

# The Benefits of Conditional Cash Transfers: Learning from the Recipients of PKH Aid in Alor, East Nusa Tenggara

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## Abstract

Conditional cash transfers in Indonesia is better known as the *Keluarga Harapan Program* (PKH). This program offers aid to poor members of society and is intended to break the poverty cycle through education and healthcare. This aid is granted continuously, with certain conditions that must be met by recipients. The question is to what extent usage patterns are linked to the program's conditioning and its social function for recipients, and how local contexts influence the program's institutional and functional conditioning. This conditioning and usage patterns cannot be separated from the social, ecological, and economic conditions of the local community. After making the desire changes to social welfare, this aid has other effects, particularly as related to social aspects. These involve the usage patterns and strategies of aid recipients in adapting the aid programs implemented by the government for community members who live in poverty. As such, this article is hoped to provide a better understanding and ease interpretation of the topic. Data for this research was collected from four villages in East Nusa Tenggara using qualitative methods (observation, interviews, FGDs) and an MSC approach.

## Keywords

aid, conditional cash transfers, PKH, education, healthcare.

## INTRODUCTION

Conditional cash transfers (CCTs) are programs that provide financial aid to poor populations, provided that certain criteria are met. This often involves recipients' education and healthcare (Fiszbein & Schady, 2009), positively associated with current modern contraceptive use among adolescent and young adult women (Darney, B, 2013:212). CCT programs have been implemented in thirty countries in Africa, Asia, the Middle East, southern Europe, as well as

Latin America and the Caribbean (Waters, 2010) as alternatives to previous social aid programs which tended to be more charity-oriented, including (in Indonesia) the Rice for the Poor, gas subsidy, and unconditional cash transfer programs (Kwon & Kim, 2015). CCTs became the centrepiece of regimes of social protection in Latin America, which

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cast aside notions of social rights and labour protection and embraced instead a focus on poverty and 'the poor' (Llobet, V., & Milanich, N. (2018: 172). the CCT arm had a significant edge in terms of schooling outcomes (Baird, S. 2011:1713; Das, J., Do, Q., & Özler, B. (2005: 58). The use of conditional cash transfer programs as a means of combating poverty has increased dramatically in the past decade. (P. McQueston, K., Silverman, R., & Glassman, A, 2013; Narayan, S, 2011).

In Indonesia, the CCT program is one of six social welfare and aid programs offered to the poor, with the oldest and most dominant of these being the Rice for the Poor program. Several studies have indicated that this program has endured owing to its political and social benefits for the government in power (Widjaja, 2012). Meanwhile, the conditional cash transfer program, known as the Keluarga Harapan program (PKH), has been very popular owing to its real impact and broader social acceptance as compared to other aid programs. This program has been a positive credit to the government that implemented it (Widjaja, 2012). In principle, the conditional cash transfer program works toward reducing and ultimately eliminating poverty by improving human resources and access to healthcare (Bastagli, 2011; Cookson, 2008), particularly among poor children and teenagers, and thus increasing families' potential income (Soares, 2011). The main innovation of this program is its use of cash transfers for family investment and human capital development (particularly through schooling) (Behrman, Parker, & Todd, 2011; Benjamin Olken et al., 2014). Although previous studies have indicated that this program is capable of promoting social mobility among the poor (Forde & Zeuner, 2009), these cash transfers cannot be used for many goals, and their success depends greatly on their context (Narayanan, 2011). In some cases, this program has not had a positive influence on education, healthcare, nutrition, or consumption patterns (Binswanger-Mkhize, 2013; Dearden, Emmerson, Frayne, & Meghir, 2009).

The Keluarga Harapan program (PKH) has given individuals the incentive to change

their behavior, particularly by delaying the disbursement of financial aid in case they fail to meet the criteria. Some studies have shown that the program has had positive effects, including increasing families' income, even when the program's educational goals are not met. This emphasizes the fact that conditional cash transfers are more effective than unconditional cash transfers are in improving households' quality of life, particularly in terms of desired behavioral changes (Baird, McIntosh, & Özler, 2011). Conditional cash transfers are better in several aspects than unconditional cash transfers are. Narayan (2011) has shown that unconditional cash transfer programs are vulnerable to corruption, elite capture, and nepotism. The opposite holds true for conditional cash transfer programs. The long-term effects of the conditional cash transfer programs have been quite positive. In the United Kingdom, for instance, participation rates increased by 4.5% and 6.7% for the first two years of education (Dearden et al., 2009). In Mexico, after eighteen months of conditional cash transfers, school participation rates increased by 20% for female students and 10% for male students; illness rates for children under the age of six decreased by 12%; pregnant women's access to healthcare facilities increased by 8%; the average length of newborn babies increased by 1 cm (Kaiser, 2008); and adults shifted their livelihoods from agricultural to non-agricultural sectors (Behrman et al., 2011). Conditional cash transfers have also led to decreased child labor rates without affecting the number of adults in the workforce; this reduction in child labor rates has only had a limited effect on household income and consumption patterns. On the other hand, conditional cash transfers have increased investment, thus further affecting poverty rates (Fiszbein & Schady, 2009).

There is, however, a paradox in the poverty alleviation efforts in Indonesia. On the one hand, various poverty alleviation programs have been implemented by involved stakeholders, yet on the other hand the poverty rate has not yet seen any significant decrease. Data from Statistics Indonesia in-

dicates that 28.51 million Indonesians lived below the poverty line in September 2015, an increase of 780 thousand compared to the previous year (27.73 million). This increase is exacerbated by the fact that the poor are vulnerable to the increased price of consumer goods. In March 2016, 28.01 million people (10.86 percent of Indonesia's population) lived below the poverty line. The poor population is unevenly distributed among Indonesia's provinces, and disparity in citizen's welfare is widespread.

