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RESEARCH REPORT

Social Protection Programs for Poverty Reduction in Indonesia (1999 – 2005)

Widjajanti I. Suharyo

Sri Kusumastuti Rahayu

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FEBRUARY 2009

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The SMERU Reserach Institute
Draft, 10 February 2009

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I. SOCIAL ASSISTANCE PROGRAMS FOR POVERTY REDUCTION IN INDONESIA: AN INTRODUCTORY NOTE

Sirojudin Arif and Widjajanti I. Suharyo

After several golden years of development that significantly reduced poverty in Indonesia, the 1997/1998 crisis had made poverty a major issue again in Indonesia's national development agenda. Some studies indicated that a significant number of people lived just around the poverty line so that any shock to their livelihood might slip them into poverty or deepen their poverty status (Suryahadi and Sumarto: 2003; Pritchett at al., 2000). In order to solve the problem, the government of Indonesia makes poverty reduction as one of its main targets, with one of its pillars relies on the provision of social protection especially for the poor. Unlike programs the previous era, in which the poor were never specifically targeted except in that of IDT (*Inpres Desa Tertinggal* – Presidential Aid for Disadvantageous Areas) program introduced by Soeharto administration in 1994/1995, many post-crisis programs were created to directly target the poor. Started with the introduction of social safety nets (SSNs) during the crisis period, the government of Indonesia (GoI) continues to maintain and improve its poverty reduction programs as also required by the Millennium Development Goals (MDGs). In terms of budget, for instance, national spending for poverty related programs increased significantly from around Rp 15 trillion in 2001 to more than Rp 50 trillion in 2007. Nevertheless, it is important to look more deeply at how these programs have been implemented so far. How effective had the programs been so far at reaching the targeted poor and helping them move out of poverty? Thus, lessons can be learned for better preparation of social protection programs to respond to the current crisis.

1.1 An Evolutionary Thinking of Social Protection[1] for Poverty Reduction

There has been a growing consensus among policy makers at both national and international agencies to place social protection at the frontier of poverty eradication agenda. Social protection is basically consisting of public policies or programs carried out by government or societies to provide support and assistance for the poor in dealing with their vulnerability, difficulty and deprivation. Its increasing popularity as alternative solution to the persistence of poverty was reflected in the World Development Report 2000 that placed social protection as one of the three pillars necessary to fight global poverty (World Bank, 2001). As risk and vulnerability become major concern in many parts of the world, it is believed that social protection could address not only the symptoms of poverty but also its causes. According to De Haan, the main strength of social protection lies primarily on its focus to extend the support to the poorest (in Barrientos and Hulme, 2008a: 3-4). Therefore, taking the idea a little bit further, some urge for the continuation of the policy at both national and international levels to strengthen solidarity and security at international level (Barrientos and Hulme, 2008a: 4).

[1]The term 'social protection' here is referring to both 'social insurance' involving private user-pay contribution and 'social assistance' involving government funded programs to assist the needy in coping with shocks and vulnerability.

In line with this development, a number of approaches or perspectives have been developed by scholars as well as policy makers. First, as promoted by the International Labor Office (ILO), some view social protection as fundamental rights that every citizen is entitled to. Commonly known as **rights-based approach**, this perspective is rooted in a number of international declarations and conventions. According to the Universal Declaration of Human Rights, '*every one has the right to a standard of living adequate for the health and well-being of himself and of his family*'. Based on the conception of human dignity, these rights consists of inter-related but indivisible components like health, education, work, information or participation in social and cultural life, the realization of which are necessary for the dignity of every person. ILO suggests these conditions reflect the Declaration's commitment to extend social protection to all. The ILO further proposes social protection not merely as a policy option but also as an obligation of governments and other international structures to secure every one's rights (Barrientos and Hulme, 2008a: 6). The Office defines social protection as '*a form of social security which provides assistance to persons of small earnings granted as of right in amounts (that should be) sufficient to meet a minimum standard of need*' (ILO 1942: 84 in Munro, 2008: 32).

Widely known as **needs-based approach**, the second approach comes from the United Nations (UN). Unlike the ILO's proposal, the UN views social protection as policies or programs to help poor families or individuals in response to various contingencies that may affect their income. Underlying this perspective is the idea that every individual or household should have certain amount of income to fulfill their needs. Yet unlike the proponents of the mainstream economic development, that sees growth and the increase of per capita income as the main goal to be achieved, the UN places social protection policy as an effort to achieve both human and economic development. The foundational work in this perspective suggests the importance of distributional issues in addition to the growth of gross national product per capita as the development goals. The idea is that every one has basic needs to be satisfied, and the satisfaction of these needs was the pre-condition for human and economic development (Barrientos and Hulme, 2008b: 6-7). Within such perspective, the task of the state in providing social protection is to ensure that these basic needs if they cannot be met by individual or community efforts (Munro, 2008: 35).

Finally, the third approach is centered on the notion of risk so that it is often called **risk-based approach**. The salient example of this approach is the Social Risk Management (SRM) proposed by the World Bank. More problem-oriented in nature, the perspective assumes that risk and vulnerability are the main causes behind people's falling into the trap of poverty. A person could fall into poverty due to his/her vulnerability to respond properly to risks arising from economic and political shocks or natural hazards. Economic transformation may only pose some risks for the poor though the transformation may also provide some opportunities. It can be that risk and vulnerability constrain the poor from gaining advantage of economic opportunity, but on the contrary avoiding risks may also reduce future welfare levels (Holzmann and Kozel, 2007: 8). Therefore, by reducing vulnerability or providing a better risk management, social protection provides the poor with the assistance not only to cope with shocks or crisis but also to help them move out of poverty in the long term. According to Bender et al., (2008: 3), '*by reducing existential fears of the members of society, social protection policy encourages individuals to take risks that they would not otherwise be willing to take, such as investing in new business opportunities*'.

The history of international development has witnessed the rise and fall of the three approaches. The risk-based approach dominated the discourse in the 1960s, before the human needs approach was introduced in the 1970s. For years, the human needs approach did not develop much until the appearance of human development goals in the 1990s, which in many

respects can be seen as a re-interpretation of human development from the human needs perspective. Another important development was the introduction of rights based approach during the last decade with the support of the UN agencies, especially ILO and several non-government organizations (NGOs) that support the right based approach. Meanwhile, the supporters of risk based approach continuously improving their theory and show its strength trough enforcing Social Risk Management of the World Bank since late 1990s.

Nevertheless, Munro (2008) notes minimum interaction between the three approaches. On the contrary, there are many disputes and disagreements among them. For example, the supporter of risk-based approach rejects right-based approach because it does not explain as how to prioritize when the economic resources are limited. According to risk-based approach, the provision of sustainable social policy should take into account pragmatic consideration such as efficiency and the cost-benefit of a policy model. Right can only be used as value judgment but it can be used only in determining goal. If the goal is agreed upon, then how to achieve the goal should rest in the hand of necessary technical skill. In contrast, the supporter of right based approach considers the separation between way and end as unacceptable. Right is a right, so that any negligence, even small, is considered as a violation. For the needs based approach, the supporter of right based approach also deliver strong critics on the basis that the paternalistic and caricative moral judgment the needs based approach can not provide strong basis for the development of social policy.

Indeed, further exploration finds several points that allow interaction and a more constructive dialogue between the three approaches. Based on Munro's assessment (2008), besides using international laws and agreements, the right based approach also using human basic needs as a foundation. Thus, it can be seen that both are developed based on the same foundation, which is human basic needs. While regarding the risk based approach, citing Viner's view, Munro explained that every human should have the right for utility, and consequently government should assure that all citizen will get their utility right. Because of that, 'welfare losses', following this line of thinking, can be categorized as a violation of right (Munro, 2008: 38).

In addition, it might not be realized that each approach and the discourses that it raised, are at different level of discourse. While risk based approach is focusing on operational and technical framework, right based approach talks more on philosophical basis, and needs based approach is located in the middle of the two. Compared to risk-based approach, both the right-based and human needs approaches are more concentrated on the goal or the ideal condition to be achieved by the social protection without adequately considering problems to be addressed in the field or reliable methods to tackle the problem. There is no explanation on how the government can fulfill the rights or the basic needs as assested by both approaches. Yet at the philosophical level, it is apparent that the right-based approach is the theoretically strongest in spite of being too literalist and hyper-legalistic. Both the principles of utility of the risk based approach and of human basic needs of the basic needs approach still need to be further elaborated as to provide strong philosophical foundation for establishing a good social protection system. While the human basic need suffers from its weaknesses of being charitable and paternalistic, calculate ing for efficiency or cost-benefit in the risk based approach will potentially not benefiting the poor, especially the poorest. Thus, the fact that the differences are originated from differences in the level of discourse, and the existence of common views, provide sufficient reasons to the possibility of opening a more positive dialogue across approaches.

Nevertheless, besides basic theory as discussed by Murno that has been discussed in the above passage, it is of the same important to assess the empirical how social protection programs are implemented in the community. Such assessment can also assess the applicability and

effectiveness of social protection programs, as not all plans can be implemented especially because the plan in not implemented in a socially vacuum place but in a certain community that has its own history and characteristic of its social development. That is why the success of social protection program is not only affected by its theoretical foundation but also by the social context where the program is implemented. As reflected in the Indonesian case that will be explained in the following passage, besides the history of the social protection system that was affected by the crisis, the actual condition at the local level will affect the implementation of social protection programs.

1.2 Social Assistance Programs in Indonesia

The establishment of social assistance in Indonesia has been shaped much by the country's historical development, namely its effort to deal with the impact of economic crisis that hit the country in 1997. Due to its magnitude, the crisis had increased the number of poor people significantly as the national economy slowed down and many people lost their jobs. During the crisis period, Indonesian Rupiah was highly depreciated and the inflation rose sharply. Within only a year, domestic prices rocketed by nearly 80 percent and nominal food prices increased threefold (Sumarto, et al., 2008: 121). Meanwhile, many banks were liquidated from bankruptcy, and increasing number of people was laid off from their work places. In short, unemployment, under-nutrition, withdrawal from schools and poverty became the general picture people might think about the situation in Indonesia during the crisis. Indeed, as had been expected, the headcount poverty rate increased from 15.3 before the crisis in the mid 1997 to 33.2 at the end of 1998. Therefore, in order to mitigate the depleting impacts of the crisis, the Government of Indonesia (GoI), with the support from donors like the World Bank, the Asian Development Bank and other bilateral agencies, launched social safety net (SSN) programs in 1998/1999 (Sumarto et al., 2004: 1).

Prior to the crisis, Indonesia had no formal or state-run social protection system that specifically designed to prevent its citizens from any economic or social risk affecting their livelihood. The insurance provided by the state only covered the military and civil servant. While a limited number of insurance schemes were already available, but they only covered certain groups of people on private basis. Thus, only those able to pay the premium might be protected, while the rest in general had to rely on their own resources. Yet for poor people in particular, such resources might be very limited or even not available at all. Several studies have shown that borrowing from others or reducing expenditures are the most common mechanism for the poor to cope with the risk or shocks. Some might diversify their income sources or try to increase the income in general, yet in time of crisis or shocks it seems quite difficult for them to do so. What is much easier is to cut non-primary expenditures such as those on recreation, clothing, or transportation; or to borrow some money from families or neighbors (Perdana, 2005: 5-7; Sumarto et al., 2008: 124). While the first might decrease the quality of their life or well-being, the second will be dependent very much on the generosity of others. In the case of big shocks like the 1997 economic crisis, it is very likely that such mechanism will not work. Meanwhile, a formal system of social protection was not developed yet to help these people to cope with the impacts of such shocks.

From this perspective, the implementation of SSN program in 1998 characterized the new effort of the country in dealing with the vulnerability aspect of poverty. Previously, Indonesia's strategy to address the problem of poverty was generally based on economic growth as the main tool the increase people's welfare. Some programs were meant for the poor, but they were also implemented through general development programs like funding for basic health and education

services, development programs for improving economic productivity of the poor and small programs for disadvantaged people (Sumarto et al., 2008: 124). Not until the early nineties did more specific programs specifically targeted to the poor appear on the priority of Soeharto administration, namely IDT program in 1993. Yet it is apparent that they had different natures and goals from those of the SSN program. While the IDT program used community as the basis of program targeting, the SSN targeted mainly the individual poor. It was meant as social assistance to help traditionally poor or newly poor people cope with the impacts of the crisis. Other than to ensure the availability of food at affordable prices, the program also aims to increase the purchasing power of the poor through the creation of employment, and to preserve their access to basic social services like education and health.

The SSN program was initially classified as 'emergency' or 'ad hoc' program for poverty alleviation during the crisis. Once the crisis has been solved, the program will be terminated (Remi and Tjiptoheriyanto, n.d.: 3). However, by the GoI, the program was then modified and continued after the crisis to develop social protection program for the whole country. A number of external and policy induce shocks, such as the reduction of fuel subsidies in 2000, were thought to have disturbing impacts on poor people's welfare condition. To mitigate disturbing impacts of such changes, as well as other disturbing shocks possibly affecting the country again, the government had to prepare again some policy instruments to help the poor, or at least to minimize the impact of such shock on their welfare condition. Some programs previously implemented under the SSN were modified to make better its weaknesses so that their main goals to help the poor mitigate the depleting impacts of the shocks could be achieved effectively.

Table 1. The SSNs for the 1997/1998 Crisis and Its Later Modification

Safety Net Area	During the Crisis	After the Crisis
Food security	Special Market Operation (*Operasi Pasar Khusus*, OPK) program: sales of subsidized rice to targeted households.	Rice for the Poor (Raskin); subsidies in kind (rice) targeted directly to poor households
Education	Scholarship and block grants, providing: • Scholarships directly to elementary (SD), lower secondary (SLTP), and upper secondary (SMU) students; and • Block grants to selected schools	*Bantuan Operasional Sekolah* (BOS) or school operational fund; instead of providing scholarship to students from poof households and block grants to selected school, the BOS channeled operational funds to all schools qualified to receive the funds.
Health	Health Sector Social Safety Net (JPS-BK); a program providing subsidies for: • Medical services; • Operational support for health centers; • Medicine and imported medical equipment; • Family planning services; • Nutrition (supplemental food); and • Midwife services	*Jaminan Pemeliharaan Kesehatan untuk Keluarga Miskin* (JPK Gakin), the employment of insurance principles to establish a health-financing scheme that enables poor people to access health care in public facilities, including primary and secondary health care.
Employment creation	Program *Padat Karya*: a loose, uncoordinated, collection of several 'labor intensive' programs in a variety of government departments	These two categories of programs were then simplified and modified further with some programs deleted from the list. Later, the program was then named employment creation program to include particularly some labor intensive programs on infrastructural developments.
Community empowerment	Regional Empowerment to Overcome the Impact of Economic Crisis (PDM-DKE); a 'community fund' program that provides block grants directly to villages for either public works or revolving fund for subsidized credit	

Source: Sumarto, et al., 2004.

Besides improving the distribution system, particularly related to targeting, the GoI also made some changes in the design of the programs (Table 1). These changes were not merely intended to improve program implementation but also to increase the effectiveness as well as the performance of the programs in general. The various community empowerment programs during the crisis has been simplified and merged with labor intensive programs focusing on the improvement of infrastructure in disadvantage regions. In health sector, program improvements have been continuously progressing by means of introducing insurance principle in social protection in the provision of health services by implementing health care for poor family (*Jaminan Kesehatan untuk Keluarga Miskin* – JPK Gakin) program. To improve targeting in the provision of food assistance, the OPK that was initiated during the crisis has been modified to become rice for the poor (Raskin). The modification is intended to make clear that the purpose and target of the program are the poor families. Finally, the most significant change was introduced in education sector. Started in 2004/2005 academic year, the GoI has changed the scholarship for poor families at the primary and junior high school levels for School Operational Assistance (*Bantuan Operasional Sekolah* – BOS) program. Different from the previous program that was specifically targeted for the poor, BOS is more universal in nature as not only the poor, but all schools that are willing to meet government requirement, are eligible to receive the assistance.

1.3 About this Paper

This paper is intended to discuss the social assistance programs that were implemented in Indonesia after the 1997/1998 crisis, until 2004/2005. The programs are discussed individually so that the reader can select the chapter of interest. Every chapter discusses in detail the program history and development, coverage and targeting, program impacts, funding, and the institutional structure. The program assessment presented in this paper is basically based on literature review, supported by additional quantitative analysis mostly from the social economic survey (SUSENAS) conducted by Statistics Indonesia (BPS). Although the review covers a rather old dated data up to 2004/2005, it is hoped that the assessment will enriched policy analysis for the improvement of social assistance program in Indonesia.

After the introductory note in Chapter I that discuss the discourse of social protection in the poverty reduction framework and the brief development of the Indonesian social assistance programs, Chapter II to Chapter VI will discuss the individual programs. Chapter II discusses social assistance to support food consumption, in the form of subsidized rice for the poor. Chapter III talks about social assistance in education sector. Chapter IV and V are focusing on health sector. Chapter IV specifically discusses health service assistance for the poor, while Chapter V is focusing on immunization and prevention of communicable diseases. Finally, Chapter VI presents infrastructure and clean water programs that were part of job creation efforts.

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II. RASKIN – RICE (SUBSIDY) FOR THE POOR

The *Raskin* (rice for the poor) program is a program of the Government of Indonesia intended to provide social protection to poor families in meeting their food adequacy needs and reducing their financial burden by providing rice at a subsidized price. It is supposed to distribute 20 kg of rice per family per month at a price of Rp 1,000 per kg at the distribution points. In 2002-2004, the target of the program was maintained around 8.6 million poor families, with the highest target in 2003 reaching nearly 9.8 million poor families. Yet the realization data shows that the actual beneficiaries of the program were always larger than the target. On average, it reached around 12 million poor families in 2002 – 2004. Unfortunately, this increase in the number of recipients was not followed by a better delivery system. Some studies reveal that considerable part of the rice went to 20 percent of the highest quintile expenditure, making the ratios of the targeting nealyb 0.9, wich means that the opportunity of the poor and the non-poor in receiving the rice was almost the same. Based on the data on the quantity purchased by average households and the prices they paid, it is also apparent that only a very small fraction of the subsidy through the Raskin program was received by the poor and the near poor, for whom the program had been designed.

2.1 Background and Brief Detail of the Program

The Raskin program is basically a continuation of the food support program for the poor, which was known as *Operasi Pasar Khusus (OPK) Keluarga Pra-Sejahtera* or Special Market Operations for Pre-Prosperous Households, introduced in July 1998 under the Social Safety Net (SSN) program in response to the 1997 economic crisis. The original design of OPK called for the National Logistics Agency, BULOG, through its provincial and district (*kabupaten*) logistic storehouse offices, to make available 10 kg, and later 20 kg, of medium-grade rice every month at a purchase price of Rp1,000/kg for targeted poor households. In its operation, OPK is implemented in collaboration with local government in all provinces and districts, and the National Family Planning Board (BKKBN). The definition of poor households used in this program refers to *Pra-Sejahtera* (Pre-Prosperous or poor) and *Sejahtera I* (Prosperous level 1, which is near poor) based on BKKBN classifications.

By the second half of 2001, it became obvious that the problems and weaknesses of OPK needed to be addressed so that the aim of delivering the benefit to the poorest families could be achieved. Some changes had been introduced starting in 2002 and the most obvious one was the change of name. Since OPK did not indicate anything about the real purpose of the program, a new label "*Raskin – Beras untuk Masyarakat Miskin*" was introduced to better reflect the nature of the program, i.e. to provide subsidized rice only for poor families. This message was also reinforced through a national television advertising campaign. The program was no longer considered to be an emergency measure, but rather a social protection program with the target provision of rice in the amount of 20 kg -a change from the previous program design that provided a minimum of 10 kg and a maximum of 20 kg. The target group within the population, however, remained the same as it was under OPK, which was families who were poor and at risk of being unable to provide an adequate measure of food security. There was also a serious attempt to introduce the use of VAM (Vulnerability Analysis and Mapping) methodology, but it did not win the support of provincial and district administrations. There were, therefore, essentially few differences between the *Raskin* and the OPK programs (Hastuti and Maxwell, 2003).

In the second half of 2001, the Government of Indonesia made an allocation of food relief under a temporary program known as the Program for Reducing the Impact of Reduced Energy Subsidies (PPD PSE). Similar allocations, which amounted to Rp500 billion were also made in the 2002 budget under the Fuel Subsidy Compensation Program (*Program Kompensasi Subsidi BBM:* PKS BBM). Both programs had been integrated into the existing OPK program, although BULOG had required that its own internal financial administration and internal reporting of the PKS BBM program be kept separate from *Raskin*. In almost all locations, the rice provided under the PKS BBM program was simply added to the *Raskin* allocation so that from the perspective of the villagers there has been a single subsidized rice program in operation since 2002.

2.2 Coverage and Targeting

From 1998 to 2004, the OPK and *Raskin* programs together had disbursed more than 12.8 million tonnes of subsidized rice to all provinces in Indonesia. With the exception of the 1999/00 period when OPK was in full operation to mitigate the crisis impact, rice distribution was increasing during the period of 1998/99 to 2002, and then it slightly decreased in 2003 and 2004 (Figure 1). During the period of 1998/99 to 2002, most of the rice was distributed in Java/Bali (64%) where most of the population and the poor live, followed by Sumatra (16%); while Papua received the least of around 1.8% (Figure 2).

