization data; (c) an independent audit firm, with established expertise, conducting a complete audit of PKH PMIS in reference to the required enhancements and providing recommendations on additional enhancement measures; and (d) relevant audit recommendations implemented.			
2	Production of operation monitoring statistical reports for all districts regularly generated and disclosed to related stakeholders	This indicator measures if the enhanced PKH PMIS is able to generate district-specific operation monitoring statistical reports. Having this capability will improve evidence-based policy making at both the central and local level. It will also lead to a better level of communication between the central and local implementers of PKH. Using PKH's PMIS, reports for each district should be generated encompassing key indicators that describe PKH's performance in those districts.	Annually	PKH PMIS	MoSA
3	Share of sub-districts with PKH beneficiary families having switched to cashless payment methods	This indicator captures the progress on electronic payment through banking services network, which is key to the Government's financial inclusion agenda. MoSA has been collaborating with the association of four state-owned banks (*Himpunan Bank Negara*, HIMBARA) to determine the rollout plan of their ATM and bank agent networks. By the end of 2016, 1.2 million PKH beneficiary families living in 45 cities and 24 districts switched to bank accounts and the target for 2017 is 3 million or half of the existing currently enrolled PKH beneficiary families through e-Warongs and bank agents/ATMs. The specification of districts and sub-district will be based on the Ministry of Home Affairs standard.	Biannually	PKH PMIS	MoSA
4	PKH uses digital platforms and mass media to regularly disclose information about program performance and the program manages to carry	This indicator will measure the creation of a multiyear information dissemination and communication strategy. The scope of the strategy should be discussed in mid-2017 and launched by the end of 2017. The strategy should involve multiple stakeholders and media outlets and include the creation of a PKH website with basic information about the program's purpose and functioning; a dedicated page for complaints should exist as well.	Annually	Communications strategy	MoSA

Indicator Name		Description	Frequency	Data Source/Methodology	Responsibility for Data Collection
	out social promotion				
5	HR capacity building plan and performance monitoring system implemented for program implementers at the subnational level	This indicator will assess whether a capacity-building plan and performance monitoring system for PKH facilitators has been implemented. Capacity building means training beyond the most basic training that all facilitators receive to execute PKH's business process core functions (validation, verification, and data updating). Currently, only basic training is given and depending on funding availability, additional training is provided on topics such as FDS implementation. For performance monitoring: as the program expands, the management of facilitators will become more and more complicated; a system should be in place to evaluate and manage their performance. Such a system should be in line with national standards. Such a system will contribute to quality improvement in the long run.	Annually	Capacity-building plan and performance monitoring report	MoSA
6	An enhanced GRS rolled out after evaluation of pilot	This indicator measures improvements in PKH GRS, including that it (a) is in place in all sub-districts where PKH is in operation and easily accessible by all stakeholders; (b) is well equipped to allow program implementers to respond adequately, within one month, to complaints on a case-by-case basis; (c) is capable of receiving, sorting, and making referral of complaints through multiple sources and media (phone call, short messaging service SMS, website entry, paper, and other agencies); (d) shall record essential information of all complaints and process them properly according to a protocol; and (e) has related roles and responsibilities clearly defined within the JSK. A pilot is to be designed and implemented by the second half of 2017. After evaluation and adjustments in 2018, an enhanced GRS shall be rolled out no later than 2019	Annually	PKH PMIS	MoSA
7	Error, fraud, and corruption detection systems implemented	This indicator will measure whether or not a system is implemented to detect EFC. Learning from international best practices, an EFC framework will be designed building on various existing pieces. Based on the evaluation of pilot experience, a system of EFC detection will be implemented for the whole program and supported by PKH PMIS.	Annually	EFC implementation report	MoSA
8	Share of PKH beneficiary families, for which verification	This indicator measures the foundational capability of PKH delivery system, that is, verification of conditionality compliance. As PKH cash transfer incentivizes beneficiary families' utilization of health and education services, it is critical to ensure that the	Biannually	PKH PMIS	MoSA

Indicator Name		Description	Frequency	Data Source/Methodology	Responsibility for Data Collection
	of their respective conditionality is recorded in PKH PMIS	incentives remain as strong as they are designed to be. One important lever is the verification process of utilization of those services and feeding the verification output data to the benefit determination process. The number and nature of conditionality (as specified in PKH Operation Manual) to be verified depend on each family's demographic composition (for example, age) as well as specific circumstances (for example, woman is pregnant or nursing) that make them eligible for PKH benefits.			
9	Share of PKH beneficiaries receiving other social assistance program benefits	This indicator will measure the share of PKH beneficiaries receiving benefits from three of the main SA programs in addition to PKH. The programs are Rastra, PIP, and PIS and they all target at least the poor and so PKH families should be receiving all three. This indicator will be measured using PKH PMIS containing information collected about existing PKH families' participation in other SA programs by facilitators during the data updating stage.	Biannually	PKH PMIS	MoSA
10	Share of PKH beneficiary families whose NIK numbers have been verified	This indicator measures to what extent PKH beneficiaries have obtained the NIK, recorded on identity cards or KKSs). This number is important on its own not only to establish each individual's legal identity, but also because the ownership of this number facilitates access to all public services provided by the central and local governments. The verification of NIKs against the Government's identity management database will help detect error and duplication. It will also help greater complementarity with other social programs.	Biannually	PKH PMIS	MoSA
11	Share of children aged 7–18 years in PKH beneficiary families attending primary, junior, and senior secondary school at least 85% of the time	This indicator measures the share of school-aged children in PKH families attending classes at least 85% of the time. This indicator is a core part of the program's goals to improve long-term human development outcomes by encouraging enrollment and attendance to school. The existing PMIS is to be used to track changes in the fulfillment of this indicator.	Biannually	PKH PMIS	MoSA
12	Share of children aged 0–6 years in PKH beneficiary families who	This indicator assesses the effectiveness of the program in improving health outcomes for young children as another core element of the program. According to the program's protocol, children should have complete childhood immunization and take	Biannually	PKH PMIS	MoSA

Indicator Name		Description	Frequency	Data Source/Methodology	Responsibility for Data Collection
	received basic health and nutrition services in accordance with protocol	Vitamin A capsules twice a year; and they should be given check-ups for growth monitoring (monthly for infants 0-11 months, and quarterly for children 1-6 years). The existing PMIS is to be used to track changes in the fulfillment of this indicator.			
13	Number of PKH mother groups that have received FDS from trained facilitators	This indicator measures the efforts made to increase PKH mothers' knowledge and skills and promote positive behavior changes, which will supplement the cash benefits with knowledge on how to improve their families' opportunities and productivity. PKH mother groups usually consist of 20 to 25 PKH mothers who nominate a group leader. PKH facilitators first receive a training on the FDS modules. After completing the training successfully, facilitators will receive a decision letter from the JSK Director to prove they have completed the training. Subsequently, the trained facilitators provide at least one session according to their FDS plan, which can be flexible in the sequence of modules in response to local needs.	Annually	PKH monitoring report	MoSA
14	Total number of PKH beneficiary families	This indicator measures the number of beneficiary families who have enrolled in PKH and have received cash transfer payments. It reflects the coverage of the program and will be measured as the total number of beneficiary families who have been paid PKH benefits in the first payment of the calendar year.	Annually	PKH PMIS	MoSA
15	Ratio of number of PKH beneficiary families to number of the targeted families in areas categorized by the Ministry of Social Affairs as remote and border areas	This indicator measures to what extent PKH has managed to expand its coverage in remote and border areas (where program implementation is more challenging than in a typical area). Remote sub-districts are still considered challenging areas and so are included in this indicator as well. The ratio is constructed by calculating the share of PKH beneficiaries to potential beneficiaries ranked at or below the 25th percentile in the targeting database.	Annually	PKH PMIS	MoSA
16	Number of PKH beneficiary families that also receive benefits for severely disabled or elderly	This indicator captures both the identification of eligibility and receipt of cash transfers for severely disabled and elderly members within PKH families. Families that have severely disabled or elderly members living in the household face significantly higher expenditures to provide them with sufficient care. The indicator is in line with MoSA's policy to include new components in PKH and	Annually	PKH PMIS	MoSA

Indicator Name		Description	Frequency	Data Source/Methodology	Responsibility for Data Collection
	family members	increase the program's inclusivity, absorbing existing but small coverage MoSA programs, such as the old age assistance program.			

Annex 3: Disbursement-Linked Indicators, Disbursement Arrangements, and Verification Protocols

Disbursement-Linked Indicator Matrix

	Total Financing Allocated to DLI	As % of Total Financing Amount	DLI Baseline	Indicative Time Line for DLI achievement*
				2017–2020
DLI 1. PKH PMIS enhancements implemented	—	—	No	(1) Enhancement Action Plan developed (allocated amount US$3 million); (2) Enhancement Action Plan implemented satisfactorily (US$4 million); (3) PKH PMIS audited and enhancements recommended (US$1 million); (4) Audit report recommended enhancements implemented (US$2 million);
Allocated amount:(US$, million)	10	5%	—	
DLI 2. Share of sub-districts with PKH beneficiary families having switched to cashless payment methods	—	—	15%	The target value of 73% is expected to be achieved by the end of 2020. The indicative time line is provided in the annex 2 Results Framework Matrix.
Allocated amount: (US$, million)	30	15%	—	
DLI 3. An enhanced GRS rolled out after evaluation of pilot	—	—	No	(1) Enhanced design developed (allocated amount US$1 million); (2) Pilot implemented and evaluated (US$3 million); (3) Enhanced GRS rolled out (US$5 million); (4) Grievance analysis produced (US$1 million);
Allocated amount: (US$, million)	10	5%	—	
DLI 4. Share of PKH beneficiary families, for which verification of their respective conditionality is recorded in PKH PMIS	—	—	40%	The target value of 90% is expected to be achieved by the end of 2020. The indicative time line is provided in the annex 2 Results Framework Matrix.
Allocated amount: (US$, million)	30	15%	—	
DLI 5. Share of PKH beneficiaries receiving other social assistance program benefits	—	—	13.6%	The target value of 95% is expected to be achieved by the end of 2020. The indicative time line is provided in the annex 2 Results Framework Matrix.
Allocated amount: (US$, million)	30	15%		
DLI 6. Share of PKH beneficiary families whose NIK numbers have been verified	—	—	73.5%	The target value of 95% is expected to be achieved by the end of 2020. The indicative time line is provided in the annex 2 Results Framework Matrix.

	Total Financing Allocated to DLI	As % of Total Financing Amount	DLI Baseline	Indicative Time Line for DLI achievement*
				2017–2020
Allocated amount: (US$, million)	10	5%		
DLI 7. Number of PKH mother groups that have received FDS from trained facilitators	—	—	7,357	The target value of 106,000 is expected to be achieved by the end of 2020. The indicative time line is provided in the annex 2 Results Framework Matrix.
Allocated amount: (US$, million)	40	20%		
DLI 8. Total number of PKH beneficiary families	—	—	5.98 million	The target value of 10 million is expected to be achieved by the end of 2020. The indicative time line is provided in the annex 2 Results Framework Matrix.
Allocated amount: (US$, million)	20	10%		
DLI 9. Ratio of number of PKH beneficiary families to number of the targeted families in areas categorized by the Ministry of Social Affairs as remote and border areas	—	—	48%	The target value of 85% is expected to be achieved by the end of 2020. The indicative time line is provided in the annex 2 Results Framework Matrix.
Allocated amount: (US$, million)	20	10%		
Total Financing Allocated: (US$, million)	**200**	**100%**		If disbursement-linked results (DLRs) would be achieved as anticipated in annex 2, then the annual disbursement amounts, calculated per annex 3 World Bank Disbursement Table unit prices, would be US$53 million, US$53.4 million, US$53.5 million, and US$40.1 million respectively for FY2018–21.

Note: *Calendar year for verification will be from January 1 to December 31 each year.

DLI Verification Protocol Table

#	DLI	Definition/Description of Achievement	Scalability of Disbursements (Yes/No)	Protocol to Evaluate Achievement of the DLI and Data/Result Verification		
				Data Source/Agency	Verification Entity	Procedure
1	**PKH PMIS enhancements implemented**	This indicator measures various improvements in the data integrity, security, and operational soundness of PKH PMIS. The four results reflect the iterative nature of information system upgrading and development, in particular when policy and operation requirements are expected to continue evolving. The results are (a) a time bound Enhancement Action Plan developed based on a comprehensive gap analysis in reference to the minimum required protocols and standards of data integrity, security and operational soundness; (b) the Enhancement Action Plan satisfactorily implemented and the upgraded PKH PMIS operational, which include information on payment realization; (c) an independent audit firm, with established expertise, conducting a complete audit of the upgraded PKH PMIS in reference to the required enhancements and provides recommendations on additional enhancement measures; and (d) relevant audit recommendations implemented. The Enhancement Action Plan shall address the existing gaps observed in PKH database, PKH applications, system security, and in-house capacity.	No	• Time bound Enhancement Action Plan with resources allocated approved by MoSA • Implementation progress report • System Audit ToR as approved by an expert committee • System Audit report with additional enhancement recommendations • Additional enhancement measures implemented	IVA	PKH PMIS implementation progress reports, verified against the Enhancement Action Plan and System Audit report

#	DLI	Definition/Description of Achievement	Scalability of Disbursements (Yes/No)	Protocol to Evaluate Achievement of the DLI and Data/Result Verification		
				Data Source/Agency	Verification Entity	Procedure
2	**Share of sub-districts with PKH beneficiary families having switched to cashless payment methods**	This indicator captures the progress on electronic payment through banking services network, which is key to the Government's financial inclusion agenda. MoSA has been collaborating with the HIMBARA to determine the rollout plan of their ATM and bank agent networks. The rollout unit is sub-districts in both urban and rural areas. By the end of 2016, 1.2 million PKH beneficiary families living in 45 cities and 24 districts (in total 846 sub-districts) switched to bank accounts and the target for 2017 is 3 million or half of the currently enrolled PKH beneficiary families through e-Warongs and/or bank ATM/agent networks.	Yes	• PKH PMIS • HIMBARA disbursement dashboard and banks' payment records	IVA	PKH PMIS payment report for the third payment cycle of the calendar year, verified against HIMBARA banks' payment records and disbursement dashboard

#	DLI	Definition/Description of Achievement	Scalability of Disbursements (Yes/No)	Protocol to Evaluate Achievement of the DLI and Data/Result Verification		
				Data Source/Agency	Verification Entity	Procedure
3	**An enhanced GRS rolled out after evaluation of pilot**	This indicator measures improvements in PKH GRS, including that it (a) is in place in all sub-districts where PKH is in operation and easily accessible by all stakeholders; (b) is well equipped to allow program implementers to respond adequately, within three months, to complaints on a case-by-case basis; (c) is capable of receiving, sorting, and making referral of complaints through multiple sources and media (phone call, SMS, WhatsApp message, website entry, paper, and other agencies); (d) shall record essential information of all complaints and process them properly according to a protocol; and (e) has related roles and responsibilities clearly defined within the JSK and each subnational team. The results are (a) an enhanced GRS design that meets the above desired features; (b) a prototype GRS is developed for piloting and the pilot is evaluated; (c) adjustments are made to the GRS design and the enhanced GRS is rolled out to the whole program; and (d) analysis using the grievance data is carried out.	No	• Enhanced GRS design • Pilot implementation report • Pilot evaluation report • GRS rollout implementation report • Grievance analysis report	IVA	GRS design, pilot report, rollout plan, and grievance analysis report

#	DLI	Definition/Description of Achievement	Scalability of Disbursements (Yes/No)	Protocol to Evaluate Achievement of the DLI and Data/Result Verification		
				Data Source/Agency	Verification Entity	Procedure
4	**Share of PKH beneficiary families, for which verification of their respective conditionality is recorded in PKH PMIS**	This indicator measures the foundational capability of PKH delivery system, that is, verification of conditionality compliance. As PKH cash transfer incentivizes beneficiary families' utilization of health and education services, it is critical to ensure that the incentives remain as strong as they are designed to be. One important lever is the verification process of utilization of those services and feeding the verification output data to the benefit determination process. The number and nature of conditionality (as specified in PKH Operation Manual) to be verified depend on each family's demographic composition (for example, age) as well as specific circumstances (for example, woman is pregnant or nursing) that make them eligible for PKH benefits.	Yes	• PKH PMIS	IVA	PKH PMIS verification report. Data to be verified on a sample basis using a random sample of 1,000 beneficiary families for whom their conditionality has been verified
5	**Share of PKH beneficiaries receiving other social assistance program benefits**	This indicator measures to what extent PKH beneficiaries are also receiving other three main SA benefits—Rastra (subsidized rice), PIP, and PIS, all of which by design cover at least the poor population. Hence, PKH beneficiary families should be receiving all three. The enrollment status of these three programs are collected by PKH facilitators during the data updating stage.	Yes	• PKH PMIS beneficiary report • SISKADA • Susenas where possible	IVA	PKH PMIS beneficiary report. SISKADA reports and information as the primary verification source and if needed, Susenas survey data to be used to supplement this source.

