

A. Objectives, Design, and Implementation of the Program

| Program Overview

The Family Hope Program (PKH) is a conditional cash transfer (CCT) initiative launched by the Indonesian government to address poverty and improve health and education outcomes for the country's most vulnerable populations. The program specifically targets the bottom 20% of households based on socioeconomic status, focusing on families with pregnant women, infants, children, and adolescents. By providing cash incentives tied to specific health and educational conditions, PKH aims to empower households to invest in long-term human capital development (Ministry of Social Affairs, Republic of Indonesia, 2017).

| Objectives

1. **Reduce Poverty**: provide financial support to the poorest households
2. **Reduce Preventable Disease**: encourage check-ups for mothers & children
3. **Increase School Attendance**: incentivize and mandate primary education
4. **Break the Cycle of Poverty**: promote human capital investment
5. **Improve Decision Making about health**: reduce out of pocket expenditures

| Target Population

The PKH program targets the **poorest 20% of households** in Indonesia. As of 2019, this translates to approximately **9.8 million families** or around **44 million individuals**, but with calculations across the paper, we The focus groups within these households include (World Bank (2012):

- **Pregnant and lactating women** who require prenatal and postnatal care.
- **Children aged 0-6 years** who need regular health check-ups and nutrition support.
- **Children aged 6-18 years** to ensure consistent school attendance and reduce dropout rates.

| Program Targeting

The first step in the PKH implementation is geographic targeting. The program initially selects regions based on poverty rates and supply-side readiness. In 2007, seven provinces were chosen for the pilot phase. Within these provinces, 49 districts/cities were identified as eligible, and further selection occurred at the subdistrict level. A marginality index and proxy-means test (PMT) are used to identify the poorest households from Statistics Indonesia. Data collection is conducted through surveys and “sweeping” interviews to ensure all eligible households are included (World Bank 2012).

| Program Administration

The PKH program operates through a **multi-tiered administrative structure** that ensures effective delivery and oversight:

- **National Level:** The Ministry of Social Affairs (Kemensos) leads the overall implementation and policy design. Other ministries involved include the National Development Planning Agency (Bappenas), Coordinating Ministry for Social Welfare (Kemenkokesra), Ministry of Health (Kemenkes), and the Ministry of National Education (Kemdiknas).
- **Provincial Level:** Each province has health leaders and supervisors who coordinate activities and monitor implementation at the district level.
- **City Level:** UPPKH officials oversee the execution of program activities, including training and beneficiary management. Healthcare facilitators play a crucial role in verifying compliance and collecting data.
- **District Level:** Health facilitators help supervise the community health-workers as well as facilitate communication between the UPPKH and village leaders/beneficiaries as primary points of contact
- **Community/Village Level:** Community Health Workers (CHWs) and local volunteers ensure beneficiaries meet program conditions through home visits, health checks, and education workshops.
- **Service Providers:** Healthcare workers (nurses, midwives, doctors) provide essential health services, while teachers ensure educational compliance.
- **Cash Delivery:** The national postal agency (PT Pos) distributes cash transfers to beneficiaries, typically on a quarterly basis. These are included within the community health-workers.

| Program Activities

The PKH program involves nine activities, each requiring meticulous planning and execution. These mirror the activities of a Honduras study, the only study that includes a bottom-up activities-based costing approach (Fiedler, 2003).

1. **Policy Design:** Development of guidelines and frameworks at the national level.
2. **Socialization and Communication:** The Ministry of Communication and Information (Kemenkominfo) informs communities and addresses concerns to prevent misinformation.
3. **Household Targeting and Baseline Study:** Conducted by Statistics Indonesia (BPS) to identify eligible households and establish baseline data.
4. **Training:** Health leaders, facilitators, and CHWs receive training on program implementation and compliance verification.
5. **Advanced Training:** Community-health workers are trained by facilitators and UPPKH officials on the procedures of weighing babies and administering needles.
6. **Monthly Community Meetings:** Meetings are held to engage beneficiaries, provide updates, and address concerns.
7. **Quarterly Community Meetings:** Facilitate the distribution of cash transfers and verify compliance with program conditions.
8. **Monthly Home Visits:** CHWs conduct monthly visits to monitor health and education compliance.
9. **Supervisor Visits:** Provincial supervisors perform oversight visits to ensure program quality and integrity.