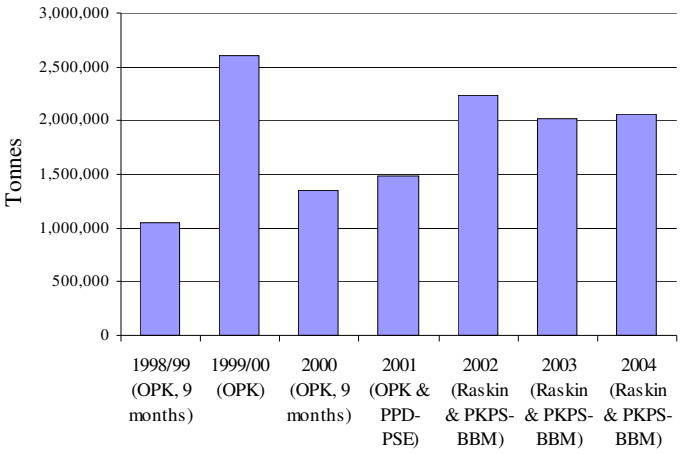

Figure 1. Disbursement of OPK and Raskin

Sources: Hastuti and Maxwell (2003) for 1998/99 – 2001; Tabor and Sawit (2005) for 2002-2004

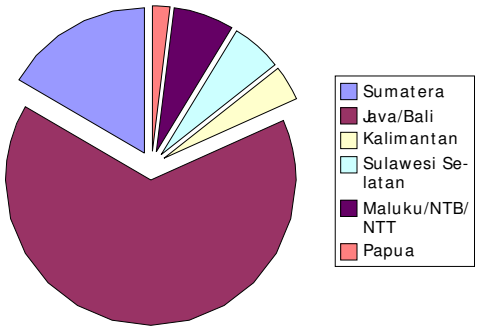

Figure 2. Distribution of OPK and Raskin Across Religions, 1998/99 - 2002

In 2000, OPK was designed to assist 7.5 million families, and increased to 8.7 million and 9.8 million families in 2001 and 2002, respectively. In 2003 and 2004, the target was maintained at around 8.6 million families. Based on BULOG's estimation (Table 1) this target should cover around 58% of the total poor (and vulnerable) of around 15 million families in 2001. The coverage target was increased to 66% of the poor and vulnerable families in 2002, 57% in 2003, and 55% in 2004. Indeed, the realization data (based on BULOG's report) shows that except for 2001, the numbers of actual beneficiaries were always larger than the target, and it reached around 12 million families in the 2002-2004 period. Assuming that there were, in total, around 50 million families in Indonesia in 2000, this would account for around 24% of the total number of families in Indonesia. So, on paper, it should be enough to cover all households in the lowest expenditure quintile, if perfect targeting applied.

Table 1. Estimated Target and Realization of *Raskin* (2000 – 2004)

	2000	2001	2002	2003	2004
Number of poor families		15,000,000	14,782,000	15,135,561	15,746,843
Quantity of disbursed rice (tonnes)	1,353,248	1,481,829	2,235,137	2,023,698	2,060,198
Target (Plan):					
Number of target (family)	7,500,000	8,700,000	9,790,000	8,580,313	8,590,804
% target to poor families		58%	66%	57%	55%
Rice quantity (kg/family/month)	15.0	14.2	19.0	19.7	20.0
Realization:					
Number of beneficiaries (family)	10,934,861	8,316,185	12,333,923	11,832,897	11,664,050
% beneficiaries to poor families		55%	83%	78%	74%
% beneficiaries to target	146%	96%	126%	138%	136%
Rice quantity (kg/family/month)	10.3	14.8	15.1	14.3	14.7

Source: Calculated from BULOG, 2005

Table 2. Coverage and Targeting of OPK and *Raskin* Program

	Percentage of each quintile covered by the program			
	1999	2001	2002	2003
Indonesia	***40.09***	***39.72***	***43.86***	***36.57***
Quintile 1	52.64	57.87	61.88	52.10
Quintile 2	46.24	46.98	51.26	42.75
Quintile 3	41.71	39.00	43.61	36.62
Quintile 4	35.76	32.51	36.70	30.35
Quintile 5	24.33	22.26	25.88	21.07

Sources: Sumarto and Suryahadi (2001) for 1999; 2001-2003 are calculated from the 2002, 2003 and 2004 SUSENAS data.

The SUSENAS data, on the other hand, revealed a rather different picture of how rice had been distributed in the community. Based on the 1999 SUSENAS data, Sumarto and Suryahadi (2001) estimated that the program had covered a larger portion than the BULOG estimation, as around 40% of households received the subsidized rice in 19992, and it was distributed among households in all expenditure quintiles (Table 2). Estimations for 2001, 2002 and 2003 based on SUSENAS 2002, 2003 and 2004 also reveal a similar pattern. The largest coverage of around 44% was attained in 2002, the year when the quantity of rice disbursed was also the largest compared to the disbursement in 2000, 2001, and 2003 (see Table 1). On average, around 50%-60% of the households in the poorest expenditure quintile bought Raskin rice while around 20% of the highest quintile also enjoyed it. These figures indicate that there was almost no targeting in the disbursement of Raskin rice. Less than 30% of the subsidized rice went to the household in the lowest quintile3, and a total of around 50%

[2]This was around 16 million households, assuming that total number of households was 40 million.

[3]Similarly, McCulloch estimates based on the 2002 SUSENAS, that the poor received around 26% of the benefit of the program.

went to the two lowest quintiles (Table 3). This has made the targeting ratios of around 0.9, which means that the opportunity of the poor and the non-poor in receiving Raskin rice was almost the same, with very limited preference given to the poor. The time series data also shows that, in general, the targeting performance did not change over time, indicating no improvement in targeting of the program. The targeting ratio is calculated as the proportion of non-poor who received the program divided by the proportion of the non-poor in the population.

Table 3 also presents variations in the targeting performance across regions. The targeting was relatively better in Maluku/NTB/NTT, which are among the poorest regions in Indonesia. On the other hand, the targeting in Kalimantan and Papua regions were the worst, where the households in the two lowest quintiles only received around 30% of the program benefit. In Kalimantan, there was a tendency for the targeting performance to get worse over time; while the targeting performance in Papua was improving over the course of 2001 – 2003.

A similar targeting feature was also reported by Suryahadi et.al. (1999). In the earlier stage of OPK, he calculated data from 100 Village Survey (covering 10 districts) that showed that two districts in Central Java had been highly successful in ensuring that the poor received the benefits of the program and the program coverage of the poor was over 90%. The coverage of the poor in 8 other districts in the survey ranged from less than 50% to 67%. The worst case was in Kutai (East Kalimantan), where curiously only 5% of the poor reported receiving the benefits of this program. In terms of targeting ratio, it showed that in most districts the value of this ratio was only slightly less than one. This indicates that the majority of districts did not target the basic necessities provisions program solely for the poorest as measured by consumption expenditure. Instead, they provided cheap rice from the program for the general population, with only a slight inclination to favor the poor.

Table 3: Targeting Performance of *Raskin* Program

	Targeting Ratio			Percentage of program benefits distributed to quintile 1			Percentage of program benefits distributed to quintile 1 and 2		
	2001	2002	2003	2001	2002	2003	2001	2002	2003
Indonesia	**0.89**	**0.90**	**0.89**	**29.1**	**28.2**	**28.5**	**52.8**	**51.6**	**51.8**
Sumatra	0.86	0.89	0.88	31.1	28.4	29.4	54.2	51.6	52.0
Java/Bali	0.90	0.91	0.92	27.8	27.2	26.8	51.9	50.9	50.5
Kalimantan	0.99	1.02	1.01	21.2	18.4	19.3	39.8	36.5	39.1
Sulawesi	0.84	0.84	0.82	33.0	32.5	34.6	56.4	55.3	58.0
Maluku/NTT/NTB	0.74	0.76	0.70	40.6	39.5	44.3	63.5	63.6	67.8
Papua	1.17	0.96	1.01	6.2	23.0	19.6	28.0	40.8	38.9

Source: Calculated from the 2002, 2003 and 2004 SUSENAS

These quantitative findings from the survey accord well with various qualitative reports that recorded various problems on the ground regarding allocation and disbursement of the subsidized rice. Regarding allocation procedures, under the *Raskin* program, the central government assumed responsibility for determining the quotas for each of the provinces. The precise allocation for each province was calculated proportionally according to the BKKBN

data on pre-prosperous households (KPS ALEK) and prosperous level 1 households (KS-1 ALEK) for economic reasons. The provincial governments were informed in November of their precise allocations for the following year. On the basis of these allocations, every provincial government was asked to determine the quotas for each *kabupaten* and *kota* within its area of jurisdiction, again drawing on BKKBN data. Finally, at the *kabupaten* and *kota* level, the local administration was given the task of deciding on the exact quotas for each of the distribution points within their region (Hastuti and Maxwell, 2003).

In relation to the selection of beneficiaries, according to the program guidelines, each village was given considerable responsibility and autonomy over the selection of the actual beneficiaries. The BULOG planners who designed the program simply stipulated that the determination of the families to be listed as beneficiaries should be made in the first instance with reference to BKKBN's data on those families classified as KPS ALEK and KS-1 ALEK. This data was subject to further discussion and consultation at village-level meetings attended by village heads (*kepala desa* or *lurah*), prominent local community leaders, local family planning and family welfare cadre (PKK and PLKB), local NGO leaders and other leading community figures. As a result of these deliberations, a list of beneficiaries was to be finalized.

In addition, the guidelines also stipulate one more important consideration, which was village decision-makers were expected to work within the limitations of the ceiling or quota that had already been determined for each village. This means that every village was to receive a specific allocation of rice each month that was intended to supply a certain fixed number of families with a 20kg allotment. Thus, in theory, the number of families listed by the village as recipients of the *Raskin* program should not exceed this quota. The agreed list of beneficiaries was to be ratified by the village head, and forwarded to the local *camat*. The list of eligible families was also to be posted in a prominent place within the village for all members of the community to see. Each family on the list was to be issued with an official *Raskin* Card containing coupons for each month of the year, which were to be used each month when the allocation of rice was collected at the distribution point. The guidelines also set out in considerable detail the procedures that were to be followed for the delivery and distribution of the rice at the distribution points, the payment process, as well as arrangements for monitoring and evaluation (Hastuti and Maxwell, 2003).

So, in principle OPK and *Raskin* make use of household-level data collected by BKKBN to identify the neediest households. BKKBN data focuses on five indicators of overall standard of living and well-being – food intake, housing, clothing, medical and religious practices. Households failing to meet a minimal standard on any one of these five variables are designated as "pre-prosperous families", or *keluarga pra-sejahtera* (KPS). These minimal standards include:

- eating at least twice every day;
- having a house with a floor that is not primarily earthen;
- having different clothes for work and leisure;
- going to a medical clinic (as opposed to a traditional healer) when children are sick; and
- following the fundamental practices of the family's religion.

In addition to the original five BKKBN criteria used to categorize families as KPS, there are three additional criteria being unofficially used to identify needy families: 1) families that consume protein only once a week, 2) families with children who drop out from school, and 3) families led by unemployed adults, or victims of PHK (*pemutusan hubungan kerja* – laid off). These additional "updating" criteria have not been formally announced by the central BKKBN office in Jakarta, but in the field they are being actively used and are considered

appropriate. In fact, PPLKB (family planning extension) workers and village administrators were the investigators of, and advocates for, these additional criteria.

In practice, several studies had uncovered problems and inconsistencies in the use of BKKBN data for calculating allocations as well as for individual targeting. In the early program implementation, the allocation faced a problem of sudden increases in the target group numbers. When the most recent data were collected in early 1998, approximately 7.3 million households were identified as KPS, or poor - roughly 15% of Indonesia's population. Soon after the program began, reports began filtering back to Jakarta that, because of the deepening economic crisis, many families in the next-higher BKKBN category – *keluarga sejahtera satu*, or KS1 – had slid down into much more desperate circumstances and were as needy as those already called "poor" (KPS). At this juncture, the government announced its intention to expand the OPK program to include KS1 families as well – an expansion which had the potential to increase the number of families served by up to 130%. The expansion is occurring gradually as people are added to the program in each district (Hastuti and Maxwell, 2003).

Later, in 2002, there was also a dispute over the decision on total allocations. How did the government arrive at the 2002 allocations? According to BULOG officials, the original quota of 9.8 million families was the result of a process of consultation with other government agencies, in particular the Ministry of Finance and the National Development Planning Board (Bappenas). The government also took into account the most recent poverty data that was available from the BPS and the BKKBN lists of family socio-economic status. According to the BKKBN data for 2000 that was available to BULOG when the 2002 programs were being drawn up, the original allocation was aimed at assisting approximately 20% of all Indonesian families, while the revised figure would assist 19% of the total number. Nevertheless, the allocation was insufficient to cover all those families in the lowest welfare categories, KPS ALEK and KS-1 ALEK, even though these were the two categories specifically referred to in the *Raskin* program official guidelines.

The 9.8 million figure was suddenly revised downwards before the program began when the government decided to set aside a special allocation of rice to assist the victims of social and political unrest in several regions that were hosting temporary camps of internally displaced refugees. As a result, the national quota for the 2002 subsidized rice program was reduced to 2,167,100 tonnes intended to assist 9,029,584 families.[4] By way of comparison, the actual disbursements of subsidized rice for each of the previous four funding periods are also included in the attached table. With the exception of the 1999/2000 OPK program – the period when the government's social safety net program was at its maximum level of operation as a result of the economic crisis – the table reveals that the amount of rice being disbursed under OPK and now *Raskin* has been rising every year. Furthermore, the allocations for the 2002 *Raskin* program represent a considerable increase over the previous year's OPK program (Hastuti and Maxwell, 2003).

With regard to individual targeting exercise, a study conducted by Olken et.al. (2001) claimed that the differences in rice distribution had many causes, both economic and political. In all villages visited, village officials reported that the BKKBN lists were not accurate representations of who in the village was actually poor. A commonly-heard situation was of a family with a good house-and therefore classified as non-poor by BKKBN-but with few other assets and little in the way of income. As a result, all villages visited making any attempt at targeting rice to the poor created their own list of who was poor. The number of people

[4]The original figure of 9.8 million families appears in the *Raskin* program guidelines. BULOG planned to revise the quotas again later in the year when the actual disbursements to the recipients were finally realized.

added to the official BKKBN lists depended on the economic conditions of the village-the more people who were near the poverty line, the more difficult it was for a village to draw distinctions and keep rice tightly targeted. Therefore, a relatively flat income distribution near the poverty line seemed to lead to a much wider distribution of rice.[5]

A second economic cause of targeting problems revealed by Olken et. al. (2001) was the fact that, in all villages visited, the rice was sold on a cash-and-carry basis. As a result, many of the very poorest families did not have cash on hand to immediately purchase the total amount to which they were entitled, creating a surplus of rice in the village. Since the village needed to pay for all of the rice received, the surplus was sold to other families, with relatively little effort made to target the surplus rice to poor families. As the team heard from one RT (neighborhood association) head, the instruction from the village head was that all rice must be sold; to whom it was sold was a lower priority.

Another study by Hastuti and Maxwell (2003) also found that although the list of rice recipients was supposed to follow the national BKKBN social welfare guidelines, in fact, village officials had almost complete authority to determine how the rice would be distributed within their villages. As a result, the implementation of the OPK program varied dramatically from village to village, even within the same sub-district. In some areas, the rice was well-targeted to poor families; in others, the rice was simply divided equally among recipients. In yet other areas, it was simply announced that cheap rice was available for sale, and whoever could afford to buy it was allowed to do so. Virtually all aspects of the rice distribution, from the generation of eligibility lists to the amount of rice each household was allowed to buy, to the price of the rice, varied dramatically from village to village.

In addition, Hastuti and Maxwell (2003) pointed out that there were several important caveats to the usefulness of the BKKBN data, which were apparently not considered in the original OPK program design. The first is that only married households are included in the BKKBN data – thus, households with single heads, or widows, or groups of single people living together, are not included. A second important drawback is that even though national policy does not require an identity card (KTP) for inclusion in the program, in specific urban areas it was found that many families cannot be included and categorized if their head of household does not possess a national identity card issued by, and valid for, the location in which they are living. The crisis has intensified the movement of newly unemployed workers and families displaced by drought and fires, adding to the already acknowledged high number of unofficial residents of big cities like Jakarta, Semarang, Surabaya, and Medan. Consequently, the KTP issue in urban areas is a substantial one which may represent an under-counting of literally millions of people who should be listed as poor and food-insecure.

2.3 Impacts and Outcomes

The provision of rice at a subsidized price through OPK and *Raskin* is a form of indirect transfer to the program recipient. The benefit accrued will depend on the prevailing market price in the location. Olken et. al. (2002) estimated that the monthly distribution in 1998 represented the equivalent of a cash transfer of about Rp 15,000 per household, which was less than 30% of the official poverty line for a household of one person and less than 6% for a household of five. For a typical poor household receiving the full 20kg of rice at the subsidized price, the subsidy would be equivalent to approximately 10% of annual monthly

[5]Olken et.al. (2001) argued that this case was not necessarily a bad thing. The fact that local governments had the authority to spread OPK rice to such families may have been welfare-improving.

household expenditure. Meanwhile, according to Tabor and Sawit (2005), in 2003, *Raskin* provided a transfer benefit equivalent to 4% of the minimum income, and 10% of rice expenditures of the average beneficiary household. The gross transfer benefit (GTB)[6], or indirect income transfer from *Raskin* was equivalent to Rp3.5 trillion in 2002, Rp3.1 trillion in 2003, and Rp3.1 trillion in 2004, for a three year annual average of Rp3.25 trillion (See also Annex 2). Some 53% of the total GTB was received by beneficiaries in Java, and 47% by beneficiaries elsewhere. The amount of GTB per beneficiary family was Rp 246,581 or about Rp 20,500 per month (if we assume that the program reached an average of 13.2 million families and an average ration of 13.3 kg/month). Assuming an average family size of 4.9 persons, this implies a GTB per capita of Rp 50,322 per beneficiary per year, or Rp 4,200 per capita per month. On a per kilogram basis, the subsidy equivalent of *Raskin* averaged Rp 1,550 or 61% of the total cost of the *Raskin* rice.

A related concern, however, is that the quantities of *Raskin* rice distributed in some of the poorest villages, in certain regions, may be as low as 4 to 5 kilograms per family per month. Those poor families who are only able to obtain 4 to 5 kg per month from *Raskin* would draw substantially less benefits from the program, so that their annual average transfer benefit would be equivalent to Rp92,600 per year, or just Rp8,000 per month (Tabor and Sawit, 2005). Various studies also confirm the differences in quantity of rice purchase from *Raskin*. Strauss et. al. (2004) estimate that the actual average amount of rice received per month by targeted households is around 6 kilograms, while the LP3ES survey (2000) found that it was about 10.4 kg. Meanwhile, SMERU's qualitative study found that during the period of 1998-2000, the actual average amount of rice received per moth was estimated between 3-11 kilograms.

The 2004 SUSENAS has added a specific question regarding the purchase of rice from *Raskin*. In addition to the question that was already on the 2002 and 2003 SUSENAS questionnaire on whether the respondent (household) received *Raskin*, the 2004 survey asked about the quantity of rice that has been bought from *Raskin* in the past three months and the price of the rice purchased. An estimation using this data set shows that on average a household bought around 15 kg of *Raskin* during the past three months or equivalent to about 5 kg per month. This quantity is very low compared to the 20 kg stated as the target, but it is quite possible since the SUSENAS data also revealed the fact that around 20 million households actually bought *Raskin* rice, instead of 8.58 million households set in the target (see Table 1).

As can be seen from Table 4, the quantities of *Raskin* rice purchased vary across regions and across welfare levels. The average quantity purchased in Java/Bali was the smallest at around 4 kg/month, while on average a household in Papua purchased the largest quantity of around 9.64 kg per month. In most regions, the average quantity purchased was almost the same across quintiles of expenditure group, except in Maluku/NTB/NTT and Papua where the richest groups seem to have bought more than the poorest. This data, indeed, is similar to the qualitative findings in showing the variation of rice quantity bought from *Raskin*.

Regarding the price of rice, the SUSENAS data shows that, on average, a household bought *Raskin* rice at the price of Rp 1,157 per kg. The Rp 157 difference from the target price of Rp1,000 at the distribution point was the cost of delivery from the BULOG distribution point to the local distribution points. It is still possible, however, that a household still had to pay additional transport costs from their home to the local distribution points where they collect *Raskin* rice. This average price also varies across regions, with the lowest price paid in Maluku/NTT/NTB and the highest paid in Kalimantan.

[6]GTB = Market price – co-payment (Rp1,000 per kg) – incidental charges borne by beneficiaries.

Table 4. Average Quantity of *Raskin* (kg/month) Purchased by Household in 2003

	Indonesia	Sumatra	Java/ Bali	Kalimantan	Sulawesi	Maluku/ NTB/ NTT	Papua
Total	***5.14***	***8.19***	***4.76***	***8.35***	***7.69***	***8.26***	***9.64***
Quintile 1	5.26	8.16	4.83	8.19	8.23	7.97	8.96
Quintile 2	5.11	8.06	4.77	8.59	7.60	8.26	7.15
Quintile 3	5.05	8.60	4.79	9.13	7.03	8.30	9.60
Quintile 4	5.05	7.89	4.64	8.41	7.71	8.57	11.64
Quintile 5	5.17	8.26	4.67	7.46	7.23	9.65	10.71

Source: Calculated from the 2004 SUSENAS

Table 5. Average Price of *Raskin* (Rp/kg) Paid by a Household

	Indonesia	Sumatra	Java/Bali	Kalimantan	Sulawesi	Maluku/ NTB/ NTT	Papua
Total	***1,157***	***1,240***	***1,135***	***1,371***	***1,145***	***1,093***	***1,306***
Quintile 1	1,158	1,244	1,150	1,358	1,120	1,072	1,269
Quintile 2	1,154	1,233	1,138	1,361	1,137	1,092	1,185
Quintile 3	1,155	1,245	1,131	1,404	1,156	1,112	1,179
Quintile 4	1,149	1,237	1,122	1,356	1,152	1,124	1,204
Quintile 5	1,173	1,244	1,124	1,379	1,216	1,141	1,644

Source: Calculated from the 2004 SUSENAS

Table 6. Average Monthly Subsidy Received by *Raskin* Beneficiary Household/Rp

	Indonesia	Sumatra	Java/Bali	Kalimantan	Sulawesi	Maluku/ NTB/NTT	Papua
(Market Price: Rp2,790)							
Total	***8,393***	***12,692***	***7,870***	***11,849***	***12,659***	***14,023***	***14,300***
Quintile 1	8,593	12,621	7,920	11,736	13,741	13,695	13,638
Quintile 2	8,364	12,546	7,881	12,281	12,563	14,020	11,482
Quintile 3	8,260	13,289	7,948	12,653	11,481	13,918	15,455
Quintile 4	8,280	12,258	7,736	12,052	12,634	14,283	18,463
Quintile 5	8,351	12,771	7,783	10,518	11,383	15,922	12,276
(Market Price: Rp3,340)							
Total	***11,235***	***17,222***	***10,500***	***16,468***	***16,914***	***18,592***	***19,629***
Quintile 1	11,504	17,134	10,590	16,267	18,293	18,103	18,595
Quintile 2	11,191	17,001	10,519	17,032	16,768	18,586	15,438
Quintile 3	11,054	18,045	10,598	17,702	15,368	18,505	20,762
Quintile 4	11,070	16,623	10,300	16,700	16,900	19,024	24,901
Quintile 5	11,208	17,339	10,366	14,642	15,382	21,260	18,200

Source: Calculated from the 2004 SUSENAS

Based on the quantity bought and price paid by *Raskin* beneficiaries, it can be estimated that, on average, a beneficiary household could receive subsidy equivalent to around Rp 8,393 to Rp 11,235. Assuming that average household size was 4.9 people, this monthly subsidy was equivalent to a per capita transfer of Rp 1,713 to Rp 2,293 or around 1.7% to 2.2% of the

official poverty line. These estimations are calculated on the assumption that the market price of rice was somewhere between the BULOG procurement price of Rp 2,790 and the GoI purchase price from BULOG of Rp 3,340 per kg.[7] Because of the differences in quantity bought and price paid by *Raskin* recipients across regions and across different welfare levels, the subsidy received also varies. On average, the household in the fourth quintile in Java received the lowest subsidy, while the household in the fourth quintile in Papua received the highest of more than double the subsidy received by the average household in Java.