#	DLI	Definition/Description of Achievement	Scalability of Disbursements (Yes/No)	Protocol to Evaluate Achievement of the DLI and Data/Result Verification		
				Data Source/Agency	Verification Entity	Procedure
6	**Share of PKH beneficiaries whose NIK numbers have been verified**	This indicator measures to what extent PKH beneficiaries have obtained the NIK, recorded on identity cards or KKSs. This number is important on its own not only to establish each individual's legal identity, but also because the ownership of this number facilitates access to all public services provided by the central and local governments. The verification of NIKs against the Government identification database will help detect error and duplication. It will also help greater complementarity with other social programs.	Yes	• PKH PMIS • SISKADA	IVA	PKH PMIS beneficiary report. SISKADA reports and information.
7	**Number of PKH mother groups receiving FDSs from trained facilitators**	This indicator measures the efforts made to increase PKH mothers' knowledge and to promote positive behavior changes through FDS sessions, which will supplement the cash benefits with knowledge on how to improve their families' opportunities and productivity. PKH mother groups usually consist of 20 to 25 PKH mothers who nominate a group leader. PKH facilitators first receive a training on the FDS modules. After completing the training successfully, facilitators will receive a decision letter from the JSK Director to prove they have completed the training. Subsequently, the trained facilitators provide at least one session according to their FDS plan, which can be flexible in the sequence of modules in response to local needs.	Yes	• PKH FDS monitoring report	IVA	PKH FDS monitoring report. Data to be verified on a sample basis using a sample of 100 facilitators who have received training in the year

#	DLI	Definition/Description of Achievement	Scalability of Disbursements (Yes/No)	Protocol to Evaluate Achievement of the DLI and Data/Result Verification		
				Data Source/Agency	Verification Entity	Procedure
8	**Total number of PKH beneficiary families**	This indicator measures the number of beneficiary families who have enrolled in PKH and have received cash transfer payments. It reflects the coverage of the program and will be measured by the total number of beneficiary families who have been paid PKH benefits in the first payment cycle of the calendar year.	Yes	• PKH PMIS • PSP payment records	IVA	The verification process will involve the review of PKH PMIS report on enrollment and the PSP payment records, both for the first payment of the calendar year
9	**Ratio of number of PKH beneficiary families to number of the targeted families in Papua and other areas categorized by MoSA as remote areas**	This indicator measures to what extent PKH has managed to expand its coverage in remote and border areas (where program implementation is more challenging than in a typical area). Remote sub-districts are still considered challenging areas and so are included in this indicator as well. The ratio is constructed by calculating the share of PKH beneficiaries to potential beneficiaries ranked at or below the 25th percentile in the targeting database.	Yes	• PKH PMIS • PSP payment records	IVA	The verification process will involve the review of PKH PMIS validation and enrollment report and validate the PSP payment records for the first payment of the calendar year

World Bank Disbursement Table

#	DLI	World Bank Financing Allocated to the DLI (US$, million)	Deadline for DLI Achievement	Minimum DLI Value to be Achieved to Trigger Disbursements of World Bank Financing	Maximum DLI Value(s) Expected to be Achieved for World Bank Disbursements Purposes	Determination of Financing Amount to be Disbursed against Achieved and Verified DLI value(s)
1	**PKH PMIS enhancements implemented**	10	December 31, 2020	Enhancement Action Plan developed	Audit report recommended enhancements implemented	The financing amounts associated with the four DLRs achieved and verified are specified in the DLI Matrix.
2	**Share of sub-districts with PKH beneficiary families having switched to cashless payment methods**	30	December 31, 2020	23%	73%	US$10 million to be disbursed on achievement of 23% DLI value. DLI scalable after 23% value has been met. Between 23% and 73%, US$400,000 will be disbursed for every 1 percentage point increase.
3	**An enhanced GRS rolled out after evaluation of pilot**	10	December 31, 2020	Enhanced design developed	Grievance analysis produced	The financing amounts associated with the four DLRs achieved and verified are specified in the DLI Matrix.
4	**Share of PKH beneficiary families, for which verification of their respective conditionality is recorded in PKH PMIS**	30	December 31, 2020	50%	90%	US$10 million to be disbursed on achievement of 50% DLI value. DLI scalable after 50% value has been met. Between 50% and 90%, US$500,0000 will be disbursed for every 1 percentage point increase
5	**Share of PKH beneficiaries receiving other social assistance program benefits**	30	December 31, 2020	40%	95%	US$8 million to be disbursed on achievement of 40% DLI value. DLI scalable after 40% value has been met. Between 40% and 95%, US$400,000 will be disbursed for every 1 percentage point increase.
6	**Share of PKH beneficiary families whose NIK numbers have been verified**	10	December 31, 2020	80%	95%	US$4 million to be disbursed on achievement of 80% DLI value. DLI scalable after 80% value has been met. Between 80% and 95%, US$400,000 will be disbursed for every 1 percentage point increase.

#	DLI	World Bank	Deadline for	Minimum DLI Value	Maximum DLI	Determination of Financing
7	**Number of PKH mother groups that have received FDS from trained facilitators**	40	December 31, 2020	32,000	106,000	US$10.4 million to be disbursed on achievement of 32,000 DLI value. DLI scalable after 32,000 has been met. Between 32,000 and 106,000, US$400,000 will be disbursed for every 1,000 increase of mother groups
8	**Total number of PKH beneficiary families**	20	December 31, 2020	8 million	10 million	US$10 million to be disbursed on achievement of 8 million DLI value. DLI scalable after 8 million value has been met. US$5,000 will be disbursed on achievement of each additional 1,000 PKH beneficiary families until 10 million PKH beneficiary families
9	**Ratio of number of PKH beneficiary families to number of the targeted families in areas categorized by the Ministry of Social Affairs as remote and border areas**	20	December 31, 2020	60%	85%	US$5 million to be disbursed on achievement of minimum DLI value of 60% has been met. DLI scalable after the 60% value has been met. US$600,000 will be disbursed on achievement of each one percentage point increase until 85%

Annex 4: Summary Technical Assessment

I. Program Strategic Relevance and Technical Soundness

Strategic Relevance

1. **The World Bank's initial technical assessment of the sector confirms that the proposed operation is strategically relevant to the Government's development objectives.** The RPJMN recognizes the need to support special programs for the poor such as PKH and integrate family-based SA schemes for poor and vulnerable families that have children, disabled, or elderly members. The proposed PforR operation responds to a request by MoSA, and its proposed development objective aligns with improving the effectiveness of fiscal spending in poverty and inequality reduction in Indonesia, as stated in the RPJMN (2015–2019).

2. **The Program is also well aligned with the World Bank Group's twin goals of eliminating extreme poverty and increasing shared prosperity.** It supports the CPF for Indonesia FY16–FY20, in particular under EA 4: Delivery of Social Services and Infrastructure; EA 6: Collecting More and Spending Better; and SB II: Shared Prosperity, Equality, and Inclusion. The task also contributes to the achievement of the CPF objective indicators on (a) percentage of mothers and children receiving maternal and child health and nutrition services in community health center and its network in targeted areas (EA 4); (b) Central Government spending on health, capital expenditure, and SA (EA 6); (c) number of households benefiting from PKH, disaggregated by gender (SB II); and (d) increase in the number of SA beneficiaries receiving payments digitally (SB II). Finally, with a strategic focus on delivery systems strengthening, promoting human capital, and increasing coordination across SA interventions, the Program is aligned with the World Bank's Social Protection and Labor Strategy 2012–2022.

Technical Soundness

3. **The proposed Program is technically sound and is expected to have positive impacts on the Government's effectiveness in delivering the CCT as one of the core pillars of Indonesia's social safety nets to protect and enable those who otherwise do not have the capability to participate in the economic growth process.** The Program builds on MoSA's past nine years of capacity and experience in implementing PKH. Much capacity has been built over that time, and evidence suggests that the program has had important impacts. In addition to the coverage expansion, MoSA has also been continuously reviewing the program's implementation, business processes, and delivery systems and has been making the necessary adjustments to improve implementation performance. Three key principles guide this review and revision process: simplicity, clarity, and accountability. As the program scales up in size, those three principles become exponentially more important than with smaller programs.

II. Findings from the Technical Assessment

Targeting

4. **Before the 2016 expansion, which has enabled PKH reach all districts in the country, district selection had been based on essentially three factors—district government's commitment, supply-side readiness, and national priority.** In addition to

having adequate educational facilities and health facilities to support PKH, district governments must provide district and sub-district UPPKH secretariats and contribute funds through local budgets, of at least 5 percent of the total annual transfers. Among the districts meeting the first two factors, priority was given to disadvantaged districts, affected districts (social and natural), and border districts**.**

5. **The selection of 2.5 million new eligible families, when PKH was scaled up in 2016 from the previous 3.5 million to 6 million families, was handled by the JSK.** First, province- and district-level quotas were generated and agreed upon. The quotas were calculated as the latest district-level number of poor households estimated using the most recent BPS Susenas data minus the total number of existing PKH beneficiary families in those districts. As a result, the district quotas vary significantly. For example, some districts received zero quota for new eligible families due to a combination of a fall in the poverty rate and a sufficiently high number of existing PKH beneficiaries. Second, of the new 2.5 million eligible families, around 2.1 million will be allocated in the districts with PKH operation already and the remaining 400,000 will be allocated to the new districts in Papua and Maluku. Among the existing districts, it was also decided not to add new villages but rather 'saturate' the existing villages with additional beneficiaries.

6. **After the quotas for new eligible beneficiary families were decided, the lists of new eligible families at province, district, and village levels were created using the validated and verified data.** The JSK office then distributed the lists to the corresponding provincial UPPKH offices and then to the district UPPKH offices. Lastly, PKH facilitators are assigned to carry out initial validation of the new eligible families to ensure their eligibility. Upon validation, the truly eligible families are registered into PKH beneficiary master database. In practice, about 3.4 million potential beneficiaries' data was sent out to districts for facilitators to verify. The additional 800,000 plus families were added because of the expectation that some potential beneficiary families would be found to be ineligible upon verification by facilitators.

PKH HR Management

7. **Facilitators carry out myriad core and supporting functions,** ranging from conducting socialization (that is, outreach, communication, and awareness raising) and advocacy; running initial meetings and validations; assisting beneficiaries in withdrawing cash quarterly at a nearby post office; updating, verifying and entering data; organizing and leading FDSs; handling complaints and case management; recording and reporting beneficiaries' utilization of health and education services and compliance with PKH conditionality; reporting on payment reconciliations; distributing PKH cards to participants; preparing weekly activity reports, and so on. In other words, the facilitators are the all-purpose 'foot soldiers' of PKH implementation model currently in place. They carry the bulk of the day-to-day responsibilities to ensure that the program is run as designed on the ground.

8. **The high workload of the facilitators has prevented them from focusing more on assisting families and monitoring conditionality.** Firstly, based on the analysis of the implementation guidelines reviewed together and the end-to-end implementation planning, the current workload appears to be unevenly distributed, with too many hours of work required to complete all duties assigned to the facilitators, and importantly without clear separation of duties

between beneficiary management (determining enrollment/eligibility) and disbursement (authentication and manual payments reconciliation). The excessive involvement of the facilitators, presents possible pressure points along the delivery chain and poses internal control risks that could result in error and fraud occurring and going undetected. Secondly, overloading the facilitators with an array of manual tasks may hamper the timely achievement of the end-to-end implementation. For instance, some facilitators are taking one to two weeks to provide operators with updated beneficiary information, done manually using a large Excel spreadsheet (as compared to PT Pos which reconciles electronically directly with the JSK), thus lengthening the reconciliation process and delaying payments by several weeks.

9. **Despite the extensive and heavy workload, facilitators have relatively poor employment conditions and receive little financial or administrative support.** They, like other PKH field staff, are hired on renewable annual contracts with a relatively low pay (not more than IDR 3 million per month) and a minimum benefit coverage (that is, no health insurance coverage). For some areas the offered wage is below some of the regional minimum wage standards set by the Government. No additional allowances are provided and this is a problematic feature of the current remuneration design, especially in the more difficult areas (where high transportation costs are very burdensome on the salary of the facilitator). According to a number of anecdotes, PKH field staff often have to cover work-related expenses, such as the cost of transportation for field visits, maintenance of the office utilities (for example, electricity and Internet) and stationary/printing, out of their own pockets. Originally, it was envisioned that the operational costs, around IDR 400,000 per month, could be paid by local governments as part of the cost-sharing initiative (5 percent of total benefit value in the district) to actively contribute to the implementation of PKH. The perceived lack of long-term job stability, the low pay, and the difficult working environment leads to a relatively serious challenge of high turnover (around 20 percent a year).

10. **The need to manage thousands of field-based contracted employees (more than 20,000) all over the very large country from a relatively small central unit continues to be a difficult structural challenge in PKH management.** The 2015 reorganization of the JSK was limited to rearranging the organizational structure at the central level and has therefore left the arrangement for managing the field staff untouched. As the recent wave of expansion into 6 million beneficiary families has been completed, the number of PKH field staff has surpassed 25,000, deployed in 34 provinces and 514 districts. One of the greatest institutional challenges of PKH management is to manage this contingent of centrally recruited field staff.

11. **The current performance management and monitoring of facilitators is functioning sub-optimally and will benefit from redesigning and strengthening, pending further analysis**. At the moment, performance monitoring for facilitators is conducted in October, without the use of operational performance indicators but only a type of competency evaluation. Performance M&E is done at the national level which places a heavy burden on the program, given the extensive number of facilitators and operators. It is mainly done by observing data entry and progress in the information and communication technology dashboard which informs on business processes. Every year in November, the local social affairs office will announce whether the facilitators' contract is continued or not and relays these decisions to PKH's central authorities. However, throughout the year MoSA faces a significant limitation in monitoring all facilitators' activities on a weekly basis leading to less than adequate program oversight

12. **Lastly, given the many government agencies that employ facilitation systems to deliver results at the village and household, a key opportunity to enhance PKH results is linking these systems together.** Indeed, a key policy priority espoused by the MoSA leadership is accelerating social protection program coverage convergence for poor families at the national and local levels. Linking facilitation systems at multiple levels will present a key opportunity to help achieve this policy priority. The MoV has a facilitation system that differentiates roles[30] between different levels (village, sub-district, and district). In particular, while this position is still under development, at the district level there will be an expert on service delivery which could open up possibilities to link with other technical agencies, including local Social Affairs Offices. Through its facilitators, MoV is able to reach the villages and the village-based organizations and as such there is potential for PKH to build on this system in the long run.

Capacity Development for PKH Facilitators, Operators, and Coordinators

13. **MoSA and the central PKH management team established a standard training mechanism to ensure that PKH facilitators, operators, and coordinators can perform according to their respective job descriptions.** This mechanism stipulates a series of regular trainings and ad hoc technical workshops (called '*BimTek*', that is, technical guidance). PKH facilitators and operators are obliged to participate in the *BimTek*. These *BimTek* are supposed to be conducted at national as well as subnational (province and/or district) levels. According to the standard mechanism, which was developed in 2012, the *BimTek* are not stand-alone trainings but embedded in the cycle of conditionality verification, payments, payment reconciliations, and regular coordination meetings of PKH field staff with representatives of administrations and social service providers at the district, province, and national levels (called Rakor). By design, various *BimTek* focus on different content. The first *BimTek* is supposed to address the issues of (a) how to facilitate and conduct the initial meeting with PKH beneficiary candidates for the validation process and (b) how to conduct the verification process of the education and health components (for example, filling out forms and reporting documents). The second and third *BimTek* are supposed to refresh, provide more detail to the procedures, and more importantly—because PKH guidelines continuously evolve—update on recent changes (for example, new calculation of PKH transfer per family composition). In addition to this, facilitators, operators, and coordinators would likely receive irregular training, which is provided in collaboration with MoSA's internal training unit, the Training and Research Agency (*Badan Pendidikan Penelitian*, BADIKLIT). Irregular trainings are conducted to equip facilitators with knowledge to implement the FDSs, as well as in case of significant technical or methodological changes. For example, when the DMR technology was introduced to process the conditionality verification forms, operators were required to attend the DMR trainings.

14. **There are several implementation issues related to this standard mechanism: First, the content needs to be enriched further.** The *BimTek* focused on the 'nuts and bolts of PKH, that is, its broad objectives, basic program facts like calculation of benefits, UPPKH structure, and its guidelines, procedures, and processes. Given PKH's ambition and its main target group

[30] Improvement in the system as well as in its implementation mechanisms is certainly possible as the MoV is working to get everything in place to provide the necessary support to the 73,000 villages especially in the light of optimizing the opportunities emerging from the implementation of the UU6/2014 Village Law.

(that is, very poor and marginalized households), the facilitators themselves experience and articulate the need for additional capacity development, especially in communication skills, basic knowledge of social protection, and knowledge of other national and subnational social programs, which are of relevance for their clients.[31]

15. **Second, the abovementioned defined standard mechanism, however, has not been fully implemented due to budget constraints.** For instance, in 2016, only the initial training (first regular *BimTek*) for PKH facilitators, operators, and coordinators was conducted and was also belated (after the June payment), while the second and third *BimTek* were not (yet) implemented.[32] The main reason for this is related to budgeting. Because PKH is a nonpermanent program, its budget is planned on an annual basis. Budget allocations to the program depend on the overall availability of government finance. Therefore, due to two cross-board budget cuts in 2016,[33] MoSA had to maintain PKH benefit payment levels by reducing the allocations to other lower priority tasks. Hence, payment and training cycles for PKH were altered to cope with this situation. Given the standard one-year contract duration for facilitators and regular re-contracting of the same facilitators the next year, many of them received trainings with identical or similar content (for example, the content of first *BimTek* repeated in second and third *BimTek*) several times, but are less often—if at all—exposed to additional or new content and therefore stagnate on the same level of capacity.

16. **Third, as PKH is encouraged to use MoSA's internal training unit, BADIKLIT, the training quality is subject to BADIKLIT's operational and technical capacity.** There have been times when BADIKLIT could not actually provide the trainings in the expected quantity and quality due to capacity constraints despite budget availability. Going forward, BADIKLIT needs to substantially strengthen its capacity in both staffing and training program development (content and training methods) and MoSA needs to search for multiple channels to carry out trainings.

17. **To improve the standard mechanism and its implementation, a thorough assessment of PKH facilitators', operators', and coordinators' respective skills needs is critical to inform the development of more comprehensive training curricula.** Additional to the 'nuts and bolts' of PKH program itself, these capacity needs are likely to include soft skills like communication, a basic understanding of social protection, and knowledge of other relevant national-, provincial-, and district-level social (protection) programs. Moreover, because one important reason for inadequate capacity of PKH field staff is a lack of trainings due to limited overall budget availability, ensuring sufficient and predictable allocations of the national budget to MoSA will go a long way toward increasing the capacity of UPPKH staff. Moreover, given the frequent changes to PKH guidelines as well as the huge costs involved in bringing all PKH

[31] GIZ, in 2013, developed and conducted a pilot communication skills development training for PKH facilitators, aimed at improving their communication with their clients. The pilot training was captured on video tapes and handed over to MoSA/UPPKH for further general implementation as part of the *BimTek.* This, however, never materialized due to limited capacities and budget in UPPKH.

[32] The implementation of the 2016 *BimTek* cycle, moreover, got disrupted by new MoSA leadership at the director and general director level, new organizational structures, and the upscaling of PKH. The latter required a massive recruitment process, which absorbed substantial working time of UPPKH staff at the national level.

[33] Due to decreasing oil and gas revenues, the Government had to cut its budget allocations to all LMs in 2016.

field staff regularly to Jakarta, more cost efficient solutions for their capacity development could be envisioned and developed; for example, ensure a consequent decentralization of trainings (to be conducted either by the provincial UPPKH secretariats and/or by MoSA's seven regional training facilities) and/or stepping up MoSA's ongoing efforts to develop and implement e-learning modules for their social workers.

PKH PMIS

18. **From a process perspective, there are several places that additional automation of data collection, entry, and transmission could improve both efficiency and quality.** From an IT perspective, PKH PMIS needs to be enhanced to address the following system performance, information security, communication technology, and capacity issues:

(a) **Application.** The Online SIM Application slows down and responds abnormally during the peak load, likely due to suboptimal application design. For example, the Final Closing module computes the payment amount for each PKH participant using their verification data of each month. As it is a user-driven process, the Final Closing module is often stuck when multiple operators simultaneously execute the same module, consequently affecting application performance with severe database deadlocks. In addition, the Online SIM Application exchanges data in plain text using a protocol without encryption. Furthermore, the Offline Validation Application and the DMR application are both stand-alone applications and are yet to be fully integrated with the Online SIM Application.

(b) **Infrastructure.** JSK has a server room with its infrastructure built in 2007. The server room keeps 5 Sun Sparc Application Servers with 8 GB RAM and 1 Sun Sparc database server with 16 GB RAM. The Sun Storage has 7 TB of space which is connected through a SAN switch with the database server. The server room also contains a Business Intelligence Server from Sun. There is a disaster recovery site in Batam but it is not functional at present. The physical load balancer from Brocade is also nonfunctional at present. All the hardware and infrastructure are not under active support and maintenance contract at the present.

(c) **Database.** The current size of PKH Master Database is 60 GB and contains only textual data. The largest table in the database is the table of payments that contains a total of 37,338,948 rows and has a size of 7.97 GB. There is no regular data archiving mechanism in place and the historical data remains in the main tables. The database often receives deadlocks during the Final Closing process as there is large payment computation involved in the process and is dependent on the payments table. The database backup is not a regular feature and there is no database backup policy and protocol in place. The tape libraries in the server room are not usable as there are no trained resources to take backups using tape libraries. There is no feature to record payment realization.