Recognizing Indonesia's poverty problem and poverty alleviation programs, it is necessary to understand them—particularly the PKH program—on a more micro level. This paper uses a community perspective to understand the PKH program. Two research problems will be answered here: how communities understand the meaning of the PKH program and their practices at the local level. Have these programs been capable of contributing to an increased quality of life and, ultimately, poverty eradication, or the opposite? The fundamental assumption is that the conditional cash transfer program's success depends on a comprehensive understanding of communities' perspectives about said programs and how they receive financial aid.

Theoretical perspectives on conditional cash transfer programs are diverse, drawing their roots from John Lock's views of justice and redistribution or from Robert Nozick's views of freedom (Abelsohn, 2011). These two views of the role of the State in social welfare are mutually opposed. John Lock tends to emphasize the role of the State as the creator of fair distribution, while Nozick emphasizes the importance of individual freedom in realizing welfare, considering the State to have the potential to act against individual rights and freedoms. Unlike these two experts, Arthur Ripstein emphasizes redistribution through precondition, a third view based on a political assumption. As explained by Ripstein, "The level of redistribution should be enough to allow the individual to fulfill his most necessary natural needs: a level of social provision which enables them to have the opportunity

to engage equally in a united will". In this context, all citizens are viewed as having the right to manage their own resources (Abelsohn, 2011).

In the context of discussions of preconditions, Ripstein develops Emanuel Kant's views of the redistribution of taxes as the individual rights of citizens. For Kant, the State is responsible for supporting the poor. This is the basis for promoting education and healthcare through conditional cash transfers, as it is assumed that education can allow individuals to affirm their own rights within the State. Education will allow them to protect themselves from poverty and dependence on the State, and consequently funding public education is important to ensure that individual rights are protected. The State has its own interest in educating its population and in promoting the public good. As such, it is appropriate for the State to require children to go to school and for citizens to pay for their rights through taxation. It is here that the views of Ripstein and Kant met, and this will be applied for analyzing conditional cash transfers.

The importance of conditional cash transfers can also be seen through communities' perspectives and understandings of the programs as well as theories of change. Change is often understood holistically, through macro-micro level and contextual factor analyses. Macro-micro level theories explain change in terms of human resource investment, asset productivity, and risk reduction. Others explain social change as a process of social transformations through relations between citizens and the State. One theory on change was put forth by Bastagli (2010), who makes the important point that, owing to the conditions in conditional cash transfers, there are two important social categories: poor residents who should receive aid and non-poor residents who should not receive aid. As such, people will change their behavior to access to the program, hoping to improve the quality of life (Bastagli, 2010).

The patterns through which PKH aid recipients utilize their aid must be under-

stood on the premise that socio-cultural conditions are responsible for the issues faced by humans, and that each culture has its own best practices for handling/responding to external factors. Adaptation is a dynamic process, as neither organisms nor environments are constant or fixed (Hardesty, 1977). Adaptation can be seen as an effort to ensure one's continued survival in the face of change. Humans are born with the capacity to learn unlimited social structures and cultural guidelines. Each community has its own potential for continued survival, which differs based on its risks, conscious responses, and opportunities (Ellen, 1989). Adaptive dynamics refer to individual, community, and national behaviors that are planned to meet certain goals, fulfill certain necessities, satisfy certain desires, or have certain consequences. Here, the patterns in which PKH aid recipients use their financial aid depicts how the people of Alor respond to this government program.

## RESEARCH AND METHOD CONTEXT

### Context

This paper examines the conditional cash transfer program in East Nusa Tenggara Province, Indonesia. There are several important reasons for this. In the macro-context, this program is one of the government's most promoted programs, as well as one of the most comprehensive intended to alleviate poverty. However, an understanding of the conditions at the micro-level is paramount, given the diverse socio-cultural aspects that can influence program management. East Nusa Tenggara must become an entry point for discussing poverty alleviation programs at the micro level, given that it has one of the highest poverty rates in Indonesia, ranked fourth nationally after Papua, West Papua, and Maluku. The poverty rate in Kupang Regency, East Nusa Tenggara, in 2009 reached 65 percent, with 374,632 persons living below the poverty line. At the provincial level, the poverty rate reached 20.21 percent in September 2012,

with 1,029,000 persons living under the poverty line. In absolute terms, this was an increase from 986,500 the previous year, but a decrease from the previous year's poverty rate of 21.48 percent (*Kompas*, September 2011). In 2013, the poverty rate was 20.24 percent, a decrease of 0.17 percent. East Nusa Tenggara and West Nusa Tenggara are classified into region with the highest poverty index. i.e in 2005, there is 67% to 45% rates of malnutrition (Rodliyah, 2017:102). In terms of location, between September 2012 and September 2013, the percentage of the poor population living in urban areas decreased by 2.11 percent, while it increased by 0.28 percent in rural areas.

As stated in the Alor Regency profile, food security is lacking, as farmers' activities depend greatly on the extreme climate (Alor, 2014). Local residents have adapted to this condition through dry field agriculture. According to Statistics Indonesia, of Alor Regency's 43,038 residents, 78.40% earn their income as farmers. The PKH aid recipients in the regency also earn their income through agricultural activities. Their food needs for the course of the year are met by one-hectare plots of land owned (despite not having any legal documents) and cultivated by families from generation to generation. It is not uncommon for the specters of pests, weeds, and extreme weather to haunt them from year to year. The failure (or success) of their harvest depends on the year, not as recorded on government calendars but as calculated by reading the stars and other signs. As odd-numbered years are believed to be more vulnerable to pests and failed harvests, farmers plant fewer crops on less land. Their harvests in odd-numbered years are thus unable to fulfill their needs throughout the year. As such, they cannot waste their harvests during even-numbered years, instead saving any leftover crops. To fulfill their families' need for food, they depend on the harvests from their lands, and they thus rarely sell their crops. To earn money for purchasing other goods and necessities, they plant candlenuts, turmeric and tamarind.