As presented in Table 7, out of the total *Raskin* subsidy received by the people, only 29% went to the 20% poorest households, and only around 52.4% went to households in quintile 1 and 2 combined, that can be considered as the poor and the vulnerable (near-poor). The proportion of subsidy received by the poor and the vulnerable was largest in Maluku/NTB/NTT regions, followed by Sulawesi. On the other hand, the poor and the vulnerable in Kalimantan and Sulawesi received the least. In total, most of the *Raskin* subsidy went to Java (65%) and Sumatra (21%), and the rest was distributed to other regions (Figure 3).

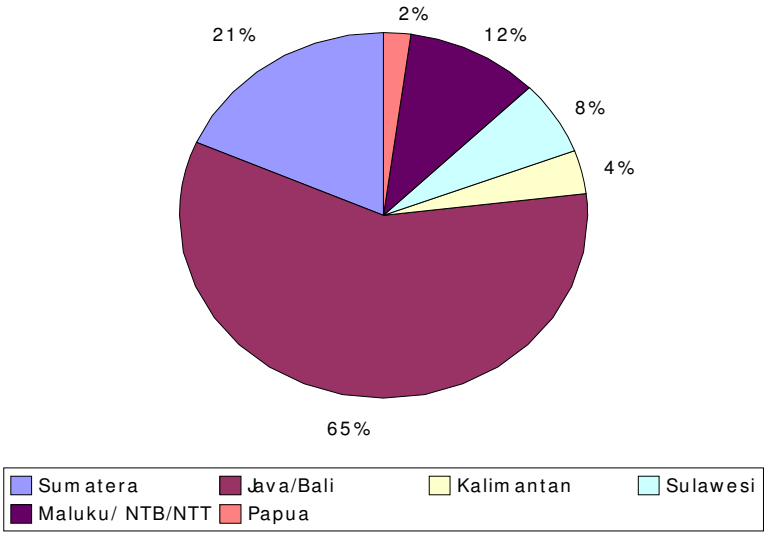

Figure 3. Distribution of Raskin Subsidy Across Regions, 2003

Table 7: Proportion of Subsidy (%) Received by Various Welfare Levels

	Indonesia	Sumatra	Java/Bali	Kalimantan	Sulawesi	Maluku/ NTB/NTT	Papua
Total	***100***	***100***	***100***	***100***	***100***	***100***	***100***
Quintile 1	29.1	29.3	27.0	19.1	37.5	43.2	18.8
Quintile 2	23.3	22.3	23.8	20.6	23.2	23.5	15.6
Quintile 3	19.7	19.9	21.1	21.1	16.8	15.0	21.7
Quintile 4	16.4	15.6	17.0	21.3	13.9	10.6	24.6
Quintile 5	11.5	12.9	11.2	17.9	8.5	7.6	19.3

Source: Calculated from the 2004 SUSENAS

[7]These prices could be used as a benchmark estimate, as the current (2005) price of rice in Jakarta for medium quality rice, for example, ranges between Rp2,800 to Rp3,000 per kg.

2.4 Budget Allocation and Effectiveness

In 2002, the GoI allocated almost Rp4.23 trillion for the *Raskin* program, and it increased to Rp4.83 trillion in 2003, Rp4.83 trillion in 2004, and Rp4.68 trillion in 2005. The budget for 2005 is not fixed yet, and other sources stated that the 2005 budget for *Raskin* will be Rp4.99 trillion, or Rp4.97 trillion. These budgets accounted for around 0.20 percent of Indonesia's gross domestic product (GDP) during this period. *Raskin* also took a substantial portion of the Government's development expenditures. In 2002, the *Raskin* budget accounted for around 11% of the development budget, and it decreased to 8.2%, 7.8% and 5.6% in 2003, 2004 and 2005, respectively (Tabor and Sawit, 2005).

Although *Raskin* is one of Indonesia's biggest social protection programs, the effectiveness of the program is still debatable. A study conducted by Tabor and Sawit (2005) argued that the real cost incurred by BULOG was greater than what has been paid by GoI, meaning that BULOG is actually subsidizing the program. According to Tabor and Sawit's calculation, the total costs of the *Raskin* program were Rp7.4 trillion in 2002, Rp7.2 trillion in 2003, and Rp7.6 trillion in 2004. Of these total costs, Rp2.23 trillion were covered as co-payments from beneficiaries in 2002; Rp2.02 trillion from beneficiaries in 2003, and Rp2.06 trillion from beneficiaries in 2004. Excluding costs recovered, the total *Raskin* costs were Rp5.12 trillion in 2002, Rp5.16 trillion in 2003, and Rp5.6 trillion in 2004. They came up with this cost after considering other costs, which include: procurement, packaging, exploitation, management, interest charges, and carry over costs. Annex 2 provides the budget and cost estimation.

On the other hand, McCulloch (2005) argued that it could not be the case. According to his calculation, assuming BULOG pays the rice purchase price of Rp2,790/kg for the rice it purchases and sells it to households at Rp1,000/kg, then the subsidy to households is Rp3.69 trillion. The remaining Rp1 trillion or 21% of the *Raskin* budget is retained by BULOG to cover their operating costs. Regarding BULOG's claim that additional funds are needed to cover the operational costs of the program, most notably the interest cost which they incur when they borrow for the purpose of making the initial purchases, he argued that private traders also borrow for the purpose of making purchases of *gabah*, which is milled and transported to village markets at the market price. In principle, therefore, all BULOG should need is the difference between the market price and the price at which it sells the rice (Rp1,000/kg). In practice it is paid the difference between the administrative purchase prices which is above the market price. Furthermore, he pointed out that an analysis of the 2002 SUSENAS data indicates that only 26 percent of the *Raskin* recipients are poor. This implies that only Rp0.96 trillion, or 20 percent of the *Raskin* budget is provided as a subsidy to the poor, with Rp2.73 trillion going to the non-poor.

An estimation based on the 2004 SUSENAS is presented in Annex 4. This estimation revealed that total rice purchased from *Raskin* in 2003 was around 1.237 million tonnes, an amount equivalent to 61% of the rice quantity disbursed in 2003 reported by BULOG (see Table 1).[8] Out of this purchased quantity, only 29% went to the 20% poorest quintile and, in total, 52% went to the poorest and the near poor (quintiles one and two). So, it implies that only 17.68% of the *Raskin* rice (as reported by BULOG) was received by the poorest (quintile one), and around 31.72% received by the poorest and the near poor (quintile one and two).

[8]This estimation is based on the data on the amount purchased during the last three months (around November 2003 – January 2004) and multiplied by 4 to estimate rice purchased in one year. There is a possibility, however, that the rice distribution was not stable in one year period and this might cause this gap.

Based on the data on the quantity purchased by average households and the prices they paid, it can be estimated that the total subsidy received by all *Raskin* beneficiaries could range between Rp2,020.78 billion to Rp2,704.95 billion, or 42% - 56% of the *Raskin* budget in APBN 2003. This estimate is calculated using two market price assumptions, which is the BULOG purchasing price (Rp2,790 per kg rice) as the minimum price and GoI purchase price from BULOG (Rp3,340 per kg rice) as the maximum price. The household purchasing price is taken from the household purchasing price collected in SUSENAS, as it reflects the real cost paid by the households. Because only 29% of the rice was enjoyed by the poorest, and around 52% was enjoyed by the poorest and the near-poor, the estimated subsidy that went to the poorest quintile was around Rp588.95 billion to Rp788.50 billion, which is equivalent to 12%-16% of the APBN budget for *Raskin*. If the target was to be the poorest and the near-poor that belong to the first and second quintiles, the subsidy that they received was around Rp1,058.22 to Rp1,416.33, or equivalent to 22% to 29% of the *Raskin* budget in APBN. These figures indicate that only a very small fraction of the subsidy through the *Raskin* program was received by the poor and the near poor, for whom the program had been designed.

2.5 Institutional Structure and Incentive Effects

The *Raskin* program is implemented though a collaboration between various government agencies:

- The Ministry of Home Affairs (MoHA) through the Directorate General of Regional Community Development (PMD) is responsible for guiding and implementing the program.
- The Ministry of Finance (MoF) through the Directorate General of Budget is responsible for providing the subsidy.
- BKKBN is responsible for the provision of data to determine poor families who will receive the programs' benefits.
- *Perum* BULOG (The National Food Logistics State Company) is responsible for providing the rice, distributing it to localities, and collecting the subsidy from MoF.
- Local governments are the implementing agencies for the program at local level (provincial, district) but the structure depends on the existing administrative arrangements of each agency and this varies across localities.
- The sub-district and village administration are responsible for the distribution of the rice to targeted families and collecting payments from them. Although the distribution points are determined based on the agreement between local government and local BULOG office, they are usually located at the village government's office.

With regards to monitoring and evaluation, neither BULOG nor any other institution has a regular monitoring mechanism for *Raskin*'s targeting performance (McCulloch's note, 2005). The only routine monitoring mechanism has been developed through SUSENAS by including questions since the 2002 SUSENAS on whether the sample household received benefits from several programs including *Raskin*. BULOG, however, seems to have rarely used the result for their evaluation. Local government and the PKPS BBM monitoring team should conduct regular monitoring activities to look at whether the program has been delivered to the right target, in the right amount, at the appropriate time, in the appropriate quality, and has been utilized for the stated purpose. It is not clear, however, how this monitoring will contribute to the betterment of the program. Evidence shows that it works only in cases where large-scale corruption or misuse of rice was found.

In non-regular monitoring activity, both OPK and *Raskin* have been monitored and evaluated, both by implementers and by independent NGO and University teams. On OPK, the first evaluation from independent institution was the HIID project at the Ministry of Finance that conducted rapid field assessments of OPK in Lombok and West Java. This was followed by

the teams of SMERU's Crisis Impact researchers who visited 10 districts in five provinces to learn more about the implementation of OPK: the targeting, leakage, quality of rice, administration and deliver issues. Other site-specific analyses conducted included the study by *Tim Pengendali JPS*, LP3ES, Ministry of Finance, and Benjamin Olken in collaboration with the SMERU Research Institute team. More than 10 prominent universities spread across the provinces were also asked by BULOG to evaluate the program. Based on BPS's 100 village-survey in 1999 and the 1999 SUSENAS, SMERU did quantitative analysis of targeting of the program. Apart from that, until 2001, there has not been a systematic representative or nation-wide assessment of OPK and its implementation or impact. In addition, for *Raskin*, notable examples of field-study based evaluations of the *Raskin* program include Hastuti and Maxwell (2003), University of Indonesia (2003 and 2004), Gajah Mada University (2003), Brawijaya University (2003) and a group of 35 universities and the Coordinating Minister for Social Affairs (2004). Finally, the most recent study was a macro assessment conducted by Steve Tabor from Emsi and Husein Sawit from the Ministry of Agriculture.

This institutional arrangement seems to be too loose in the sense that there is no single government agency or institution that is mandated to lead the program, and accountable for the overall performance of the program. The multi-agencies cooperation could possibly lead to nobody accepting responsibility for failures, or blaming other agencies for the poor program performance. This provides no incentive for any agencies involved to look into, and improve, the program performance over time. In addition, according to Hastuti and Maxwell (2003), the institutional arrangement of *Raskin* suffers from at least three weaknesses, namely: (1) lack of coordination among related government agencies; (2) additional workload of sub-district and village government officials; and (3) lack of transparency in the distribution of the operational funds.

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Annex 1. Subsidized Rice Programs 1998/1999 – 2002: Disbursements and Quotas

Province	1998/1999 OPK (tonnes)	1999/2000 OPK (tonnes)	2000 OPK (tonnes)	2001 OPK (& PPD-PSE) (tonnes)	2002 *Raskin* (& PKS-BBM)				
					Allocation (tonnes)	Disburse-ments (tonnes)	Target No. of Families	KPS ALEK	KS1 ALEK
Aceh Darussalam	17,418	79,993	48,596	58,793	77,977	85,691	324,070	237,059	213,891
North Sumatra	8,552	46,121	26,092	31,933	40,310	32,224	167,958	184,886	394,293
Riau	9,354	35,315	20,086	24,472	33,856	26,573	141,069	76,632	157,460
West Sumatra	1,417	18,289	11,672	17,975	24,789	25,470	103,286	16,307	117,442
Jambi	7,758	22,399	10,526	14,774	20,426	21,434	85,109	118,203	11,067
South Sumatra	26,644	65,865	21,209	42,119	57,886	63,886	241,192	248,842	307,910
Bangka & Belitung	–	–	–	–	6,441	7,641	26,838	–	–
Bengkulu	5,695	13,523	9,770	17,411	23,315	25,612	97,147	44,541	85,979
Lampung	65,590	122,501	64,969	72,324	114,139	125,585	475,579	429,916	297,011
DKI Jakarta	6,804	18,172	12,915	20,559	28,278	24,258	117,825	11,794	116,157
West Java	115,976	435,145	197,200	233,026	270,867	266,522	1,128,613	1,100,809	1,823,309
Banten	–	–	–	–	44,348	53,691	184,783	–	–
Central Java	367,383	706,206	357,946	325,658	498,007	498,006	2,075,031	1,934,757	710,172
Yogyakarta	16,082	41,350	21,144	31,829	43,385	43,385	180,770	128,052	143,764
East Java	299,006	579,827	277,314	250,305	428,763	424,619	1,786,511	1,799,518	933,541
West Kalimantan	4,364	30,772	18,856	25,184	30,431	30,364	126,797	9,990	188,822
East Kalimantan	1,521	14,453	7,766	12,956	17,599	21,590	73,331	35,677	93,016
South Kalimantan	4,160	31,310	17,917	24,893	34,187	36,013	142,444	50,955	146,350
Central Kalimantan	3,934	12,492	10,075	13,575	19,969	22,079	83,206	43,897	88,056
North Sulawesi	8,673	42,449	16,509	24,087	18,224	20,206	75,933	73,296	69,471
Gorontalo	–	–	–	–	11,660	13,116	48,582	–	–
Central Sulawesi	3,764	21,070	16,376	28,521	30,604	34,559	127,516	128,116	90,648
Southeast Sulawesi	4,921	18,969	23,699	19,323	19,902	22,438	82, 925	87,537	114,390
South Sulawesi	10,146	69,432	28,235	32,858	40,370	44,634	168,207	191,868	335,171
Bali	691	7,015	6,453	7236	11,003	12,922	45,844	37,896	56,030
West Nusatenggara	25,549	68,836	39,170	42,442	65,784	72,731	274,099	312,236	244,175
East Nusatenggara	15,674	44,970	40,191	47,374	84,355	92,828	351,481	585,538	–
Maluku (Ambon)	3,745	8,907	18429	31,630	21,609	28,928	90,038	135,605	69,578
North Maluku	–	–	–	–	10,020	7,702	41,750	–	–
Irian Jaya (Papua)	8,429	35,853	31,135	30,574	38,596	42,141	160,816	236,400	92,181
East Timor	7,124	6,947	–	–	–	–	–	–	–
Total	**1,050,374**	**2,598,180**	**1,353,248**	**1,481,829**	**2,167,100**	**2,226,847**	**9,029,584**	**8,260,327**	**6,899,8844**

Source: Hastuti and Maxwell, 2002:

Notes:

(a) Figures for 1998-1999, 1999-2000, 2000, and 2001 are the actual disbursements of subsidized rice. The data are sourced from BULOG records. The time span of the 1998-99 and 2000 phases of the OPK program was nine months only; all other phases were for a full twelve-month period.

(b) Figures for the 2002 *Raskin* program (including PKS-BBM) are BULOG's own announced allocations (tonnage quotas and the target number of families that the program was intended to reach) and the actual tonnage of rice disbursed throughout the course of the twelve months of the program. The data on disbursements are taken from BULOG's own official figures based on the monthly reports received from Dolog offices in all provinces. The figures on KPS ALEK and KS-1 ALEK included above are those used by BULOG to allocate quotas to each of the provinces in 2002, and were drawn from BKKBN 2000 data.

Annex 2. *Raskin* Budget and Cost

	2002	2003	2004	2005
APBN *Raskin* (Billion Rp)	**4,238.7**	**4,830.8**	**4,827.1**	**4,682.5**
APBN-Revised *Raskin* (Billion Rp.)	-	-	-	4,968.0
Government Purchase Price for Rice from BULOG (HPP Rp/kg)	2,804.0	3,343.0	3,343.0	3,494.0
APBN *Raskin*/GDP (%)	0.23	0.24	0.21	0.19
APBN *Raskin*/Development Expenditure (%)	11.91	8.23	7.82	5.60
BULOG Procurement Price (Rp/kg)				
- Rough Rice (*gabah*)	1,519.0	1,725.0	1,725.0	1,765.0
- Milled Rice (*beras*)	2,470.0	2,790.0	2,790.0	2,790.0
Realized *Raskin* Program Costs per kg delivered				
Procurement Cost	1,781.55	1,582.09	1,410.14	
Packaging Cost	96.59	106.74	36.83	na
Exploitation Cost	157.54	175.75	175.84	na
Management Cost	87.54	84.52	90.35	na
Bank Fees	21.53	25.32	21.41	na
Interest Charges	280.51	277.44	232.32	na
Historic Cost and Carry Over Costs	677.21	1,086.98	1,494.67	na
Total Realized APBN Costs	3,102.47	3,338.84	3,461.56	na
Distribution Point to beneficiary Indirect Costs *) (Rp/kg)	190.00	210.00	250.00	na
Total Costs/kg delivered to program beneficiaries	**3,292.47**	**3,548.84**	**3,711.56**	**na**
Total Tonnages (,000 kg) and Cost (Rp1,000/kg)	2,235.14	2,023.70	2,060.20	na
Total Costs (million Rp.)	7,359.12	7,181.78	7,646.55	na
Total Costs less beneficiary co-payment (trillion Rp)	**5.12**	**5.16**	**5.59**	**na**

Source: Tabor and Sawit, 2005: 12-14
Note: *) Estimated total costs of distributing the rice from the distribution points to the communities (including the use of local labor to distribute and manage the program).
These figures are based on field-based program evaluations
Na = data not available

Annex 3. Target and Realization of *Raskin* Program

	2000	2001	2002	2003	2004
Number of Target (Planned) - families	7,500,000	8,700,000	9,790,000	8,580,313	8,590,804
Number of Beneficiaries (Realization) - families	10,934,861	8,316,185	12,333,923	11,832,897	11,664,050
Number of poor families		15,000,000	14,782,000	15,135,561	15,746,843
% Target to the Number of Poor Families		58.00	66.23	56.69	54.56
% Beneficiaries to the Number of Poor Families		55.44	83.44	78.18	74.07

Source: BULOG, 2005

Annex 4. Estimation of *Raskin* Benefit and Efficiency, 2003

APBN *Raskin*	4,827.10	Billion Rp		
Raskin Quantity (BULOG)	2,023,698	tonnes		
Number of Target (Plan)	8,580,313	families		
Rice/Family (Plan)	235.85	kg/year		
	19.65	kg/month		
GoI Purchase Price (I)	3,343	Rp/kg		
BULOG Procurement Price (II)	2,790	Rp/kg		
Raskin Selling Price	1,000	Rp/kg		
Total Subsidy (I)	4,741.52	Billion Rp	98%	of APBN
Total Subsidy (II)	3,622.42	Billion Rp	75%	of APBN
Subsidy/Family (I)	46,050	Rp/month		
Subsidy/Family (II)	35,182	Rp/month		
2004 SUSENAS Data:				
Total Population	54,862,825	households (HH)		
Raskin Beneficiaries - Total	20,063,738	HH		
Q1	5,711,865	HH	28%	of Total
Q1 & Q2	10,400,946	HH	52%	of Total
Quantity of *Raskin* Purchased - Total	5.14	kg/HH/month		
Q1	5.26	kg/HH/month		
Q1 & Q2	5.19	kg/HH/month		
Price of *Raskin* - Total	1,157	Rp/kg		
Q1	1,158	Rp/kg		
Q1 & Q2	1,156	Rp/kg		
Raskin Purchased - Total	1,237,198.30	tonnes	61%	of BULOG Quantity
Q1	360,856.44	tonnes	29%	of Total
Q1 & Q2	647,570.18	tonnes	52%	of Total
Subsidy/HH (I) - Total	11,235	Rp/month		
Q1	11,504	Rp/month		
Q1 & Q2	11,348	Rp/month		
Subsidy/HH (II) - Total	8,393	Rp/month		
Q1	8,593	Rp/month		
Q1 & Q2	8,479	Rp/month		
Total Subsidy (I) - Total	2,704.95	Billion Rp	56%	of APBN
Q1	788.50	Billion Rp	16%	of APBN
Q1 & Q2	1,416.33	Billion Rp	29%	of APBN
Total Subsidy (II) - Total	2,020.78	Billion Rp	42%	of APBN
Q1	588.95	Billion Rp	12%	of APBN
Q1 & Q2	1,058.22	Billion Rp	22%	of APBN

III. SSN AND PKPS BBM FOR EDUCATION SECTOR SCHOOL GRANTS AND SCHOLARSHIPS

At the start of 2005/06 academic year (July 2005), the Government of Indonesia (GoI) introduced a big change in the programs to compensate the removal of fuel subsidy (PKPS-BBM) for education sector by introducing a new scheme known as *Bantuan Operasional Sekolah* – BOS (assistance for school operational costs) for primary and junior high schools (SD and SMP), whilst maintaining *Beasiswa Khusus Murid* – BKM (scholarship for students) for students at senior high school level (SMA). These schemes replaced the previous schemes consisting of BKM (*Bantuan Khusus Murid* – Special Assistance for Students) managed by the Ministry of National Education (MoNE) and the Ministry of Religious Affairs (MoRA)[9], and BKG (*Bantuan Khusus Guru* – Special Assistance for Teachers) managed by MoRA. The objective was that such programs are important to maintain enrollment rate of students at primary and secondary schools. Based on SMERU studies and other related sources this paper will analyze how this program worked and the impact it generated on the provision of basic education in the country.