(d) **Network.** All the subnational PKH offices use the Online SIM Application and exchange data with JSK using dedicated connectivity. Nearly 470 offices use a dedicated VPN over fixed line connectivity to access the PMIS, while 34 offices use National Telecom VSAT service to access the PMIS. Each year PKH hires a service provider to provide support, maintenance, and dedicated connectivity with the subnational offices. A large extent of the IT budget is spent on supporting the

dedicated VPN and VSAT connectivity. More importantly, due to lack of appropriate network segmentation, users can have unauthorized access to other computers on the network, which is a serious system security concern.

(e) In-house IT team. The IT team has technical specialists, including (a) an IT manager, (b) a database administrator/developer, and (c) a network administrator. The capacity is far below what is required to support the operation needs of the program and manage the system development process.

19. **Furthermore, the current PKH information system could have potentially supported three additional functionalities.** First, the existing HR recruitment and training systems do not connect with the existing applications that mainly serve the beneficiary families. However, lack of integration or interoperability clearly has been detrimental to the program's HR management, including performance management. Second, PKH operational data has not been used adequately for monitoring purposes in a transparent manner, and does not have a feature on payment realization record data. For example, very little operational information has been disclosed regularly to the public on the MoSA website. It is important to build a business intelligence tool to assist the management with information analytics and support information disclosure for transparency purposes. Third, the current PKH PMIS does not have a regular data exchange mechanism or protocol with other government systems. For example, PKH implementation can benefit from using the existing national identification system's authentication service.

20. **A comprehensive gap analysis in reference to business requirements is required for developing a strategic IT plan for PKH information system.** However, in the short term, certain stopgap measures need to be taken to address the most immediate needs, particularly supporting the coverage expansion to 6 million beneficiaries by the end of 2016. In the medium and long term, PKH information system needs to be redesigned afresh to support the future scale-up of the program and better integration with other SA programs.

Table 4.1. PKH PMIS Gap Analysis

Issue	Solution Options	Urgency
Application performance degradation	Database tuning and separation of payment calculation and payment list generation	Short term
Database archiving and backup	Developing geographical codes mapping and transforming	Short term
Mismatched location coding	Automating mapping of location codes between the BPS and Ministry of Home Affairs	Short term
Lack of IT development strategy	Developing a PKH IT strategic plan	Medium term
Inadequate IT technical capacity	Building in-house capacity based on skill needs assessment and exploring partnership options	Medium term
Disconnection between software application design and business requirements	Develop/update business requirements in consultation with all users	Medium term
Fragmented database design	Develop an integrated and coherent data model	Medium term
Lack of information system architecture	Develop data, application, and technology architecture	Medium term
Low reliability of IT infrastructure	Utilize MoSA data center infrastructure, as well as its platform for disaster recovery, network, and interoperability	Long term

	arrangements	

Payment Systems[34]

21. **Indonesia's overall payment systems have continued to evolve in the past decades.** More recently, Bank Indonesia (BI), the central bank, has intensified its efforts to promote the use of electronic payment instruments. In 2015, BI upgraded its systemically important payment and settlement systems (BI-Real Time Gross Settlement and BI-Scripless Securities Settlement System as well as its clearing house. In addition, a series of regulatory reforms have accelerated introductions of new payment services and agent banking. Key regulatory reforms include BI's regulation on electronic money (2009) as well as its revisions (2014 and 2016), and the Financial Services Authority's regulation on branchless banking (*Laku Pandai*) in 2014.

22. **In November 2016, President Joko Widodo launched the National Strategy for Financial Inclusion together with a *Perpres* on financial inclusion. Government-to-person (G2P) payments are considered instrumental to the ambitious financial inclusion agenda.** Since G2P payments such as PKH cash transfer will significantly contribute to an increase of access to transaction accounts, the Government has committed to fully shifting social transfer payments from paper-based accounts (cash) to digital accounts (for example, bank accounts, e-money accounts) by 2019, which certainly requires further development of payment systems infrastructure in Indonesia. Meanwhile, PT Pos' role as PSP for PKH is expected to be reduced significantly.

23. **To ensure effective PKH benefit payment delivery while switching to cashless payment modalities, MoSA needs to ensure the following minimum requirements to be followed by all PSPs:**

(a) **Accessibility**

(i) The cost, both financial and nonfinancial costs (for example, distance traveled by a beneficiary to reach a pay point) should be minimized; and
(ii) The method of payment is appropriate to the needs and the capacity of the beneficiary (for example, it may not be appropriate to require use of a password to an illiterate beneficiary); among other considerations.

(b) Robustness

(i) The payment delivery should be reliable and secure in the timing, the amount delivered, and so on; and
(ii) The process should be properly monitored, controlled, and reported on so that there is clear traceability of money flow and accountability for entire transactions.

[34] The payment section is mainly taken from Interagency Social Protection Assessments Social Protection Payments - Payment Mechanism Assessment: PKH.

24. **There are multiple payment models for PKH to leverage when moving from cash to electronic payment.** Access points for financial services are key to success for noncash delivery of SA payments. In Indonesia, networks of both *Laku Pandai* bank agents and LKD e-money agents are rapidly expanding.

25. **The transition of PKH payments to cashless methods depends on the spatial distribution of *Laku Pandai* and LKD networks.** MoSA has been working with HIMBARA, since early 2016, to plan the transition. HIMBARA currently consists of four banks—Bank Mandiri, Bank Negara Indonesia, Bank Rakyat Indonesia, and Bank Tabungan Negara—and it is currently using the link network. PKH's transition to cashless payment started in 2016 in 69 cities and districts where the HIMBARA's ATM/Point of Sale network and PKH beneficiary families are most overlapping. For 2017 and beyond, further expansion of PKH cashless payment will follow the expansion of HIMBARA's payment network infrastructure. For each sub-district to be considered for switching to cashless payment methods, there must be at least two agents already in service and their capacity to serve the existing PKH families is deemed adequate.

26. **In addition, the Government will also introduce a 'Combo Card' to facilitate disbursement of SA cash and in-kind benefits.** This Combo Card combines functions of both a program card for SA programs (KKS) and a payment card (a debit card and an e-money instrument). All SA benefits, including subsidies, will use electronic money. Such subsidies will be credited to e-money accounts. The beneficiaries will need only one card to receive cash benefit payments from different programs and make payments for goods (at times limited goods) and services. Currently, Bank Negara Indonesia is the only acquirer of merchants and all four banks are issuers of Combo Cards. PKH beneficiaries can receive and make payments for purchases with the Combo Cards with the debit card function.

27. **Another innovation under Indonesia's SA programs is a shared delivery model called e-Warong.**[35] From a financial sector regulators' point of view, e-Warong is a merchant acquired by banks for card payments. *Laku Pandai* banks and bank e-money issuers may have e-Warong as their agents. When this e-Warong is managed by a group of PKH mothers after having exited from the program through a cooperative structure, it is an innovative approach to 'graduation'. Because this is a new way of disbursing SA payments, a proper assessment and adjustments are required before implementing the model at a full scale.

28. **The Government will start with 44 cities in 2017, although a full conversion of SA payments into noncash payments requires further development of payment systems infrastructure, acceptance of new payment instruments, and awareness among beneficiaries among other things.** Further, to make noncash payments sustainable for financial inclusion, beneficiaries should continue to use the accounts for multiple purposes, not only one particular purpose (for example, PKH disbursements). The planned effort to consolidate different SA program cards into one 'Combo Card' is a step in the right direction.

[35] Currently it serves three roles: as a bank agent to disburse SA transfers cards and Point of Sale terminals, a distribution agent to disburse subsidized rice and other in-kind food items, and as a trader to market local products made by community members. While it is assisted by the Government through initial seed money and management support, it is designed to be self-sustaining in the long run.

Grievance Management

29. **PKH has established a Public Complaints System (SPM) as a mechanism both at the central and local levels to handle complaints from PKH beneficiaries, stakeholders, and the general public related to PKH program implementation.** The SPM is perceived as a way to increase community participation and social interaction to channel both suggestions and complaints on performance of facilitators, abuse of power, political interference, and other program-related issues. By design, complaints can come from multiple channels—in-person reporting, fax, letter, email, phone, SMS, MoSA website, or through an online application developed by the central UPPKH/JSK. Usually the complaints fall into four categories:

(a) Inquiry or clarification due to lack of information;
(b) Incorrect or to-be-updated beneficiary information;
(c) Behavior or performance issue of a facilitator or other staff; and
(d) Benefit cut or termination.

30. **In principle, all complaints must be responded to within one month.** Depending on the nature of complaints, there are two response options—administrative response and field investigation. Most complaints can be handled administratively. If a complaint is related to a certain business process, it would be handled by the nearest staff of the responsible team. If there is a complaint about a member of the PKH implementation team, it would be handled by someone senior to that person. However, if the complaint involves corruption or fraud or otherwise deems important and involving multiple parties, then a field investigation is initiated and the facts and findings subsequently become the basis of decision or action.

31. **However, not all complaints have been recorded in one centralized system for analysis and reporting purpose.** It is estimated that, in 2016, on average there have been about 10 and 20 complaints received by the PKH program every day through SMS, website, email, and letter. Besides complaints coming in through digital media or are deem important to trigger field investigation, most of the other complaints are not likely to be recorded. Furthermore, it is not very clear if the complaints have been handled in a satisfactory manner to the people who have raised them. Lack of potential impact may discourage people from raising complaints in the first place.

32. As this mechanism is critical to the expansion of the program, which likely leads to an increase in complaints, it is important that MoSA conducts an assessment to understand if the current SPM is serving the program as it is designed to do and what changes can be made to improve its effectiveness.

FDSs

33. **Both an FDS qualitative study[36] and the observations from the field visits to seven districts during February to December 2015 revealed that FDS implementation often did not comply with the design.** In some areas there was lack of teaching and learning materials (*Buku Pintar*) and brochures. Furthermore, most sessions were not implemented monthly and

[36] Akatiga Consulting Firm, conducted in March–April 2015 and November 2015.

delivered less than the 120 minutes of training required by design. The *Prestasi* pilot evaluation has not been able to identify any strong impact of the FDS Health module, likely due to implementation issues. Hence the FDS implementation process needs to be improved.

34. **There are several areas that can be strengthened to improve FDS implementation and impact.** First, FDS implementation should be monitored much more closely at every PKH management level, particularly when FDSs are widely implemented. For example, in Lamongan district, there could be as many as 200 FDS meetings for 7,429 beneficiaries in seven sub-districts in one month. District coordinators should work closely with sub-district teams to plan and monitor the FDS implementation. Information on how sessions being conducted in the field, including session duration, contents, technical problems, the challenges and suggested solutions, could be collected systemically to support the further development of the FDS.

35. **Facilitator's skills and knowledge are critical to the success of the FDSs. In addition to the knowledge of the messages of each session, facilitators need to learn how to listen and help PKH mothers who may feel uncomfortable to speak in public**. This type of facilitation skill should be introduced as a core element of the FDS training of facilitators. Another useful skill is how to plan each session—not only schedule it to fit into the mothers' group's availability, but also clearly lists what should be said and done in sequence. Facilitators need to prepare related posters, flipcharts, and films and make best use of the venue's space so that it is possible for both the posters and flipcharts to be displayed. Facilitators also need to manage the time efficiently to go through the listed activities.

36. **In addition to further adjustments to the FDS contents based on practical lessons and to the delivery method, lack of financial support at the provincial and district levels needs to be addressed.** The 5 percent fund contribution by districts should also include the FDS operational expenses in the field for CCT facilitators. Alternatively, MoSA may consider a collaboration with other programs that employ similar instruments. For example, it might be more efficient—and possibly also effective—to embed the FDS Health module within the wider range of locally administrated health and nutrition services and thereby share the implementation responsibility with local governments. This will require a more horizontally integrated and owned implementation arrangement and may need some time to develop and stabilize. MoSA has planned to strengthen FDS implementation in the future by (a) developing the FDS' technical guidelines, (b) providing the FDS to PKH beneficiaries at an earlier time, from the second year onwards, (c) developing an FDS M&E system and link with HR performance management system, and (e) establishing an FDS operational fund.

Institutional Arrangements for PKH Implementation

37. **MoSA has been managing PKH competently, steadily expanding its coverage from less than half a million families in seven provinces in 2007, to 3.5 million by 2015, to about 6 million families in virtually all provinces by end 2016.** However, the relatively effective implementation in the past is not necessarily an accurate indication of MoSA's capacity to manage PKH going forward due to the following recent changes: (a) the decision to overhaul the

organizational arrangement for PKH management;[37] (b) the increase in PKH coverage from 3.5 million to 6 million families in 2016, including by entering into challenging geographic areas such as Papua and West Papua where PKH had hitherto not reached; and (c) the introduction of a range of enhancements to PKH design, such as the addition of elderly and disability benefits, which adds complexity and taxes the JSK's capacity to manage the program.[38]

38. **On the surface, the JSK's current organizational design follows a relatively straightforward logic based on a linear sequence of PKH implementation process from eligibility determination and enrollment to benefit payments and other beneficiary interfaces.**

39. **In practice, however, the JSK is still going through 'growing pains' to hammer out some of the finer details of role definitions across units or among individuals within each.** For example, there appears to be a residual level of ambiguity regarding the locus of responsibility for handling beneficiary data. The quality and timely availability of beneficiary data is essential for a range of PKH business processes, including eligibility determination and enrollment (Subdit 1), compliance verification (Subdit 3), and benefit payments (Subdit 2). Multiple subdits make use of the beneficiary data to do their jobs and yet it is not clear whether any single unit is ultimately responsible for their completeness, veracity, timeliness, and so on. The new organizational design also does not clearly specify which unit will be responsible for the cross-cutting functions of M&E and grievance handling. The assignment of some of the contracted 'experts' who used to handle M&E and grievance handling in the old UPPKH to Subdit 3 (Beneficiaries) in late 2016 appears to reflect the JSK's de facto decision in this regard. Apart from the question about the appropriateness of assigning strategic cross-cutting functions like M&E and grievance handling to one unit, the assignment of these roles to Subdit 3 has not been formalized, unless these core functions are considered to be aspects of 'M&E of beneficiaries' which is one of the Subdit 3 sections. Another ill-defined functional responsibility of the JSK's current structure is the day-to-day management of the field staff. Subdit 4 (Resources) recruits and pays the field staff but the other three subdits heavily rely on their work to carry out their respective institutional roles. In the end, it is as though the field staff report to all four subdits. In contrast, the previous UPPKH structure operated with a centralized command structure with three regional coordinators (also contracted 'experts') in the Implementation Division, sitting at the top of the pyramidal structure of reporting lines to oversee a set of provincial coordinators within their respective regions. For accountability, it is important that the new arrangement consolidates itself into an efficient working model with clear definitions (and mutual understandings) of the roles and responsibilities of each unit, roles, and skill profiles of each individual within it, and working relationships between units.

40. **Some of the ambiguity might be because of the 2015 ministerial decree itself, which lacks precision in defining exactly what is entailed in each subdit's key mandate.** The decree merely lists a range of common generic responsibilities (for example, formulate policies, issue norms, and so on) in each subdit's respective domain (for example, validation and termination,

[37] Ministerial Decree, October 2015.
[38] In addition to elderly and disability benefits, other enhancements include introduction of cashless payments and efforts to facilitate PKH beneficiaries' access to a set of complementary programs.

SA, beneficiaries, resources) without clearly specifying what the tasks of each domain actually entail. It is therefore ideal to prepare a more detailed description of the core responsibilities of each subdit, in light of the assessed business needs and step-by-step identification of key tasks along the business processes for PKH implementation.

41. **The JSK leadership is in principle committed to prepare more detailed 'job descriptions' to guide more precise demarcation of organizational responsibilities across its internal units.** It is recommended that this exercise be completed as soon as possible. While an early resolution of the remaining ambiguity is relatively urgent, it is also recommended that those definitions of subdits' 'job descriptions' are considered as preliminary, a midterm review is conducted, say, after a year or so, to assess whether additional adjustments would make sense, and the arrangement based on this review is consolidated, at which time a new ministerial decree, if necessary, might be issued to consolidate the new structure.

42. **Under this evolving context, the most critical consideration in assessing the JSK's capacity to manage the expanded and more complex PKH is that this is a unit on its learning curve because of its recent (and still-unfolding) organizational change.** In the previous arrangement, virtually all the work on PKH implementation was handled by contracted 'experts' at the center and PKH field staff on the ground. However, since the 2015 restructuring formally dismantled the previous UPPKH structure, the new structure has been put in place gradually and the entire JSK staff (of around 50 civil servants) have been learning the specific aspects of PKH implementation and business processes through 'learning by doing'. In practice they continue to rely extensively on services rendered by around 50 contracted UPPKH 'experts' who have remained in the JSK. Furthermore, the contracted 'experts' are currently working under the contracts that refer to the previous organizational structure (UPPKH) and are not in that sense formally assigned to any of the current subdits, although renewal of their contracts for 2017 may rectify this situation.

43. **Another possible obstacle to building subdits' institutional capacity is the degree of informality in PKH implementation.** Facing tight deadlines to deliver on a variety of tasks to meet the ambitious expansion target in 2016, the JSK has, at times, operated with informal arrangements in assigning specific tasks to staff/units. A case in point is the assignment of the task to oversee the recruitment of around 10,000 additional field staff to the subdirector who was initially appointed to head the Beneficiaries Subdit, when on paper this was the responsibility of the Resources Subdit. While a particular circumstance may have necessitated or even justified this decision, it appears to have generated a degree of confusion among the staff. Such an informal arrangement should ideally be kept to a minimum as it will dilute the unit-level accountability and could also hamper capacity building by way of learning by doing.

44. **MoSA has hoped for and formally requested collaboration and support from the subnational governments.** The DG of Social Security and Protection has issued annual letters 'requesting' local governments to allocate the equivalent of 5 percent of PKH benefit budget allocated for a particular local jurisdiction as administrative budget to support PKH implementation. The 5 percent budget is meant to support activities such as 'socialization' (communications and outreach activities), secretarial, and other office support for PKH field staff, field-level operational costs (for example, cost of printing a form for compliance verification, stationaries, facilitators' travel costs to reach beneficiaries, and so on), monitoring

and supervision of PKH activities by local government staff, and so on. While comprehensive statistics are unavailable, the extent of compliance with this request among the provinces and the districts seems uneven, although almost all subnational governments do provide at least a minimum level of support by 'housing' PKH field staff (however, there are cases where PKH field staff themselves are shouldering the cost of office rentals and other maintenance expenses).

45. **A 2015 study[39] on the role of local governments in PKH implementation, found local PKH teams formally headed by the local social affairs office, were generally performing well in implementing the program.** It did, however, note that lack of personnel, both in number and capabilities, could be a hindrance to more extensive and effective support for PKH implementation. The study also noted inadequacies, especially with respect to the levels of ownership and understanding of the program among various local institutional stakeholders, starting with the Social Affairs Department but also health and education departments. One of the reasons cited is ineffective communication and information sharing between PKH and these departments.