## RESEARCH METHOD AND DATA

This article will describe the background behind the PKH program in Alor, East Nusa Tenggara, as well as the strategies used by recipients. This article is based on qualitative data collected through the Survey of Healthcare and Education Services (2013). This qualitative data was collected through structured in-depth interviews with PKH aid recipients. Twelve households receiving PKH aid were taken as informants. These households were spread over four villages and two districts in Alor Regency: Belemana Village and Maukuru Village in East Alor District, as well as Morba Village and Pintu Mas Village in Southwest Alor District. These four villages were selected based on the distance and road conditions faced by communities in accessing healthcare and education facilities. Belemana and Morba villages are close to healthcare and education facilities, with each village having an elementary school and being located within one or two kilometers of a junior or senior high school. The roads to these facilities are already paved smoothly, and thus easily travelled by affordable public transportation. Maukuru and Pintu Villages, meanwhile, also have elementary schools, but are located between five and six kilometers from the nearest junior or senior high school and clinic. This distance must be traversed on foot or using expensive motorcycle taxis. Owing to the poor condition of the roads in these villages, *otto* (trucks used for transporting people and goods) do not operate therein. Households were selected based on which component of the PKH program they receive: six receive education aid and six receive healthcare aid. Some of these households had been receiving aid since 2007, while the remainder had begun receiving aid between 2008 and 2010 (2007= 6 households, 2008= 4 households, 2009= 1 household, and 2010= 1 household). The stories collected were then discussed, with the most representative stories being used to understand the changes that informants had perceived. Interviews were also done with PKH counselors; health-

care and education facility staff; influential government, religious, and customary leaders; and other relevant informants. Furthermore, most significant change (Davies & Dart, 2005) were collected from informants to understand the benefits they felt from the program. After these stories were collected, they were discussed to select the stories most representative of respondents' experiences. Qualitative and quantitative methods were used in this research, as done previously by Waters (2010) in Panama; research activities involved focus group discussions, key informant interviews, and participatory observation.

### Design of the PKH Program

The issue of poverty is central to the Millennium Development Goals or MDG's (UNDP, 2014). Governments have sought various solutions for reducing poverty rates and otherwise overcoming this issue. One such solution has been conditional cash transfer programs. Although this model has been criticized, as noted by Myrdal (in Gilbert & Terrel, 1998)—it is difficult to control the use of cash transfers and to ensure aid is used as intended—it has successfully been applied in such countries as Mexico, Bangladesh, and Brazil. Studies have shown that such programs have increased education among poor households (Schultz, 2004) a significant impact on educational achievements among non-poor households (Bobonis & Finan, 2005), increased the benefits and efficiency of self-investments (P. Gertler, Sebastian, & Rubio, 2005), and improved mother and infant health (Paul Gertler, 2004).

In 2007, the Indonesian Government introduced the *Keluarga Harapan* program (PKH), the first conditional cash transfer program in Indonesia. This program is targeted at the poorest households in Indonesia and intended to improve human resource quality through education and healthcare. PKH has reduced the obstacles faced by Indonesia's poorest households by assisting them in their education and healthcare investments (Nazara & Rahayu, 2011).

In their studies Binswanger-Mkhize (2013), Fiszbein & Schady (2009), and (La-

garde, Haines, & Palmer (2009) have conducted international comparative studies of the benefits and services of conditional cash transfer programs. These studies indicate a rapid increase in access to mother and child healthcare services. The program's positive influence has also been seen in Indonesia. According to a report from the National Development Agency (BAPPENAS, 2009) the PKH has led to increases in several healthcare indicators: visits to integrated family planning clinics have increased by 3%; child monitoring has increased by 5%; and immunization rates have increased by 0.3%. Education indicators have also seen an increase; class attendance has increased by 0.2%. The PKH program has also successfully increased monthly household expenditures per capita for healthcare and education. Furthermore, research by the World Bank (2010) indicates increased access to healthcare facilities in locations where PKH has been implemented; women's pre- and post-natal visits to healthcare facilities are 7 to 9 percent higher in such areas compared to elsewhere. The number of children weighed at healthcare facilities in areas where PKH has been implemented is 15 to 22 percent higher than in areas where it has not. Doctor- or midwife-assisted birth rates at healthcare facilities are 5 to 6 percent higher in areas where PKH has been implemented. Research by the World Bank has also shown that the effects of the PKH program have been more prominent in urban areas than in rural areas. Nevertheless, in terms of education, analysis indicates that there is no significant differences at all levels of the nine-year compulsory education program between areas where PKH has been implemented and areas where it has not.

A quantitative study on PKH in 2013 indicates that the implementation of PKH has had a positive effect, especially in improving the academic performance of students from poor households, as measured by their enrolment (participation) rate, attendance, and subject grades attained. Despite the above positive impacts, PKH has not helped alleviate some key problems that parents perceive as equally important in

improving the quality of education service: high rates of teacher absenteeism and poor quality school facilities. These two factors are perceived as undermining the quality of students' academic performance. The public perceives these factors as causes for concern, and as such urgent resolution is required if the government is serious in its efforts to enhance students' academic performance (Hadna & Kartika, 2017).