B. Program Effectiveness

One major observed outcome is the increase in skilled childbirths. The PKH program resulted in a 23% increase in births attended by skilled health professionals (World Bank, 2020). This aligns closely with findings from similar programs like Nicaragua's RPS Program, which reported a 19% increase (Maluccio & Flores, 2005), and Honduras' PRAF Program, which recorded an 18% increase (Fiedler, 2003). These results highlight the effectiveness of conditional cash transfers in improving maternal health services.

In terms of immunization coverage, the PKH program shows an estimated increase of 27% in immunization rates, though exact data remain uncertain (World Bank 2020). Comparatively,

Nigeria's NI-ABAE program achieved a 27% increase in full immunization (Babatunde et.al 2017), and Mexico's CCT programs reported gains of 5-6% for tuberculosis (TB) and measles immunizations (Neufeld & Preedy, 2012).

The program also contributes to reducing maternal and child mortality. Although the PKH's impact is uncertain, data from Mexico indicate a 10% reduction in maternal mortality in rural areas and a 5-7% decrease in under-five mortality (Fernald et. al, 2009). Nicaragua's RPS Program documented a 12% reduction in under-five mortality, demonstrating the potential of CCT programs in enhancing child survival rates (Maluccio & Flores, 2005).

For child stunting, the PKH program reduced stunting by 9% (World Bank, 2020), with estimates ranging from 11% to 23% in comparable contexts such as Mexico (Neufeld & Preedy, 2012). The Philippines recorded a 10% reduction in stunting (World Bank 2011), indicating that CCT programs effectively address malnutrition and improve child growth outcomes.

Educational outcomes were also positively impacted. The PKH program led to a 4% increase in school enrollment and a 53% reduction in dropout rates for unenrolled children (World Bank, 2020). Similar improvements were observed in Brazil's Bolsa Familia Program (7-8.5% increase) and the Philippines (9% increase). These figures underscore the role of CCT programs in boosting educational participation (de Janvry et al. 2006).

Finally, the PKH program helped reduce out-of-pocket healthcare expenditures by 20% (World Bank, 2020), comparable to Mexico's Oportunidades Program (18% reduction) (Fernald et al., 2008). and Brazil's Bolsa Familia (12% reduction) (de Janvry et al., 2006). These reductions indicate improved financial protection for low-income families.

C. Program Costs

| Assumptions

We tackled costing the program by understanding the difference between fixed and variable costs, and reading through previous literature, specifically the CCT in Honduras (Fiedler, 2003), as a reference.

Assumptions

- I can apply the same line-item and ratios of personnel to calculate costs for each activity.
- Honduras' decentralized government and health system mirrors that of Indonesia's fragmented island system.
- Islands can be traveled through via vans, so vans were used as the only source of transportation
- Because cost of administration is heavily weighted in personnel, I assumed that community-health workers needed not be skilled physicians to cater towards areas that did not have/have access to hospitals.

| General Labor Cost Estimation (Salary)

Salaries from Glassdoor and World Salaries were averaged to achieve a weighted sum-average to calculate salaries for each cadre involved. I took two data points for each salary from World Salaries, “Salaries by Experience” and “Average Salary” for government officials to allow the former to standardize the later. Taking this standardized average, I also averaged it with the Glassdoor Salary for each cadre equivalent.

$$\text{Salary 1} = \frac{\text{World Salaries (By Experience)} + \text{World Salaries (Government Average)}}{2}$$

$$\text{Final Salary} = \frac{\text{Salary 1} + \text{Glassdoor Salary}}{2}$$

Monthly Benefits were calculated with the following scheme

- 20% of salary for remunerated senior cadre with a supervisory role
- 10% of salary for all other remunerated cadre
- \$50 per month for cadre with no salary (2022 US\$)

Table 1. Monthly Cadre Salary + Benefit

Cadre	Monthly Salary (USD)	Monthly Benefit (USD)
Central Coordinators	1101.494	2 2 0 . 2 9 8 7
Provincial Leaders	756.1137	1 5 1 . 2 2 2 7
UPPKH Coordinators	644.8197	2 2 0 . 2 9 8 7
Health Facilitators	525.2062	105.0412
Community Health Workers	N/A	50

| General Labor Cost Estimation (Quantity)

In 2008, the PKH program expanded to cover 620,848 beneficiary families across 13 provinces, 70 cities, and 654 districts, encompassing approximately 7,513 villages. Each village had an average of 83 families, calculated from the ratio of villages per district (11.488) and the total number of families (Syamsulhakim & Khadijah, 2021).