46. **Short of a major overhaul in the intergovernmental arrangement for PKH implementation, one option will be to explore administrative measures to elicit a minimum level of operational support from the provinces and the districts.** For example, MoSA could transfer a fixed amount as estimated administrative and operational costs to sustain PKH teams in each subnational jurisdiction, instead of asking the subnational governments for financial and in-kind support. In any case, it will be helpful to first collect relatively accurate information on the actual cost of delivering PKH at the local level. The 5 percent contribution that the MoSA requests is not based on any such estimation, and it is quite likely it does not fully reflect the actual cost. In addition, portions of the costs are incurred privately by PKH field staff, which are not captured in any available financial reporting.

Supply-side Readiness for Health and Education Service Delivery

47. **Inadequate funding and/or lack of staff are also issues of concern as they hamper both service availability and quality.** World Bank estimated that about 340,000 teachers, or 17 percent of the teaching force, will need to be transferred to ensure all schools have the minimum number of teachers. The problem of shortages is amplified by absenteeism. It is also estimated that approximately 33.5 percent and 43 percent of Indonesian teachers were absent on any given school day in Papua and remote schools, respectively, compared with 14 percent nationally. In fact, the average length of absence among a sample of absent teachers in Papua was 70 days and some even a year.[40] This could not only make it difficult for beneficiaries to comply with conditionality but also prevent PKH families from achieving better human development outcomes.

48. **Logically, the only way to be certain that whatever commitments to address supply-side constraints are fulfilled in practice is to track them systematically.** Since the JSK's PMIS has the capability to track those data, and yet it does not seem these are regularly and

[39] *PKH Program Management: A Study in 6 PKH Implementing Areas,* GIZ SPP Team, June 2015.
[40] Organisation for Economic Co-operation and Development 2015, citing Surhati (2013)

systematically reported, it may be worthwhile starting the practice of regular tracking of the supply-side readiness and service availability (if not quality) as part of the routine program monitoring. Also, PKH can learn from other CCT programs about establishing different conditionality and/or frequency of compliance monitoring, taking into account supply-side issues as done elsewhere (Brazil in the Amazonia and the Philippines in conflict Mindanao or indigenous isolated areas).

Inter-sectoral Coordination

49. **It is difficult to ascertain how active the national-level coordinating bodies have been and how central their roles have been in improving inter-sectoral coordination.** At the local level, however, available information[41] all point to the high likelihood that they are not fully functioning. To improve PKH beneficiary families' access to complementary benefits and services, MoSA recently issued a Minister's Decree to further require that all benefits and services targeting the poor and vulnerable should use the integrated database for targeting purpose (MoSA has worked with the Ministries of Education and Health on PIP and PIS to synchronize the data or provide priority access to PKH beneficiaries).

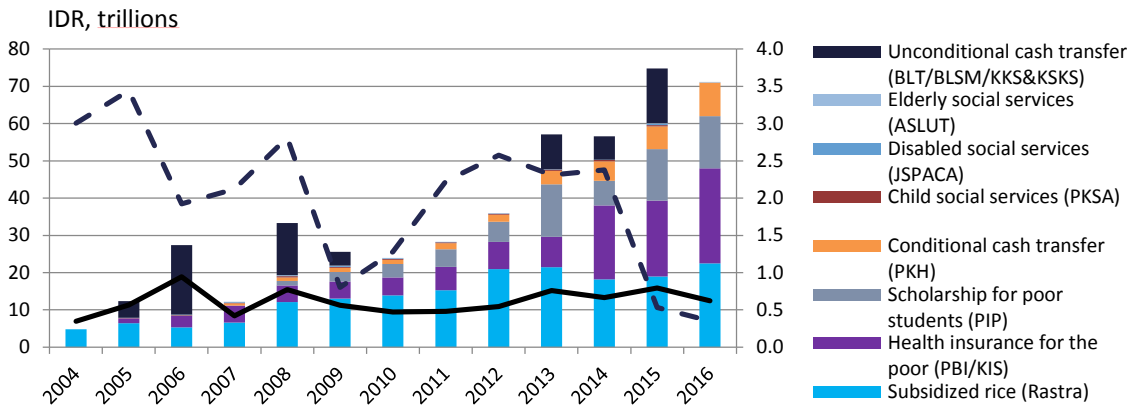
50. **Finally, recent changes in PKH design to include elderly/disability benefits and facilitate beneficiaries' access to a set of complementary programs, will require greater clarity and specification of institutional arrangements.**

III. Description and Assessment of Program Expenditure Framework

51. **While the Central Government has been increasing SA spending since 2010, its share of GDP has remained constant.** The total expenditure on household/family based SA is US$5.74 billion in 2016, approximately 0.6 percent of GDP. The four largest programs by expenditure are the PIS/JKN-PBI, Rastra (subsidized rice), PIP, and PKH. While these four programs account for more than 90 percent of the total spending on the poor and vulnerable families, their combined spending is still dwarfed by the fiscal cost of untargeted subsidies, which is over 12 percent of the central government budget. Even with the latest expansion in 2016, PKH expenditure is still the smallest among the four. Because the Government will continue to reduce the untargeted subsidies and move the saved budget to the more effective SA programs such as PKH, its budget is expected to increase further.

Figure 4.1. Central Government Expenditures on SA

[41] Including the six-province study by GIZ.



Source: MoF and BAPPENAS.

PKH Budget

52. **PKH budget has seen a significant increase in recent years, from IDR 1.9 trillion in 2012 to IDR 8.7 trillion in 2016.** The Government had to make a rather drastic budget cut across the board in mid-2016 after the overly optimistic revenue growth did not materialize. As a result, PKH's revised budget was reduced by 13 percent in comparison to the initially approved budget. Its 2017 budget is increased by 59 percent relative to its revised budget and by 36 percent relative to its initial budget in 2016, respectively. The increase mainly reflects its expanded coverage.

Table 4.2. PKH Budget, 2016–2017

PKH Budget (IDR, billions)	2016 Planned	2016 Revised	2017 Planned
Total	9,998	8,683	12,748
Benefit Transfer	8,708	7,621	11,340
as % of total	87	88	88
Administration Cost	1,290	1,011	1,408
as % of total	13	12	12

53. **The administrative cost of PKH is relatively high, when compared to large CCT programs in other countries, mainly due to its extensive program-specific facilitation process.** Out of the 2016 initial budget, 13 percent of the total PKH budget was required to implement the program. While the ratio is already reduced from the previous years—14 percent in 2009 with no expansion and 17 percent in 2010 with expansion—it is supposed to fall further to 12 percent of the 2017 planned budget. Within the administrative cost, the top three biggest elements are compensation for labor inputs by tens of thousands of field-level staff (facilitators, district operators, and coordinators), fee to PT Pos for payment services (14 percent), and training cost for 19,000 facilitators to carry out FDSs (10 percent). Moving forward, the fee to PT Pos is expected to be greatly reduced due to transitioning to bank account-centered cashless payment methods. Also the training on FDSs is not expected to be repeated. Furthermore, MoSA will continue to streamline PKH business processes and further automate data entry, transmission, and information generation-related tasks that are currently manual, the program efficiency is expected to be gradually improved.

Table 4.3. PKH Budget by Main Categories, 2017

Administration Cost by Activity Type	Share of Administration Cost (%)
Compensation for contracted field staff	62
Compensation for contracted national and provincial staff	2
Fee for payment services (PT Pos)	14
Training cost on FDS	10
IT (network and operation)	5
Field operation cost (cards, forms, meetings, and so on)	4
Others (HR management, M&E, publication, socialization, and so on)	3

Budgeting Process

54. **The budget preparation is based on two laws—No. 17 of 2003 on the State Finances and No. 1 of 2004 on the State Treasury. Indonesia follows a unified budgeting system that recognizes no distinction between routine and development budgets.** The Budget Authorization Document (*Daftar Isian Pelaksanaan Anggaran,* DIPA), is produced for echelon 1 officials (highest ranked civil servants, such as DGs) and for each spending units (for example, Directorates) in LMs. A number of regulations have been issued to support the implementation of the two laws on budget preparation, execution, and revision.

Table 4.4. Government Budget Cycle

Budget Activities and Agencies Responsible	Time Line
LM/agency reviews activity list prepared by its spending units and makes adjustments	January–February
LM/agency prepares annual work plan (Renja) for next fiscal year based on its strategic plans (Rentra)	March–April
MoF and BAPPENAS jointly issue program priorities for each echelon 1 official, including priority targets and an indicative budget; LM/agency revise its Renja incorporating the specified program priorities.	March–April
BAPPENAS prepares the Government's annual work plan (BKP) based on Renjas and presents it to the House of Representatives (*Dewan Perwakilan Rakyat*, DPR); LM/agency has consultation sessions with the relevant commission counterparts in the DPR and introduces new activities if needed; and an interim overall budget and budget ceilings are agreed upon.	May–June
LM/agency prepares a budget work plan (RKA-K/L) based on the budget ceilings and submits to the MoF. The DG of the Budget of MoF, along with BAPPENAS review RKA-K/L to ensure its consistency with the prescribed priority programs and activities and appropriateness of detailed budget allocation.	July–September
The MoF prepares the consolidated budget work plan and final budget ceilings (by unit, expenditure type, function, program, and activity) and submits to a full session of the DPR for approval to become the Annual Budget Law	October
The MoF issues definitive budget ceilings; LM/agency accordingly prepares its definitive budget work plan and discusses it with the DG of the Budget of MoF	November
LM/agency prepares the DIPAs based on a Presidential Decree issued following the Annual Budget Law; once the DIPAs are approved by the MoF, line/ministry/agency prepares internal operational guidelines for each working unit	December

55. **In July and August each year, the Government and DPR discuss the necessary changes to the Annual Budget Law of the current year in response to the adjustments needed to be made to the macroeconomic framework.** The revised national budget may require LMs to revise their work plan. Examples include budget cuts, top-ups, and reallocation.

Individual revisions may be made throughout the year, though the deadline date for revision may change. Either the MoF or LMs can initiate budget revisions, but the process between the initial proposal and the approved revised budget may take as long as 12 weeks.

IV. Description and Assessment of Program Results Framework and M&E

56. **PKH has two mechanisms to monitor and evaluate the program.** The first mechanism is routine monitoring activity under PKH uses several types of data collection forms including the following, among others: family data update form, student attendance verification form, health verification form, PKH beneficiary complaint form, and non-beneficiary complaint form. Data thus collected is the input for PKH PMIS and is carried out by field workers. Data analysis is conducted by the JSK/national UPPKH and seeks to answer the following questions:

(a) Has the validation process been implemented to ensure that PKH helps the right persons?
(b) Have PKH beneficiaries fulfilled their responsibilities?
(c) Have PKH beneficiaries received benefits in accordance with the rules?
(d) Have PKH beneficiaries' data been updated to ensure that all components and responsibilities are correctly accounted?
(e) Have PKH beneficiaries in the designated areas attended FDS?

57. **The data thus collected is used to establish a set of performance indicators, which span across input, process, and output aspects and the comparisons between the target values and actual achievements measuring the program implementation progress.** The data are regularly collected (monthly, quarterly, and yearly) and reported hierarchically upwards. The second mechanism is evaluation, which is selectively carried out to identify causes of either success or failure in achieving results and to provide lessons and options, often specific to certain business processes. The 2015 PKH M&E, for example, focused exclusively on assessing three activities: verification of commitments, cash transfer distribution, and data updating. Also, it is unclear how useful such an exercise is, in large part because of the study design including sampling (purposive sampling method[42] with a sample size of maximum 15 poor beneficiary households per selected location). The objective is to carry out such evaluations (previously done by TNP2K) annually, although it was not done in 2016.

58. **Thus, in the PKH context, M&E mainly covers its business process, but does not assess impacts or outcomes.** Evaluation of these other dimensions would also be required at regular intervals. The program guidelines envisage other forms of M&E, including monitoring by community and the local government, but these are yet to be operationalized.

[42] The criteria for selecting districts differed with the objective. In the case of verification of commitments, districts/cities selected were a mix of those with a high level of verification (above 95 percent) and a low level (under 3.5 percent). To evaluate cash transfer distribution, districts/cities selected were those with high levels of 'dormant accounts.' And finally, evaluation of data updating was carried out in districts/cities with unchanged data over time on household members and change of address as well as continually changing data on beneficiary caretakers (PKH M&E Report 2015).

59. **Although some program monitoring data is produced upon request, more regular standardized reporting needs to take place to be used by management and made available to other stakeholders and eventually to the public.** While JSK has a dedicated M&E Wing, the new organizational design does not clearly specify which unit would be responsible for M&E. However, the assignment of some of the contracted "experts" who used to handle M&E in the old UPPKH to the Subdit 3 (Beneficiaries) in late 2016, appears to reflect JSK's de facto decision in this regard. In the immediate run, it would be beneficial to formalize this arrangement so as to clarify roles, responsibilities and accountability for this crucial function. However, assigning the M&E role to the same unit that is involved in key aspects of program implementation runs counter to a good practice worldwide, which has been to elevate the hierarchical status of these functions and keep them independent of implementation. JSK may want to revisit this arrangement over the medium term as a necessary part of reviewing its organizational arrangement based on actual experience on the ground.

60. **The Results Framework will be monitored using the PKH program's own M&E capacity.** In particular, the PMIS will be an important instrument to assess quantitative indicators at the level of the families receiving the program such as compliance to conditionality, receipt of transfer, complementarity of PKH with other SA programs. It is best that the indicators on FDS implementation, complete training of facilitators, and the rollout of the GRS are also tracked by the M&E team supported by provincial coordinators and 514 district coordinators. The remaining indicators which are measured through outputs or deliverables (completion of a communication strategy and HR competency and performance monitoring system implemented) are to be monitored by the JSK and other stakeholders jointly.

V. Error, Fraud, and Corruption

61. **As PKH channels a large amount of public resources to eligible poor families, EFC would not only reduce the economic efficiency of the program by decreasing the amount of money that goes to the intended beneficiaries, but more importantly, erode the political and public support for the program.** Like most CCT programs, PKH faces particular implementation challenges from a governance and anticorruption perspective, because it is large in scope, with 6 million beneficiaries and involves a high volume of financial transactions. It is politically high-profile and engages multiple government actors at the national and subnational levels. By targeting the poorest of the poor, the program locations are often in remote and inaccessible areas, exacerbating implementation challenges and increasing risks.

62. **While PKH does not have an explicit strategy, the program contains some features that could be consolidated into a clear and practical EFC strategy.** Availability of data from the PMIS, spot checks, and an SPM have already reduced the potential for EFC. A strong EFC strategy built on various existing mechanisms can be institutionalized within the M&E framework. As detailed below, the potential major vulnerabilities of PKH are a mixture of technical, governance, and political risks, and can be addressed with potential mitigation measures:

(a) **Interference or errors in the process of targeting and registering beneficiaries.** Unintentional survey or enumeration errors could exclude eligible beneficiaries. Beneficiaries could provide false information to create bias in eligibility decisions.

Politicians or government officials could register supporters or exclude opponents for political purposes. Updating the status of beneficiaries is also another area of potential fraud or corruption. When beneficiaries move to non-program areas, an eligible recipient passes away, or other status changes occur, there are few incentives for beneficiaries to report such changes in circumstances.

(b) **Interference or errors in the process of monitoring compliance with program conditions.** Compliance monitoring is a complex process, demanding significant capacity to collect and manage data. Failure to effectively manage this data can either delay payment or effectively create an unconditional cash transfer program, which would not only undermine program outcomes but be politically untenable in the Philippines context. Compliance monitoring must be made as simple as possible.

(c) **Interference or errors in the payment process.** PKH has two main exposures on fraud and corruption payment risks, especially at the lowest level. The first risk is illegal deduction of the payment from the Post payment officer. Besides internal control procedures in PT Pos Indonesia, PKH has set up complaint-handling mechanism that recipients can report to and submit any issues on the payment process. PT Pos Indonesia includes regular staff rotation and supervision to the Post Payment Unit into PT Pos Indonesia internal control procedures.

(d) **Political risks.** Political abuse of power could take several forms: (a) politicians or officials seeking to expand the program into new areas without following poverty criteria; (b) registration of supporters or exclusion of opponents from the PKH beneficiary list; or (c) local officials imposing additional conditions or 'taxes' on beneficiaries.

63. **Some degree of EFC is inevitable.** However, many of the possible risks can be prevented as they are related to the strengthening of the implementation system that MoSA has undertaken and which this proposed Program supports through the activities and DLIs in Results Area 1:

- **Objective targeting system.** The main preventive strategy in CCTs is the establishment of an objective, scientific, poverty-based mechanism to select geographic areas and individual household beneficiaries. As mentioned earlier, in Indonesia, PKH uses a proxy-means test to identify individual households based on the UDB, that it is regularly updated.

- **Improved oversight and monitoring.** In addition to the regular Program audits mentioned earlier, preventive measures can be underpinned by a strong monitoring framework. While the PforR will support the revamp of the PMIS and the GRS, a recommendation is for the program to undertake regular spot checks. To be executed by an independent third-party organization (nongovernmental organization, university, or private firm), the spot check methodology combines quantitative and qualitative assessments to assess the integrity of targeting, compliance monitoring and payment systems. In addition to generating valuable

monitoring data, the threat of a spot check also acts as an incentive for officials to follow Program guidelines. In addition to its own GRS, PKH beneficiaries should be made aware of additional complaint-handling mechanisms operating in Indonesia, such as the Ombudsman, online community complaints (LAPOR), and the anticorruption commission (KPK).

- **Move to more secure and efficient payments:** The recent move toward delivering payments through cash cards can help mitigate most of the concerns regarding payment disbursements to the correct beneficiaries, improve liquidation process, and mitigate the risk of facilitators 'taxing' beneficiaries.

- **Sanctions and remedies:** The final element is a set of sanctions and remedies that stops the preventive and corrective measures detailed earlier. The Program staff or officials are subject to prosecution if evidence exists of corruption. Protocols are articulated in the Program Operational Guidelines on the process for addressing such cases, though they need to be strengthened. With regard to political risks, many other CCTs have frozen new registrations three months before elections to prevent possible perception of abuse. As a measure of last recourse, in cases of widespread or systemic abuse of power, entire municipalities can be excluded from the program or the transfer of funds can be suspended or terminated.

64. **The World Bank has also shared the 'Guidelines on Preventing and Combating Fraud and Corruption in Program-for-Results Financing' with MoSA which applies to the entire Program.**

VI. Program Economic Evaluation

Rationale for Public Provision and Financing

65. **PKH is one of the key programs comprising Indonesia's social safety net and warrants sustained government intervention for several reasons.** A comprehensive social safety net is an important prerequisite for sustained and inclusive economic growth. Generally, it reduces poverty by providing direct income support, through cash transfers such as PKH and PIP, and protects the poor and vulnerable against economic shocks by fostering their access to social insurance through PIS. It also leads to increasing overall employment and employability of poor and vulnerable households by providing skills training and promoting access to the labor market. Direct transfers to poor and vulnerable households, through programs such as PKH and PIP in particular, can make government-driven policy reform more palatable, thereby encouraging robust economic growth.