A study of PKH aid use in Binjai, North Sumatra, indicates that the program has significantly increased the welfare of recipients and been maximally utilized for education and healthcare, despite frequently being mistargeted (Sarif, 2016). This study does not provide in-depth or detailed examination of usage strategies, stopping simply at the targeting. Another study was conducted in Madusari, a village in Kubu Raya Regency, West Kalimantan, and showed that most (60% of respondents) used PKH aid to fulfill their everyday needs, 15% of respondents used PKH aid for education; 13% for business capital, and 10% to provide healthcare to children and infants (Punali, Nuraini Asriati, 2014). Unfortunately, this study also stops at identifying usage patterns, without exploring their background.

According to research into the PKH and PNPM Generasi (National Social Empowerment Program for Future Generations) conducted by SMERU (2008), residents of East Nusa Tenggara are limited in their access to healthcare and education owing to inappropriate facilities, distance, and societal knowledge regarding these issues. Alor, one regency of East Nusa Tenggara, was one of forty-eight pilot regions for the PKH program. This regency was selected owing to its high poverty rate, poor nutrition, poor crossover from elementary school to junior high school, poor availability of healthcare and education facilities, and the provincial/regency governments' commitment (SMERU, TNP2K, 2013).

According to data from Statistics Indonesia, 28,924 of the 40,177 households in Alor Regency lived beneath the poverty line in 2009, spread over 17 districts. Southwest Alor, Teluk Mutiara, East Pantar, Northe-

ast Alor, South Alor, and East Alor had the highest poverty rates. Education rates in the regency are relatively good, with data from the National Development Agency indicating a literacy rate of 93.41 percent among residents aged 15 years and older. School participation rates for children aged 7–12 are 92.71 percent, decreasing to 79.17 percent for children aged 13–15; it may thus be concluded that 7 to 8 children of every hundred do not complete elementary school, and that 21 of every hundred children do not complete junior high school.

Regarding maternal and child health, Alor Regency is one of the greatest contributors to the maternal and infant death rates in East Nusa Tenggara (Statistics Indonesia/BPS, 2010). Most maternal and infant deaths are caused by bleeding/infection during birth. Almost half of live births are assisted by shamans (53.22%) or family members (0.87%); the remainder are assisted by healthcare professionals (National Institute of Health Research and Development, 2013). The high maternal and infant death rates are exacerbated by the lack of healthcare professionals at the local levels; many villages are isolated because of their geographic conditions and limited access to transportation. This high maternal and child death rate led the government to implement what it terms the “KIA Revolution”<sup>1</sup> in Alor and other regencies in East Nusa Tenggara, a program that has been (somewhat) successful. The KIA Revolution in Alor has successfully placed healthcare professionals at points easily accessed by isolated villages. However, not all health workers are willing to live in these isolated areas, instead spending much of their time in the regency capital. The pro-

<sup>1</sup> The KIA (Kematian Ibu dan Anak; Maternal and Child Deaths) Revolution is touted as the most important program for reducing maternal and infant death rates in East Nusa Tenggara. The KIA Revolution program was formulated by the East Nusa Tenggara government working with the Australia–Indonesia Partnership for Maternal and Neonatal Health in 2004. It was intended to expedite the reduction of maternal and infant death rates in healthcare facilities, as previously done in Srilanka, Malaysia, and Singapore.

gram has established shelters for the families of pregnant women who are giving birth in clinics, a move intended to promote women giving birth in clinics instead of at home.

### The Keluarga Harapan Program (PKH)

The Keluarga Harapan program (PKH) is known internationally as a conditional cash transfer (CCT) program. It is targeted at families living in extreme poverty (Rumah Tangga Sangat Miskin; RTSM) (Statistics Indonesia/BPS, 2015) and provides financial aid to families that meet specific criteria and obligations. Obligations for recipients include presence at education facilities (for school-age children) or healthcare facilities (for infants and pregnant mothers). The fulfillment of these obligations is verified by special officials tasked with ensuring that all recipients comply with the requirements. Households that do not meet the attendance criteria will receive less financial aid. Generally, this program is intended to expedite the achievement of Indonesia’s Millennium Development Goal targets. Specifically this program is intended to increase recipients’ access to education and healthcare. It is hoped that, through this program, recipients’ level of education and healthcare can be improved.

The PKH program is targeted at families with pregnant or nursing mothers. During pregnancy, with the criteria that expectant mothers most undergo a minimum of four prenatal care sessions (once during the first trimester, once during the second trimester, and twice during the third trimester) and receive iron supplements; during birth, mothers must receive assistance from healthcare professionals; nursing mothers must undergo healthcare checks and receive family planning services at least three times, in the first, fourth, and sixth weeks after birth; newborn babies must receive early nursing, health checks, warming blankets, Vitamin K, hepatitis vaccinations, and eye ointment; neonatal children must receive a minimum of three health checks, first in the 6–48 hours of life, second between the ages of 3–7 days; third between the ages

of 8–28 days; children between the ages of 0–6 months must be exclusively breastfed; children between the ages of 0–11 months must be fully immunized (BCG, DPT, Polio, Measles, Hepatitis B) and weighed monthly; children between the ages of 6–11 months must receive a minimum of two Vitamin A supplements in a year, in February and August; children between the ages of 12–59 months must receive additional immunizations and be weighed monthly; children between the ages of 5–6 years must be weighed monthly to check their development and/or participate in Early Childhood Education if available; and children with disabilities must receive healthcare checks with specialists or psychologists, as required.

Meanwhile, in terms of education the program is targeted at families with children between the ages of five and seven who have not yet begun elementary school. PKH recipient households with children between the ages of 7 and 15 years are required to register their children at elementary or junior high school institutions, and children must have a minimum of 85% attendance rate over the course of the school year. Children between the ages of five and six years who have entered elementary school must meet specific criteria. Special needs children who are still capable of attending regular class may join elementary/junior high school programs, while those who are not capable of doing so may enter special schools. Families with children between the ages of 15–18 who have yet to finish elementary school are required to register their children for schooling or for school equivalency tests. Working children of PKH recipient households, or those who have left their schooling for some time, must join a remedial program to assist their reintegration into school. Such programs are offered in shelters run by the Ministry of Social Affairs (for street children) and the Ministry of Labor and Transmigration (for child workers).