Based on a hierarchical structure inspired by Honduras’ organizational chart, the estimated cadres were:

- National Officials: 18
- Provincial Leaders: 35 (2.692 leaders per province)

- UPPKH Officials: 262 (3.737 per city)
- Health Facilitators: 2,735 (1 facilitator per 227 families)
- Community Health Workers (CHWs): 62,086 (8.26 CHWs per village, overseeing 10 families each)

In 2019, the PKH program expanded to serve 9,841,270 families being served by 363 health facilitators (Hamid et al., 2024). To determine a more accurate measure of health facilitators, I divided the number of families by health facilitators to calculate 2375 (this number ended up being similar to our scaled up number). To determine the appropriate scaling factor, the 2019 beneficiary count (9,841,270 families) was divided by the 2008 beneficiary count (620,848 families), resulting in a scaling factor of 15.85:

$$\text{Scaling Factor} = \frac{9,841,270 \text{ families}}{620,848 \text{ families}} = 15.85$$

Applying this scaling factor to the 2008 cadre estimates, the adjusted workforce estimates for 2019 are:

- National Officials: 159 (18×15.85)
- Provincial Leaders: 412 (35×15.85)
- UPPKH Officials: 2,378 (262×15.85)
- Health Facilitators: 23,775 ($2,735 \times 15.85$)
- Community Health Workers (CHWs): 984,064 ($62,086 \times 15.85$)

| Non-Labor Fixed and Variable Costs

Activity #1 Facilitator Training Prevention and Promotion Component Materials per Training Session	
1. Printing of Materials	
Guide for Training MOH Personnel	110
Enlarged Plastic laminates	330
Growth chart	
Base line study form	
Summary of monthly activities	
Bar Graphs of AIN-C Indicators (6 months)	
Sick child visit recording page	
Referral slip	
Picture of sick child care (n=4)	
Counselling card	
Action guide	
Weight gain table	
Kilograms to pound conversion table	
Sub-total:	440
2. Office Supplies	
Bond paper	70
Three colored markers (black, red, blue)	30
Three colored, fine-point markers	30
Flipchart paper	50
Cardboard for making posters	8
Masking Tape -- 2 rolls	20
Glue (one bottle)	15
36 inch large ruler (yardstick)	20
Correction fluid (1 bottle)	15
Sub-total:	258
3. Equipment	
1 Salter scale with baby-holder	340
Video of AIN-C	100
Sub-total:	440
Total:	1,138
Recurrent Supplies:	258
Equipment and Durable Supplies:	880

Activity #4 Facilitator Training Curative Care Component Materials per Training Session	
1. Printing of Materials	
Training Guide: Mangement of the Sick Child	80
Enlarged Plastic laminates	120
Sick child visit recording page	
General Danger Signs in a Sick Child	
Counselling cards (4)	
Action guide	
Sub-total:	200
2. Office Supplies	
Three colored markers (black, red, blue)	30
Three colored, fine-point markers	30
Poster/chart paper	20
Cardboard for making posters	4
Masking Tape -- 1 roll	10
Correction fluid (1 bottle)	15
Sub-total:	109
3. Equipment	
Timer	100
Cups	15
Spoons	10
1 liter pitcher	5
Video of AIN-C	100
Sub-total:	230
4. Medicines	
Trimetoprine Sulfametoxazol	4
Paracetamol	4
Ferrous Sulfate	2.6
Vitamin A	0.4
Oral Rehydration Salts	4
Mebendazol	3
Sub-total:	18
Total:	557
Recurrent Supplies:	127
Equipment and Durable Supplies:	430

Using the

above line-items costs, I generalized main fixed costs into the following:

- Office Spaces
- Vans
- Community Meeting Spaces
- Height Boards/Length Boards
- Temporary Shelters (for Disbursement)
- Printers/Photocopiers
- Laptops
- Projectors
- Whiteboards
- Salter Scales with Baby Holders

I generalized main fixed costs into the following:

- Utilities for Office Rentals
- Telecommunication Expenses
- Stationery & Office Consumables
- IT Maintenance
- Fuel & Maintenance

Leaving me with a total activity-based costing figure of the following

Table 2. Activity-Based Costing

Activities	Total Costs
Policy Design	12640.30533
Implementation Socialization	550520.1813
Household Targeting/Community-Baseline	63200.69333
Training of health leaders	309655.602
Advanced training for facilitators, nurses, and CHW's	6955947.413
Monthly community meetings	13137484.83
Quarterly community meetings (Cash transfer implementation)	867803824.8
Provincial Supervisor visits	36807.31689
Monthly CHW's Visits	585038334.3