3.1 Brief Description of the Program

The main objective of the BOS program is to ease the burden of the people in paying school fees in order to complete 9 years compulsory basic education. BOS provides block grants to primary and junior high schools to be used for paying selected school operational costs in order to provide free education or reduce school fees and maintain the quality of education, as well as providing special assistance in the form of a transportation allowance to the needy. The amount of the block grant is calculated based on the number of students enrolled. Its complementary payment, the BKM for students in senior high schools is aimed at providing assistance to senior high school students from poor families in order to prevent school dropouts at the senior high school level. These programs are managed by the Ministry of National Education in cooperation with the Ministry of Religious Affairs.

Historically, the government has provided assistance to schools and students through various programs. Table 1 presents the evolution of this assistance. Before fiscal year (FY) 1998/1999, government assistance for paying school operational cost was funded by government routine budget called *Bantuan Operasional Pendidikan* (BOP). In addition to BOP, school operational costs were covered by parents' contributions known as *Badan Pembantu Penyelenggara Pendidikan* (BP3). BOP for primary schools was funded by *Kabupaten/Kota*, while BOP for junior and senior high schools was funded by provincial and central governments.[10] Because of the limited fiscal capacity of *Kabupaten/Kota* governments and the large numbers of public primary schools that are located in almost all villages, the condition of primary schools was relatively poorer compared to public junior and senior high schools. There was also scholarship program with very limited coverage (around 1% of total students). These scholarships were provided by various sources, including GN-OTA (National movement of foster parents), Supersemar Foundation, and other private institutions and foundations.

[9] MoRA manages public Islamic schools.

[10] After the implementation of regional autonomy in early 2001, district governments still provide financial assistance to primary, junior high and senior high schools, especially public schools, although the amount of grants is usually small and varies across districts.

As a response to the economic crisis in 1997, the GoI initiated social safety net (SSN) programs for the education sector starting in 1998/1999 academic year. This program lasted until the 2002/2003 academic year. The SSN program for education sector consisted of block grant to schools known as *Dana Bantuan Operasional* (DBO) and scholarship program. The schools eligible for this program were all private, public and religious schools, including: primary schools (*Sekolah Dasar* - SD), primary schools for students with special needs (*Sekolah Dasar Luar Biasa* - SDLB), Islamic primary schools (*Madrasah Ibtidaiyah* – MI), junior high schools (*Sekolah Menengah Pertama* - SMP), junior high schools for students with special needs (*Sekolah Menengah Pertama Luar Biasa* - SMPLB), Islamic junior high schools (*Madrasah Tsanawiyah* – MTs), senior high schools (*Sekolah Menengah Atas* - SMA), senior high schools for students with special needs (*Sekolah Menengah Luar Biasa* - SMLB), vocational schools (*Sekolah Menengah Kejuruan* - SMK), and Islamic senior high schools (*Madrasah Aliyah* – MA). DBO was aimed at maintaining the education service provided by schools after the crisis that significantly increased the cost of education. It provided block grants to selected schools amounting to Rp2 million per month for SD, Rp4 million per month for SMP and Rp10 million per month for SMA. In addition, the scholarship program provided money to poor students in the amount of Rp10,000 per month for primary school students, Rp20,000 per month for junior high school students, and Rp25,000 per month for senior high school students. This scholarship was to be used for paying all costs related to schooling activities, including transportation costs. This scholarship was intended to prevent student dropouts, so that students from poor families could continue their study, at least until they completed junior high school. This program was managed by the Ministry of National Education in cooperation with the Ministry of Home Affairs (MoHA) and Ministry of Religious Affairs (MoRA).

Table 1. The Evolution of Grants and Scholarship Programs

1997	*1998*	*1999*	*2000*	*2001*	*2002*	*2003*	*2004*	*2005*
1. BOP & Scholarship								
	2. SSN for Education Sector – DBO & Scholarship							
				3. PKPS – BBM for Education Sector				
				3a. BKS, BKM & Scholarship for university students	3b. MoNE (BKM & Scholarship for university students); MoRA (BKM & BKG)			3c. BOS for SD & SMP, and BKM for SMA

Following the removal of the fuel subsidy in 2001, the GoI also created programs for the education sector to compensate for the removal of this subsidy (PKPS-BBM). This PKPS BBM[11] program for the education sector was designed to complement the ongoing SSN program in the sector. In 2001, the PKPS-BBM for the education sector was implemented by MoNE and it consisted of scholarships for students at primary, junior high and senior high schools called *Bantuan Khusus Murid* (BKM), and block grants to schools called *Bantuan Khusus Sekolah* (BKS). BKM provided scholarships to selected students in the same amount as provided by scholarships under the SSN program. BKS was, however, distributed for only one semester in the amount of Rp40 million for primary schools, Rp50 million for junior secondary schools and Rp60 million for senior secondary schools for one semester. The BKS was no longer continued in the following years.

[11]In 2001 and 2002, this program was called PPDPSE, an acronym for *Program Penanggulangan Dampak Pengurangan Subsidi Energi* (Program for reducing the impact of reduction in energy subsidy).

In 2002, the management of the programs was split into two. One was managed by the Ministry of National Education and the other was managed by the Ministry of Religious Affairs.[12] Since this year, the program managed by MoNE only consisted of BKM for public and private schools and it was integrated through the JPS Program. It had been implemented by structuring *Bantuan Khusus Murid* - BKM (scholarship for students) in such a way that it provided scholarships to the groups that did not receive scholarships under the SSN program. In the first semester of the program, the BKM was targeted at students in primary school grades 1 to 4, and grade 1 in junior high school, as these groups were not covered by the SSN scholarship program that were awarded to grade 4 and above in primary school. Similarly, in the following years the BKM scholarships moved in where the SSN scholarship moved out, and as of August 2003 the BKM has completely replaced the SSN scholarship (Sparrow, et al., 2003).

The program managed by MoRA adopted a slightly different arrangement by diverting part of the program to provide assistance to school teachers that mostly did not hold civil servant status. So the program under MoRA management consisted of BKM, assistance for teachers known as *Bantuan Khusus untuk Guru* (BKG) and assistance for contract teachers known as *Bantuan Khusus Guru Kontrak* (BGK) for Islamic schools (*Madrasah*).

For primary and junior high schools, the BKM, both under MoNE as well as MoRA management, lasted until the end of the 2004/2005 academic year, and was replaced by the new scheme, BOS. Meanwhile, the BKM program for senior secondary schools still continues although the scholarship benefit has been increased to Rp 65,000 per student per month.

3.2 Coverage and Targeting Performance

The SSN scholarship program was targeted to cover around 6% of students at primary school, 17% at junior high school level, and 10% at senior high level. The BKM introduced under the PKPS BBM program added more than two million scholarships for primary school students, more than one million for junior high school students, and around 400 thousand for senior high school students. As presented in Table 2, these additional numbers should increase the scholarship coverage to more than 10% of students at primary school in 2001/02 and by as much as 20% in 2003/04. For junior high school students, the coverage increased to 21% in 2001/02 although it decreased to around 16-18% in 2003 and 2004. For students at senior high school level, the coverage increased to more than 10% in 2001/02 and the following years.

In addition, the school grants, DBO, was targeted to cover around 60% of schools at all levels or some 1,094,968 primary schools, 18,282 junior high schools and 9,374 senior high schools. The BKS that lasted only one semester, which was in the first semester of the 2001/02 academic year, provided grants to a very limited number of schools (3,500 or 11% of total SD) primary schools, 2,030 (1% of the total) junior high schools, and 685 (2%) senior high schools. These grants were distributed to all districts (*kabupaten/kota*), except 35 districts that already received assistance from School Improvement Grant Programs provided by Dutch Trust Funds.

By allocating to a limited number of students, the scholarship programs, both those provided through SSN scholarships and BKM, was intended to be targeted to the needy, which were students from poor or low income families. To be able to reach the target group, both

[12]The argument for this split was because most Islamic schools under the supervision of MoRA need to be better captured by the program.

programs had developed a decentralized mechanism of allocation and selection using a combination of geographical targeting in defining regional allocations and individual targeting using certain criteria in selecting beneficiaries. The process involves four levels of committees (central, district, sub-district and school levels) in the case of SSN and three levels of committees (central, district and school levels) in the case of BKM. It started with allocation at the central (national) level and ended at the selection of students at the school level by the school administration and school committees that in theory should include the participation of the wider community. The individual selection was based on a consideration of family socio-economic backgrounds, such as families living in poverty, single parent and large households, orphan, or family welfare status according to BKKBN classifications. In addition, there were also other considerations such as distance of the house from school and the threat of dropout because of economic reason. In principle, both programs adopted similar mechanisms with slight differences in the use of criteria and the omission of the *kecamatan* (sub-district) selection team in the allocation of BKM program (details of the mechanism and criteria for selection are presented in Annex 1.).

Looking at the performance in the early implementation of SSN scholarship, an analysis using data from the 1999 SUSENAS special module found that the scholarship program only covered approximately 4% of students at the primary school level, 8% at junior high school, and 4% at senior high school (Sumarto and Suryahadi, "Principles and Approaches.."). This figure is relatively low compared to the planned coverage, while another study by Cameron using the 100-villages survey data, found a more encouraging result that the scholarship was received by 8.4% of students at primary school level, 13.6% at junior high school, and 9.6% at senior high school (Cameron, "Did Social Safety…"). The low estimation produced by the 1999 SUSENAS data might be due to the fact that it had not yet covered the whole program implementation. The 1999 SUSENAS covered only the previous six months of its implementation. On the other hand, the 100-villages is more limited in scope and focused more on poor villages so that it potentially gave an overestimation result (Perdana and Maxwell, 2004). Another estimation based on a nationwide survey by CIMU ("The Scholarship and Grant") found that the scholarship coverage in the 1999/2000 academic year was 7%, 20% and 11% among students in primary, junior high, and senior high school respectively. The improvement over the previous academic year was claimed to be attributed to the refinement in information dissemination resulting in a better performance by the allocation committee.

Using the 100-villages data set, Suryahadi, Suharso and Sumarto (1999) found that the coverage of the scholarship program varies greatly across districts included in the survey.[13] The scholarship coverage among primary school students ranged between 26.9% (in Banjarnegara) and 0.87% (in Sumedang), while among junior high school students ranged between 53.68% (in Banjarnegara) and 1.60% (in Sumedang). This might reflect the unequal distribution across districts, resulting from the allocation process done by the national committee.

[13]This survey covered 100 villages located in 10 districts that spread across 8 provinces.

Table 2. Coverage Plan of the Scholarship and BOS Programs

Academic Year/ Semester		Primary School					Junior High School					Senior High School		
		SSN Scholarship	BKM MoNE	BKM MoRA	BOS	Total	SSN Scholarship	BKM MoNE	BKM MoRA	BOS	Total	SSN Scholarship	BKM MoNE	Total
1998/99	I	6,20%				6,20%	17,00%				17,00%	9,30%		9,30%
	II	6,20%				6,20%	17,00%				17,00%	9,30%		9,30%
1999/00	I	6,20%				6,20%	17,00%				17,00%	9,30%		9,30%
	II	6,20%				6,20%	17,00%				17,00%	9,30%		9,30%
2000/01	I	6,20%				6,20%	17,00%				17,00%	9,30%		9,30%
	II	6,20%				6,20%	17,00%				17,00%	9,30%		9,30%
2001/02	I	4,10%	7,60%			11,70%	11,40%	10,32%			21,72%	6,20%	7,41%	13,61%
	II	4,10%	7,60%			11,70%	11,40%	10,32%			21,72%	6,20%	7,41%	13,61%
2002/03	I	2,10%	7,60%	0,35%		10,05%	5,70%	10,32%	4,13%		20,15%	3,10%	7,41%	10,51%
	II	2,10%	7,60%	0,55%		10,25%	5,70%	10,32%	0,83%		16,85%	3,10%	7,41%	10,51%
2003/04	I		19,87%	0,55%		20,42%		18,06%	0,83%		18,89%		11,12%	11,12%
	II					n.a.					n.a.			n.a.
2004/05	I					n.a.					n.a.			n.a.
	II		20,49%			20,49%		24,29%			24,29%		11,86%	11,86%
2005/06	I				99,81%	99,81%				110,86%	110,86%		12,95%	12,95%

Using the 2002, 2003 and 2004 SUSENAS data set, Table 3 shows that the coverage of scholarships among households with children attending primary to senior high schools was around 9.5% in 2001, decreased to 5.9% in 2002, and rose again to 7.6% in 2003. Although it was significantly higher than the estimation produced from the 1999 SUSENAS, it was certainly not significantly different from, or even slightly lower than, the CIMU estimation for the 1999/2000 academic year. Indeed, the comparison with the 1999 estimation (from SUSENAS) indicates that the BKM had increased the scholarship coverage in general, although it had not achieved the targeted coverage as presented in Table 2. It should be noted, however, that the structure of the question in SUSENAS only allowed for analysis at the household level without detailed information on individual children.[14] So, there is a possibility that a household received more than one scholarship if they have more than one child attending school.[15] On the other hand, there is also the possibility that the parents did not know that their children received scholarships as they are not well informed about it. On the ground studies conducted by SMERU in 2000 and 2003[16] (SMERU, 2000), for example, discovered that some schools kept the scholarship money and deducted unpaid parents contributions directly from that money so that no money was physically given to the students and the parents. In a very limited number of cases, it was even used to pay incentives to contracted teachers or other school operational costs. This practice was found more frequently in Islamic primary schools managed by MoRA since the school and also the students were very poor.

Table 3. Coverage and Targeting of Scholarship Programs, 2001-2003

	% HH received scholarship*)			% Q1 received scholarship*)			% of scholarship received by Q1			Targeting Ratio**)		
	2001	2002	2003	2001	2002	2003	2001	2002	2003	2001	2002	2003
Indonesia	**9.53**	**5.93**	**7.60**	**14.87**	**9.41**	**12.08**	**39.11**	**39.74**	**39.33**	**0.76**	**0.75**	**0.76**
Sumatra	8.05	5.02	6.54	12.37	7.20	8.99	38.67	35.38	35.10	0.77	0.81	0.81
Java/Bali	9.38	5.64	6.74	15.04	9.51	11.45	38.11	40.46	39.25	0.77	0.74	0.76
Kalimantan	11.36	8.61	9.00	14.50	11.32	9.85	25.18	24.05	19.52	0.94	0.95	1.01
Sulawesi	8.14	4.10	7.38	11.90	5.98	11.51	43.6	41.0	47.8	0.71	0.74	0.65
Maluku/NTT/ NTB	19.44	11.35	21.15	24.52	14.83	26.13	56.91	54.98	54.37	0.54	0.56	0.57
Papua	1.75	14.58	13.86	4.15	20.90	14.68	39.85	46.91	22.23	0.75	0.66	0.97

Source: Calculated from Susenas Kor, 2002, 2003, 2004
Note: *) % out of HH with children attending school; **) 0-perfect targeting, 1-no targeting, 1.25-completely mis-targeting

Further disaggregation across regions revealed that the coverage varies across regions with higher coverage in poorer regions such as Maluku/NTB/NTT, Papua and Kalimantan. The changes in coverage over time across regions also show a significant increase in scholarship coverage in Papua that had a very low coverage in 2001. This phenomenon indicates changes in district allocation that might have resulted from the use of different data for calculating the allocation. The allocation of scholarships for each district in 2001 and 2002 used the 1999

[14]It is also not possible to disaggregate the education level of the children involved. The 2002, 2003 and 2004 SUSENAS did not ask questions on the scholarship received by each individual child in the household. Instead it only asked whether the household received a scholarship and this could be one or more scholarships.

[15]It implies that the estimation potentially provides a lower estimation and can not be directly compared to data at the individual level.

[16]The 2000 study was aimed at evaluating the DBO and scholarships programs, and it was carried out in Pontianak, Tangerang, Lombok Timur and Sleman. The 2003 study was aimed at analyzing the targeting and implementation of SSN scholarship and BKM program, particularly at primary and junior high school levels, and it was carried out in Blitar City, Kabupaten Pontianak, Kabupaten Blora and Kabupaten Lombok Timur.

poverty index (Human Poverty Index) that was significantly different from the 2002 updated version of the poverty index being used for calculating the allocation for 2003 and 2004.

The distribution of scholarship recipients across quintiles based on per capita expenditure revealed the targeting performance of the program. The analysis conducted by Sumarto and Suryahadi (2001) using the 1999 SUSENAS special module, estimated that at the primary school level, only 5.8% of the households at the lowest quintiles benefited from the program, while 2% of the highest quintiles also received scholarships. At the junior high school level, 12% of the lowest quintiles received scholarships, while 4.8% of the highest quintiles also received it. At the senior high school level, only 5% of the lowest quintiles received it, while 1.9% of the highest quintiles also received it. The analysis also revealed that the proportion of recipients in the second lowest expenditure quintile was higher for junior and senior high school students compared to those at the primary level.

Responding to this phenomenon, CIMU (2000) argued that, apart from the data problem, one possible explanation for the mistargeting evident among the upper secondary students was the fact that, at this level, students who receive scholarships may be among the poorest at their school, but they are not always the poorest segment of society.[17] In addition, another problem raised in the CIMU report was that by directing scholarships to students who were already in school, a substantial number of the poorest children of school age who have already dropped out of school and are no longer attending school were not eligible for the scholarship. The scholarship coverage among school age children is therefore lower than those figures.

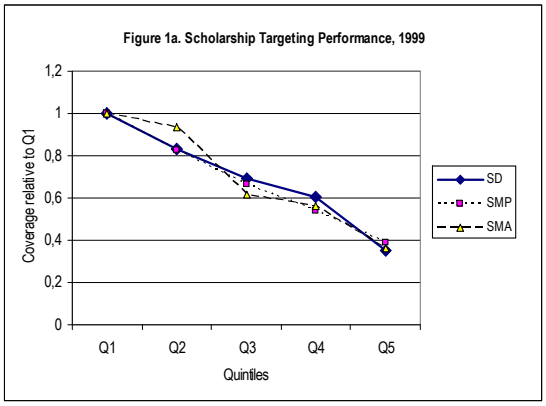
Compared to the 1999 targeting performance, the targeting performance in the 2001-2003 period as presented in Table 3 seems better, in terms of relatively higher coverage of the lowest expenditure quintile. It reflected a tendency of better targeting compared to 1999. A similar trend is also presented by Sparrow (2003). Based on analysis using the 1999 and 2002 SUSENAS data, he found that in the 2001/02 academic year, 70% of the scholarships went to the poorest two quintiles, based on per capita expenditure, and this was an increase from 60% in the first year of the program in 1999. Indeed, it could be said that the targeting performance during 2001-2003 was not good enough as the targeting ratios[18] are still around 0.7, a value close to 1 that implies low or almost no targeting. Even if the households in the second lowest quintile is considered poor, the targeting ratio is still around 0.6, since only 10%, 6% and 8% of the households in the second lowest quintile got scholarships in 2001, 2002 and 2003, respectively.

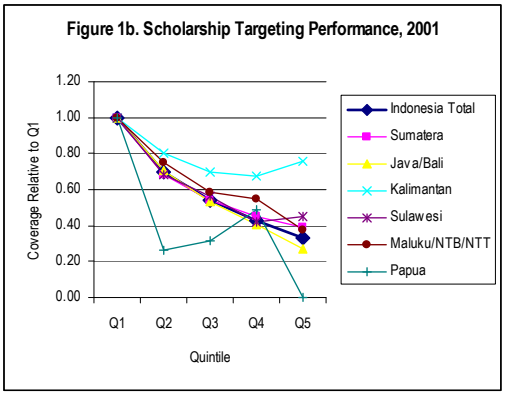
The targeting ratio in different regions has uncovered interesting features. The value of the targeting ratio shows that poverty targeting in the poor regions of Maluku/NTB/NTT is relatively better and stable compared to other regions during the 2001 to 2003 period. On the contrary, the targeting performance in Kalimantan is the worst and is tending to get worse over time. The targeting ratio of Kalimantan in 2003 showed that the proportion of scholarships received by non-poor is almost equal to the non-poor proportion in the population meaning that both poor and non-poor have similar opportunities to get

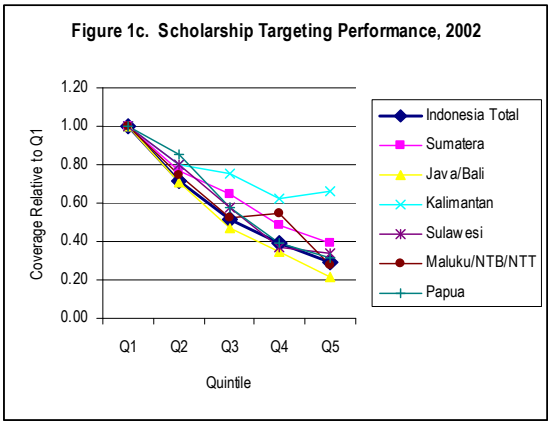
[17]This argument is rather weak, since the estimation based on SUSENAS data has calculated the beneficiaries in each quintile from the population of households that have children in school., and not from the total number of households.

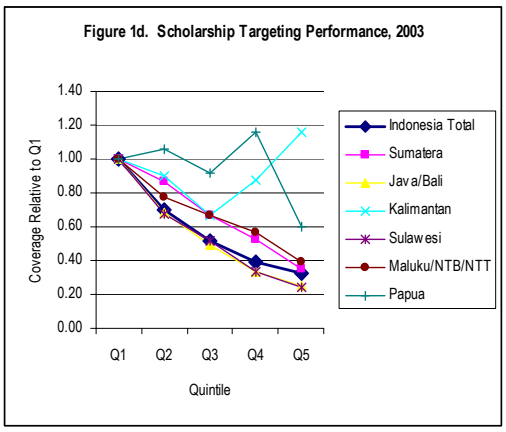
[18]Targeting Ratio (TR) is defined as; TR=Bn/Pn, where Bn is the proportion of beneficiaries who are non-poor (Q2-Q5), and Pn is the proportion of the non-poor out of total population (=80%). If all beneficiaries are poor or perfect targeting, TR=0 as Bn=0; if all beneficiaries are non-poor or completely mis-targeted, TR=1.25; and if TR=1 or the proportion of non-poor beneficiaries is equal to the proportion of the non-poor population, it means there is no targeting.

scholarships. Other regions that show a decrease in targeting performance are Sumatra and Papua. In the Papua case, it seems that a significant increase in scholarship coverage in 2002 and 2003 was not supported by better targeting. The worsening targeting performance indicates that, despite the increase in program coverage in this island, the marginal benefit went more to the non-poor.