66. **PKH directly encourages positive change in health and education behaviors of poor families by tying cash disbursements to the fulfillment of conditionality.** PKH can thus assist poor and vulnerable households as they mitigate risks to their welfare by encouraging larger or more consistent investments in family members' human and financial capital as well as reducing reliance on negative coping behaviors which can sacrifice those productive investments in the future for the sake of higher consumption now. This helps households absorb and mitigate negative shocks flexibly so that welfare losses are less severe and do not compound.

Furthermore, the provision of cash transfers itself, have been proven to result in significant micro economic effects at the individual level in the short to medium term, while also leading to longer-term human development outcomes. The microeconomic effects of PKH, proven in the two rounds of impact evaluations, and the relatively higher efficiency in reducing poverty and inequality versus the other main SA programs, justify the program's expansion in coverage, adequacy, and complementarity with other social protection programs in Indonesia.

Program's Economic Impact

67. **Evidence has shown that PKH has led to significant effects on household consumption, reduced child labor, school enrollment, and health behaviors.** In Indonesia, both midline and end line impact evaluations have been conducted; the former revisited families after approximately three years of experience with the program, while the latter revisited families after more than six years of experience. Results from these evaluations, indicate that PKH was directly responsible for greater investments in education and health, while providing consumption budget support. The midline evaluation demonstrated that PKH was responsible for statistically significant increases in prenatal care. The likelihood of attending at least four prenatal visits increased by 9 percentage points while newborn delivery at a facility or attended by a professional increased by 5 percentage points. Postnatal care improved by almost 10 percentage points, while immunizations and growth monitoring checkups increased by 3 percentage points and 22 percentage points, respectively. Significant impacts were registered in the likelihood of children receiving immunization (PKH households saw an increase of 7 percentage points), while severe stunting (height for age) decreased 3 percentage points. PKH improved neonatal visits by 7.1 percentage points but it had no significant impact on outpatient visits or increased intake of iron tablets. With regard to education, according to end line results there were statistically significant increases of 2 percentage points in the gross participation rate for elementary school and almost 10 percentage points in the junior high school gross participation rate. The probability of a PKH child continuing to secondary school increased by 8.8 percentage points but there was no significant impact on decreased child labor attributable to PKH.[43]

68. **At the macro level, the provision of cash transfers supports the costs of access to health and education services, while also decreasing the poverty rate. Increased consumption leads to lower rates of poverty while the steady provision of cash also reduces income uncertainty and so helps protect the beneficiaries against economic and social shocks.** Concretely, the midline evaluation demonstrated that PKH households experienced a statistically significant 10 percent increase in average monthly expenditures. The increase was used mainly to buy high-protein foods and to cover health costs. The end line evaluation showed that beneficiary expenditure increased by 3.3 percentage points while beneficiary households' expenditure on food was 3.4 percentage points higher than non-beneficiary households. For protein consumption, the impact was considerably lower, at 1 percentage point.

World Bank's Value Added

[43] See World Bank. 2011. "Program Keluarga Harapan: Main Findings from the Impact Evaluation of Indonesia's Pilot Household Conditional Cash Transfer Program", and TNP2K. 2015. "Evaluation Longer-Term Impact of Indonesia's CCT Program: Evidence from a Randomized Control Trial." Final publication forthcoming.

69. **By supporting the implementation of the CCT, the Program is expected to benefit approximately 6 million poor Indonesian families** who will receive non-reimbursable contributions aimed at increasing household consumption and human capital investments and increasing beneficiaries' health, education, and productivity.

70. **The World Bank is well placed to advise MoSA as it supports CCT programs in over 40 countries, 22 with lending operations, including Mexico, Brazil, Colombia, Kenya, and the Philippines.** The World Bank in Indonesia has been supporting MoSA since 2010 when it supported, among others, the development of the first generation information system. Since then, the World Bank has also developed most of the FDS modules and advised in their implementation and operation design, including M&E of its implementation as it was piloted in 2015. More recently, in response to requests from MoSA, the World Bank team has been providing technical inputs across all of the program's operation. The World Bank team comprises key international experts on CCT implementation from the Social Protection and Labor Global Practice and also includes experts from several other key Global Practices to provide advice on aspects of payments, targeting, HR development, and the institutional set up.

Results of Economic Evaluation

71. **By providing cash to poor households, PKH contributes significantly to poverty reduction.** The observed reduction in the poverty headcount of about 0.3 percentage points in early 2016 has in part (almost 30 percent) been attributed to expansion of PKH from 2.8 million to 3.5 million households.[44] In addition, simulations of the expansion of PKH from 3.5 million to 6 million households using the latest available Susenas data (2014 September) predict a reduction in the poverty head count of about 0.8 percentage points, while other conditions remain the same. Inequality was also simulated to fall slightly by 0.25 Gini points.[45]

72. **Moreover, recently completed World Bank fiscal incidence analysis based on 2012 survey and expenditure data further support the claim that PKH is an effective tool to reduce poverty and inequality in the short term.** The analysis shows that PKH has the highest effectiveness in reducing inequality and poverty of all main SA programs as well as compared to subsidies and in-kind transfers on health and education.[46] Yet, to date PKH has received a lower budget than other, less effective, programs; for instance Rastra, is expected to cost IDR 22.5 trillion in 2016, while PKH is expected to cost IDR 9 trillion.[47] In addition, based on the socio economic household survey, PKH has consistently revealed high and improving targeting accuracy; in 2014, the poorest 10 percent of households received over one-third of the benefits available; the bottom 20 percent received over half of the benefits available; and the bottom 30 percent received over two-thirds of the benefits available, while exclusion errors are also the lowest among the main SA programs. This puts PKH on par with similar programs such as Brazils' *Bolsa Familia* and the Philippines' *Pantawid Pamilya* which had CCT benefits accruing

[44] Indonesia Economic Quarterly October 2016. Pressures Easing. World Bank, Indonesia.
[45] Susenas 2014 data and World Bank staff calculations and internal documentation. World Bank, Indonesia.
[46] Jellema, Wai-Poi and Afkar. 2015. The Distributional Impact of Fiscal Policy in Indonesia and Ministry of Finance and; World Bank. 2015. *Taxes and Public Spending in Indonesia: Who Pays and Who Benefits*.
[47] MoF, Financial Note 2016.

to 57 percent and 52 percent of the poorest 20 percent of households, respectively.[48] While the poverty headcount rate fell by about 2 percentage points between 2010 and 2014, the share of PKH benefits accounted for by the poor group increased by approximately 8 percentage points.[49] This trajectory indicates that as the micro-level poverty situation changes—many households exit poverty year to year, while fewer enter—PKH has continued to add significant numbers of the poor households that remain.

VII. Technical Risk Rating

73. **The technical design related risk is Substantial.** The Program supports an expansion of the CCT that includes new geographic areas, including remote and hard to reach areas (for example, Papua region) and expansion to new components (elderly and disabled), at a time when its delivery systems (technological, HR, institutional) are in need of strengthening. The risk is mitigated by the fact that several ongoing experiences in the country, as well as abroad, will provide lessons for the design.

74. **The implementation capacity risk is Substantial.** MoSA has been implementing SA interventions for a long time. However, PKH has been implemented by a program implementation unit largely staffed by consultants and attached to one subdirectorate within MoSA. The current MoSA leadership has begun to mainstream and transfer the responsibilities of PKH implementation to regular civil servants of a whole directorate. This is a welcome change that, if successful and sustained, will enhance sustainability of efficient PKH implementation over time. However, changes in institutional leadership may jeopardize these efforts. The new design package within PKH which will increase implementation workload, could also pose implementation risks by further overwhelming MoSA's implementation capacity. These risks will be mitigated by ensuring that staff are appropriately trained, IT support strengthened, GRS and M&E systems are strengthened, and linkages with experienced partners in this area (other government agencies and international development partners as well as local governments) fostered.

[48] World Bank Atlas of Social Protection Indicators of Resilience and Equity Database 2016.
[49] Susenas 2014.

Annex 5: Summary Fiduciary Systems Assessment

Summary

1. An FSA was carried out to evaluate the arrangements relevant to PKH and to determine whether they provide reasonable assurance that the Program's funds will be used for their intended purpose. The integrated fiduciary assessment comprised assessment of the fiduciary risk relating to the Program's (a) financial management systems; (b) procurement systems; and (c) fraud and corruption risk. Taking into account the improvement required and the agreement on the actions needed for strengthening MoSA's systems (which are reflected in the Program Action Plan), the overall fiduciary framework is considered to be adequate to support the Program's management and achieve the desired results with due attention to principles of economy, efficiency, effectiveness, transparency, and accountability. Some areas of further improvement were identified for each of the three functions mentioned above and are included in the summary table of the key risks along with their corresponding mitigation actions.

2. The annual procurement expenditure is expected to be around 2 percent of the Program expenditure, while the bulk of the Program funds are directed to the cash transfers which do not fall in the purview of procurement. Similarly, the recruitment of facilitators under the Program, to be carried out by MoSA following the applicable procedures for recruitment of staff, also does not fall under the purview of procurement. Procurement under the Program is limited to a small number of contracts for goods and services (other than consultant services), most notably the contract of service providers for distribution of the cash transfers. The Program does not envisage any large-value contracts that could exceed the Operational Procurement Review Committee threshold. Procurement is carried out by MoSA under the *Perpres* No. 54/2010 on Government Procurement, last amended through *Perpres* No. 4/2015, and its technical guidelines and operational technical provisions for electronic procurement, which aim to support economy, efficiency, and transparency in the procurement process. Based on the information provided by MoSA, the procurement processes during the last three years were generally carried out on time.

3. Fiduciary risks are Substantial. The Government has existing fiduciary controls that will be used for the Program. However, the Program entails a rapid expansion of the CCT program in a short span across the country and in scope of beneficiaries. The design of the CCT is very complex given the release of grants to beneficiaries in scattered areas and challenging locations. In addition, the external auditors have expressed a disclaimer on the 2015 financial statements of MoSA, stating that the flow of funds could not be traced adequately to the end beneficiaries and that reasonable assurance was lacking on the ending balance in post office accounts. The main risks are: (a) lack of an automated system to record and reconcile data of payments to beneficiaries; (b) inadequate follow-up on external audit findings; (c) need to improve program internal controls; (d) need to launch interim mitigation measures until MIS implementation; (e) absence of a complaint-handling mechanism which could be a deterrent to bidder's participation in bidding; (f) risk of noncompliance to the World Bank's list of debarred/temporarily suspended firms; (g) interference or errors in the payment process; and (h) detection risks. The proposed mitigation measures are: (a) implementation of an MIS to capture detailed data at the beneficiary level; (b) monitoring of implementation of external auditor recommendations with support of the IG of MoSA; (c) instituting periodic internal audit of the program; and (d) enforcing timely submission of payment realization reports by facilitators including confirmation of receipt of

payments by beneficiaries; (e) MoSA to develop a procurement complaint-handling mechanism, consistent with Government regulations; and (f) MoSA to put in place a mechanism to ensure that the ULP at each of procurement process checks and records in the file that the recommended firm is not on the World Bank's list of debarred/temporarily suspended firms. The recent move toward delivering payments through cashless methods can help mitigate most of the concerns regarding payment disbursements to the correct beneficiaries and improve the liquidation process, and mitigate the risk of facilitators 'taxing' beneficiaries. In addition to existing controls already in place in MoSA, it is recommended to PT Pos' internal audit unit and MoSA IG to have selected verification of payments to beneficiaries during the audit assignment.

Assessment of Program Fiduciary Systems

Legal Framework

4. PKH is a CCT program. It is a national program and is being implemented since 2007. PKH is implemented by multiple agencies at the national as well as local levels. The program implementation is coordinated by the PMU under the Director General of Social Protection and Security. To implement PKH, there are three laws which form the basis for the public financial management framework: (a) Law No. 17 (year 2003) on State Finance; (b) Law No. 1 (year 2004) on State Treasury; and (c) Law No. 15 (year 2004) on State Financial Management and Accountability. MoSA's new structure is based on Presidential Decree No. 46 (year 2015).

5. The procurement of goods, works, consultant services and non-consultant services carried out by MoSA is governed by *Perpres* No. 54/2010 on Government Procurement, last amended through *Perpres* No. 4/2015, and its technical guidelines and operational technical provisions for electronic procurement, which aim to support economy, efficiency, and transparency in the procurement processes. The regulations provide for use of competitive procurement methods as the default requirement, while noncompetitive methods may be used for very small-value procurement and under certain circumstances and conditions described in the regulations. Foreign firms are allowed to participate in bidding for contracts estimated to cost more than IDR 20 billion (equivalent to US$1.5 million) for goods and non-consulting services; however, given the values and the geographically dispersed implementation of the contracts that are expected to be procured under the Program, it is unlikely that foreign bidders would be interested or suitable for participating in bidding for the contracts.

6. The use of the LPSE e-procurement system is mandated for procuring contracts exceeding IDR 200 million (equivalent to US$16,000). A wide range of Standard Bidding Documents are available for use by the procuring agencies. Dedicated ULPs are required to be established for carrying out the procurement in each agency. The results of contract award are also required to be published in a national website. Government officials and local private sector suppliers and consultants are familiar with the existing procurement framework. The *Perpres* also include provisions for handling complaints, resolution of disputes, as well as remedies for breaches in integrity during the procurement process. The Government is in the process of preparing a new procurement regulation which will replace *Perpres* No. 54/2010 with the aim to further simplify and streamline the procurement procedures.

Planning and Budgeting

7. The planning and budgeting process is assessed as adequate and the risk is Moderate. The Program covered 3 million families in 2016 and plans to cover 6 million in 2017. The MoF needs to double the budget to cover more beneficiaries. There is a risk that the Government does not have enough budget to cover more beneficiaries. Currently the government revenue has been declining. Inadequacy of budget availability encouraged the Government to find other resources, including tax amnesty programs and overseas financial resources such as external donor finances.

8. PKH is included in the government plan as part of poverty reduction program. The program is budgeted annually like other government programs. After a decision is made on the overall budget ceiling for the next fiscal year in June, MoSA prepares the program budget in July and submits it to the MoF for budget consolidation as for other government programs. MoSA discusses the budget with the relevant commission in the DPR during August–September. At the end of October, MoSA's consolidated budget work plans and final budget ceilings (broken down by organizational unit, type of expenditure, function, program, and activity) are approved by a full session of the DPR and adopted as the draft Annual Budget Law.

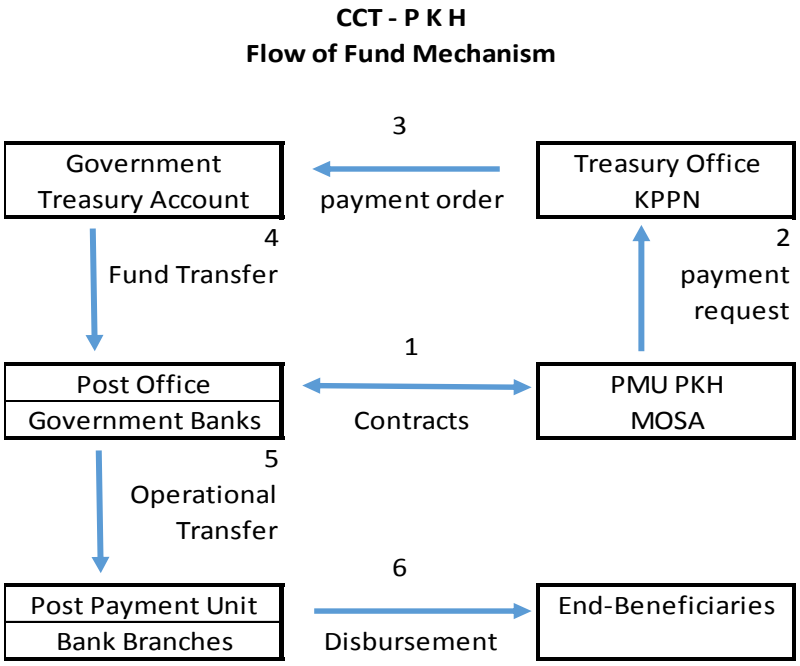
9. In November, the MoF issues circulars setting out definitive budget ceilings. Each LM, including MoSA then prepares its definitive budget work plan and discusses with the DG of the Budget (DG Budget) at the MoF. These discussions cover the definitive LM budget work plan and supporting documents, including the ToR and the Expenditure Plan. Then DG Budget approves the budget per work unit document and submits this to the DG of the Treasury (DG Treasury) at the MoF.

10. Following the issuance of the Annual Budget Law in December, a *Perpres* is issued setting out the details of the budget as approved by the DPR. Based on this *Perpres* and the budget per work unit document, the LM prepares the DIPAs. The LM submits these DIPAs to the DG Budget and they will be endorsed and forwarded to the DG Treasury. The DIPAs are approved by the DG Treasury and signed by echelon 1 officials in the LM. Once the DIPAs have been approved, the LM prepares budget detail or Operational Instructions, which are internal operational guidelines for the work units that elaborate on what is contained in the LM budget work plan for the next fiscal year. Due to limited resources, PKH has not yet covered all the poorest people.

Treasury Management

11. The treasury management system for the Program is adequate. The system has reasonable time to transfer the funds from the Treasury Office (KPPN) to the third parties or to the beneficiaries through post office/government banks at reasonable time. There is a risk on payment delay if the PMU submits incomplete documents. A checklist of required supporting documents helps the PMU submit the documents to the KPPN completely.

Figure 5.1. PKH Flow of Fund Mechanism



12. The Program follows the existing government treasury system. A new treasury system has been working effectively since 2015. Once the DIPAs are effective, the Commitment Officer (*Pejabat Pembuat Komitmen*, PPK) in MoSA can execute the budget and enter into commitments with third parties. With regard to the CCT funds, there are two methods of fund flow: (a) post office and (b) government banks for cashless method.

13. The PPK enters into commitments and signs a contract with a third party. The PMU signs a contract with PT Pos, Indonesia, and some government banks (member of HIMBARA) to distribute the money to the end beneficiaries. After signing the contracts, the flow of funds begins. The PPK submits a payment request to the MoF KPPN through a payment officer (PPSPM). The PPSPM reviews and verifies the payment request and supporting documents. After reviewing the documents, the PPSPM issues a payment order (SPM) to the KPPN.

14. The KPPN reviews the SPM and checks whether the SPM is made under the relevant DIPA and is supported by adequate budget balance. The KPPN then issues an SPM/instruction to the Government Treasury Account (GTA). The GTA transfers the funds directly to the third parties (for CCT fund to post office and some government banks). The KPPN has one working day standard for processing SPMs when all documents are correct and complete. In practice, the KPPN processes in one to three days. The LM or spending unit can monitor the payment process online through the treasury's website. Figure 5.1 depicts the CCT's fund flow mechanism.

15. The PMU issues a standing instruction once the post office/government banks in Jakarta have received the fund. After getting the instruction, post office/banks instruct the nearest post office/bank branches (*Cabang*) to pay/transfer the money to the beneficiary within a certain period. All recipients in one area (village or community) normally withdraw the money on the same date at the nearest post office. The recipients can withdraw the money any time if they have received the fund in the government bank. The recipient normally withdraws the full amount. If

the recipient does not withdraw the money three times after receiving the fund, the beneficiaries account becomes a dormant account at the post office. All remaining balances, including dormant accounts should be refunded to GTA.