Table 3. Segmented Costs (Total)

Capital	Overhead	Overhead	Consumables	Total	Cost/Person
30882202.28	15168.29028	1473893242	5.33	1504790618	152.906141

D. Societal Costs

This section outlines the approach used to estimate the indirect productivity losses due to morbidity and mortality for four key illnesses—pneumonia, diarrhea, malnutrition, and maternal complications—as well as the overall cost of illness. The calculations incorporate time spent in healthcare, productivity proxies, and Years of Life Lost (YLL) to quantify the societal cost of these conditions.

| Morbidity-Related Productivity Losses

1. Time Spent in Healthcare:

- For each illness (pneumonia, diarrhea, malnutrition, and maternal complications), average wait times for inpatient and outpatient care were estimated based on research data (see previous prompts and screenshots).

Illness	Inpatient (days)	Outpatient (days)
Pneumonia	3.7	0.9
Diarrhea	2.0	0.7
Malnutrition	3.5	1.0
Maternal Complications	5.0	1.0

2. GDP Per Capita (Proxy for Productivity):

- The GDP per capita value for Indonesia was used as a proxy to estimate the daily and hourly productivity losses (World Bank, 2023):
 - Annual GDP per capita: \$4,940.50
 - Daily GDP per capita: \$13.53 (assuming 365.25 working days)
 - Hourly GDP per capita: \$1.69 (assuming 8 working hours per day)
- Using the following two formulas:

$$\text{Indirect Cost (Daily)} = \text{Time Spent (days)} \times \text{Daily GDP/capita}$$

$$\text{Indirect Cost (hours)} = \text{Time Spent (hours)} \times \text{Hourly GDP/capita}$$

- We have the following loss estimates for each illness:

Illness	Indirect Costs
Pneumonia Inpatient	\$50.05
Pneumonia Outpatient	\$12.17
Diarrhea Inpatient	\$27.05
Diarrhea Outpatient	\$9.47
Malnutrition Inpatient	\$47.34
Malnutrition Outpatient	\$13.53
Maternal Complication Inpatient	\$67.63
Maternal Complication Outpatient	\$13.53
Total Cost/Day	\$240.77
Total Annual Cost	\$87,940.90

| Mortality-Related Productivity Losses

To estimate the productivity losses due to mortality, we considered Years of Life Lost (YLL) for individuals who died prematurely. For this intervention, we assumed the average age of death to be 30 years, with a life expectancy of 68 years (World Bank, 2023). Therefore, the YLL is:

$$YLL = 68 \text{ Years} - 30 \text{ Years} = 38 \text{ Years}$$

The GDP per capita of \$4,940.50 was used as a proxy for annual productivity. A discount rate of 3% was applied to account for the present value of future earnings over the 38-year period.

Using this approach, the average productivity loss due to mortality was calculated to be

\$116,064.51.

| Conversion to Beneficiary Families

Now that we have calculated productivity losses from mortality and morbidity, we have to calculate additional costs associated incurred by society, government, and each household.

Table 6: Summary of the observed outcomes.

Observed outcomes	Effectiveness (%)	Risk of disease or death (%)	Number of individuals (households)
Cases averted	25%	20%	15,000 (3750)
Deaths averted	10%	0.4%	360

18% was calculated as an average of all of the percentages I had in Assignment #1, but I will choose 25% from a Kenyan study (Baird et al, 2011). Risk of disease was based off annual incidence rates of diarrhea and malnutrition (Black et al., 2020). Mortality rates for pneumonia and malnutrition are approximately 0.2%, and 10% for childhood preventable diseases (Walker et al, 2013) but since I am also counting motherly complication (0.2% maternal mortality) and diarrhea (9%-10 children under five) are around the same (Liu et al., 2016). I will increase the risk of disease or death and multiply it by 2.