The distribution of scholarship benefits across quintiles based on household per capita expenditure, compared to the benefit received by the household in the lowest quintiles are presented in Figure 1a, 1b, 1c, and 1d. These figures provide a better picture of who got more benefit from the scholarship programs in each region, and it also uncovered the targeting problems in Kalimantan and Papua. Given the poor condition of infrastructure in these two big islands, this problem could have its roots in the difficulty in reaching the poor who live in remote areas, while the relatively poorer students selected in the school in an accessible location might not belong to the lowest expenditure quintile by island wide standards. This bias could also happen in the collection of SUSENAS data, because an under-representation of the remote regions in the sampling frame could lead to bias for higher portion of non-poor beneficiaries or under-recording of poor beneficiaries in the remote areas.

In regard to the problems of low coverage and mistargeting revealed above, several qualitative studies and monitoring reports have identified various problems related to coverage and targeting issues. In the early implementation of the SSN program, the allocation of scholarships and grants to districts and to schools was intended to mitigate the impact of the crisis so it should have been based on the estimated impact of the crisis on poverty in each district. The original allocations to districts in 1998 were, however, based on school populations and the 1996 district poverty index. These criteria proved to be only partially effective, and did not reflect the actual impact of the crisis, which affected some parts of the

country far more seriously than others, such as urban areas of Java (CIMU, 2000). A similar problem was also observed in the SMERU rapid appraisal that found that the allocation was based mainly on poverty condition and less on the crisis impact mainly due to lack of data on crisis impact. In addition, this rapid appraisal also identified the problem in the application of IDT village criteria that tent to divert the target focus from the areas hit hardest by the crisis to the poorest districts and poorest regions within the district. This problem was then partly solved by the use of more updated poverty data in 1999.

At the school level, the SMERU rapid appraisal on SSN scholarship and DBO (SMERU, 2000) found that it was difficult for school committees to allocate scholarships among poor students because, in most cases, the scholarship quota was smaller than the number of students that are considered poor and in need of assistance. In some places this had led to the scholarship being awarded in rotation so that more students could be assisted, sharing of the scholarship money with poor students that did not receive scholarship, or even the use of scholarship money to pay all delayed school fees regardless of whether it belonged to the students who got scholarship or not. In some places, however, there were also students from well off families receiving scholarships, and this was mainly due to the limited involvement and control of the wider community. Sparrow et.al. (2003) conducted a qualitative study in Kota Blitar, Kab. Blora, Kab. Lombok Timur and Kota Pontianak in 2003 and still found the same practices. In addition, this study also found that targeting seems to work better in the program under MoNE management than under MoRA, partly because the quota for MoRA was too small compared to the number of poor students and better dissemination of information in the MoNE operation. In general, however, most primary schools complained about the insufficient scholarship quota, a complaint that was less frequently mentioned in junior high schools. The targeting problem in junior high schools is more the result of the limited knowledge of the school and the school committee about the socio-economic background of the students and this made the selection process more difficult.

Unlike scholarship programs that can be evaluated using a nationwide survey like SUSENAS, DBO targeting performance could not be captured from the existing nationwide data collection. It is, therefore, rather difficult to assess the coverage and targeting performance of DBO. A small study conducted by SMERU (2000) in 2000 discovered that in the four visited districts, DBO was given to relatively poor schools. There were, however, a large number of poor schools that did not receive DBO because of the limited DBO allocation. The use of IDT village criteria was widely criticized, especially in selecting junior high schools because students came from surrounding villages so that this criteria was difficult to apply. Complaints about insufficient quota was more prevalent within Islamic schools and poor private schools because they felt that they were poorer than the average public schools but they got less attention and more limited DBO quota. CIMU (2000) also highlighted that poor private schools received 10% less than public schools. In addition, a monitoring study conducted by the Demographic Institute of the University of Indonesia and SSN Work Force in 2000 found that one school reported as DBO recipient was not actually receiving it (Irawan et.al., 2001).

BOS, which was introduced at the start of 2005/06 academic year, makes allocations to all students at primary and junior high school levels, including students in traditional Islamic boarding schools, Islamic schools, and non-Islamic religious schools so that in theory it will cover 100% of students at that level (Table 2). Meanwhile, the allocation of BKM for senior high school students only increased slightly compared to the allocation in the previous year.

Although it means to cover all students at primary and junior high schools, BOS is significantly different from the scholarship program as it does not provide direct transfers to individual students but rather to the school. This scheme is more like a new and bigger grant to schools, complemented with additional tasks for the school to provide special assistance to poor students. The guidelines state that the schools which agree (by signing a letter of agreement) to receive BOS should provide free education to all students if the school's budget can be fully covered by the fund provided by BOS. In the case where the school budget could not be covered by BOS, the school should at least provide free education to poor students, and deduct student tuition fees in the amount that can be compensated by BOS. In addition, one of the costs that can be financed from BOS is a transport allowance for poor students. By signing the agreement, the schools that receive BOS also agree to a financial audit of the school financial reports, including the use of BOS and other funds.[19]

So BOS is a form of across-the-board (non-targeted) subsidy to basic education at primary and junior high school, which is now considered as part of the 9 years of compulsory basic education program. In theory, there is no poverty targeting in the program, although in practice the task of poverty targeting is handed over to school level authorities consisting of school headmaster and school committee. By so doing, it has the potential to provide free education to a larger portion of students, particularly those located in rural or poor areas where the education cost can be covered by BOS funds. It indeed also solves the problem of too low a scholarships quota that has led to rotating practice found in some poor schools. The distribution of benefits across welfare levels, however, could be more dispersed. This will, however, be determined by the decision made at school level by school administrations (or the headmaster) and school committees, and how responsive they are to the need of poor students. A recent monitoring study conducted by the monitoring team of the PKPS BBM program revealed the fact that only a very limited number of schools have allocated BOS funds to pay for a transportation allowance for poor students, and this reflects a limited understanding by the school that BOS funds should be prioritized towards assisting poor students, and not merely to pay school operational costs (Tim Pemantau Penyerapan dan Pemanfaatan Dana PPK, 2005).

3.3 Impact and Outcomes

The SSN and PKPS BBM scholarship and grants programs were intended to provide direct and indirect transfers to increase the access of the poor to good quality education. As presented in Table 4, the scholarship scheme provided by SSN and BKM were the same until the end of the 2004/05 academic year. The new BKM scheme for senior high school students introduced in the 2005/06 academic year more than doubled the benefit from Rp25,000 per month to Rp65,000 per month for each student. The scholarship benefit for primary school students that was Rp10,000 per month only covered 70% of education expenses of the poorest expenditure quintile children at this level, while the Rp20,000 per month scholarship benefit for junior high school students covered 55% of the education spending of the poorest expenditure quintiles for the same level. Sparrow et. al. (2003) revealed that the people felt that the scholarship amount was adequate to cover school expenses for students in some regions especially in the outer islands, but was not sufficient for Java. There was also an argument that the education expenses were not the same for all levels. The costs of education for grades 1 and 6 in primary school are higher than for other grades of primary school, while the same also applies for grade 1 and 3 in junior and senior high school where the costs are

[19] A school with strong financial capacity that does not want to be audited financially is allowed to refuse BOS.

higher than those for grade 2. In addition, there was also criticism that the scholarship scheme did not guarantee that students would continue their study from primary to junior high and to senior high school, the transitional periods with a higher dropout probability for the poor.

Despite this limitation, various studies generally found a positive impact of the scholarships and grant programs that had been provided through SSN and PKPS BBM. CIMU (2001b) highlighted that the scholarship and grants programs had initially contributed to preventing enrollment rates from declining sharply between the 1997/98 and 1998/99 academic years. It has also contributed to increasing enrollment rates in subsequent years, as the enrollment rate for all age groups increased in the 1999/2000 and 2000/01 academic years, with the largest increase enjoyed by students from the poorest expenditure quintile. Another study by Cameron (2002) applying regression analysis of the probability of students becoming school dropouts using the 100-villages survey data, argued that the scholarships significantly reduced the probability of dropout at the lower secondary level, but did not affect dropout rates in primary and upper secondary schools, at least during the first few months of the program's operations. This study, however, has not provided a complete picture on the impact of the program. Daley and Fane (2002) argued that the scholarhip program might have a greater impact on re-enrollments at the start of a school year. The impact could not be captured from analysis using the data set, which has been used in Cameron study.

Table 4. The Amount of Scholarship and Grant Benefit

Program	Unit	Primary School	Junior High School	Senior High School
SSN - Scholarship (1998-2003)	student/semester	60,000	120,000	150,000
PKPS BBM - Scholarship (2001-2004)	student/semester	60,000	120,000	150,000
PKPS BBM - Scholarship (2005)	student/semester	-	-	390,000
SSN - DBO (1998-2003)	student/semester	12,000,000	24,000,000	60,000,000
PKPS BBM - BKS (2001)	student/semester	40,000,000	50,000,000	60,000,000
PKPS BBM - BOS* (2005)	student/semester	117,500	162,250	-

Regarding DBO, surveys by CIMU revealed that it would be hard for many schools to survive and provide adequate education services without grant. Over 80% of schools used some of the block grant they had received to purchase teaching aids and stationary, and to fund essential maintenance of school buildings. Meanwhile, around 64% of them also used some of the grant to assist the students who had not been covered by the scholarships program, usually with a scholarship-style fee relief (CIMU, 2001b). By meeting the cost of some essential materials and some of the shortfall in income from outstanding student fees, the block grant has no doubt enabled some schools to keep fees lower than they would otherwise have been. This may in turn have enabled some more children to stay in school (Jones and Hagul, 2001). SMERU (2000) also discovered that for many Islamic primary and junior high schools that have very small budgets and have difficulty paying most of their semi-voluntary teachers, DBO contributed a lot and some of them even used scholarship money to support the overall school operation, as they considered it gave the benefit to all of the students that are all poor. Similar evidence also pointed by CIMU (2000). According to the CIMU study, in 1999/00 about 18% of rural primary schools relied on grants for over 50% of school income, while on average the DBO contribution to primary school budgets in 1998/99 was 21% and in 1999/00 and 2001/02 was around 17%. For junior and senior high schools in general, the

DBO contribution was 3% in 1998/99 and 2.5% in 1999/00. For Islamic junior school (MTs) the BOS contribution was more significant, which was 20%-30% of the school budget. Both SMERU (2000) and CIMU (2000) revealed an alarming point on the transparency in the use of DBO because some school did not have good book keeping or no book keeping at all.

3.4 Efficiency and Administrative Costs

The SSN education program that lasted for five years starting 1998 was funded jointly by the World Bank, the Asian Development Bank and the Government of Indonesia (GoI). For the first three years, some Rp1.2 trillion was allocated to this program each year. The allocation for the fourth and fifth year of the program was decreased to Rp913 billion and Rp639 billion respectively. The PKPS BBM that began in 2001 was fully funded by GoI from the funds set aside from the reduction of fuel subsidy. In 2001, the real expenditure for the education sector amounted to almost Rp1.3 trillion, increased to Rp1.8 trillion in 2002 and increased again to Rp2.6 trillion in 2003[20], but decreased to Rp563 billion in 2004 (Table 5). With the introduction of BOS in 2005, the allocation increased sharply to Rp 6.2 trillion in 2005 and Rp11 trillion in 2006, with around 80% to 90% going to BOS for 2005 and 2006 respectively (Table 6 and 7).

Table 5. Budget Allocation for SSN and PKPS BBM Education Sector (Billion)

SSN - Education		PKPS BBM			
			Education (MoNE)	Education (MoRA)	Education (MoNE)
Year	Allocation		Actual	Actual	Plan
1998/99	1,200				
1999/2000	1,200				
2000/01	1,200				
2001/02	913	2001	1,279		
2002/03	639	2002	1,495	335	
		2003	2,132	534	
		2004	0.28	563	
		2005			6,272
		2006			11,076

As can be seen from Table 7, the SSN program has allocated a relatively larger proportion for program administration and safeguarding, while the latest PKPS BBM program only allocated 2% for administration and safeguarding. Although it gives an impression that the latter is more efficient, it could also raise a concern on the safeguarding, dissemination of information and monitoring of this huge program, as these will play a critical role in supporting the effectiveness of the overall program.

[20]According to PKPS BBM Monitoring manual, BKM for 2003 amounted to Rp1.395 trillion, and the rest was allocated for scholarships for university students, support to non-formal education (*pendidikan luar sekolah*), and training for skill improvement.

Table 6. PKPS BBM Budget for Fiscal Year 2005 and 2006

2005

No	Activities	Target (num. of students)	Unit Cost	Total Cost	
1	**BKM (January-June)**			**734,184,000,000**	**11.71%**
	SD/MI/SDLB	5,930,000	60,000	355,800,000,000	
	SMP/MTs/SMPLB	2,353,200	120,000	282,384,000,000	
	SMA/SMK/MA/SMLB	640,000	150,000	96,000,000,000	
2	**BKM (July-December)**			**272,398,620,000**	**4.34%**
	SMA/SMK/MA/SMLB	698,458	390,000	272,398,620,000	
3	**BOS (July-December)**			**5,136,933,035,147**	**81.90%**
	SD/MI/SDLB	28,779,709	117,500	3,381,615,807,500	
	Salafiyah – SD	108,177	117,500	12,710,797,500	
	SMP/MTs/SMPLB	10,625,816	162,250	1,724,038,646,000	
	Salafiyah – SMP	114,433	162,259	18,567,784,147	
4	**Safeguarding**			**128,423,300,131**	**2.05%**
	Total			**6,271,938,955,278**	

2006

No	Activities	Target (num. of students)	Unit Cost	Total Cost	
1	**BKM (Jan.-Dec.)**			**544,797,240,000**	**4.92%**
	SMA/SMK/MA/SMLB	698,458	780,000	544,797,240,000	
2	**BOS (Jan.-Dec.)**			**10,273,864,010,500**	**92.76%**
	SD/MI/SDLB	28,779,709	235,000	6,763,231,615,000	
	Salafiyah – SD	108,177	235,000	25,421,595,000	
	SMP/MTs/SMPLB	10,625,816	324,500	3,448,077,292,000	
	Salafiyah – SMP	114,433	324,500	37,133,508,500	
3	**Safeguarding**			**256,846,600,263**	**2.32%**
	Total			**11,075,507,850,763**	

Source: Ministry of National Education and Ministry of Religious Affairs

Table 7. Administration and Safeguarding Allocation in SSN and PKPS BBM Education Program

Program	Year	Total Cost	Scholarship & School Grant		Administration & Safeguarding	
		(Rp million)	(Rp million)	%	(Rp million)	%
SSN	1998/99	1,204,529	1,137,623	94%	66,906	6%
	1999/00	1,172,979	1,137,623	97%	35,356	3%
	2000/01	1,204,529	1,137,623	94%	66,906	6%
	2001/02	918,978	883,622	96%	35,356	4%
	2002/03	664,978	629,622	95%	35,356	5%
PKPS BBM	2005*	6,271,939	6,143,516	98%	128,423	2%
	2006**	11,075,508	10,818,661	98%	256,847	2%

Note: * - transition from BKM to BOS; ** BOS for SD & SMP, BKM for SMA

Figure 2 displays the amount of budget allocations across regions in 2001, 2002, 2003 and 2005. This shows a big jump in the BOS budget in all regions, while the budget for BKM for students in senior high schools has not significantly increased. As can also be seen from Figure 3a and 3b, the proportion of allocations across regions of the assistance directed to primary and junior high schools has not changed much, although the allocation for Java and Bali increased slightly mainly due to allocation based on number of students. For senior high school BKM, however, the proportion allocated to Sumatra increased significantly in 2005.

Figure 2. Budget Allocation for PKPS BBM - Education Sector BKS, BKM and BOS (Thousand Rupiah)

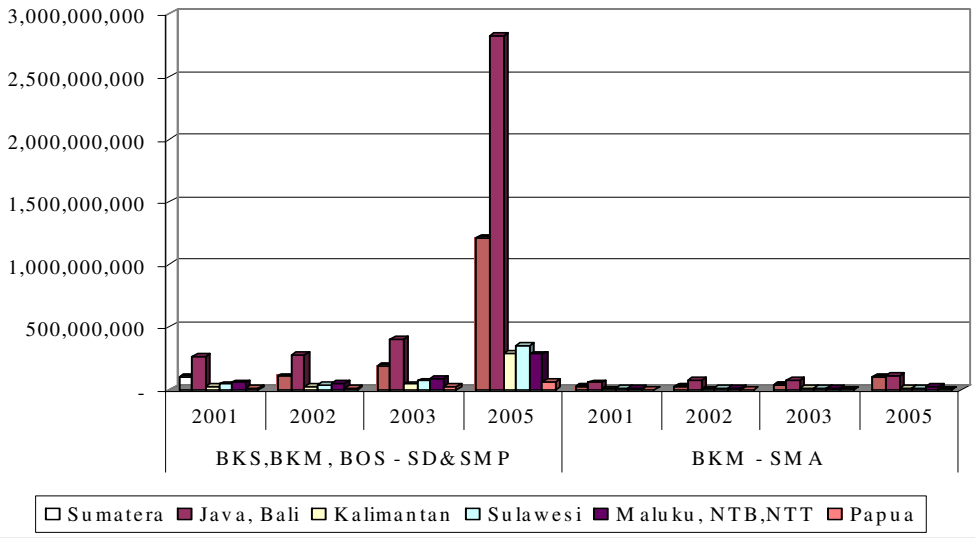


Figure 3a. Allocation of BKS and BKM (2001-03) and BOS (2005) for Primary and Junior High Levels across Region

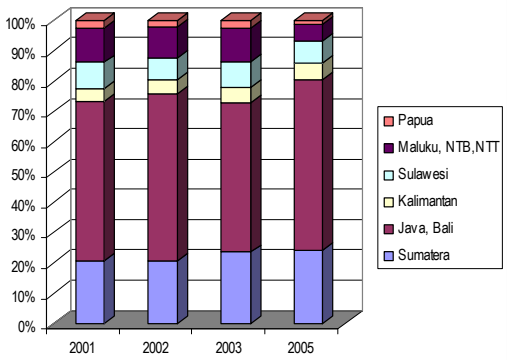
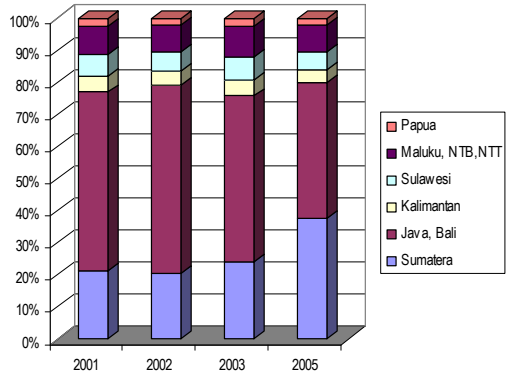


Figure 3b. Allocation of BKM for Senior High Level across Region



3.5 Institutional Structure and Incentive Effects

The SSN programs made some innovations in their allocation and delivery systems. These include the establishment of various levels of committee with the task of determining allocations based on pre-defined criteria and channeling information as well as increased public awareness of the program, direct disbursement and channeling of funds through post offices, and the establishment of an independent monitoring unit. At the central level, the

allocation performance was dependent on the availability of basis data. The same also applied at the district and sub-district level. The weakness of data availability has been improved over time, especially at the central level. Basis data for allocations within districts was not, however, readily available, so that the performance of data collection and allocation relied heavily on the capacity and capability, as well as political willingness of district committees. From the four districts that had been visited in 2003, Sparrow et.al. (2003) found that in districts where the district team was well trained, active and had great concern over the program, the allocation performance and public awareness also tended to be better than in districts where the district committee was not active and the membership was only on paper without any real activities. In the districts with the second type of district committee, the local education office usually dominated decision making, and the transparency down to school level was also relatively weak. On the other hand, there were some districts where the members of the district committee consisted of both government and non-government institutions, that were active, not only on determining allocations but also in monitoring the disbursement of funds. So the public awareness and transparency of the program tends to be better, even at school and community level (Box 1).

Channeling of funds directly through the post office was considered a good innovation in the effort to reduce corruption and prevent non-recipients from misusing the funds. It seemed to be partly true; at least in ensuring that the scholarship recipients did sign the disbursement forms because in most cases the claims were made collectively by the school. There were various reasons for this practice, despite strong advice in the guidelines for direct collection by the students themselves. Among the reasons were: individual collection would be more time consuming as the withdrawal should be done during office hours when children have to attend school; it is also more expensive, especially where the location of the post office was beyond walking distance as post offices are only located in the sub-district capital; the post office also had limited staff so that they also prefer collective withdrawal; and it was of interest of the school to have some control over the money so that they can deduct, at the first instance, for all delayed school payments from the scholarships. In spite of this practice, the use of post office in fund disbursement and tight administrative control had limited corruption and misuse of scholarship benefits.

Box 1. SSN Scholarships in Kota Blitar

In general, the allocation process in Kota Blitar is transparent. Dissemination of information and monitoring seemed to be in accordance with the guideline. The district committee monitored the program in all sub-districts every six months. This consists of monitoring post offices on disbursement of funds, monitoring schools on disbursement to students, and checking the responsibility report. Schools also reported having been monitored by the district education office, sub-district education office, and district surveillance office (*Bawasda*) and NGOs.

There is evidence that community participation did influence the selection of students by school committees. Village leaders were consulted on the poverty status of households, and community members were sometimes part of the allocation committee. Moreover, public knowledge of the program was reasonable, which benefited the transparency of the allocation and targeting process. Students seemed well informed on why they or others had received scholarships. In public schools, in particular, there was communications on the use of funds between schools and parents. Information about the SSN program was disseminated to the public through radio programs ("*Hallo OSIS*" and "*Hallo Sekolah*"), which also served to facilitate the resolution of complaints.

(Source: Sparrow, et.al., 2003, "Mechanism and Practices..")