Accounting and Financial Reporting

16. As part of the Government program, PKH uses the SAI to record the overall program expenditures as well as its line item. The SAI application may produce the financial reports on a regular basis quarterly, by semester, and annually. The Government has been following accrual basis of accounting since FY15. However, the accounting records for PKH is maintained at aggregate expenditure levels instead of details of expenditures to individual end users. To record individual end user expenditures, MoSA has developed simple Excel-based stand-alone records. The system records transactions of individual recipients by name, address, and amount.

17. The PMU signed a contract with PT Pos, Indonesia, and some government banks to distribute the funds to end beneficiaries. Based on the PMU's instruction, the post office/government banks pay/transfer the amount to the beneficiaries in four tranches annually. To monitor the fund distribution, the PMU hired about 25,000 facilitators. The facilitators' main roles are to monitor fund distribution at sub-district level and to check beneficiaries' compliance to the eligibility conditions.

18. The government banks have an adequate system to transfer the CCT fund through cashless method to beneficiaries' accounts. The banks' coverage is one of the inadequacies, especially in remote areas. It may take time before the banks have adequate coverage area. The post offices cover areas which are not covered by the banks.

19. The facilitators receive the beneficiaries' list and monitor the program implementation when the beneficiaries receive the fund. There is sufficient reconciliation between the facilitator and post office's records at the sub-district level after each payment realization. These reconciliation reports are submitted to the PMU, Jakarta, by email with a copy to the district and provincial Program Implementing Units. The PMU, Jakarta, compiles the consolidated report manually which increases the accounting and reporting risks. It creates some discrepancies in the report compilation due to mistakes in posting figures. Currently, the PMU does not have an adequate monitoring system on report compilation. There is no early warning system or red flag on payment realization. In addition, the PMU does not have a feature for tracking record errors. This makes it difficult for the PMU to monitor payment realization and the balance refunded from the post office.

20. The post office has an adequate system to produce a payment realization report through a web-based system. The post office system is able to monitor the payment status at each post office in all levels. The post office provides payment realization reports to the PMU regularly. The PMU may also access some information through an online system. Since the post office's report is more reliable, the PMU uses those reports as a basis for payment realization reports.

21. It is noted that the BPK, as external auditor, raised some issues on the payment status such as dormant accounts, overpayments, and remaining balance from current and previous fiscal years. As the PMU does not have an adequate accounting and recording system for PKH, the

team noted that the BPK used the post office report, instead of the PMU's report, as a reference to the fund remaining balance. There is a plan to develop an integrated SIM for PKH which includes information on payment realization. In the interim, it is recommended that the PMU enforces discipline to all facilitators to submit timely payment realization reports in an agreed format. The PMU should exercise a financial penalty, such as allowance deduction to facilitators for late submission of reports. The PMU may explore using SMS gateway on data collection for a while before the implementation of a new SIM (DLI-PMIS enhancement).

Procurement Profile of the Program

22. The procurement expenditure under the Program represents only a small fraction of the total Program value. During 2013 to 2015, the annual procurement spending varied between IDR 93 billion (approximately equivalent to US$7 million) to IDR 131 billion (approximately equivalent to US$10 million). During this period, the share of procurement in the annual Program value ranged between 1.9 percent to 2.6 percent. In 2015, a total of six contracts were awarded by MoSA under PKH, ranging between US$16,000 and US$7.2 million per contract, the largest contract being for the services/transaction fee for distribution of the fund which represents about 83 percent of the total annual procurement expenditure, while the remaining smaller value contracts were for supply of supporting equipment for facilitators (uniforms, bags, and so on), IT equipment and related services (database maintenance and upgrading IT applications), rental of network, and printing and distribution of PKH cards. The Program does not envisage any large-value contracts that could exceed the Operational Procurement Review Committee Threshold. Also, contracts for civil works and consultant services are not expected under the Program.

Procurement Methods for SA Program

23. In practice, MoSA applies competitive bidding methods under *Perpres* No. 54/2010 to all procurement processes under the Program and using the SPSE e-procurement system. In accordance with the *Perpres*, all contracts for goods and other services with an estimated cost more than IDR 5 billion (approximately equivalent to US$385,000) were procured by MoSA following the public bidding method which requires advertising of the bidding notice for at least seven working days. This includes the largest-value contract procured annually by MoSA (approximately US$7.2 million equivalent, representing 83 percent of the total annual procurement expenditure in 2015) for the services/transaction fee for distribution of cash transfer funds. MoSA followed the public bidding competitive method, even though each year only one bid was received from the Government's Postal Department, PT Pos, Indonesia, which is likely due to the nature of the contract as the distribution of funds to a large number of beneficiaries at the local level across the whole country requires the service provider to be licensed for providing financial services and have experience in providing SA services with an extensive network of nationwide branches, including in remote rural areas. The selection of a Government agency, in this case PT Pos, Indonesia, a state-owned enterprise (*Persero*) reporting to the Ministry of State-Owned Enterprises, is considered to be appropriate for provision of the fund distribution services under the Program. The contract for supporting equipment for facilitators (that is, uniform and bags, approximately US$1.1 million equivalent, representing 12 percent of the total annual procurement expenditure in 2015) was also procured through the public bidding method.

24. For the remaining smaller value contracts of non-complex nature with an estimated cost between IDR 200 million (equivalent to US$16,000) and IDR 5 billion (equivalent to US$385,000), MoSA followed the simplified competitive bidding method which requires advertising for not less than three working days. This includes procurement of IT equipment and related services, renting of network, and printing and distribution of PKH cards, which cumulatively represents about 5 percent of the total procurement expenditure in 2015.

25. While MoSA also engages a large number of individuals as facilitators under the Program, the recruitment of the facilitators is carried out by MoSA based on the Government's staff recruitment framework. Thus, for the purpose of the World Bank-financed program the recruitment of facilitators will continue to be carried out in accordance with the Government's applicable staff recruitment procedures and is not a procurement activity and hence is not considered in this assessment.

26. Based on the data provided by MoSA, all contracts for goods and non-consultant services under the Program in 2015 were procured through competitive methods, with 95 percent of the contracts, by value, procured through the public bidding method and 5 percent through the simplified bidding method.

Evaluation and Award Criteria

27. The procedures for qualification, evaluation, and award are relevant and nondiscriminatory. The pass/fail evaluation under *Perpres* 54/2010 criteria was mostly used by MoSA for the procurement of goods/other services, while the scoring evaluation system and life time economic value evaluation system are applied for complex procurement goods/other services.

Procurement Organization and Capacity

28. The procurement process of goods and other services under the Program is carried out in the MoSA's ULP. The procurement is required to be carried out by procurement accredited staff in the ULP, whose certification is valid for three years and can be extended by the National Public Procurement Agency, if they are still working as procurement staff. MoSA's ULP in the head office currently consists of 34 procurement accredited staff, while another 62 procurement accredited staff are working in MoSA's regional offices across the country. The ULP in the head office has been managing all procurement packages (works/goods/other services and consulting services) under the Program, and its current staffing level and capacity is considered adequate for meeting the continuing procurement needs of the Program.

Procurement Performance

29. The information provided by MoSA on the procurement processes of contracts awarded over the last three years indicates that the time period allowed for bid submission is consistent with the requirements of the *Perpres* as 8–16 days were provided for public bidding and 6–11 days for simplified bidding. The level of competition, with regard to the number of bidders submitting bids, generally ranged from 3–4 bidders per bidding package, while a much larger number of firms (12–62) registered in the LPSE e-procurement system and viewed the bidding documents. However, in the case of the largest contract for services/transaction fee for

distribution of the fund, there was only one bid received from PT Pos, Indonesia, which as explained earlier is likely due to the particular nature of these services which the postal department seems to be strongly positioned to offer. MoSA took between 12–24 days for public bidding and 8–15 days for simplified bidding from advertisement to contract award, and a further 2–11 days from contract award to contract signing, which indicates that the procurement processes were carried out on time.

30. Though the contract implementation data for the past three years was not readily available during the assessment, MoSA informed that normally there are no major cost or time overruns during the contract execution.

Internal Controls

31. The internal control system at the national level follows the existing government system. The Government issued a Government Regulation No. 60/2008 and adopted Committee of Sponsoring Organizations of the Treadway Commission as its control framework in August 2008. The Financial and Development Supervisory Agency has collaborated with the IG, MoSA, to ensure that they are providing support to MoSA in strengthening controls. There is no study yet on the effectiveness of the Committee of Sponsoring Organizations of the Treadway Commission framework implementation in MoSA.

32. PKH beneficiaries list is based on the UDB. The UDB is Indonesia's social registry that is currently managed by TNP2K, under the Office of the Vice President. The PMU, MoSA, prepares the list and distributes it to the social unit (*Dinas*) at the local government, as well as the PSPs (the post office and government banks). The list has information included by name, identification number, and address of beneficiaries.

33. *Dinas* at local level, works together with program facilitators to cross-check the eligibility and inform the beneficiaries of further processes. The post office, Jakarta, will create beneficiaries' account in the system and distribute the list to all post payment units through district post offices. The post payment units will pay the fund to the beneficiaries on a certain date. The post payment units will only pay the beneficiaries who are included in the system. The post office runs a web-based system to monitor the payment process.

34. For the cashless method, the government banks in Jakarta will transfer the fund directly to the beneficiaries' account. The beneficiaries withdraw the fund at the nearest branch. This method just started at the end of FY16. The government banks have adequate internal control and transfer the funds through an online system. One of the risks in this method is changing of beneficiaries' condition/status after the transfer has been done. The program mitigates the risk through facilitators who verify and conduct recertification to the beneficiaries.

35. The PMU monitors the payment process through facilitators at the sub-district level. The facilitators assist and ensure that the right beneficiaries receive the fund at the right time and the right amount. Internal control at the lowest level is adequate. The recipient list is prepared and verified by two different agencies. Sub-district facilitators ensure that the post payment units pay the fund to the right beneficiaries. The facilitators also conduct cross-checks to determine

whether the beneficiaries are eligible for future payments. Any movement or condition changes should be reported to the PMU, Jakarta, for the next list preparation.

36. The IG of MoSA plays a role as internal auditor of the program. The IG also supervises and monitors the follow-up actions of external audit findings. The IG's assignment mostly involves conducting compliance audits on the operational aspects of MoSA, including PKH. IG audit reports are mainly submitted to the minister. There is no audit assignment from the IG to PKH in FY16. The IG has limited assignment on facilitation which includes payment reconciliation. The IG has planned to conduct an internal audit assignment of PKH in FY17. The audit will focus to accounting and reporting of PKH payment.

37. Based on the BPK audit report, there are some internal control issues on PKH implementation, especially on monitoring and reporting of funds transfer to the end beneficiaries. The PMU needs to improve the monitoring and reporting system at the national level. The PMU should use a SIM, instead of a manual system. The current manual system does not have adequate internal controls to monitor the payment processes in over 400 districts in Indonesia. The PMIS is expected to also include a feature that allows facilitators to input information certifying the receipt of fund by beneficiaries, the amount, and the date of the receipt. Such inputs can be aggregated at the PMU level to allow better monitoring of funds receipts by each beneficiary. Implementation of a better PMIS will reduce the risk and improve the monitoring and reporting system in the program. An improved PMIS is expected in FY18 (DLI on PMIS enhancement). Controls over payment to beneficiaries are also expected to be improved by switching to a cashless payment method to beneficiary families (DLI 2).

38. To improve control before the implementation of the PMIS, it is recommended that the PMU enforces discipline to all facilitators to submit timely payment realization reports in an agreed format, including confirmation that the beneficiaries have received the funds. The PMU should exercise a financial penalty, such as allowance deduction to facilitators for late submission of reports. The PMU may also explore the use of an SMS gateway on data collection.

Program Audit

39. As PKH is a major program in MoSA, the BPK has conducted a performance audit of the program for FY10–FY14. The performance audit report was issued on January 27, 2016. The issues raised by the auditor included (a) the need to enhance MoSA's role in database management; (b) inadequate budget to cover significant eligible participants; (c) inadequate budget sharing from the local government; (d) insufficient indicator on selecting the target; (e) verification not in accordance with the agreed regulation; (f) payment delay in some locations; and (g) inadequate recertification of end beneficiaries.

40. MoSA has conducted some follow-up actions on the BPK audit findings and recommendations. However, some actions have not been completed and need further follow-up. For example, inadequate budget allocation is still not addressed due to limited budget availability at the central as well as the local levels.

External Audit

41. Based on Law 15 (year 2014), the BPK as Indonesia Supreme Audit Institution has a mandate to audit all the government agencies, including MoSA. The BPK has achieved many good results in the public sector auditing area. This has been pointed out by peer review reports from Netherland SAI in July 2009 and Poland SAI in April 2014.

42. The BPK audits MoSA's financial statement annually. Because PKH has more than one-third of MoSA's budget, the BPK always covers PKH expenditures in its financial audit scope. The BPK expressed a disclaimer opinion on MoSA's financial statement for the period ending December 31, 2015. One major qualification is that the flow of funds could not be traced adequately to the end beneficiaries and that reasonable assurance was lacking on the ending balance at the post office's account. The ending balance was IDR 804.8 billion, which was raised by the BPK. Of the balance, 98% has been refunded to the treasury account. To solve the issue, the PMU plans to enhance the SIM which includes payment realization reports. Otherwise, this issue will remain.

43. There is a dispute between the BPK and the post office on the flow of fund mechanism. The BPK advises that the post office must transfer the fund directly from PKH special account. On the other side, the post office uses its business practices by using an operational account to transfer funds to the end beneficiaries. The operational account is used for all post office operational purposes and not just for PKH payments. Therefore, the auditor could not trace the fund to the end beneficiaries through the operational account. The dispute has not been resolved yet and may remain an outstanding issue for a future audit assignment. It is recommended that MoSA reviewed the contract agreement with PT Pos on January 5, 2017, and clarified the right and obligation of both parties.

44. MoSA has conducted some follow-up actions on the BPK audit findings and recommendation. One follow-up action is improving the SIM that includes reporting system on the payment information. An improved PMIS will make the payment reconciliation at the national level easier and provide more reliable financial reports. The system is expected to have some features which include tracing the flow of fund to beneficiaries adequately (DLI on PMIS enhancement). Because PKH is a primary program for the ministry, the World Bank requires a financial audit of the ministry, instead of a program audit. The external auditor, BPK, will include the program in the ministry audit assignment and share a copy of the audit report with the World Bank no later than six months after the end of the Government's fiscal year.

45. The procurement process at MoSA is also audited by the BPK and the assessment noted that there are no audit findings in the procurement process.

Transparency

46. Based on Law No. 14 (year 2008) regarding the Transparency of Public Information, all public information is open and accessible by every user of public information. An exception to public information is information that is restrictive and limited. Every public information applicant shall be able to obtain public information fast and promptly at low cost and in a simple manner.

47. The exception is when it is classified as confidential information pursuant to the law, ethics, and the interest of the public; based on an examination with regard to the consequences that occur if the information is provided to the public; and after careful consideration that covering up public information can protect a larger interest rather than opening it or vice versa.

48. The LMs may use electronic and non-electronic media as facilities to disseminate the information. However, it is not clear whether LMs should provide the information actively, or passively (only on demand basis). There is no M&E from the Ministry of Information whether LMs follow the law and regulation on transparency of public information.

49. It is noted that MoSA provides some basic information regarding PKH in the ministry website. The information is not detailed on budget amount, location, and end user information. TNP2K as the government agency for acceleration on eliminating poverty, provides more information on the program than MoSA's website. Some local governments made a complaint on availability of PKH information, because the local governments need to provide budget sharing to the program, and some questions were raised by poor families who did not get PKH benefits. It is also noted that PKH posters are limited to local government offices. To improve transparency, there is a plan to make PKH information more open and accessible to all stakeholders. The PMU plans to improve its communication strategy at the central and local levels, develop an M&E system, and strengthen the complaint-handling mechanism. The PMU expects that PKH will be more transparent by implementing this action plan (result matrix and indicator on transparency).

50. Procurement plans and bidding opportunities are publicly disclosed in the Information System for Procurement Planning (*Sistem Informasi Rencana Umum Pengadaan*) website (https://sirup.lkpp.go.id/sirup). The bidding reference number, package description, procuring agency, owner estimate, and location are published in the website. Bidding information, from advertisement to award information, including bidding schedule, name of registered bidders, quoted and evaluated prices, and bid evaluation are publicly disclosed in the SPSE e-procurement system. Contract award information is also published in the national website of the public procurement agency which is freely accessible to the general public.

Complaint Handling

51. The *Perpres* includes provisions allowing bidders to submit complaints on the procurement process, and the LPSE e-procurement system also allows complaints to be submitted through the system. During the procurement assessment, MoSA staff informed that procurement-related complaints have rarely been received in the contracts awarded during the last three years, and in case of receipt of such complaint it is forwarded to the concerned ULP for action. There does not seem to be an established system in place, in MoSA, for redressal of procurement-related complaints, and this is an area which can be further strengthened under the Program.

Fraud and Corruption

52. Like most CCT programs, PKH faces implementation challenges from a governance and anticorruption perspective. It is large in scope, with 6 million beneficiaries and a high volume of

financial transactions. It is politically high profile and engages multiple government actors at the national and subnational levels. And by targeting the poorest of the poor, program locations are often in remote and inaccessible areas, exacerbating implementation challenges and increasing risk.

53. The potential major vulnerabilities of PKH along with potential mitigation measures are interference or errors in the payment process. PKH has two main exposures on fraud and corruption payment risks, especially at the lowest level. The first risk is illegal deduction of the payment from the post office PPSPM. Beside internal control procedures in PT Pos, Indonesia, PKH has set up a complaint-handling mechanism that recipients can use to report and submit any issue on the payment process. PT Pos, Indonesia, includes regular staff rotation and supervision of the post payment units in its internal control procedures. The recent move toward delivering payments through cashless methods can help mitigate most of the concerns regarding payment disbursements to the correct beneficiaries and improve the liquidation process and mitigate the risk of facilitators 'taxing' beneficiaries since the cashless methods transfer the fund to beneficiary accounts directly.

54. **Detection risks.** For a big program like PKH, detection risk will continue to be a challenge as some level of fraud and corruption is inevitable because of the sheer scale of coverage. Some factors contributing to this risk are (a) funds not targeting eligible beneficiaries; (b) eligible beneficiaries being excluded from the list of recipients; (c) possible delays of funds transfers to beneficiaries; (d) incomplete/inaccurate database of beneficiaries; (e) influential beneficiaries receiving more payments; and (f) failure of beneficiaries to notify the program of change of their circumstances or failure of the program to act on this information. To mitigate these risks, many controls are in place. The recipient list is prepared and verified by two different agencies. The sub-district facilitator will ensure that the post office/banks pay the fund to the right beneficiaries. The facilitator also cross-checks to determine whether the beneficiaries are eligible for the future payments. The post office has also set up internal control procedures which include regular staff rotation and supervision of the post payment units from the district post office. Control over payment to beneficiaries is also expected to be improved by switching to a cashless payment method to beneficiary families (DLI 2). It is also recommended that the post office's internal audit unit and the IG, MoSA, conduct selected verification of payments to beneficiaries during the audit assignment. In addition, PKH has set up a complaint-handling mechanism that recipients can use to report any issue on the payment process. (DLI on standardize and improved GRS). Moreover, the beneficiaries or others may raise the issue to other grievance resolution systems, such as the Ombudsman, online community complaints, internal/external audit, and the anticorruption commission.