The amount of aid received by households varies, depending on the components for which they require aid. “Fixed Aid” amounting to Rp 200,000/household was given during the second phase of the pro-

gram, between 2007 and 2012. In 2013, this amount increased by Rp 100,000, reaching Rp 300,000. The amount of aid received by households depends on the type of aid, the components involved, and the household’s ability to meet certain criteria. Households will receive an additional Rp 1,000,000 in a toddler/pregnant woman/nursing woman in the family; an additional Rp 500,000 if there are any elementary school-age children; and Rp 1,000,000 if there are any junior high school-age children.

Data is verified on a monthly basis, showing participants’ activeness in accessing education and healthcare facilities. The PKH counselor determines whether households will receive any aid. Recipients must reach a minimum attendance/participation rate at the appropriate facilities. For instance, PKH recipients receiving education aid must register their children and ensure that their children participate actively at school (85% attendance in a month) and send their children to an appropriate level of schooling. Verification reports and aid calculations are conducted at the Keluarga Harapan Implementation Unit (Unit Pelaksana Program Keluarga Harapan, UPPKH), while distribution is handled by the post office. Aid is distributed on a quarterly basis (i.e. every three months). However, lateness in aid distribution is not uncommon, and is often attributed to issues with the verification and distribution system. For example, several news outlets reported in 2010 that delays in the second-stage PKH distribution in three districts in East Nusa Tenggara, including in Alor, had been caused by issues at the UPPKH and post office level.

In 2006, Alor and 47 other regencies became test sites for the PKH program. Alor was selected was selected owing to its high poverty rate, poor nutrition, poor crossover from elementary school to junior high school, poor availability of healthcare and education facilities, and the provincial/regency governments’ commitment. To ease the implementation of the program, each district had its own team tasked with socializing the program and with verifying the fulfillment of the various healthcare/educa-



tion criteria. Given the size of districts and difficulty traversing them, different sub-teams were established. In fulfilling their duties, counselors worked with village institutions to introduce and socialize the program. PKH groups, each consisting of three people, were established at the village level to support counselors in their duties. These groups mobilize their members during community activities to ensure their continued practice; if meetings are discontinued, these groups serve as extensions of the counselors. It is not uncommon for these groups to fulfill other duties, such as collecting data at the household level and verifying households' meet their obligations.

Counselors are also expected to work with local healthcare and education facilities to record the attendance rates of and services received by recipients at schools, clinics, and integrated family planning clinics. Counselors commonly feel that they are hindered in accessing data, unless they offer bribes. As such, counselors often request that PKH recipients assist them in collecting data from local healthcare and education facilities. Their own personal proximity and status as recipients is considered to ease their access to the necessary data, which is then collated at the regency-level UPPKH and then forwarded to the Ministry of Social Affairs so that aid can be distributed.

The distribution of PKH assistance is conducted by the post office, under the supervision of the Department of Social Affairs and related government offices. In the first year of the program, aid was distributed at the capital of each district. However, as not all participants were capable of easily reaching the capitals, distribution of aid was then conducted by the different sub-groups in each district. The news that aid will be distributed is broadcast by the counselors, through the village administration, no less than a week before distribution takes place. In 2013, various departments began distributing aid through post office accounts opened in the name of each family member that is receiving aid. This new system was hoped to ease the distribution of funds to recipients.

On the day of aid distribution, recipients travel to the offices of the district or village chief to collect aid. In order to collect aid, recipients must present their PKH participant card, which is given the adult woman in to each household; in cases where there is no adult woman in a household, then an adult male may take her place. According to the National Team for the Acceleration of Poverty Reduction (TNP2K), giving funds to the adult women in households is more effective in promoting family education and healthcare (TNP2K, 2013). Officially, the collection of financial aid may not be delegated, except through a legal document. However, in practice anyone carrying the PKH participant card may receive the money, even without the necessary legal documents. For example, *Mama Wallu* in East Alor asked her daughter, Samalina, who was still in the second year of junior high school, to represent her in collecting financial assistance. As Wallu was illiterate and spent most of her time working the fields in the 'old village', she did not have the opportunity to collect the aid. Such situations are common, and thus the persons in charge of aid distribution are lenient.

## Social Benefits of PKH in Alor

### a. *Patterns of Aid Use*

Todaro (2006) writes that efforts to increase the income of poor families will lead to increased demand for domestically produced goods, including foodstuffs and clothing. Such increased quality and quantity of consumption has also been experienced by PKH recipients. Generally, most recipients use their aid to fulfill their everyday needs, including foodstuffs. Interviews indicate that more than half of the PKH aid is used to purchase household necessities, including staple foods, shelter, and betel. Most of the aid is used by recipients to purchase foodstuffs when their crops are insufficient to fulfill their annual needs. Harvests are used not only to fulfill families' nutritional needs, but also to promote social, cultural, and religious activities at the family, clan, church, or village level. Shortcomings in

food production owing to failed harvests are covered by plants—corn, rice, and beans—purchased with the proceeds from selling candlenuts, turmeric and tamarind. Money that should be invested or used to purchase items that families cannot produce themselves is thus spent purchasing foods that residents could grow in their fields. Financial aid received through the PKH program thus provides an alternative method for fulfilling shortcomings in harvests and purchase household necessities.