Observed outcomes	Direct medical cost per case (\$/IDR)	Direct non-medical cost per case (\$/IDR)	Productivity loss due to morbidity or mortality (\$/IDR)	Total cost per 100,000 individuals (\$/IDR)
Cases averted	1020	450	87,940.9	5,558,590
Deaths averted	1020	450	116,064.51	10,979,367

E. Consumer Demand

| Rollout Program

The PKH targets the poorest 20% of households in Indonesia, focusing on families with pregnant or lactating women, children aged 0-6 years, or children aged 6-18 years. As of 2019, this includes approximately 9.84 million households or 44.3 million individuals (World Bank, 2012). Given the clear benefits in health, education, and financial stability, demand for the PKH

program is expected to be high. However, several factors may reduce demand. Given that it is a policy that has been extensively studied, the total population, according to the 2024 population, of households that are eligible for PKH is around 13.5 million (World Bank, 2023). Looking at an 18-year rollout program, we have the following numbers and their associated cost.

	H	I	J	K	L
	Year	Target population size (A)	Total annual cost of the intervention (C)	Total annual benefit of the intervention (F)	Savings or costs (G – J + K)
1	2007	387,947	59319478.68	64158509.79	4839031.106
2	2008	620,848	35611993.15	38517068.28	2905075.136
3	2009	726,376	16135879.25	17452175.74	1316296.49
4	2010	774,293	7326803.558	7924493.071	597689.513
5	2011	1,052,201	42493839.83	45960306.79	3466466.957
6	2012	1,454,655	61537688.07	66557671.28	5019983.206
7	2013	2,326,533	133315500.4	144190812.7	10875312.25
8	2014	2,871,827	83378801.25	90180489.7	6801688.447
9	2015	3,511,088	97746932.6	105720712.2	7973779.573
10	2016	5,981,528	377745447	408560316	30814869.06
11	2017	6,228,810	37810936.36	40895391.94	3084455.583
12	2018	10,000,232	576673584.1	623716165.6	47042581.52
13	2019	9,841,270	-24306266	-26289067.9	-1982801.936
14	2020	10,000,000	24270791.76	26250699.86	1979908.099
15	2021	10,770,000	117737728.6	127342272.4	9604543.795
16	2022	11,600,000	126912097	137265046.8	10352949.81
17	2023	12,500,000	137615526.9	148841617.1	11226090.15
18	2024	13,530,000	157493325.2	170340961.7	12847636.51

| Risks to Demand

1. Geographical Limitations: Remote or rural areas may experience reduced access due to inadequate infrastructure and long travel distances to intervention sites.
2. Infrastructure Challenges: Limited availability of healthcare facilities and schools may prevent eligible families from fully participating.

3. **Cultural and Social Barriers:** Certain communities may have low trust in government programs, or traditional beliefs may discourage participation in maternal and child health services.
4. **Administrative Challenges:** Disputes between village leaders regarding program inclusion can lead to uneven distribution of benefits and potential exclusion of deserving households.

| User Fees

Introducing user fees for the PKH program seems to be a feasible option to fund the program! The estimated marginal cost per user is \$152.91. Assuming \$100 as the additional benefit, adding user fees of \$5 to \$20 may be feasible for urban and peri-urban populations, where willingness-to-pay is higher. However, for rural households, fees above \$40 may discourage participation and negate the program's intended impact. A system of fee waivers or subsidies for the most vulnerable households could be considered to balance affordability and program sustainability.

F. Comparison with Similar Programs

| SWOT Analysis

Below, I've conducted a SWOT analysis of the PKH system (and CCT's) as a whole as compared to other interventions for LMIC's.

Category	Details
Strengths	<ul style="list-style-type: none"> - Targets the poorest 20% of households, ensuring resources reach the most vulnerable. - Comprehensive design addressing both health and education. - Proven positive impact on child health, nutrition, and education outcomes. - Utilizes community health workers (CHWs) and health facilitators, reducing the need for highly specialized labor.
Weaknesses	<ul style="list-style-type: none"> - High administrative complexity due to multi-tiered government structure. - Dependence on accurate data collection and distribution. - Potential delays in benefit disbursement due to logistical challenges. - Significant cost and workforce requirements for scaling the program.
Opportunities	<ul style="list-style-type: none"> - Growing national focus on poverty alleviation and healthcare equity. - Potential to leverage digital technology for better monitoring and implementation.