55. **Noncompliance to World Bank's debarred/temporarily suspended firms.** The assessment revealed that MoSA complies with the National Public Procurement Agency's blacklisted firms. The World Bank discussed and shared the Guidelines on Preventing and Combating Fraud and Corruption in Program-for-Results Financing (Anticorruption Guidelines) with MoSA which applies to the entire Program. The World Bank and MoSA also discussed MoSA's obligations under the Anticorruption Guidelines for the Program to monitor and comply with the World Bank's list of debarred/temporarily suspended firms.

Fiduciary Risk Assessment

56. The overall fiduciary risk is Substantial.

Table 5.1. Fiduciary Risk Assessment

Risk	Mitigation Measure
Lack of automated system to record and reconcile data of payments to beneficiaries	Implementation of PMIS enhancement to captured detail data at the beneficiary level
Inadequate follow-up on external findings	Monitoring of implementation of external auditor recommendations with support of the IG, MoSA
Need to improve program internal controls	Instituting periodic internal audit of the program
Addressing interim mitigation measures until PMIS implementation	Enforcing timely submission of payment realization reports by facilitators, including confirmation of receipt of payments by beneficiaries
Absence of complaint-handling mechanism could be a deterrent to bidder's participation in bidding	MoSA to develop a procurement complaint-handling mechanism consistent with Government regulations
Risk of noncompliance to World Bank's list of debarred/temporarily suspended firms	MoSA to put in place a mechanism to ensure that ULPs at each of procurement processes check and record in the file that the recommended firm is not on the World Bank's list of debarred and temporarily suspended firms
Interference or errors in the payment process	The recent move toward delivering payments through cashless methods can help mitigate most of the concern regarding payment disbursements to the correct beneficiaries and improve liquidation process and mitigate the risk of facilitators 'taxing' beneficiaries
Detection risks	In addition to existing controls already in place in MoSA, it is recommended to PT Pos, Indonesia's internal unit and the IG, MoSA to conduct selected verification of payments to beneficiaries during the audit assignment

Fiduciary Inputs for Program Action Plan

57. Based on fiduciary assessment, the following areas are considered for compliance/institutional strengthening as part of the Program Action Plan: (a) enhance the SIM to include information on payment realization; (b) take follow-up action on the BPK audit findings and recommendation; (c) conduct internal audit of the Program by IG, MoSA; (d) enforce timely submission of payment realization reports by facilitators (including confirmation that beneficiaries have received the fund) during transition to the PMIS to improve internal controls.

Annex 6: Summary Environmental and Social Systems Assessment

A. Background

Scope of the ESSA

1. The assessment builds on earlier work conducted assessing the operation and performance of PKH, including previous impact assessments, studies, and consultation minutes. A series of field trips were completed by the assessment team to meet and learn from a range of stakeholders, including the local government representatives, PKH beneficiaries, facilitators, and service providers. The assessment team visited four districts that were intentionally selected based on several criteria, including (a) the size of beneficiaries; (b) geographical characteristics, including urban, peri-urban, and remote areas; and (c) new and existing PKH areas. The locations for the field visits were jointly selected with MoSA and the World Bank teams. In each of the districts and municipalities visited, the team used a combination of approaches, including focus group discussions, in-depth informal interviews, and casual conversations, particularly with community members.

2. There are no infrastructure and other physical activities that are supported and/or financed through PKH CCT and therefore it is not expected that the program will generate potential environmental impacts that may result in the loss, degradation or conversion of natural habitats, pollution, and/or changes in land or resource use. The program only supports the demand for services, particularly in the areas of health and education and not the supply side, which is not under the purview of MoSA. The program will not demand nor provide incentives to broader the Government of Indonesia's supported programs to expand health and education services facilities. The program, however, could have social risks associated with exclusion from the program and low understanding of the aim and scope of the program due to inadequate outreach and socialization, which could foster perceptions of unfairness and suspicion, particularly among households who do not receive PKH.

3. Under such considerations, the assessment has placed an emphasis on social inclusion, particularly to better understand whether

(a) There is equitable access to PKH;
(b) The Program meets the needs of poor and marginalized groups; and
(c) The Program provides adequate space for community consultations and feedback, including grievances.

4. These issues were approached by focusing attention to how the poor and marginalized communities are identified, surveyed, and eventually enrolled in the program. Specifically, the assessment took into account issues around targeting, gender, timing and means of cash transfers, power dynamics at the community level, the role of facilitators, cadres, and service providers with regard to access to the Program, and lastly the existing complaint-handling mechanisms. The assessment was done both at the national and sub-national levels, covering several districts that have been participating in PKH and also new districts that were recently included for the program expansion. The districts visited include Medan and Serdang Bedagai Districts in North Sumatera and Serang and Lebak Districts in West Java.

5. Public consultations for the draft ESSA were conducted at both national and sub-national levels, in Tual Municipality of Maluku Province and Kepulauan Seribu of DKI Jakarta and the GIZ's scoping study, covering nine districts in Papua and West Papua which were selected based on accessibility and the existence of similar programs. The consultations were jointly prepared by MoSA and the World Bank. The national ESSA public consultation was hosted by MoSA in Jakarta on March 15, 2016. The consultation involved a broad range of participants from relevant government agencies, academics, research organizations, and nongovernmental organizations. Two locations with supply-side constraints were selected for sub-national consultations, including Tual Municipality in Maluku Province and Kepulauan Seribu District in DKI Jakarta, with the latter being a new expansion area. Both locations are characterized as: island geography, extreme remoteness for some islands combined with lack of basic services, and high transportation costs. The selection of the locations took into account the following factors to assess social aspects of PKH, including accessibility for PKH to operate effectively and conflict potentials, and availability of basic services for the program to be sustainable.

B. Equity of Access

6. Enforcing stringent conditionalities can be challenging in areas where there are serious supply-side issues and therefore, attempts to make conditionalities and verification protocols more contextual become critical to promote social inclusion for communities in underserved areas. Once PKH has been expanded nationwide, introducing flexibility in conditionalities and verification protocols by factoring in local contexts becomes critical to ensure that the poor and marginalized groups have adequate and continued access to PKH benefits. However, this may suggest that PKH's overall goal with regard to health and education attainment can be potentially compromised. In addition, tailoring conditionalities and verification protocols on the basis of supply-side readiness may stretch the already strained PKH management and resources.

7. Although eligibility criteria are clearly defined in the Operational Manual (page 22–28) and facilitators were able to articulate the conditionality relatively well, community beneficiaries on the other hand and even local government officials who met during the assessment, indicated a varying degree of understanding of such criteria and conditionality. Common perceptions of such criteria include either having school children, being pregnant, or having a baby whereas the newly introduced components of disabilities and the elderly were not yet known. Facilitators reported that PKH beneficiaries were often confused about the different amounts of cash transfers received and were often not clear about why deductions were made due to not fulfilling program criteria, how such deductions were made and calculated, and also why others who were perceived ineligible or being richer were still getting payments. In addition, the 'graduation' (exit) scheme in PKH is not widely understood by beneficiaries and it is often presumed that there is no time limit to PKH provided that their children are still attending school. Such issues were presumably associated with the lack of socialization and community outreach. In one of the districts visited, facilitators took the initiative to create information display materials such as sign boards and posters using their own sources, initially to contain constant questions and complaints from people who did not get selected for PKH. However, such an initiative did not last due to the absence of support and rewards.

8. At a national aggregate level, PKH's leakage to non-targeted populations is reported to be minimal, although there are occasions where transfers have been made to the near and non-poor

deciles. The World Bank's forthcoming Public Expenditure Review update indicates that the share of PKH beneficiaries from the lowest three poorest deciles has risen by approximately 8 percent between 2010 and 2014, thus suggesting growth in coverage and improved targeting accuracy for the poorest households (World Bank 2016). However, such statistics are often not shared by local stakeholders, including local and village government officials and community beneficiaries themselves. Targeting was often seen as problematic.

9. In principle, the aggregated and disaggregated UDB data can be accessed by a variety of institutions for poverty reduction planning and targeting purposes upon request. The UDB has been mainly used to identify beneficiaries of the largest national social protection programs such as PIS, scholarships (BSM, now PIP), CCTs (PKH), and subsidized rice (Raskin, now Rastra). Local governments have also demonstrated a strong interest in the use of the UDB to support the implementation of local poverty programs, with more than 500 district and provincial government institutions having reported use of the data. The UDB is intended to assist government institutions to have streamlined poverty reduction efforts, which have historically been overlapping and also save some resources which would otherwise be diverted to beneficiary identification, targeting, and selection.

10. However, upon cross-checking with local stakeholders, there are a few perceived issues around the UDB, which consequently affected their perceptions of PKH:

(a) Since this database is centrally managed and baseline data were collected by the district and provincial BPS offices, which sit outside the local government structures and directly report to the President, there is a perceived lack of local government involvement and the actual targeting processes were not fully understood by local stakeholders.

(b) There is a perceived inaccuracy of UDB data and exclusion errors were considered high, particularly following the addition of new households for the expansion in 2016, where there were overlaps and unidentifiable names reported. Perceptions of high level of error in UDB data were often fueled by the general public's complaints particularly in beneficiary selection and such inadequacies were often attributed to TNP2K and BPS.

(c) Data error was also associated with the quality of data collection processes. PPLS data were collected by the district and provincial BPS offices through their enumerators. These enumerators were often recruited from community members and some local government officials in the districts who were visited suggested that selection of enumerators, capacity building, and oversight should be improved.

(d) New poor households were proposed as part of the UDB's updating process in 2015 and such proposals came from community representatives and village government officials who were invited to the Public Consultation Forums (*Forum Konsultasi Publik*, FKPs). However, local government officials reported that some of the new households had not been surveyed by the BPS and for some which were surveyed, their names were not included in the new UDB lists.

11. The main challenge facing PKH and any cash transfer program is the limited quotas available. Even with the best targeting and other beneficiary identification approaches, the programs with their current resource level are largely limited in coverage. Given this limitation, the potential for beneficiaries to see the process as being 'dubious' is high. A series of conversations with local stakeholders highlighted a number of factors as to why people miss out on PKH and other SA programs, some of which are related to administrative requirements and others are more related to survey constraints.

12. People who are not formally registered in their current place of residence are likely to miss out on SA other than PKH, and this was reported as a persistent problem. There are various reasons for such exclusion. Unregistered individuals may not be formally recognized by their villages or wards as residents and therefore are often not eligible for other SA programs. Secondly, these individuals are not likely registered as residents and even if they are, they might be registered in their original place of residence and therefore may miss out on censuses and surveys. Article 15 of Law No. 23/2006 on Population Administration stipulates that any individual who leaves his/her original place of residence must obtain a transfer letter from village heads or authorized officials to be registered in his/her new place of residence. Family and/or ID cards could only be amended upon obtaining the transfer letter. This presents challenges for individuals who may not be aware of the procedures or who may perceive that such procedures are cumbersome and entail some cost. In addition, such a provision becomes difficult to be applied for transient populations, such as nomadic, seafaring, farming communities, or temporary and migrant workers, and who therefore have a higher likelihood of being excluded.

13. Since PKH entitlements are tied to conditionality associated with meeting certain health and education indicators, the availability of services becomes critical for PKH households, for them to be verified against required indicators and, therefore, continue to be eligible. However, in some remote locations such as small islands, forests, or highland areas, verification of compliance to conditionality can be very much compromised by the lack of basic services and previous assessments on supply-side readiness. Such constraints often stem from uneven distribution of personnel such as teachers and midwives, rather than the absence of facilities or infrastructure.

C. Meeting the Needs of the Vulnerable

14. PKH beneficiaries who were met expressed gratitude for PKH payments they received and mentioned that they felt assisted in meeting basic needs particularly paying school fees and purchasing school kits and high-nutrition foods for infants. Not much was reported on the correlation between PKH transfers and health expenditures, presumably because health care has now become increasingly affordable for the poor through PIS.

15. Several mothers who were met during the assessment mentioned that PKH transfers, although useful, often did not come on time, especially when the need for cash is greatest, such as the months when school tuition fees are due or the beginning of new school enrollment, when a large amount of cash is often needed to pay registration fees and buy new school kits. In a private elementary school that was visited, late PKH payment was acknowledged to affect parents' timeliness in paying their children's tuition fees and, consequently, the school often had to offer some flexibility by giving PKH parents some extra time until they received the transfers.

However, this was seen as creating another problem because the school relies on fees collected from parents to pay their teachers and supplement their already meager operational costs from School Operational Assistance.

16. Financial needs become greater for PKH families as children start entering senior high school or tertiary education because all school-related costs such as pocket money, transport, and photocopying may triple. There was some hope that PKH can be extended to tertiary education because university costs could represent a major portion of their current household expenditures overall. In some other cases, there were occasions where PKH beneficiaries were reported to sell or use their cards as a loan collateral due to the need for quick cash.

17. Associated costs with regard to PKH payments borne by beneficiaries could act as a disincentive for them to fully engage in the program. There is a need for further assessments with regard to payment cycles and logistical costs for beneficiaries and whether payment schedules need to be bundled or streamlined to reduce costs. E-payment could be considered as an option, however, areas that suffer from high transportation costs are usually areas not covered by banking services.

18. MoSA recently launched a new initiative, the FDSs, which consist of a series of group learning activities in several thematic areas, including economic development, child rearing, health, education, and so on. FDSs are aimed to equip PKH families with knowledge and skills needed to improve their welfare and health status. Started in November 2014 and continued until December 2015, FDSs were piloted in three 2007 cohort provinces, that is, DKI Jakarta, West Java, and East Java. The pilot involved 122 sub-districts in 33 districts. Because the initiative is still new, the assessment team's understanding whether this program helps address some of the challenges faced by PKH families or whether the program is relevant is still preliminary. However, anecdotal evidence shows that FDSs were positively received by PKH mothers, and such acceptance tends to hinge upon the skills of facilitators to deliver and tailor the FDS modules to the needs of PKH households. One PKH mother mentioned that she already felt some positive change in her child-rearing behavior after attending several sessions and that she managed to develop more constructive approaches to educate her children.

19. Initial inputs from both FDS participants and facilitators suggest the following:

(a) FDSs are considered under-resourced because facilitators were not equipped with the necessary tool kits to make the sessions more interactive and engaging. There are videos and visuals to be displayed in the training package, however, there were no media devices, such as laptops or projectors being provided. As a result, facilitators, had to use their own laptops and the FDS participants could only watch the videos and visuals on a small screen. Some facilitators mentioned that they collected some cash to purchase their own projector and used it.

(b) The training modules were considered too standardized and did not accommodate the diverse needs of the FDS participants; for example, health modules for the elderly who become caregivers for PKH children. The modules often need to be modified by facilitators and require some resources if new materials need to be developed.

(c) There is a greater need for strengthening the facilitators' facilitation skills to deliver the FDS rather than only understanding of the FDS modules, which eventually often need to be improvised. The FDS Training of Trainers that facilitators received before the rollout was considered insufficient to equip them with the confidence to deliver the FDS effectively. This was the case particularly among new and young facilitators.

(d) FDS contents need to accommodate practical lessons.

(e) Specific to areas with high prevalence of HIV/AIDS, such as Papua and West Papua, the FDS could be used as an outreach platform for raising awareness and prevention.

20. By 2019, PKH's payment modality is expected to fully transition from cash to digital accounts (that is, bank accounts and e-money accounts). The assessment indicates that such a transition is more of an issue in remote areas than in urban and peri-urban areas where financial infrastructure is more developed. In this case, access points are critical for the delivery of non-cash payments and therefore, further feasibility assessments and testing of different models are required before implementing the model on a full scale. Typical for remote districts, case studies in Papua indicate that access to banking services could be severely restricted and the costs of transport both for PKH beneficiaries and financial services to reach remote areas can be prohibitive. Two key considerations need to be taken into account, including, (a) accessibility and associated costs borne by PKH households to reach pay points and (b) appropriateness of the payment modalities, that is, use of identifiers (passwords/Personal Identification Number), requirements for bank account application (for example, legal identity), and so on.

D. Consultation and Voice

21. The FKPs are an innovation introduced to strengthen the role and participation of local governments and community representatives in the identification of potential beneficiaries for SA programs, including PKH. Resurveying and use of the FKPs was held as part of the UDB updating processes given that the PPLS survey was last conducted in 2011 and therefore circumstance may have changed over time. The updating process aims to ensure that the households listed in the UDB are correctly categorized according to their predicted poverty status. The FKPs were led by the BPS and consultations were held nationwide at the village and urban-ward level, involving a wide range of stakeholders, including village governments, community representatives, and other interested stakeholders. The purpose of the FKPs was to verify and get community representatives to agree on the UDB prelist and include new participants who may not be registered in the UDB at the village levels. The proposed names and agreements on the prelists had to be endorsed by district heads and/or mayors, which would then be validated by the BPS through a household economic survey for inclusion in the UDB. The TNP2K reported that 3,514,488 households, or approximately 14.3 percent of the previous PPLS data in 2011 have been added to the UDB (TNP2K 2015).

22. The FKPs were received by local stakeholders with a mixed response. The FKPs were reported to suffer from lack of coordination with district and sub-district governments and did not involve a wide range of stakeholders as should have been. Secondly, there is confusion over

the use of the FKPs because PKH targeting in 2016 was perceived to inadequately reflect what was previously proposed and there was no official explanation to the large extent of overlaps and unidentifiable names for PKH expansion. In another district in West Kalimantan, BAPPEDA officials reported that not all villages were involved in the FKPs, and this was based on reports from several village heads.

E. Access to Information

23. Access to information was considered lacking across levels, and this is often attributed to the widespread lack of awareness and misunderstanding particularly on the issues of targeting. When there were questions or complaints, people would come to district government offices (Social Agency or BAPPEDA), facilitators, village heads, or service providers and when no clear answers could be provided, it added to their perceptions of lack of transparency. An earlier study by Reality Check Approach a qualitative survey firm, indicates that communities often assume there is some corruption and misuse of funds due to confusion of how the selection took place and what their entitlements were and had no means and channels to voice their concerns and demand accountability. In addition, the plethora of SA programs both from national and local initiatives and the many changes that have taken place tend to confuse people further.

24. Strengthening the capacity and knowledge, including access to information, to facilitators and PKH group leaders were considered strategic because PKH beneficiaries often use such communication channels through direct and interpersonal communication with facilitators and PKH group leaders. Reliance on the facilitators and PKH group leaders (Ketua Kelompok) to relay information about the program to PKH beneficiaries was perceived effective. However, there was no formal capacity-building interventions available for PKH group leaders to strengthen their leadership and communication skills. Exploring innovative communication channels, such as social media, were also proposed.

F. Management of Risks and Impact

25. The Program's M&E function to track grievances, as well as potential impacts and risks is currently not formally defined. Similar to other key tasks, the M&E team is operating on an ad hoc arrangement and under the new organizational design, the unit that should be responsible for M&E is not clearly defined. A team of consultants, previously assigned in the UPPKH, is in charge of managing M&E responsibilities and is currently placed under Subdirectorate 3 (Beneficiaries).[50] Such an arrangement presents limitations to the level of independence that the M&E function should assume and potential conflict of interest because Subdirectorate 3 is also implementing parts of the program. The good practice globally is to elevate the M&E function in the hierarchical structure and keep it independent of implementation.