More specifically, households receiving healthcare support through the PKH program consider the decision to use the financial aid received to purchase foodstuffs as being supported by PKH counselors, healthcare professionals, and the general populace. Although recipients and the general populace do not receive instructions specifying such a use of money, they view it as the most proper and appropriate use of financial aid. Healthcare is ensured, they argue, by improving their family's nutritional situation, particularly for pregnant women, nursing women, infants, and schoolage children.

Most recipients stated that they spent their healthcare aid preparing for childbirth and holding birth rituals. Although women are not charged money for giving birth at healthcare facilities, not all of them are comfortable doing so. Not all PKH participants are willing and capable of travelling to the clinic, instead preferring to pay a shaman for assistance in childbirth. As such, they use the financial assistance provided by PKH to cover the cost of the shaman. For example, *Mama Naomi* of East Alor, decided to give birth at home despite a clinic being located less than two kilometers from her house. All of her children were born with the assistance of a shaman, and she experienced no difficulties in childbirth. She considered shamans to be more practical, as the shaman could be invited to her home, could come at any time, and provided post-natal care for both mother and child. Furthermore, she would not have to undergo overnight treatment at the clinic and thus spend the night away from home. Despite education

programs for local women from the clinic, integrated family planning clinic, and village government, she had greater trust in and felt greater comfort with shamans. Another consideration in choosing a shaman is the fact that healthcare facilities are not always staffed, and that they are located quite a distance from her home.

Even when childbirth occurs at the clinic, families prefer to have a shaman provide post-natal treatment to the mother and child. This treatment is intended to assist mothers and children in everyday activities (bathing, massaging), given their weak condition. Such assistance cannot be provided by clinic staff. The post-natal assistance provided by the shaman is part and package with the childbirth assistance; as such, the cost of this assistance the same even when mothers do not receive childbirth assistance. The amount of money given to the shaman may vary, depending on the family's economic condition and generosity. Generally, however, the average cost of childbirth and post-natal treatment is Rp 50,000 or one liter of rice, several kilograms of sugar, and some packages of coffee.

Childbirth is considered an important part of life by the people of Alor, and as such it is celebrated by communities through traditional ceremonies. Although these celebrations are not as elaborate as those for marriages or university graduations, during childbirth ceremonies the family provides food and drinks to guests (kin, neighbors) who are visiting the mother and child. The elaborateness of the celebration depends on the socio-economic condition of the family. Influential families will provide, at minimum, rice and pork. Families with a lower socio-economic status may only provide guests with *ketema boshe* (a dish made of corn and beans) with chicken or fish. At the very least, families must remove corn or rice from storage and prepare no less than Rp 300,000 to purchase betel, sugar, coffee, etc. It is not uncommon for guests to bring materials such as firewood or foodstuffs to support the celebration. *Mama Selvince* of Southwest Alor mentioned that, for the celebration of her youngest child's birth, she

had to save her PKH financial assistance to purchase pork and other items. Her family is part of a prominent clan in Pintu Mas, specifically in Lakafeng Hamlet, and as such she was expected to provide guests with better food than expected from less respected families.

It may be stated that families receive an amount of PKH aid that is large relative to their weekly expenditures. It is not uncommon for recipients to receive financial aid in a lump sum owing to distribution difficulties at the provincial or regency level. After aid is allocated for household needs, childbirth preparation, and social activities, part of the remainder is saved in a savings account, either through the nearest financial institution (generally a cooperative) or group savings account.<sup>2</sup> The adults who hold these accounts intend use their savings for emergencies, such as illnesses and accidents, as well as child education and rituals/celebrations. For example, *Mama Marice* of East Alor saves some of the money she receives through the PKH program in a credit cooperative account. This savings account is intended to ensure that she can cover her child's education or any emergency situations.

People living in isolated areas must allocate funds to cover their transportation to and from clinics and healthcare facilities, something that is not prevalent among women who live near midwives or clinics. Before they received financial assistance through the PKH program, these women would not force themselves to travel to a healthcare facility for prenatal care. After receiving financial assistance, recipients were obliged to travel to healthcare facilities for prenatal

care. As they must allocate much time and money for each trip, recipients only travel to healthcare facilities once or twice and are thus unable to fulfill their obligations. For example, *Mama Selvince*, who lives in Southwest Alor, had to travel six kilometers each way for her prenatal care at the clinic. As village-level healthcare facilities are rarely operational, she must travel this great distance to be checked by a midwife or doctor. The roads are in poor condition, and thus can only be traversed by foot or using expensive motorcycle taxis. As such, they consider it unwise to travel to the clinic. Many healthcare aid recipients, particularly pregnant women in isolated villages, prefer not to travel to healthcare facilities and fulfill their obligations.

Financial assistance for education provided by the PKH program, aside from being used to cover everyday expenses, is also used to purchase the school supplies for children. Although there are no special instructions, PKH counselors, schools, and the community expect families to pay attention to their children's education. Although PKH only obliges children to meet a minimum attendance rate, schools and local communities expect children to be better dressed at school. Families fear that, if children are not better dressed, they will be reprimanded by their teachers or mocked by their neighbors. Facing this pressure, some parents have chosen to use the financial assistance they receive to purchase better uniforms and supplies for their children. Unfortunately, such changes in appearance are not followed by increased school attendance. Owing to annual harvest practices, the attendance requirements cannot be met.<sup>3</sup> As such, it can be

<sup>2</sup> Generally, they feel uncomfortable saving their money at the bank, as they consider the administrative costs too high. They prefer saving their money at cooperatives or savings group. Such facilities charge no administrative fees and allow the lending of money with a low interest rate and without collateral. Nevertheless, there are still those who do not trust banks, cooperatives, or savings groups, and thus prefer to keep their money at their homes.