Another SSN initiative was the establishment of an independent monitoring unit, CIMU. CIMU stands for Central Independent Monitoring Unit, a body established and funded jointly by several international agencies exclusively to monitor the implementation of the school grant and scholarship program, as well as to investigate reported irregularities in the implementation of the program. The mission of this unit was to provide timely and accurate data with objective analysis to key stakeholders in government, lending agencies, donors, the media and the NGO community. CIMU was not a part of the program implementation and management teams but operated as an independent organization, separate from government agencies. It did, however, work closely with the central Program Management Unit (PMU) in helping identify ways to improve the programs. The concept and practice of this unit developed progressively throughout the program. It had expanded from a means of assessing compliance with program rules and to safeguard the investment, to include monitoring program management and providing advice to PMU, building monitoring capacity in districts, investing complaints, tracking complaint resolution, publicizing findings and managing a relationship with the press. Although the activities of such an independent unit were seen cautiously by program implementers in its early operation, it was widely accepted as it provides a real contribution to the operation of the program.

SSN scholarship and grant programs had established a decentralized allocation mechanism, and BKM has followed a similar mechanism and used similar criteria for allocations particularly at the school level. There are some differences, however, between the SSN and BKM scholarship programs. These include:

- Allocation mechanism that bypassed sub-district committees;
- A larger scale of BKM program and it reached all grades (SSN scholarship only targeted students at grade 4 primary school and above);
- The management of BKM consisted of two separate ministries, instead of a single management unit. MoNE manages BKM for public and non-Islamic private schools, and has integrated BKM through the existing SSN program; while MoRA manages funds for Islamic schools, and implemented it in a different manner;
- There is no built in extensive independent monitoring system such as CIMU of the SSN scholarship and grant program. Although there are monitoring teams supported by the Ministry of Finance to monitor the overall implementation of PKPS BBM programs, its scope of activities are smaller and less intensive than CIMU; and
- BKM has no fixed time horizon and the amount of funds is more uncertain as it depends on the cuts in energy subsidy in the near future.

A qualitative study on SSN scholarship and BKM implementation in four districts, namely Kabupaten Blitar, Blora, Lomok Timur and Pontianak, conducted in 2003 by Sparrow et.al. (2003) found that, in general, the SSN scholarship seems to work well and has provided good infrastructure for the implementation of BKM. Common people, however, did not distinguish between the two programs and saw them as the same scholarship. This study also revealed that the involvement of sub-district teams in the scholarship allocation had a positive impact on dissemination of information. The omission of this layer in BKM allocation had contributed to less accurate targeting, and weaker dissemination of information and public control. Regarding the BKM management, this study found that the program management of MoNE was better than MoRA in terms of allocation and compliance to the rules set in the guidelines. Because most *madrasah* (Islamic school) are relatively poorer than public schools, it is more common in *madrasah* to modify the rules set in the guidelines such as dividing the scholarships between more students (higher than the quota) so that the money can be used to settle unpaid school fees, and using scholarship money to pay other school operational costs.

BOS introduced a new and very different approach compared to the previous grants and scholarship programs, as there is no allocation decision to be made and no pre-determined selection of poor students to receive free education or scholarship-like assistance. In theory, all schools are eligible for BOS, as long as they are willing to follow the obligations required of BOS recipients. These include basically to use the money as set out in the guidelines, to provide free education for students from poor family backgrounds, to provide free education for all students or to reduce school fees depending on the size of the school budget, and to allow for financial audit on school budget and expenses of funds provided by BOS as well as other sources. So, elite (or rich) schools that do not want to be audited are not required to apply for BOS.

The BOS allocation is only determined by data on the number of students in each school in each district and province that should be collected through a bottom up mechanism from the school to the PKPS BBM team at district, province and finally at the central level. The PKPS BBM team at central, provincial and district level then defines the allocation based on this data. The PKPS BBM team at each government level[21] also holds the responsibility for cross checking all data/information, receiving complaints and monitoring complaint resolution as well as the overall implementation of the program. In addition, the program is also open for external monitoring and evaluation. The disbursement of BOS funds is channeled through post offices or state owned banks that transfer the fund directly to school accounts. The money is disbursed once in six months and the school headmaster, under the authority of the head of the school committee, can withdraw the money at any time as needed. In regard to assistance to poor students, the decisions to provide free education and special assistance to poor students are delegated to schools, with the expectation that the decision will be made by the school together with the school committee and involving wider community participation.

Compared to the previous schemes of school grants and scholarships, the huge expansion of BOS has some advantages including:

- Much wider school coverage, so that both private and public primary and junior high schools have the same opportunities. There is, however, criticism that it still discriminates against poor and small private schools that still have difficulty in fulfilling the administrative requirements to apply for BOS.
- Allocation based on number of students, so that it does not discriminate against small schools - the schools that were not eligible for DBO because they did not pass the requirement on minimum number of students. BOS still applies the same benefits for all regions, which is a rather strange assumption as the unit cost will very likely vary across regions as well as urban/rural locations.

On the other hand, there are some shortfalls that might impede program effectiveness, including:

- Lack of transparency and capacity of most school managements in ensuring the proper use of funds and protecting them from corruption that should be supported by good book keeping and disclosure of school budgets. The experience of DBO, and other initiatives such as CLCC show that in most schools the school budget plan (RAPBS) does not exist and book keeping performance is very low.
- Low community involvement in school management that is critical in supporting transparency and pro-poor school budget allocations. Various studies and monitoring activities of the previous programs have found that effective school committess exist in only a very limited number of schools.

[21]This team consists of government officials from the planning office, education office and Ministry of Religious Affairs office.

In its early implementation, several problems have been encountered. One of these is the slow disbursement of funds in some provinces. Up to 27 September 2005, the disbursement rate has reached 95%, but there are three provinces with very low rates, they were North Sulawesi (22.61%), West Irian Jaya (9.72%) and Papua (0%). In addition, there were three other provinces with relatively slow disbursement rates, namely North Sumatra (78.19%), Maluku (76.84%) and Aceh (76.08%). Among the factors that affect this delay were: incomplete data about schools, not all schools already have a bank account, very low access to transportation and communication that includes availability of post offices and banks in some regions, and low performance of local governments as well as other unexpected circumstances. Finally, the PKPS monitoring team has found that:

- Only very limited numbers of schools have allocated some of the funds to provide transportation allowances for poor students;
- The working team at the district level did not conduct verifications on school budget plans and the numbers of students provided by schools, so that school budget plans seem unreliable and data on numbers of students were inaccurate in some schools;
- Most schools had withdrawn 50%-80% of the funds at the first disbursement, leading to potential misuse of the money;
- Different districts applied different rules in regard to the need to have a letter of recommendation from the district education office for disbursement of funds;
- There was no training for schools on the use and management of BOS, and the information was only disseminated through a meeting of school principals. This led to a limited understanding on the purpose of grants and a misunderstanding in the wider community that there will be free education for all after schools receive BOS.
- Most schools do not have BOS guidelines and there was no strict rule from the central team about the use of BOS funds so that schools allocated it to almost all school expenses.

(Tim Pemantauan Penyerapan dan Pemanfaatan Dana PPK,*2005*)

Since BOS in practice has delegated almost full authority to schools and the schooling community in the use and poverty targeting of the funds, there is an urgent need to provide strong support to improve the capacity and performance at the school level. Given the large numbers of primary and junior high schools nationwide, almost all of which are joining this program, this will be a huge exercise that needs good and persistent efforts that can be costly. An initiative like the school management and community participation components of CLCC could be one of the supporting models that need to be developed nationwide. This should also be complemented by capacity building at sub-district, district and provincial education offices, so that their routine activities could support the overall effectiveness of the program. The existing PKPS BBM teams at central, provincial and district levels seem to be too small to provide this support. While they could play a role in the overall program management, a special initiative, which can be larger than the previous CIMU and CLCC, will be of particular importance in developing proper program infrastructure to ensure its effectiveness and pro-poor bias, at least for the first few years if BOS is continuously implemented.

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Annex 1. Main Features of School Grants and Scholarship Programs under SSN and PKPS BBM

	SSN (1998-2003)		***PKPS BBM (2001-2004)***		***PKPS BBM (2005)***	
	DBO	***Scholarship***	***BKS (2001)***	***BKM***	***BOS (SD & SMP)***	***BKM (SMA)***
Beneficiaries	60% of schools (SD/SDLB/MI, SMP/SMPLB/MTs, SMU/SMK/MA/SMLB) that are considered in most need	Students in public and private schools: • Grade 4,5,6 in SD, SDLB & MI • Grade 1-3 in SLTP, SLTPLB & MTs • Grade 1-3 in SMU, SMK, SMLB and MA	All public and private schools: I. SD/SDLB/MI II. SMP/Open SMP/SMPLB/MTs/Open MTs III. SMU/SMK/MA	Students in public and private schools: • Grade 1-6 in SD, SDLB & MI • Grade 1-3 in SLTP, SLTPLB & MTs • Grade 1-3 in SMU, SMK, SMLB and MA	All public and private schools, but does not include *Kejar Paket A, B* and open junior high school (SMP)	Students in senior high school level including SMA, SMK, MA, SMLB and Islamic boarding school and small/remote SMAs run by SMP.
Who is eligible	• Not a rich school. • Public school and private school that at least hold registered status. • Minimum number of students: SD – 90; SDLB – 60, SMP/MTs/SMPLB – 60; SMU/SMK/MA/SMLB – 60.	<u>Student:</u> From poor (low income) family	Not a rich school School that managed open SMP/MTs Have operation permit Not in receipt of other grants in the past 2 years or already identified as grant recipient of a minimum amount of Rp30 million Minimum number of students: SD/MI – 90 for Java and 60 for outer island; SMP/MTs/SMU/MA – 60 for Java and 50 for outer island; SDLB/SMPLB – 30 for Java and outer island.	<u>Student:</u> From poor (low income) family that are potential drop outs due to economic reason and not receiving other scholarship. <u>School:</u> Not a rich school and poses operational permit.	• All schools that are willing to sign letter of agreement and follow rules stated in the guidelines. • Private schools should have operation permit. • Rich schools are allowed to not apply	From poor (low income) family that are potential drop outs due to economic reason and not receiving other scholarship <u>School:</u> Not a rich school and poses operational permit

Allocation Process

	SSN (1998		2003) PKPS BBM (2001		2004) PKPS BBM (2005)	
	DBO	**Scholarship**	**BKS (2001)**	**BKM**	**BOS (SD & SMP)**	**BKM (SMA)**
National	National Committee allocates number of schools in each *kabupaten/kota* based on number of schools and poverty index.	National Committee allocates number of students per *kabupaten/ kota* based on certain criteria.	National Committee allocates number of school per *kabupaten/ kota* based on certain criteria.	National Committee allocates number of students *per kabupaten/ kota* based on certain criteria.	PKPS BBM team at the central level collected data on number of students in each school through provincial team, and based on this data define the draft allocation for each *kabupaten/kota* to be verified by provincial team and used by *kabupaten/kota* to define allocation for each school.	National Committee allocates number of students per *kabupaten/ kota* based on certain criteria.
Kabupaten/Kota	*Kabupaten/Kota* Committee selects SMP/MTs/SMPLB and SMU/SMK/MA/SMLB to receive DBO and allocates number of SD/MI/SDLB for each *kecamatan.*	*Kabupaten/kota* committee allocates number of students per *kecamatan* (for SD/MI) and per schools (for SLTP and SMU) based on certain criteria (score).	*Kabupaten/kota* Committee directly allocates number of school (BKM MoNE: SD, SLTP, SMU; BKM MoRA: MI, MTs, MA) based on certain criteria.	*Kabupaten/kota* Committee directly allocates number of students per school (BKM MoNE: SD, SLTP, SMU; BKM MoRA: MI, MTs, MA) based on certain criteria.	PKPS BBM team at *kabupaten* level determines the schools that are willing to accept BOS. The school that receives the grant sign a letter of agreement	*Kabupaten/kota* Committee directly allocates number of students per school (BKM MoNE: SD, SLTP, SMU; BKM MoRA: MI, MTs, MA) based on certain criteria.
Kecamatan	*Kecamatan* Committee selects SD/MI/SDLM to receive DBO	*Kecamatan* Committee allocates number of students per school (SD/MI)		No *Kecamatan* Committee involved		No *Kecamatan* Committee involved
School		School Committee nominates/selects eligible students and distributes scholarship to eligible students.		School Committee nominates/selects eligible students and distributes scholarship to eligible students.		School Committee nominates/selects eligible students and distributes scholarship to eligible students.

Allocation Criteria

	SSN (1998		2003) PKPS BBM (2001		2004) PKPS BBM (2005)	
	DBO	**Scholarship**	**BKS (2001)**	**BKM**	**BOS (SD & SMP)**	**BKM (SMA)**
National		• Poverty index and crisis impact • Number of schools and students per *kab./kota*.	• Poverty Index	• Poverty Index	Allocation based on data on number of students in each school.	• Number of students from poor families calculated based on Susenas 2003 • Poverty index
Kabupaten/ Kota		• % Pre-KS and KS-1 BKKBN • Average BP3, SPP and other fees • % of IDT villages per *kecamatan*	• % Pre-KS and KS-1 BKKBN • Average BP3, SPP and other fees • % of IDT villages per *kecamatan* • Other local indicators which indicate poverty of the school/madrasah	• % Pre-KS and KS-1 BKKBN • Average BP3, SPP and other fees • % of IDT villages per *kecamatan* • Other local indicators which indicate poverty of the school/madrasah	No allocation criteria. A school can receive grant as long as it agrees to follow the rules: 1. For school that receive funding from students lower than BOS: • Should not collect money from students to pay for application form, books, teacher capacity building, maintenance cost, all forms of exams, teacher honorarium, and schooling activities, • Should provide assistance to students from poor family that could not afford to pay transportation cost to school, … (continue)	• Data on students from poor families • Number of students in each school • Fees collected from parents • Distance from school to *kabupaten/kota* capital city • Other locally defined indicators
Kecamatan		• % Pre-KS and KS-1 BKKBN • Average BP3, SPP and other fees • IDT or non-IDT				

	SSN (1998		2003) PKPS BBM (2001		2004) PKPS BBM (2005)	
	DBO	**Scholarship**	**BKS (2001)**	**BKM**	**BOS (SD & SMP)**	**BKM (SMA)**
School		• From poor family, almost drop out • Distance to school • Has more than 3 brothers/sisters below 18; • Orphans; At least 50% to girls		• From poor family, almost drop out • Distance to school • Has more than 3 brothers/sisters below 18; • Orphans; At least 50% to girls	… (continue) • Should not manipulate data to collect money from students. 2. For school that receive funding from students higher than BOS: • Should not collect money from students from poor family • Should collect smaller amount of money from non-poor student (after subsidizing poor students) • For schools with no poor students, BOS can be used to subsidize all students.	• From poor family, almost drop out • Distance to school • Has more than 3 brothers/ sisters below 18; • Orphans; • Other consideration such as physically disabled, victims of long term disaster, parents loss their jobs, etc.
Fund disbursement	Collected by school headmaster and put in school account in post office or state owned bank.	Collected directly by the student from local post office. It can be collected by the school only if the location of post office is too far.	Transferred to school account at post office or state owned bank	Collected directly by the student from local post office. It can be collected by the school only if the location of post office is too far.	Transferred to school account at post office or state owned bank	Collected directly by the student from local post office. It can be collected by the school only if the location of post office is too far.
Disbursement period	Every six months.	Every six months	Every six months	Every six months	Every six months	Every six months

IV. SSN AND PKPS BBM FOR HEALTH SECTOR

The SSN program for health sector was launched in mid-1998 with the support of Asian Development Bank (ADB) and it lasted until 2003. However, the program was then continued by the government of Indonesia with some changes in its design as well as funding sources. The main objectives of this program was to assist poor families to cover the costs of basic health services and referrals scheme provided through community health centers (*puskesmas*), public hospitals and village midwives (*bidan desa*), and to provide nutritious supplement foods for children and pregnant mothers from poor families. Under this program, poor citizens received a card with which they were eligible for free health care services from public primary health service providers. The target beneficiaries of the program were *Keluarga Pra-Sejahtera*-KPS (Pre-Prosperous Families) and *Keluarga Sejahtera*-KS I (Prosperous Families Level 1) due to economic reasons based on BKKBN (National family Planning Board) system, and other criteria as determined by Village Team.

4.1 Program Development

In an effort to protect the poor from the adverse impacts of various shocks, due to the economic crisis in late 1997 and then the increases in fuel prices, on access to health services and on nutrition levels of infants, children and pregnant women, the Government of Indonesia (GoI) initiated several programs under the schemes of social safety net – SSN (*Jaring Pengaman Sosial Bidang Kesehatan, JPS-BK*) and fuel subsidy compensation. There were four sub-programs in the 1998/1999 SSN for health sector, namely (i) improvement of nutrition standards through the provision of supplementary foods (*Pemberian Makanan Tambahan*-PMT); (ii) midwifery services; (iii) operational assistance for *Puskesmas* (community health center) services; and (iv) Community Health Care Guarantee (*Jaminan Pemeliharaan Kesehatan Masyaraka*t-JPKM). Apart from these sub-programs, there was also a hospital referral program. The funds for referral program were distributed to general hospitals at the district and provincial levels, whereas the other SSN funds for health sector were sent directly to the accounts of the Head of *Puskesmas* and village midwife at local Post Office. Summary of the four 1998/1999 SSN health sector programs is presented in Table 1.

The objectives of the health sector SSN programs in 1999/00 onwards were the same, but it contained several new initiatives such as support to *posyandu* (integrated health care post), supplementary feedings for children aged 24-59 months, and expansion of the control of communicable diseases, particularly tuberculosis and malaria, as well as mass-immunization.[22] In addition, the JPKM was advanced by stimulating potential community participation through payment of insurance premium. In order to strengthen program implementation, various measures including mechanism to respond complaints, dissemination of information (socialization), monitoring and evaluation system, transparency and accountability had been strengthened.

[22]For the government's programs on communicable diseases and its impacts or achievement, see the next chapter in this volume on communicable disease prevention.

Table 1. The 1998/1999 Social Safety Nets Programs for Health Sector

Type of Package	Target	Funds Management	Budget Allocation
PMT (supplementary feeding)	Infants 6-11 months, children 12-23 months, pregnant mothers and post-natal mothers from poor and near-poor families	Head of the *Puskesmas*	Local distribution of food for 90 days. Rp.1,000/day/mother Rp.750/day/child.
Midwifery services	Pregnant mothers Mothers at birth Post-natal mothers	Village Midwife (BDD)	Treatment. Transportation for referrals to hospitals at district level
Puskesmas health service	All families Poor people with Health Care Cards	Head of the *Puskesmas*	Basic medication. Administering medicines. Assistance at birth, Family Planning, Immunization, Transportation for referrals.
JPKM (community health care guarantee)	Poor families General public JPKM participants	Executing Agency (Bapel) JPKM	Allocation of premium funds Rp.10.000/HH/year.

Source : Sulaksono et. al., 1999, "SMERU Rapid Appraisal.."

So, the health sector SSN programs in 1999/00 onwards consisted of five direct activities and six supporting activities (Departemen Kesehatan RI, 1999). The direct services consisted of:

- Provision of basic health services by *puskesmas*, *pustu* (auxiliary community health center), and midwife. It included activities for prevention, improvement, medication and recovery, as well as in-patient and out-patient in health care;
- Basic midwifery services provided through *puskesmas, polindes* (village birth delivery house) and midwife, and it included antenatal services (minimum 4 times during pregnancy period), birth delivery, postnatal services for baby and mother (minimum 3 times), and emergency services due to obstetric-neonatal and *puskesmas* or hospital referral;
- Nutrition improvement through *puskesmas*, *pustu* and provision of supplementary feeding (PMT) in *posyandu*. The PMT consisted of PMT recovery for pregnant and post-natal mother suffering deficiency of energy and protein, infant aged 6-11 months and children aged 12-23 months, and PMT extension for children aged 24-59 months;
- Prevention from and control of communicable diseases. It was provided through *puskesmas* with the highest priorities for pulmonary tuberculosis, malaria and immunization activities;
- Referral services provided for both in-patient and out-patient for poor patients referred by *puskesmas* to public hospital in district level.

In addition, the supporting activities included:

- Strengthening food and nutritional surveillance system (SKPG – *Sistem Kewaspadaan Pangan dan Gizi*) in order to affirm the commitment of local governments and intersectoral cooperation in supporting the movement for resolving food and nutrition deficiency problem;
- *Posyandu* revitalization in order to empower the community in supporting efforts to maintain and increase nutritional status and health conditions of mother and children through increasing the capability of cadres and the functioning and management of *posyandu*;
- JPKM that was implemented by incorporating, as much as possible, potential resources from the community;
- Socialization program to increase community knowledge about their rights to get health services through SSN programs on health sector. This was done through various means including radio, television, and indoor and outdoor printed materials. The material to be disseminated covered beneficiaries target, types of activity, delivery mechanism, budget

allocation, channeling of people's complaints, and the opportunities for community to participate in monitoring program implementation.

- Training of health service providers to disseminate information about SSN programs so that they could deliver necessary services appropriately, and to improve their technical skills;
- Program monitoring at all levels to provide information on the progress of program implementation, particularly regarding targeting performance, fund disbursement, transparency in targeting and the use of fund, community involvements in program planning and implementation, and program achievements in various indicators.

Following government policy to cut subsidy on energy prices in 2001, the GoI launched another programs aimed also at helping the poor in maintaining their access to health services and improve nutritional levels, which was called PDPSE-BK - *Penanggulangan Dampak Pengurangan Subsidi Energi – Bidang Kesehatan* (mitigation of the reduction in energy subsidy for health sector). This program lasted until 2003 and consisted of direct grant to referral public hospitals, provision of essential drugs based on the request from local governments, and Hepatitis-B vaccination for children under 5 years old. In 2004, this program was renamed by PKPS BBM – *Program Kompensasi Pengurangan Subsidi Bahan Bakar Minyak* (programs for compensating the reduction in fuel subsidy). The activities covered by this program were the same as PDPSE-BK activities, plus basic health services in *puskesmas*, and *posyandu* revitalization. This program is continued in 2005, with a new program in the form of national health insurance for the poor managed by PT Askes being added.