	- Support from international organizations and NGOs for financial and technical assistance.
Threats	<ul style="list-style-type: none"> - Geographic and infrastructure barriers in remote areas. - Political and administrative inefficiencies that may disrupt implementation. - Social and cultural resistance in certain communities. - Economic downturns affecting government funding.

| Other CCT” s

The PKH program, while unique in its local context, shares key elements with other global CCT programs. Learning from the successes and challenges of Oportunidades and Bolsa Família can help enhance PKH’s effectiveness. While the original PKH employed nurses, physicians, and medical professionals, I modeled this approach more similarly to Brazil’s Bolsa Familia program that took advantage of community health workers and emphasized training of personnel while costing the program, similar to the Honduras CCT. Because all CCT’s, even in Nicaragua, the Philippines, and other CCT’s struggle with reaching the most rural populations, adopting digital monitoring tools and community engagement strategies used in these programs may address PKH’s weaknesses in administrative complexity and geographic barriers. By leveraging these insights, PKH can strengthen its implementation and ensure long-term sustainability.

G. Affordability & Sustainability of the Program

Over the course of 18 years, we expect that the average annual total cost of the program is 114,934,449, and the average benefit to be 124,310,313.50, with total savings of 9,375,864 with a ROI of 8.1%.

Total annual cost of the intervention over 18 years <i>(sum of all C)</i>	\$114,934,449.3
Total annual benefit of the intervention over 18 years <i>(sum of all F)</i>	124,310,313.5
Total costs incurred or saved over 18 years <i>(N – M)</i>	9,375,864.181
Return on investment estimate over 18 years <i>(N / M)</i>	1.081575752 (8.1%)

When compared to Indonesia’s 2023 health budget of \$11.1 billion USD, the annual PKH costs represent a small proportion (approximately 3.7%, around the same ballpark of World Bank’s analysis of 4.3%) (World Bank, 2012). This indicates that the program is affordable within the

existing national health budget. Moreover, the program offers significant potential for long-term savings through the prevention of health conditions like malnutrition, pneumonia, diarrhea, and maternal complications, as well as unquantified gains in skilled childbirths, education, and overall human capital investment.

However, after conducting a few sanity checks assuming a 25% and 10% margin of error for program costing and benefits estimation, respectively, we found out that the ROI for each adjustment to the benefits and costs were very volatile. For example, we found that an assumption of any 25% increase in costs will leave us with a negative ROI.

G. Relevance to the Local Context

As mentioned earlier, the Program Keluarga Harapan (PKH) intervention is designed to align with Indonesia's decentralized health system. Healthcare delivery in Indonesia is managed at multiple levels—national, provincial, district, and village—allowing flexibility in implementation to cater to regional needs. The Ministry of Health establishes national policies, while provincial and district health offices oversee local execution. This decentralized structure supports targeted interventions like PKH, enabling tailored approaches for different regions, especially rural and underserved areas.

Indonesia also has a national health insurance scheme known as Jaminan Kesehatan Nasional (JKN), managed by the Social Security Agency for Health (BPJS Kesehatan). JKN aims to provide universal healthcare coverage, making essential healthcare services more accessible to low-income families. The PKH complements this system by addressing barriers to healthcare utilization, such as transportation costs and lack of awareness.

The private sector plays a significant role in healthcare delivery, particularly in urban areas, but public health services remain the primary providers in rural and remote regions. PKH leverages existing public infrastructure, including community health centers (Puskesmas) and community health workers (CHWs), to ensure effective outreach and service delivery. As for the cash transfer specifically, Pt Pos, the Indonesian postal service, handles all cash transfers. In the future, rather than in-person check deliveries, there will be more technology around fintech that could improve the ease of cash transfers.

Social Impact

| Health Equity & Access

The PKH program is expected to have a significant positive impact on equity and equality in Indonesia. By targeting the poorest 20% of households, PKH reduces economic disparities and promotes social inclusion. The program directly supports vulnerable groups, including pregnant women, young children, and school-aged children, by improving access to healthcare and education. Additionally, the conditional cash transfers incentivize preventive healthcare and educational attendance, helping break the cycle of poverty and poor health outcomes.

The program also supports gender equality by empowering mothers as primary recipients of cash transfers, ensuring they have greater control over household spending on health and education. By fostering healthier and more educated communities, PKH contributes to long-term human capital development and social mobility, narrowing the gap between socioeconomic groups and promoting a more equitable society.

| Human Capital Development

One of PKH's key social impacts is its role in human capital development. By ensuring that children receive regular health check-ups, vaccinations, and attend school, PKH builds the foundation for a healthier, more educated workforce. This investment in early childhood health and education leads to long-term improvements in productivity and economic mobility. Healthy and well-educated children are more likely to break the cycle of poverty, contribute to the economy, and contribute to positive externalities in every aspect of life that is sure to trickle down into future generations.

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