<sup>3</sup> Their fields are located in the old village (the *adat* village) dozens of kilometers from their current village. To work this land, they work in groups of ten to twenty-five people and rely on family (nuclear/clan) labor. They work in shifts, going from one field to another (in their groups) and providing mutual assistance. This group work follows several phases of field-working activities, including grass-cutting, cultivation, planting, weeding, and harvesting. This work begins every October and is marked by a ritual at the *mis-*

said that PKH and other financial aid programs only supports physical appearances without increasing school attendance. For example, before receiving PKH aid *Mama Rachel* of Southwest Alor did not prioritize her children's school needs. She received school uniforms from her older nephews and nieces to save money. The same held true for schoolbooks and writing supplies, which were limited as she was unable to purchase them on her own. After she began receiving PKH aid and other financial assistance, she began to purchase new uniforms and other school supplies. Every school year, she is able to purchase new writing supplies for her children. She does this for her two children so that they may appear passionate for their schooling, but also out of fear that she may be reprimanded by the school for not showing any change. Nevertheless, receiving aid has not increased her children's school attendance rates. During the harvest, her children cannot attend school. As there are no adult men in her household, they must assist her in the fields.

Similar to recipients of PKH aid for healthcare, recipients of PKH aid for education save some of their aid. They open accounts at the credit cooperatives that have begun entering even the most isolated villages. This allows them to both save money and to request loans. Nevertheless, not all residents of Alor trust formal financial institutions (banks, cooperatives). They prefer to invest the money received through the PKH program in pigs. As stated by Cristian-

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*bah* or blessing at the church. Every phase of these field activities involves migration from the village to the ancestral area. Only some families, who do not need to work the fields, remain in the village. Schoolchildren do not attend school for this period, as they either join their families in working the fields or accompany them for fear that they will be abandoned if they remain. One teacher at Pintu Mas Elementary School told us how children who desire to continue their studies must walk for twelve hours each day during from the old village to the current village. Upon arriving at school, these students are generally exhausted and sleep, and are thus incapable of participating in learning activities.

cho and Vining (2004), spiritual and social stability in Alor depends greatly on pigs, who have a high cultural and commercial value in society. Raising pigs is considered a promising investment, with minimal risks. Recipients invest their money in recognition of the fact that they will not always receive financial aid. As such, long-term investment in cooperatives or pigs is considered to offer parents an alternative for financing their children's education after they no longer receive PKH aid/scholarships. Furthermore, in the short term these investments may be quickly transformed into cash in emergency situations (illness, accident, death, etc.).

Based on the above discussion, it may be concluded that the financial assistance received through the PKH program offers households alternative funds for purchasing foodstuffs when their harvests fail. Although the money received is insufficient to cover all of their expenses, it serves as additional income that extremely poor families can use to improve their own situations. Furthermore, this financial aid is also used to increase the active attendance of family members at healthcare and education facilities—despite them still not meeting the minimum requirements owing to various geographical, psychological, social, and cultural hurdles. Finally, the financial aid received by households is also saved for emergencies or for children's continued education once aid is no longer forthcoming.

#### a. *Benefits Received by PKH Participants*

Janvry and Sadoulet (2006) remind us that financial conditions should never become the sole motive for participation in healthcare and education programs, as once aid is discontinued they will return to their old habits. Through the PKH program, the government has specifically attempted to access the extremely poor and provide basic healthcare and education services. In other words, this program is intended to increase participation in healthcare and education facilities; this includes, for instance, sending children who usually assist their parents to school or giving pregnant women the opportunity to receive prenatal care from cli-

nics. Aside from providing compensation, this program also “compels” participants to meet certain attendance criteria. If their attendance rate is lower than that required of them, the aid they receive may be reduced or even stopped. PKH participants must fulfill several criteria: schoolage children must be registered at the nearest educational institution and attend a minimum of 85% of classes. Pregnant women receiving PKH aid must receive prenatal care at the village- or district-level clinic a minimum of four times, in accordance with the age of the fetus; give birth at the nearest village- or district-level clinic, and receive post-natal care. Program participants with infants are expected to monitor their children’s growth at the nearest integrated family planning clinic and provide age-appropriate vitamins and vaccines.

Based on the usage model discussed above, increases in access to healthcare and education facilities have remained limited. Generally, recipients only exhibit physical changes, with their behavior and habits remaining unaffected. This can be seen in children’s changed appearance at school; they wear new, neat uniforms but do not meet the minimum attendance criteria. Likewise, although women are expected to undergo prenatal care at clinics to continue receiving aid, they are unable to reach minimum attendance rates. Their behaviors and perceptions of education and mother/child healthcare have remained the same. For example, there remains a perception that children from poor families need not receive higher education because they will continue helping their parents in the field; as such, not attending school to aid their parents remains acceptable. Pregnant women not receiving prenatal care from a midwife or doctor is acceptable under customary law. Mothers can readily give birth at home with the assistance of a shaman, and oil and prayers are considered sufficient for ensuring that there are no problems during childbirth. So long as they do not violate customary law and thus invite the wrath of the spirits, mothers are not expected to receive post-natal care. Infants need not be

immunized; they need only be massaged to ensure their strength and agility. Generally, the community views changing child education and mother/child healthcare practices as having little effect on their lives. Changing their behavior through programs such as those formulated by the government is thus difficult, given the rhythm of recipients’ social, economic, and cultural lives. As such, it may be said that PKH recipients benefit most from their increased household consumption and savings. With financial aid through the PKH program, households can increase their consumption of everyday necessities and school supplies. Furthermore, they have savings for their short- or long-term needs, recognizing that they will not always receive financial aid.