Historically, the national health insurance for the poor was originated from JPKM, which was part of SSN program for health sector. After the implementation of regional autonomy in 2001, the central government designated 15 districts in 2 provinces as pilot areas to implement locally based health-financing schemes based on health insurance principles, which was commonly known as JPK-Gakin (*Jaminan Pemeliharaan Kesehatan untuk Keluarga Miskin*). JPK-Gakin is a health-financing scheme through which the poor can access health care in public facilities, including primary and secondary health care. By employing insurance principles, the problem of administration overload of the *puskesmas* would be solved and cost-containment was made possible. This trial was expanded to other regions in the following years. The provision of JPK-Gakin was, until the end of 2004, not limited to one specific health insurance provider and as a result health insurers with different backgrounds provide health insurance in different districts. Consequently, there were differences in the benefit package, the insurer and the reimbursement system (Arifianto et. al., 2005).

In November 2004 GoI decided to expand JPK-Gakin to cover all districts in Indonesia, with a number of adaptations to the pilot projects. The main change was that from 1 January 2005, through a decree of the Minister of Health (Decree No. 1241/MENKES/SK/XI/2004), JPK-Gakin has to be provided by PT. Askes, which will run it as a government monopoly, in compliance with the newly passed Law No. 40/2004 of the National Social Security System (Arifianto et. al., 2005). Through this new scheme, the poor will receive health card from PT Askes to access free health care services in *puskesmas*, *pustu*, village midwife, and referral public hospital. The transition from the previous JPK-Gakin managed by each district through *Badan Pelaksana - Bapel* (Implementing Agency) will be subsequently implemented in all districts throughout Indonesia. The summary of the evolution of these programs is presented in Table 2.

Table 2. The Evolution of SSN and PKPS BBM Programs for Health Sector

<table>
<tr><th>1998</th><th>1999</th><th>2000</th><th>2001</th><th>2002</th><th>2003</th><th>2004</th><th>2005</th></tr>
<tr><td colspan="6">SSN for Health Sector:PMT (Supplementary feedings for infant, children under 2 years old, and pregnant mothers), midwifery services, basic health service in Puskesmas, JPKM (community health care guarantee).</td><td colspan="2"></td></tr>
<tr><td></td><td colspan="5">SSN for health (additional programs): posyandu revitalization, PMT for children 2-5 years old, control of communicable diseases, JPKM that incorporate potential community resources.</td><td colspan="2"></td></tr>
<tr><td></td><td colspan="3">JPKM (part of SSN)</td><td colspan="2">JPK-Gakin pilot program in several districts–managed by district level implementing agency (Bapel). Jointly financed by SSN program and local government.</td><td>JPK-Gakin managed by PT Askes (also known as JPK-MM)</td></tr>
<tr><td></td><td colspan="3"></td><td colspan="2">PDPSE-BK: block grant to referral public hospitals, provision of essential drugs, and vaccination for Hepatitis-B for children under 5 years old.</td><td>PKPS-BBM for Health Sector: block grant to referral public hospitals, provision of essential drugs, vaccination for Hepatitis-B for children under 5 years old, basic health services in puskesmas, and posyandu revitalization. (and other small programs)</td></tr>
</table>

4.2 Coverage and Targeting Performances

The health programs provided through SSN, PDPSE and PKPS-BBM schemes have a nation-wide coverage. It was intended to target the poor, as reflected by the way regional allocation was calculated, which was based on the proportion of poor people that was determined as the numbers of KPS (pre-prosperous families) and KS1 (prosperous families level-1) due to economic factors according to BKKBN criteria. Despite the stated objectives that the poor were the main focus of these programs, the health sector SSN, PDPSE and PKPS BBM programs consisted of several components that were channeled through health service providers and activities that can be utilized by both poor and non-poor. So it is rather problematic to measure the real benefit of the programs accrued to the poor.

Theoretically, one way to measure the benefit for the poor is by calculating the proportion of the poor who benefited from the program, compared with the non-poor. However, in reality not all programs made desegregation in recording the beneficiaries or no record was taken in program implementation, such as in the control of communicable diseases and in *posyandu*. Meanwhile some of the funds provided for *puskesmas* and hospitals were used for building maintenance and refurbishment, and buying equipments that gave indirect benefit to all users of the services.

The most direct assistance to the poor was provided through the distribution of health cards that can be used to obtain free medical services in *puskesmas*, *pustu*, village midwife, and public hospital under the referral scheme. The selection of households that were eligible for receiving health cards should be done by village team that consisted of LKMD (Village Community Resilience Board) or other community leaders, village midwife, PLKB (Family Planning Field Worker), and PKK (Family Welfare Improvement) cadre. This selection should be done based on BKKBN criteria and other local specific criteria as determined by district authority.

Another component of JPS-BK focusing on nutritional improvement was intended to target babies, children under five years and pregnant women from poor households. This was delivered by providing packages of supplementary foods. The selection criteria for this sub-program were similar to health card scheme, which was drawn from BKKBN list of recipients, but the delivery of the packages was channel through *posyandu*, under the supervision of the village midwife.

To assess the implementation of the program, an independent monitoring unit, known as CIMU HNSDP (Central Independent Monitoring Unit – Health and Nutrition Sector Development Program) was established and it operated during the period of September 1999 to May 2002. This unit reported that for the period of January-October 2000, the coverage of health cards reached around 10 million poor households, which was 92 percent of the target. Out of this number, almost 39 percent utilized health services with accumulative visit rate of nearly 20 percent. It also pointed that the coverage of pregnant mothers, birth-delivering mothers and post-natal mothers receiving basic midwifery services was 71 percent, 49 percent, and 44 percent of the targets respectively (Irawan et. al., 2001).

Other published reports of CIMU HNSDP (2002a; 2002c; and 2002d) generally claimed for good program coverage and targeting. The final report of the monthly monitoring activities stated that the coverage achieved was satisfactory. The monthly monitoring based on health center reports indicated that health card coverage reached 80 percent of poor people, as defined by the health center. Antenatal and delivery care was utilized by approximately 80 percent of poor women. General utilization of basic health services was around 15 percent of the poor population, mirroring the level for population as a whole. Coverage of the complementary and supplementary feeding components average only 50 percent of those eligible for assistance. Other components of the program were also monitored although with less clear results. The communicable disease control was not well understood and its impact low. The revitalization of integrated health post was undertaken, but its impact was hard to verify due to intermittent nature of activities at this level. Monitoring of the adequacy of drug and contraceptive supplies revealed that supplies were commonly only sufficient for 85 percent of the need. Contraceptive and emergency obstetric drug supply among village midwives was even lower, averaging only 50 percent of the monthly requirement CIMU HNSDP (2002a).

The nation wide survey, carried out in November 2000 to July 2001 found that according to health center data, health card ownership as a percentage of the number of poor families was 91.5 percent. In 5 randomly selected provinces, in total 60.4 percent of families received educational scholarship and 64.8 percent receiving rice subsidy also held a health card. The possession of a health card was seen as a positive benefit by all, and good levels of utilization were achieved in these provinces. In addition, high levels of satisfaction with the attitudes of community health center staff and with health center facilities were recorded by health card owners in exit interviews. This survey also found that birth attendance by a health provider for health card owners was more than 83 percent and exceeded that of non card holders. Regarding the communicable disease control allocated for the examination and treatment of pulmonary tuberculosis and malaria, this survey revealed that less than 70 percent of TB or malaria patients had sputum or blood examination with 80 percent treated for TB and with 70 percent of malaria patients followed up (CIMU HNSDP, 2002c).

The sentinel sites survey also made the point that the identification of the correct target group for health card ownership was generally successful. The precise criteria used varied due to differing local conditions between provinces, although all began by using the BKKBN data. Some mis-targeting occurred early in the program but this was reduced over time as staff became more astute at identifying the correct beneficiaries. One effect of the delay in

disbursement of funds was that staff faced difficulty in providing health cards to all those people qualifying for them, although most found ways to cover this. In some provinces abuse of the cards occurred. However, most problems arose due to the extreme difficulty of identifying the poor in a precise manner. In addition, no specific funds had been allocated to cover the costs involved in doing this (CIMU HNSDP, 2002d).

The assessment based on SUSENAS data, however, provides different and less successful figures both on the coverage and targeting performance of the health program, although the analysis that can be done was limited only to the health card holders, and nutritional improvement only for 1999. The proportion of households reported to have health card was around 1.7 million in 1999, around 2.9 million in 2001, 6.8 million in 2002, and 7.9 million in 2003, which was significantly lower than CIMU HNSDP report of around 10 million in 1999 based on *puskesmas* reports.

Based on the 1999 SUSENAS special module that had been added specifically to assess SSN programs, Sumarto et al. (2001) estimated that around 6.3 percent of all households in Indonesia received the health cards, and 10.6 percent of households in the poorest 20 percent of the population hold the cards. Meanwhile, around 3 percent of the richest 20 percent of the population, and in total around 5.28 percent of all households in the richest 80 percent received health cards. This reflected relatively low program coverage and targeting performance. As the non-poor beneficiaries accounted for around 67 percent of all beneficiaries, the targeting ratio of this program was 0.83, indicating near random targeting.[23] Indeed, this analysis also revealed variations in targeting performance across districts. There were 37 districts with targeting ratio of 1.25 that implied all beneficiaries were non-poor, but 10 districts with zero targeting ratio that implied all cardholders were poor households. This cross districts variation in targeting performance was also reported from the analysis using the data collected in 100 village survey in 1999 (Suryahadi, Suharso and Sumarto, 1999).

Another program that can be assessed using the 1999 special module of SUSENAS was the nutrition improvement component of the program. Concerning this sub-program, the analysis found that the coverage among the poor appeared to be higher than the health cards. The analysis uncovered that around 15.9 percent of all households participated in the nutrition improvement program, and around 16.4 percent of the households in the poorest quintile participated in the program. Meanwhile, the participation of the richest 80 percent of the population was 15.79 percent. However, as the participation among the non-poor households was almost equal to the participation among the poor households, with targeting ration of 0.99, this program could be considered performing nearly random targeting, rather than a pro-poor program.

SUSENAS for the years after 1999 still contain data regarding health card holders and the utilization of the card, but don not contain information regarding the participation in nutrition improvement sub-program. Table 3 shows the coverage of health cards by expenditure quintiles calculated from the 2002, 2003 and 2004 SUSENAS data set. These data sets indicate that the overall coverage of health cards has increased overtime, and the increase took place in all regions with Papua experienced the highest increase. In 2001, in total only around 5 percent households in Indonesia received the cards and it increased to around 14 percent in 2003. The program coverage in Papua was very small in 2001 of only 1.74 percent, reflecting the difficulties of program implementation in this region. However, it significantly jumps to around 20 percent in 2002 and 2003.

[23]Targeting ratio (TR) is defined as TR=Bn/Pn, where Bn is the proportion of beneficiaries who are non-poor, and Pn is the proportion of overall non-poor in the population (in this case is 80%). If all beneficiaries are poor, indicating perfect targeting, TR will be zero (0). But if all beneficiaries are non-poor, indicating mis-targeting completely, the TR will be 1.25. If TR is equal to one (1), the program has no targeting.

Table 3. The Coverage of Health Cards Distribution by Expenditure Quintiles

	2001	2002	2003	2001	2002	2003
	% Cardholders of Total Households (Hhs)			% Cardholders of Households in Quintile I		
Indonesia	***5.49***	***13.14***	***14.33***	***9.05***	***20.14***	***22.21***
Sumatera	4.29	10.62	12.80	6.25	15.08	18.37
Java/Bali	5.55	12.93	14.02	9.33	19.95	21.95
Sulawesi	4.79	9.36	10.48	8.74	13.68	16.15
Kalimantan	5.07	12.79	12.80	8.66	19.28	18.41
Maluku/NTB/NTT	12.20	30.62	31.27	14.44	38.37	40.19
Papua	1.74	20.21	20.79	1.65	18.64	22.78
	% Health Cards Held by Q1			% Health Cards Held by Q1&2		
Indonesia	***32.89***	***30.60***	***30.97***	***56.05***	***53.32***	***53.70***
Sumatera	28.63	27.79	28.75	49.82	50.01	49.86
Java/Bali	32.14	29.72	29.42	56.20	52.48	52.82
Sulawesi	27.30	20.06	21.65	45.39	37.37	41.38
Kalimantan	40.82	34.06	35.85	64.19	56.94	58.43
Maluku/NTB/NTT	43.24	42.91	47.82	65.60	68.64	71.43
Papua	9.88	23.32	20.63	19.75	41.47	38.36

Source: calculated from 2002, 2003 and 2004 SUSENAS

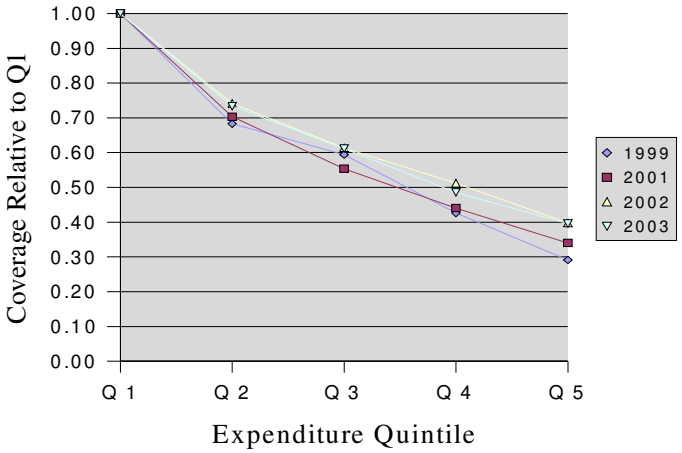
The increase in the overall health cards coverage was followed with the increase of program coverage among the households in the lowest expenditure quintiles. The 2002 SUSENAS revealed very limited health card coverage of around 9 percent of the households in the lowest expenditure quintile, slightly lower than the coverage in 1999 calculated based on the 1999 SUSENAS special module. This coverage has significantly increased to 20 percent and 22 percent in 2002 and 2003 respectively. Despite the improvement in program coverage among the poor, the proportion of cards held by the households in the first and second lowest expenditure quintiles was decreasing over time. As only around 30 percent of total health cards was held by the households in the lowest expenditure quintile, and only around 54 per cent was held by households in the first and second poorest quintiles in 2003, the targeting ratio increased from 0.80 in 1999 to 0.84 in 2001 and 0.86 in 2003. As shown in Table 4 and Figure 1, the targeting performance of the program seems slightly deteriorating during the period of 1999 to 2004, since larger proportion of the cards were received by non-poor households.

Table 4. Targeting Ratio of Health Cards

	Targeting Ratio		
	2001	2002	2003
Indonesia	0.84	0.87	0.86
Sumatera	0.89	0.90	0.89
Java/Bali	0.85	0.88	0.88
Sulawesi	0.91	1.00	0.98
Kalimantan	0.74	0.82	0.80
Maluku/NTB/NTT	0.71	0.71	0.65
Papua	1.13	0.96	0.99

Source: calculated from 2002, 2003 and 2004 SUSENAS

Figure 1. Distribution of Health Cards by Expenditure Groups in Indonesia



Several qualitative studies in the early implementation of the health cards program uncovered various factors underlying the relatively low coverage and miss-targeting of the program. The micro study involving 455 families along the Purwakarta-Cirebon route carried out in 1999 showed that health cards were very rarely used and some communities had never heard of them. Most respondents went to the puskesmas only if they were not seriously ill, preferred to visit a private practitioner for the treatment of more serious illnesses. Despite the rise in the cost of treatment, medicines, and transportation, some respondent felt that their effort to go to hospital was useless since they were treated by nurses or midwives, not by doctors. Furthermore, despite holding health cards, they were still required to pay for the medicines (Hardjono, 1999).

Another rapid study conducted in Kabupaten Gowa, Kabupaten Malang, Kabupaten Pasaman and Kabupaten Purworejo found that the selection of health cards recipients was inconsistence and potentially led to miss-targeting. It has been pointed out in the previous section that the allocation of health cards was determined based on the number of KPS and KS1 based on BKKBN criteria. Indeed, the program manual stated that the selection of health card recipients should be done based on BKKBN criteria of KPS and KS1, plus other local criteria determined by local team. Because the guideline did not specify the types or characteristics of local indicators, it allowed for variations of criteria used in different regions.

SMERU rapid appraisal during the early implementation of SSN program uncovered these variations. In Kabupaten Pasaman, the local criteria were : (i) termination of employment; (ii) does not own land; (iii) is a victim of natural disaster; (iv) suffer a social problem; (v) disability; (vi) has a record of chronic illness; (vii) owns less than 2 hectares; (viii) has a large family; and (ix) has no other income source. In Kabupaten Gowa, the local criteria were only unemployment and termination of employment. While in Kabupaten Malang, the local criteria included: (i) unemployment or termination of employment; (ii) does not own land; (iii) old age; and (iv) suffers from chronic illness (Sulaksono, et al., 1999).

So it is obvious that some of the criteria, such as the accident of chronic illness, is not always directly correlated with the characteristic of poor families, despite the potential adverse impact of chronic illness to the welfare level of the family. Consequently, not all poor families have been given a Health Care Card. Indeed, there were some cardholders discovered who did not qualify for the Health Care Card. They were given Health Care Cards for a number of reasons such as a member of the family suffers from a serious disease and must be treated by hospital, the patient has a record of chronic illness or as an incentive for *posyandu* cadres (Sulaksono, et al., 1999).

Regarding the definition of poor, there is another problem in relation to the comparison between the poor as determine according to BKKBN system and the poor as determined based on family's expenditure calculated from SUSENAS dataset. A study using data collected in 100 villages survey shows that there is a quite large degree of mismatch between the KPS and KS1 classification from BKKBN with household's welfare measured by consumption level (Suryahadi, et al., 1999). On one hand, this raised a concern over the appropriateness in the use of BKKBN system as the basis for selection of beneficiaries. On the other hand, one can argue that as the selection was done based on BKKBN system, the expenditure approach might not be an appropriate measure in targeting assessment.

Another problem found in the SMERU rapid assessment of the program in 1999 was regarding the physical distribution of the health cards. This study found that the health cards distributed in the three districts were lower than the estimated target. The gaps were 35 percent in Kabupaten Pasaman and Kabupaten Malang, and 25 percent in Kabupaten Gowa. These gaps could be attributed to: (i) most data collections were carried out by village midwives who might not understand the criteria or has limited knowledge of the intended beneficiaries; (ii) villages cadre who had better knowledge of the welfare level of the community did not involved in the selection process, whilst the village leaders tent to be not transparent in selecting the beneficiaries; (iii) since there were a direct correlation between the number of health card holders and the reduction on the income of the village midwives, they were less enthusiastic in maximizing the distribution of health cards; and (iv) the criteria related to types of floor in BKKBN system did not fit with local condition.

In addition to the above problems, Perdana and Maxwell (2004), based on various studies, also listed other factors contributing to the relatively weak coverage of the poor and the miss-targeting in health card program. These include:

- There were reports from a number of areas of recipients who sold their health card to others who were not eligible to receive cards but who were in urgent need of health care. There were also cases in Papua that some village head sold the cards to their local community.
- Problem in physical distribution of cards in some localities, as the cards were suppose to be delivered directly to the recipients. Because no specific funds to support this process, it was not always worked smoothly. In many instances, the head of Puskesmas allocated the health cards only when poor patients arrived at Puskesmas seeking treatment.
- System of providing compensation for the workload arising from patients using health card when seeking treatment. This was by lump sum transfer based on the number of health cards allocated to the district, not on the actual use of the health cards by recipients. So the doctors and midwife had a certain financial disincentive to worked to discourage them from distributing the maximum number of health cards in their area. Since most doctors and village midwives also operated a private practice, the more health cards that they distributed, the greater the numbers of patients looking for free medical treatment, thus reducing demand for their own private health service.

With the introduction of new health insurance for the poor, managed by PT Askes, the allocation at the national level is no longer using the BKKBN data, instead it uses BPS data. However, most recent monitoring carried out by the monitoring team of the absorption and utilization of the funds for poverty reduction programs of the Ministry of Finance, found that the data used for selecting beneficiaries and the criteria being used varied across districts and even across villages. In Kabupaten North Bengkulu, Kabupaten Rejang Lebong, Kabupaten Kolaka and Kabupaten Kowane, the disbursement of new health cards was based on the previous health cards distribution. In Kabupaten Belitung, the 2003 BKKBN data was used as the basis, while in Kabupaten Bangka, the results of poverty census carried out by local

government was used as the basis. As a result, district governments have come up with the total number of beneficiaries of around 54 million people, which is higher than the allocation of 36.1 million people based on BPS data. However, since there is no improvement in the selection system of the beneficiaries, the potential leverage persists.

4.3 Impacts and Outcomes

Despite the relatively low health card coverage in its early implementation, there were some evidences on the positive impacts of the program. Using 1999 SUSENAS data, Pradhan, Saadah and Sparrow (2002) revealed that on average, the health card recipients were not only poorer, but also had lower level of education. There were a high proportion of female-headed households among health card recipients and a higher probability that recipients were working in the agriculture sector compared to non-recipients. There was evidence that the distribution of health cards played important role in maintaining the use of health services. It was estimated that without the introduction of health card scheme the use of public health services might had declined below 10 percent in 1999. The proportion of households using public health care providers increased slightly during 1998-1999, while the attendance at private health care services declined. This suggests a substitution from private to public health care induced by the introduction of the health card.

Other studies carried out in 1999 also found similar evidents. The rapid appraisal study carried out by SMERU uncovered that in general the health sector SSN program in the four assessed districts had shown positive benefits for the target group. Following the issuance of health cards, the number of visits to Puskesmas (Pustu and Polindes) had increased. However, the benefits resulting from this intervention seemed to be directly proportional to the particular geographical aspects and available infrastructure of a certain area. The more urban characteristics a region and the better the quality of the local infrastructure, the greater was the benefits. In other words, the benefits of the health card program in rural areas, particularly in remote areas, tend to be less evident in comparison to those benefits accrued in urban areas (Sulaksono et.al., 1999).

Another rapid assessment conducted in 1999 by the SMERU Team at *Kelurahan* Cipinang Besar Utara, *Kecamatan* Jatinegara, indicated that because of the onset of the monetary crisis and particularly due to the distribution of health cards, the number of visits to the *puskesmas* had increased. This study also noted that the location of the *puskesmas* influenced the frequency with which community members visit these health centers. The number of *puskesmas* and *pustu* existing within a certain area happened to be crucial and distribution of health care facilities varies greatly across regions. East Jakarta, which consisted of 10 *kecamatan* (sub-district) and 65 *kelurahan* (urban village administrative area) had 87 *puskesmas*. This meant that there was at least one *puskesmas* in every *kelurahan*. By comparison, West Kalimantan, which consisted of 109 *kecamatan,* 1,033 *desa*, and 81 *kelurahan* had only 187 *puskesmas* and 688 *pustu* (Budiyati, 1999).