26. PKH facilitators are in the frontline when there are implementation issues and complaints and therefore their roles become very critical in the overall management of risks and impacts. The myriad of other administrative responsibilities that each facilitator is required to perform presents trade-offs in time and resources that should have been mobilized to strengthen their

[50] Subdirectorate 3 (Beneficiaries) is responsible to physically locate beneficiaries, verify their compliance to conditionalities, and provide capacity building to beneficiaries through FDSs.

social work responsibilities, including referring PKH households to complementary programs and program socialization, including clarifying misperceptions around the program. Capacity building for facilitators has been mainly focused on program administration and there is an articulated need expressed by facilitators to have additional capacity particularly with regard to communication and facilitation skills and knowledge of social protection programs both at the national and subnational levels through which linkages with PKH could be strengthened.

27. In some difficult locations where access is remote, there were safety issues reported by facilitators. Facilitators reported that the ratio between the number of facilitators and household beneficiaries is sometimes not in proportion despite ratio differentiation based on geographical characteristics. Some facilitators mentioned that they often need to spend long hours in the field until late at night and there were safety concerns that they believed need particular prevention measures. These issues are likely more serious in areas with conflict hotspots such as the highland districts of Papua and West Papua where there is a prolonged history of armed conflicts fueled by heavy militarization to crack down on separatist movement and intercommunal conflicts in the region.

28. The program currently does not have a systematic risk management plan for operation in conflict areas. Existing conflicts due to political rivalry, tribal tension, and land disputes were reported. Although such conflicts were not reported to have been directly exacerbated due to PKH, existing conflicts have prevented access for facilitators and other service providers from entering the communities in dispute. In addition, the safety of beneficiaries and facilitators could also be at risk when they have to encounter their oppositions or if they were perceived as enemies by people in conflict. There were two casualties involving PKH facilitators in Papua who were killed during tribal wars. Some beneficiaries were reported to have to carry protective weapons when they picked up payment at PT POS in anticipation of meeting their enemies. Local interventions to avoid clashes, such as organizing different payment schedules to avoid direct encounter and strengthening facilitation through KUBE and FDS to improve inter-communal relations, were reported. However, this heavily relies on facilitators' communication and facilitation skills and currently, there are no effective mechanisms to flag potential conflicts where inexperienced facilitators could receive additional support.

29. Limited documentation that exists on the implementation of the GRS shows that the system should be improved. The system by design uses multiple channels, including in-person reporting, fax, email, phone, or an online application developed by the central UPPKH. The current GRS design shows that complaints or issues associated with field implementation will be followed up based on an area approach, by the nearest officer in the UPPKH unit. However, lack of authority and capacity to resolve complaints at the local level has rendered the program’s GRS ineffective.

30. Based on a PKH 2016 GRS report, complaints received by the central PKH office were categorized in the following way: information and questions (33 percent); PKH recipient data (28 percent); corruption, collusion, and nepotism (23 percent); and payment delivery (18 percent). Complementing this with anecdotes from the field visits conducted for the ESSA, the majority of complaints in the first category center around why some families are not included in the program and how they can become members of the program. The report also indicates key challenges with regard to the GRS implementation, such as delayed responses, lack of

integration with the MIS, and lack of information and awareness of the available avenues and channels for complaint resolution among PKH beneficiaries.

31. There is no functioning grievance redress mechanism that the district and provincial governments can use to manage grievances or inform complainants about the status of their complaints. Theoretically, PKH households and community members can submit their complaints to facilitators who are responsible to record complaints received by filling standardized forms and relay the complaints to the related departments in MoSA for further resolution. An operational manual for grievance reporting and redress is available, but was reported not operational. In addition, the current system does not provide a space for the communities to voice their complaints in an anonymous manner.

32. Under the current management, which is highly centralized, local governments have limited capacity to resolve complaints at the local level. Complaints are only recorded in the district/provincial Social Affairs Offices and no follow-up actions can be effectively mobilized. Such a lack of authority is perceived problematic because community protests and discontent are often targeted at local governments (social agencies in most cases and occasionally, the planning department/BAPPEDA). Such complaints were often left stalled as the local governments seem reluctant to take full responsibility or be held accountable for programs where they have limited involvement. There was a report that the Social Agency Office in the District of Tolikara was burned down by angry protesters who perceived that the distribution of SA was unfair and only favored certain groups.

33. In light of PKH's recent expansion, where increasing complaints should be anticipated, a better functioning GRS is critical to maintain the legitimacy and social trust of the program. The following possible suggestions can apply to the GRS:

(a) The extent to which the GRS can be optimally used and respond to complaints effectively is contingent upon various factors. In addition to the availability of resources and local capacity to manage the system, greater clarity over what can be resolved at the local level by district and provincial governments is important. Because most complaints reported stem from exclusion issues, there is a strong need for a review of the targeting mechanism and strategies to ensure that district proposals of new beneficiaries can be accommodated on time.

(b) Agreed standard operational procedures (SOPs) for the GRS need to be developed in consultations with local governments.

(c) Selection of means for the GRS should take into account accessibility and opportunity costs for complainants to file complaints (that is, simplified procedures, confidentiality, no repercussion, and so on).

(d) Socialization of the Program's GRS should be done in a manner that is iterative and continuous, instead of one-off events, and adequate resources should be allocated for information dissemination.

G. Social Risks

34. The social risks for PKH are Moderate. The Program is fostering inclusion by expanding to mostly cover disadvantaged population groups (for example, the disabled, indigenous populations). Social risks are mainly associated with the capacity of the program to correctly target poor beneficiaries, engage with communities and make use of appropriate communication channels, roll out a responsive GRS, and create enabling environments to help PKH households use cash transfer to improve their overall welfare, health, and education outcomes.

Table 6.1. Key Risks and Proposed Mitigation Measures

No.	Description of Risk	Mitigation Measures
1.	**Inclusion of the marginalized groups, particularly those in remote districts with supply-side constraints** The scale-up of PKH from 3.5 to 6 million households presents implementation risks including the inclusion of the vulnerable, quality of program implementation and facilitation, complementarity, grievance redress, oversight, and so on. This issue is more pertinent in remote locations where PKH aims to continue to expand. Lack of access to basic health and education services will likely disadvantage PKH beneficiaries because their enrollment may get dismissed if they persistently fail to meet conditionalities. Such issues will likely be amplified in the context of weak program management, lack of coordination, and oversight.	• A review of conditionalities and verification protocols particularly in remote and underserved regions to accommodate supply-side constraints. A road map for social inclusion is currently being discussed under the sub-directorate of beneficiaries, including strengthening the MIS system and facilitators' roles to have adequate capacity to accommodate the new demands. • Clarify roles and responsibilities and strengthening coordination with local governments to support access to basic health and education services, program operation, and oversight; • Build the capacity of facilitators to be able to work across communities with different socio-economic backgrounds and cultures. This includes streamlining facilitators' job descriptions with focus on facilitation and social work responsibilities. • Strengthen the functions of GRS (point 2) and communication strategy (point 3).
2.	**Weak and ineffective GRS** The program's GRS is still currently under development and a major overhaul is currently being planned. To date, lack of authority and capacity to resolve complaints at the local level has made the current GRS ineffective	• Develop and test GRS models that are accessible and can protect the confidentiality of complainants; • Develop and test GRS modules and operation manuals in the MIS to ensure that grievances are consistently recorded and analyzed; • Designate and formalize a unit or partner, ideally independent from implementing functions with clear structure and coordination arrangements with JSK and local UPPKHs; • Strengthen the role of facilitators and operators to operationalize the GRS; • Develop and implement a comprehensive communication and socialization strategy on GRS. Means and approaches for communication should take into account literacy levels, prevalent languages/dialects, frequency, timing, and so on. to ensure that they are inclusive, accessible, and socially and culturally appropriate; • Clarify and agree on GRS structure, including aspects and cases that should be resolved locally.

No.	Description of Risk	Mitigation Measures
		This includes devolution of roles and authority to local implementing entities including the sub-national governments and consultancy teams;
3.	**Lack of sensitivity to local norms and inappropriate delivery of the program.** Centralized procurement of facilitators was reported to have caused inappropriate placement of facilitators where assigned facilitators are not familiar with local contexts or reside in faraway locations.	• Train and mentor facilitators on cross-cultural understanding; • Whenever possibly, employ local people with sufficient level of competency or people with sufficient level of familiarity about local contexts to facilitate the program; • Incorporate consultations and stocktaking exercise in the M&E activities to gain inputs and feedback from beneficiaries about the program implementation.
4.	**Ineffective communication of the program** Access to information was considered lacking across levels, and this is often attributed to the widespread lack of awareness and misunderstanding particularly on the issues of targeting, beneficiary selection, and requirements for PKH enrollment.	• Develop and test a communication strategy to ensure that there is sustained socialization, dissemination of program information, and documentation. Information about targeting including processes and criteria should be clearly communicated down at the community level. This could potentially reduce complaints and grievances that are often associated with beneficiary selection; • Recruit a team of communication specialists and develop training modules and facilitate training sessions on communication strategies targeted at implementing entities;
5.	**Targeting errors** As the program expands in coverage, program exclusion is expected to reduce. However, risks related to targeting errors and weak technical oversight become greater as JSK is currently undergoing institutional reform.	• Strengthen oversight and technical expertise within the targeting team; • Strengthen the GRS implementation (point 2) and test the program's communication strategy (point 3) with necessary capacity building and socialization to implementing entities; • Facilitate coordination and strengthen engagement with sub-national governments and other local stakeholders both public and private to mobilize efforts to ensure inclusion of marginalized groups and address exclusion issues (for example, lack of documentation, not being surveyed, not having access to basic health and education services)
6	**Exacerbating conflicts and/or tension** The key constraint to enforce implementation oversight is the lack of both human and financial resources to respond to social risks and impact. The roles of facilitators are not well defined and no effective means for social work responsibilities, including socialization of the program and responding to queries and complaints.	• Review the budget requirements for M&E, including personnel, travels, socialization, capacity building, tracking grievances, and documentation; • Assign a team of social specialists within JSK to oversee risks and impacts and advise on responses and mitigation measures; • Strengthening the M&E function with GRS responsibilities that operates independently from implementing entities. Such a function needs also be reflected in local UPPKHs; • Establish protocols for regular monitoring and reporting and recording of complaints in the GRS MIS;

No.	Description of Risk	Mitigation Measures
		• Strengthen the capacity of facilitators and operators to be able to perform oversight functions and respond and/or elevate grievances on time; • Develop a program-level risk management, including red-flagging potential or existing conflict areas to identify additional support or to suspend the program.

H. Key Action Plan

35. There are several measures that should be considered to strengthen the program's risk management and to promote social inclusion as summarized:

(a) Develop and test out a standardized GRS system, including

(i) Putting dedicated staff and defining roles and responsibilities across levels (central versus subnational implementation) with regard to grievance handling;
(ii) Socializing and providing training on the new GRS, including allocating dedicated resources for communication and outreach; and
(iii) Incorporating the GRS indicators into the PMIS.

(b) Develop a communication strategy for the central and local government levels to ensure that the following aspects are in place: (i) dedicated staff/communication specialists, (ii) resource allocation, (iii) related training, outreach, and capacity-building activities.

(c) Assess and adapt PKH procedures, conditionalities, and verification protocols for areas with implementation challenges (that is, difficult access, supply-side constraints, and so on) to increase share of PKH beneficiaries in underserved areas.

(d) Develop measures to protect personal safety, including providing health insurance, increasing oversight, SOPs for facilitators, particularly for PKH operations in conflict areas.

(e) Incorporate materials on cross-cultural communication and awareness and risk management (including GRS, communication strategy) into training modules for PKH facilitators.

(f) Redefine and streamline the roles of facilitators and the performance management system with emphasis on social work and facilitation responsibilities.

(g) Assign a team of social specialists to monitor and oversee social risks and impacts.

Annex 7: Systematic Operations Risk Rating (SORT)

INDONESIA: Social Assistance Reform Program

Stage: Appraisal

Systematic Operations Risk-Rating Tool (SORT)	
Risk Category	**Rating (H, S, M, L)**
1. Political and Governance	M
2. Macroeconomic	S
3. Sector Strategies and Policies	M
4. Technical Design of Program	S
5. Institutional Capacity for Implementation and Sustainability	S
6. Fiduciary	S
7. Environment and Social	M
8. Stakeholders	M
9. Other	
Overall	**S**

Annex 8: Program Action Plan

	Action Description	Due Date	Responsible Party
Technical			
1	**MoSA strengthens capacity of PKH IT and data team to operate and upgrade PKH PMIS, including development of an Enhancement Action Plan to address various gaps and weaknesses of the current PMIS.** MoSA will assess the HR needs of both technical and system management expertise in reference to PKH operation and monitoring requirements of PKH implementation and accordingly strengthen PKH IT and data team through training and acquiring additional expertise to (a) improve database management to ensure database security and integrity; (b) develop and implement an Enhancement Action Plan to address urgent constraints immediately and plan additional enhancement efforts to upgrade the PMIS before the end of 2018; and (c) prepare the PMIS to be interoperable with other MoSA information systems.	January 2019	MoSA
2	**PKH Operations Manual is revised and approved for dissemination and operational reference.** MoSA will revise PKH operations manual appropriately and ensure that it is adequate, coherent, complete, and internally consistent in all respects. It should also reflect all the recent changes in program design/implementation.	July 2017	MoSA
3	**PKH assessment is strengthened through structured M&E activities.** MoSA will strengthen M&E of PKH through well-designed and adequately funded activities at periodic intervals, including spot checks, qualitative assessments, and regularly generated statistics from PKH PMIS related to key processes and performance indicators.	January 2019	MoSA
4	**MoSA reviews PKH implementation requirements for Papua and other areas with challenging conditions and issues a guideline to allow more flexible implementation modalities that take into account local costs of operation and resource constraints.** It is more challenging to implement PKH in remote areas for various reasons. To include the poor families in these areas, the program rules with regard to supply-side readiness, compliance verification, and HR management and capacity building would most likely need to be modified.	December 2017	MoSA
5	**MoSA reviews the JSK's organizational structure and updates description of units and positions with regard to their roles and responsibilities as well as job description and qualifications. Subsequently training and capacity-building activities need to be carried out to ensure performance and coordination.** MoSA will strengthen PKH HR through the following activities: (a) review the workload of field-level staff (facilitators, operators, and coordinators); (b) carry out a thorough assessment of PKH field staff's respective skills needs to inform the development of more comprehensive training curricula; and (c) clarify the roles and responsibilities of all civil servants and experts and provide corresponding trainings related to their assignments.	December 2017	MoSA
6	**Recertification strategy is suitably revised and approved for implementation.** At present, PKH families' socioeconomic status is reevaluated after five years of membership in the program. MoSA will assess current practice (against international best practice), and modify this strategy to recertify families earlier and more frequently.	December 2018	MoSA
7	**Disruptions in supply/availability of related education and health services are monitored, reported, and follow-up action/protocol developed for this purpose is approved.** PKH depends critically on the proper implementation of health and education	January 2020	MoSA

	Action Description	Due Date	Responsible Party
	services. Although the JSK's PMIS has the capability to track supply-side constraints, this data is not regularly and systematically reported. MoSA will initiate the practice of regularly tracking supply-side readiness and service availability as part of the routine program monitoring. MoSA will also approve protocols for follow-up, developed for when disruptions in supply are reported.		
8	**An EFC Framework is finalized and adopted.** MoSA will undertake an assessment of the controls for tackling EFC in PKH. The purpose is to assess existing EFC controls (against international best practice) and recommend ways to improve controls over time, to enhance safeguards against EFC, and strengthen capacity. MoSA will prepare an EFC framework based on findings from that assessment, focusing on preventing, detecting, and deterring EFC in PKH.	November 2018	MoSA
Fiduciary			
9	**MoSA will take actions to strengthen its fiduciary management related to PKH.** MoSA needs to take actions to address the issues raised in the BPK financial audit report issued in January 2016, including conducting internal audit of PKH by the IG and implementing a mechanism to compile payment realization reporting rigorously.	December 2018	MoSA
Environment and Social			
10	**MoSA will assign a team of social specialists to oversee social risks and impacts and develop capacity-building and risk management strategies.** MoSA needs to have a dedicated team to manage the enhanced GRS, develop a communication strategy to ensure sustained socialization, dissemination, and documentation of program information, supports modification of PKH implementation procedures in the priority areas, and contributes to the development and implementation of a program HR management strategy, risk management in conflict areas and performance monitoring system.	July 2018	MoSA

Annex 9: Implementation Support Plan

A. Strategy and Approach for Implementation Support

1. **The World Bank task team will provide the necessary support to facilitate achievement of the PDO during implementation of the Program**. Implementation support will place emphasis on (a) reviewing implementation progress (including that of the Program Action Plan) and achievement of Program results and DLIs; (b) providing support to resolve emerging Program implementation issues; (c) monitoring the adequacy and performance of systems and compliance with the Loan Agreement; and (d) supporting MoSA in key areas needed with TA.

B. Implementation Support Plan

2. **The Program is expected to become effective in FY18 and will have a four-year implementation period**. The midterm review is scheduled in June 2019 and will assess the overall progress in implementation of the Program.

3. **The World Bank team will conduct implementation support missions twice a year to ensure that appropriate technical support is provided for the achievement of Program results**. The task team will be led by the co-task team leaders and will consist of experts/specialists on relevant technical areas, fiduciary management, social and environmental aspects, and general operations management. The World Bank team will emphasize that MoSA prepares progress reports and work plans as a basis for Program implementation review. Technical missions will be organized between the regular implementation support missions, as needed. In addition to missions, document review, and routine communications, the task team will maintain timely communication with MoSA's Program management teams, as well as staff and consultants based in the country office.

Table 9.1. Task Team Skills Mix Requirements for Implementation Support

Skills Needed	Number of Staff Weeks		Comments
	First 12 Months	12–48 months (Yearly)	
Co-responsibility cash transfers	6	4	Social protection specialist
Payments	4	2	Local payment consultant
Management information system	2	2	IT consultant
Complementary services	4	2	International consultant
M&E	4	2	Social protection specialist and local consultants
Fiduciary management	2 each	2	Financial Management and procurement specialists in-country
EFC	4	2	International consultant
Social development (including GRS and gender)	2	2	Social development specialist in-country

4. **The World Bank will also provide a comprehensive TA package (World Bank-executed, P160590), including studies, consultants, expert advice, and training/capacity**

building in the following areas (aligned with the results areas and DLIs to achieve in this Program):

(a) Program Operations Manual update
(b) Conditionality and compliance monitoring mechanism review
(c) Architecture design of PMIS and IT management capacity development
(d) FDS content, training, and delivery modality review
(e) PKH GRS enhancement
(f) Communication strategy design and implementation
(g) New process and impact evaluation for expanded PKH program
(h) PKH HR management and skill development
(i) Partnership arrangements with local governments
(j) Recertification strategy and implementation

5. **A number of development partners currently support the Government program, in particular, DFAT, GIZ, UNICEF, and World Food Programme**. The World Bank's task team will work closely with all the partners to provide harmonized implementation support to the Program, including in the areas highlighted above.