Furthermore, increased income among PKH recipients does not only affect households’ consumption, but also offers the possibility of accessing loans. Being PKH aid recipients eases them in accessing loans from shops in their villages or even cooperatives and banks. Merchants tend to be hesitant to provide loans or forward money to persons who are not guaranteed to repay them, and unpaid debts frequently lead shops to bankruptcy. Recipients of PKH aid are considered more capable of repaying their debts, as through the program they receive a fixed and regular income.

#### b. *Another Side of PKH Assistance*

The implementation of the PKH program has not only brought changes to the lives of aid recipients, but also to local communities. Although positive reactions have been recorded, there have also been new phenomena. As told by the district-level security forces and local mass media, the program’s first year in Alor was colored by protests and demonstrations from residents. People, in the names of their communities, protested the government only providing aid to a minority of residents. They felt that many families living in abject poverty had not yet been reached, or been shown the same concern. The protests, initially oral, developed into unrest at the district and agency levels. The community’s disappoint-

ment reached a peak after no new families had been added to the PKH list in a year, despite village governments and counselors having made several submissions. Congruent to the PKH program's design to not only be top down in determining recipients, the counselors and local communities were allowed to submit, through the village government, households that they considered worthy of aid.

Generally speaking, members of the community consider their own socio-economic situations little different from those of their neighbors. Very few families are considered wealthy, given that only a few of them had the capacity to mobilize people to work expansive farmlands and fill their warehouses with crops, build concrete walls, live comfortably, send their children to urban schools, and own portable generators for electricity. Most of them have similar lifestyles, working their lands tirelessly to ensure their own survival; owning small, cold homes with bamboo walls; using lanterns for lighting at night; and depending on their school-age children for help in the fields. Owing to this situation, many residents who did not receive PKH aid asked, "What difficulty do I not face, that they can receive assistance when I can't?", showing jealousy for those who had received financial aid. It was not uncommon for recipients to be mocked, both furtively and openly. "Look at *dorang* (them), state employees going to *piambil* (collect) their wages from the government," they insinuated when recipients went to collect their PKH funds. Recipients would receive the attention of their neighbors, who would mock them and their mistakes.

This social jealousy led to the weakening of the social security nets that traditionally provided for poor families. These social security nets no longer applied to PKH recipients, as the local communities considered them better off than the other poor. Alor has a traditional social security net for poor families. Those families considered poor are supported by a family (clan)-based system. Each clan, or *marga*, has a family that is considered the patron of other families. The patron family tends to have a better

economic position than other families in the clan, as they are able to mobilize people to work their fields and harvest an abundance of crops. As such, they, their children, and their kin have access to greater mobility and higher education (and thus government positions). Traditionally, these patron families help poor families when they require assistance, including during traditional rituals and social events, as well as in emergencies. Traditionally, these patron families also help poor families educate their children or offer them greater opportunities to work the fields. In return, the client families should support the lives and leadership of the patrons, including their agriculture, and reaffirm their social positions. Households that receive PKH aid are considered to no longer require the aid of their patron families, as they already receive significant income from the government, and thus face hurdles in accessing aid from their patrons. For instance, if a household that receives PKH aid requests a loan from its patron, the patron may provide this loan with a high interest rate, even when previously interest rates were low or even non-existent. As such, households now turn instead to other sources of loans, to other social security nets, by relying on the cooperatives that have begun penetrating the villages, or on government-established credit agencies such as SPP-PNPM (Savings and Loans for Women, National Independent Finance Program). By opening savings accounts at such places, they can gain access to loans while incurring low interest rates, without relying on the previous patron-client relationships.

This shift in social position has affected the social burden borne by households that receive PKH aid, as apparent (for example) in the greater demands of them made during social events. For instance, during mutual assistance activities in the fields, there was previously no rule as to the quantity and quality of the snacks served or cigarettes provided by a host. However, since receiving PKH aid households have been expected to provide more snacks and cigarettes to those who help them. If they fail to do so, those who assist them in the

fields will not work as diligently, potentially leading to a failed harvest. A similar situation can be found in donations made to newlywed couples. Previously, an amount of Rp 25,000 (approximately US\$2) was sufficient. However, since the implementation of the PKH program, recipients (including the family of the newlyweds) have been expected to donate more money. Similar increases in expected donations can be seen in churches, graduation celebrations, funerals, etc.

## CONCLUSION

The Keluarga Harapan program (PKH) is an Indonesian government program intended for poverty alleviation. Recipients have responded to the program through a number of diverse strategies. Examples of strategies used by recipients in Alor Regency include;

- a) Most recipients of the healthcare element of PKH use the money they receive to purchase basic needs such as foodstuffs and shelter. Once these needs are met, the PKH funds are saved for childbirth, for their children's educations, and for transporting pregnant women to their prenatal medical examinations. The distribution and amount of money used by recipients varies, depending on their families' needs and incomes.
- b) Most recipients of the education element of PKH use the money they receive to purchase their families' basic needs, including foodstuffs and shelter. Once these needs are met, the money is saved for their children's schooling and for emergencies. The distribution and amount of money used by recipients varies, depending on families' needs and incomes.

The above strategies do not only involve efforts to meet the criteria set by the program, but also efforts to improve the quality of life within aid recipients' households. Generally, through the aid provided, recipients more frequently utilize healthcare and education facilities. Owing to geographical, socio-political, and infrastructure conditions, however, this does not in and of itself guarantee

improved quality of healthcare and education. As such, alleviating such factors is also important.

The program has also led to increased financial consumption and savings among aid recipients' households. These families are thus able to freely access existing financial institutions in their communities, including, banks, cooperations, etc., and to partake in more massive consumptive activities than before. However, the distribution of PKH aid has weakened local-level social security networks. The erosion of patron-client relations through this aid has led to PKH recipients seeking other economic security networks (cooperations and banks), thus potentially severing their connections to existing social security networks.

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