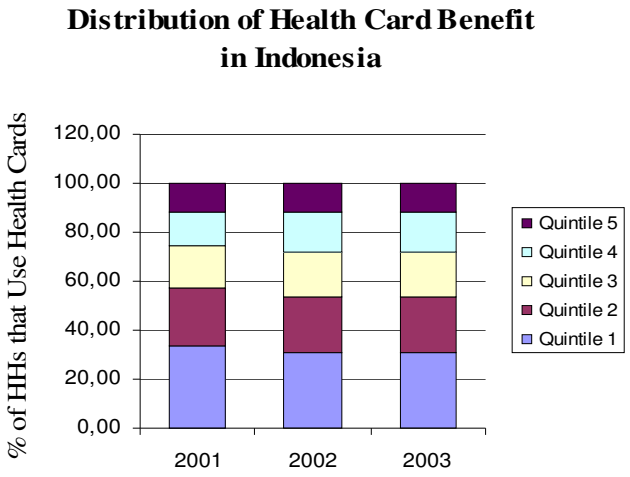
However, the benefits enjoyed by health card holders were also restricted by their real access to the health care facilities. According to the SMERU rapid appraisal in 1999, the public had faced various obstacles in the use of health cards, and these included: (i) limited time allocated for health card services, (ii) the distance from the patients' houses to the *puskesmas, pustu* and *polindes*, (iii) hospital referrals, and (iv) ineffective medicines. On the other hand, the health care staff were also faced some obstacle in delivering the program due to the administrative procedures of the program that they must carry out which take up a lot of time, and the

requirement to pay the same amount of retribution to local government as targeted despite there being less receipts because they had to provide free medication (Sulaksono et. al., 1999).

The case study on the effectiveness of JPK-Gakin also identified a number of formal and informal barriers that discourage some program members (the poor) from using the services to which they were entitled. These barriers included high transportation costs, and the delay in the distribution of their membership card. Such barriers might discourage the poor from using JPK-Gakin services and could make many JPK-Gakin members reluctant to seek treatment in health care facilities (Arifianto et. al., 2005).

Another obstacle faced during the implementation of health sector SSN program was the restrictions on the use of JPS funds for the purchase of medicines at the *puskesmas* level. This restriction was put forward by the Director General of Drugs, and had influenced the availability of medicines at the *puskesmas*, *pustu*, and *polindes* which indirectly influences the quality of medication and treatment provided. The health services are quite good and there appears to be no indication that health card holders were not treated properly by the health providers. At one of the *puskesmas* in the Purworejo Regency, a special counted was operated for health card holders. The patients who register at this counter did not feel awkward even though the counter was separated from the other counters (Sulaksono et. al., 1999).

Regarding the utilization of health cards by cardholders, based on the 1999 JPS Module in SUSENAS, Sumarto, Suryahadi and Widyanti (2001) estimated that of all those who underwent medical treatment, 6.3 percent used their health cards to obtain free services. Among the poor only, the proportion of those who used health cards is 10.6 percent, while among the non-poor 5.3 percent also used health cards to obtain the benefits of this program. The utilization rate of health cards by cardholders in 2000, 2001 and 2002, based on SUSENAS data is presented in Table 5. The utilization rate presented in this table is different from the calculation using 1999 SSN special module. The estimate from 1999 special module was calculated from cardholders that seeking health treatment, while the data structure in the 2002, 2003 and 2004 SUSENAS did not allowed for such determination, so that the utilization rate was calculated out of total cardholders regardless of their experienced of illness or not.



As presented in Table 5, on average, around 70 percent of health card holders in Indonesia used their cards to seek free medication. The utilization rate was particularly high in Papua (around 90 percent) and relatively low in Java/Bali (around 65 percent). Similar evidence was also revealed in the utilization rate among the population in the first and second lowest expenditure quintiles, which can be considered as the poor and the near poor. The proportion of health cards used by each expenditure quintile, as also presented in Figure 2, however, uncovered the high evidence of the use of health cards by non-poor population. The people in the lowest quintile only accounted for around 30 percent of all health cards used nationwide, and the two lowest quintiles only accounted for around 55 percent. The lowest proportion of cards used by the poor took place in Papua, followed by Kalimantan and

Sumatera, and this might indicate the adverse impact of low infrastructure that might limit physical access and the preference of poor households towards modern health facilities. Although of limited time frame, the 2001 to 2003 data seems to indicate the tendency of higher proportion of benefits enjoyed by the non-poor households.

Table 5. The Utilization Rate of Health Cards by Cardholders

	2001	2002	2003	2001	2002	2003
	Number of Hhs Used Health Cards			Card Utilization Rate – Total		
Indonesia	2,040,779	4,647,672	5,479,201	70.44	68.86	69.69
Sumatera	311,938	756,192	1,067,150	75.17	71.55	78.42
Java/Bali	1,285,120	2,700,072	3,104,551	67.29	64.17	63.87
Kalimantan	113,630	187,917	234,066	80.22	75.42	76.90
Sulawesi	149,831	332,169	368,334	80.18	76.51	78.14
Maluku/NTT/NTB	179,540	584,931	584,073	73.88	83.98	79.40
Papua	720	86,391	121,027	90.00	82.21	93.67
	Card Utilization Rate among Q1 (%)			Card Utilization Rate among Q2 (%)		
Indonesia	72.54	70.29	72.51	70.18	67.90	68.78
Sumatera	70.73	71.59	79.34	78.97	68.67	76.52
Java/Bali	69.74	64.96	66.91	67.55	63.30	63.77
Kalimantan	82.07	75.89	75.46	73.58	73.48	76.75
Sulawesi	80.43	78.56	76.93	77.99	76.44	79.37
Maluku/NTT/NTB	81.70	85.62	83.18	70.26	83.55	76.24
Papua	100.00	77.94	97.10	100.00	85.41	93.42
	% Utilization by Q1 (out of Total)			% Utilization by Q1&2 (out of Total)		
Indonesia	33.87	31.23	31.23	56.95	53.63	53.63
Sumatera	26.94	27.81	27.81	49.20	49.13	49.13
Java/Bali	33.31	30.08	30.08	57.46	52.53	52.53
Kalimantan	27.92	20.19	20.19	44.52	37.04	37.04
Sulawesi	40.95	34.97	34.97	63.67	57.83	57.83
Maluku/NTT/NTB	47.82	43.75	43.75	69.08	69.35	69.35
Papua	10.97	22.11	22.11	21.94	40.97	40.97

Source: Calculated from SUSENAS 2002, 2003 and 2004

4.4 Budget and Efficiency

The Ministry of Health introduced the health sector SSN Program on 7 August 1998. The program for the Fiscal Year 1998/99 was valued at Rp1.04 trillion and was funded by the ADB and the APBN/National Budget (through the IMF). The ADB provided funding for 8

provinces and the RABN funded 19 provinces. This means that all provinces were entitled to become recipients of health sector SSN program. The funds from the ADB were distributed in 4 phases, beginning in August 1998, whereas the APBN funds were given out in 2 phases, beginning October 1998. This fund was allocated for various sub-programs, with the biggest parts went to *puskesmas* (22%), JPKM (17%), and supplementary and complementary feedings for children and infant (16%).

As presented in Table 6, budget for health sector component of the SSN for FY 1999/00 was slightly decreased to 1.03 trillion, but the biggest parts still allocated to nutrition improvement (26.8%), basic health services in *puskesmas* (22%) and *posyandu* revitalization (12.9%), all of them disbursed to *puskesmas*. Hospital operation and referrals scheme got an allocation of around 13% of the budget; while the remaining was allocated to various sub-components of the program (see Appendix 1). The budgets for the three following years were significantly drop to less than Rp500 billion, and increased again to more than Rp900 billion in 2003 and 2004.

Table 6. Budget for Health Sector SSN and PKPS BBM Programs

Year	Scheme		Billion Rp	
1998/99	SSN	Plan	1,040	
1999/00	SSN	Plan	1,030	
2000	SSN	Plan	456	
2001	SSN		?	
2002	PKPS BBM	Actual	496	
2003	PKPS BBM	Actual	941	
2004	PKPS BBM	Actual	986	
2005	PKPS BBM & JPK MM	Plan	1,574	MoH
2005	JPK MM	Plan	2,300	JPK MM

Following the significant removal of subsidy for fuel prices, the 2005 budget of PKPS BBM for health sector was jumped to more than Rp1.5 trillion allocated for sub-programs under the management of the Ministry of Health, and another Rp2.3 trillion allocated for JPK MM managed by PT Askes. At the beginning of the 2005 FY, some Rp1 trillion of the state budget has been allocated for PT Askes, and an additional Rp1.3 trillion was added through additional fund *(Anggaran Biaya Tambahan*-ABT) due to significant increased of targeted beneficiaries by almost 50% of the first estimate based on BPS data on the number of poor population. Out of the budget managed by MoH, the majority still being allocated to basic health services in *puskesmas* (27%), followed by the provision of essential drugs (10%), supply of utensils for basic health care and birth delivery in *puskesmas*. Unlike the health sector SSN in FY 1999/00, the budget for *posyandu* revitalization was very small of only 0.48%.

Most of the program funds were directly transferred to *puskesmas* and village midwives through their account in local post office. To overcome imbalances in the allocation of funds that may take place between one post and another, and to prevent any misuse of funds, the Department of Health, through the Directorate General for Promotion of Community Health issued a letter No. 537/BM/DJ/JPS-BK/IV/1999 on April 8th, 1999. This letter states in point 4: ".... that re-allocation of the use of funds for the inter-activities in the *puskesmas* can be done as necessary according to the needs towards provision of good services for the poor."

Various studies and monitoring by CIMU HNSDP found that the system of releasing funds for *puskesmas* and village midwife was already satisfactory (CIMU HNSDP 2002a and 2002c; and Sulaksono, et al., 1999). However, these studies had identified several problems that might hinder the program implementation and led to ineffectiveness in the use of fund. The CIMU HNSDP monitoring highlighted the problem of late fund disbursement along the SSN program implementation as one of the factors adversely impacted the delivery of several sub-program, particularly the *posyandu* revitalization and supplementary feeding.

Another problem raised in both CIMU HNSDP monitoring and SMERU rapid appraisal was regarding the transparency in the use of funds at the *puskesmas* level. It was noted that the doctor/Head of Puskesmas plays a dominant role regarding the usage of funds, and there is also a lack of control regarding this usage (Sulaksono, et al., 1999). The head of health center, usually the individual named in the fund allocation decree, was often responsible for both expenditure and reporting. Difficulties were aggravated by the high mobility of the heads of health centers, many of whom were contract staff (PTT). To reduce this problem a policy was introduced to separate these functions. It was recommended that the fund allocation decree was made in the name of a senior administrative member of health center staff who held responsibility for accounting, while the head of health center maintained responsibility for expenditure (CIMU HNSDP, 2002a). In addition, the CIMU HNSDP national survey also found that some heads of *puskesmas* operated in an air of secrecy and failed to show the allocation decrees to their staff or to share information of the implementation of the program.

The CIMU monitoring also revealed a problem in the management of hospital referrals of the poor. The funding mechanisms for referrals differ between the community level and the hospital. The current system limits the flexibility of hospitals in responding to poor referred patients. There is also a lack of agreed criteria as to which case may be referred for free/reduced cost care CIMU HNSDP (2002a). Similar problem was also pointed by the case study on JPK-Gakin. This study found an indication of a lack of efficiency in the management of JPK-Gakin funds by health providers, especially at local public hospital (*Rumah Sakit Umum Daerah* – RSUD). In this hospital, claims were approved with little verification and inspection to ensure that they were accurate and there are indications that most of the funds were used to subsidize the care of non-poor patients rather than the poor ones who were supposed to benefit. It was also found that the unit cost per patient for each JPK-Gakin member treated at hospital in the districts being studies was quite high, ranging from Rp 480,505 in East Sumba to Rp 7,122,559 in Purbalingga. It was inconceivable that the patient's costs reflected in this calculation were all expended on the treatment of JPK-Gakin members and it was quite possible that a significant proportion of funds were "leaked" and resulted in the treatment of non-poor patients in these hospitals (Arifianto et.al., 2005).

The JPK-Gakin case study also indicated that the low utilization rate of JPK-Gakin members using the services they were entitled to, has potentially resulted in the miss-allocation of *Gakin* subsidies to the supposedly better-off members, who can actually afford to pay some of their own health care costs. It was likely that most of these funds were used instead to upgrade the buildings and medical equipment of the hospital and to subsidize other hospital patients, especially those from the upper income brackets. For instance, in Purbalingga it was estimated that 79% of the JPK-Gakin funds subsidized the health care services of non-poor patients at *puskesmas* and at the RSUD with 87.63% of overall JPK-Gakin funds went to non-poor patients (Arifianto et. al., 2005).

The SMERU rapid appraisal study conducted in 1999 also revealed a potential surplus in the allocation of funds by SSS in health sector in each assessment area as a result of a discrepancy between the initial data used to request funds and the actual number of health card holders. The surplus in the allocation of the *yankesar* (basic health services) funds in *Kabupaten* Malang, was in the range between 40,000 to 68,000 families, and in the case of *Kabupaten* Gowa, the gap was around 6,870 families. The number of patients who had just received health cards also indicated a surplus in funds. Consequently, the opportunity to use the available funds appropriately to meet the objectives of the program had been limited (Sulaksono et. al., 1999). Contrary, the CIMU national survey revealed the opposite case of an inadequate allocation of health cards beneficiaries, particularly in provinces where conflict had occurred (CIMU HNSDP, 2002c).

On the other hand, the amount of SSN funds allocated to hospitals in second-level regions was still felt to be inadequate, as hospitals did not only treat referred cases but also many cardholders who came directly to the public hospitals for treatment without referral from *puskesmas*. Yet part of the SSN funds allocated for referrals was allocated at the *puskesmas* level. The problems of referral were experienced by the public hospitals, cardholders, and non-cardholders of health cards. Compared to the expensive cost of medication and treatment at hospitals for serious disease and illness, the non-holders of health cards felt that they could not afford the cost, and consider themselves entitled to receive subsidy.

Finally, the most prominent problem is regarding budgeting of SSN program for health sectors was the issue of sustainability, as many basic services, particularly for the poor, would likely to be disrupted without the support from SSN (CIMU HNSDP, 2002c) and PKPS BBM schemes. The innovation of JPK-Gakin was not resolved this problem yet. JPK-Gakin funding largely depends on subsidies from the fuel subsidy compensation (PKPS-BBM) scheme and from the general block grant (*Dana Alokasi Umum* – DAU) given by the central government to district/local governments that largely funds the local government budget (APBD). Funding from other sources, such as member's premiums, only forms a small part of the program's overall funds. In the long run, this might make the scheme unsustainable as PKPS BBM and DAU grants are reduced, creating potential disruptions in the delivery of services (Arifianto et. al., 2005).

4.5 Institution and Incentive Effects

There were several institutions involved in the implementation of SSN in health, and the same institutional set up has been maintained during the PKPS BBM period. So, both programs adopt the same structure of program administration and implementation as well as monitoring and evaluation, with the exception in the establishment of the independent monitoring unit, CIMU HNSDP, which existed only during the live of the SSN program. According to the program's guideline, at the central level, the program is managed by program secretariat within the Ministry of Health (MoH), assisted by technical advisory team and program advisory team consisted of bureaucrats at MoH. While the overall SSN program is coordinated by the SSN advisory team consisted of various ministries lead by BPPENAS. At the provincial level, the governor establishes provincial coordination team consisted of representatives from health office, BKKBN, Office of the Ministry of Religious Affairs, education office, office of social affairs, and headed by BAPPEDA. This team should develop local policy; carry out assistance and coordination at provincial level, as well as monitoring and controlling the implementation at district level.

At the district level, program is managed by district coordination team (*Tim Koordinasi Kabupaten* – TKK) formed by the head of district (*Bupati/Walikota*). This team consists of representatives from health office, BKKBN office, education office, office of religious affairs, office of social affairs, and headed by BAPPEDA. Similar form of coordination team is also established at *kecamatan* (sub-district) level, headed by *Camat* (head of sub-district) and consisted of the head of *puskesmas*, head of sub-district education office, head of sub-district religious office, and other relevant institutions including all heads of villages. The TKK at district level plays important roles in determining local policy, allocations for *puskesmas* and village midwives, delivering the allocation to post office and other related agencies (*puskesmas*, midwives, provincial coordination team, SSN secretariat in BAPPENAS, and SSN health sector secretariat in MoH), as well as carry out monitoring, providing technical assistance, and controlling program implementation in all regions within their jurisdiction. Meanwhile the coordination team at sub-district level was to coordinate, monitor and control program implementation, and assisting in handling complaints at village level.

In the implementation level, local public hospital, *puskesmas* along with *pustu* and *polindes*, and midwives are at the forefront of service provision, and post office acts as the means of funds disbursement channel. CIMU HNSDP (2002a) claimed that program innovations regarding disbursement of funds through post office, and the allocation of block grant to *puskesmas* and village midwives attached with responsibility for planning and reporting on the use of this fund were the most successful steps, despite some minor difficulties. Indeed other report pointed some alarming evidences of the lack of transparency on the use of funds as mentioned in the cost section above. In addition, there were complaints from these service providers that the program had put too much administrative burdens and provide less income (Sulaksono et. al., 1999). A sentinel site survey, however, revealed relatively good compliance in completing book reports among village midwives as around 80 percent of them had completed the reports. In addition, only small fraction of puskesmas (around 19 percent) and slightly larger proportion of midwives (34 percent) did not update their monthly financial reports on time (CIMU HNSDP, 2002d).

Regarding the overall program implementation, the sentinel site survey also found several problems, including the difficulties in intersectoral program coordination at district as well as sub-district level, the lack of communication between TKK and service providers, and identifying target groups and distribution of health cards (CIMU HNSDP, 2002d). Meanwhile, Sulaksono et. al. (1999) observed that the monitoring of the implementation of the JPS-BK program was rather slack. Much tighter monitoring was required, so that the proposal to grant more freedom to the local program executors was not misappropriated.

Other study also highlighted two primary issues relating to public health services (Budiyati, 1999). Firstly, the issues related to the existence and the administering of the *Puskesmas*. It appears that the roles and responsibilities of this formal health institution are very significant. This was found to be particularly true in the *Puskesmas* located in remote areas, especially considering the geographical factors and physical infrastructures. One internal factor that has a strong influence is the health service policies applied by the *Puskesmas*. Some *Puskesmas* have applied a policy of 'early anticipation' in carrying out their services by optimizing the roles of all available staff and health providers. There is a strong indication that pro-active measures on the part of the *Puskesmas* have a positive influence, encouraging an increase in the number of visits to the *Puskesmas*. Other internal policies, for example, the strategy for determining fees, costs and management of the JPS-BK funds, are also influential in optimizing health services, particularly for the poorest.

Secondly, from the point of view of the community, it appears that the interaction between the community and the *Puskesmas* was influenced by several factors, in particular: 1) the cultural values underpinning local perceptions towards the *Puskesmas* and health providers; 2) the role of traditional health providers and the degree of trust held by the community towards them; 3) the level of knowledge within the community about health matters; 4) the distance between the patient's home and the *Puskesmas*; 5) the character of health providers and the quality of the services they provide; 6) the quality of the medicines; and, 7) the availability of other health facilities such as *Polindes* and *Pustu*.

Other component of the program, the JPK-Gakin have different institutional set up. In most districts, JPK-Gakin is managed by *Bapel* (*Badan Pengelola*: Management Unit), an independent body separate from the Regional Health Agency (*DinKes: Dinas Kesehatan)* that often consists partially of officials who were working for the *DinKes* prior to the establishment of the *Bapel*. In some other cases JPK-Gakin is provided by PT. Askes, which is a state-owned health insurance enterprise established by the Ministry of Health in 1968, which has an independent board of directors but is under the supervision of the Health Ministry. PT. Askes is a for-profit state-owned company that provides a number of different benefit packages in Indonesia. Benefit packages (including those for the poor) provided by PT. Askes are nationally set, so districts do not have the authority to make changes to accommodate local needs.

Study on the JPK-Gakin found that there was little involvement by non-government stakeholders, in particular, JPK-Gakin members/clients, in the design, implementation and monitoring of the scheme. JPK-Gakin members are just passive clients. Because they do not participate in the scheme's decision-making processes, the management of the program is less transparent and accountable to its stakeholders, especially its members. With the exception of East Sumba, there was no involvement by private health providers in the provision of health services for JPK-Gakin members. They were only able to seek health services in publicly managed health facilities (*Puskesmas* and RSUD). The fact that most private providers did not participate in the scheme results in a more limited choice of health providers available for its members, and, therefore, in restricted access to better quality services (Arifianto et. al., 2005).

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Appendix 1. The Allocation of SSN for Health Sector Budget in FY 1999/00

(Billion Rupiah)

Community Health to *Puskesmas* (from ADB)		
Basic Health Services	230.60	22.39%
Nutritional Improvement	276.60	26.85%
Eradication of Communicable Diseases	32.70	3.17%
Posyandu Revitalization	133.30	12.94%
Midwifery Services (to Midwives)	70.60	6.85%
Allocation for Hospital (APBN)		
Basic Health Services – Referral	48.00	4.66%
Operation	85.70	8.32%
District Health Office (APBN)		
Strengthening Food and Nutrition Surveillance System	15.70	1.52%
Supporting Activities (ADB)		
Unexpected Circumstances	10.35	1.00%
Socialization and Training for Medical Personnel	23.40	2.27%
Program Monitoring	53.90	5.23%
Central Management	49.30	4.79%
Total	**1,030.15**	

Appendix 2. The Allocation of PKPS BBM Program Budget in 2005

	Billion Rp	
January- July		
Basic Health Service in *Puskesmas*	36.0	2.29% of MoH
Hospital Referral (PT Askes)	64.0	4.07% of MoH
July – December		
Basic Health Services in *Puskesmas*	395.0	25.10% of MoH
Hospital Referral (PT Askes)	1.3	0.08% of MoH
Supporting Activities (July-Dec.)		
Posyandu Revitalization	7.5	0.48% of MoH
Remote Islands	18.0	1.14% of MoH
Supply of essential drugs	171.0	10.87% of MoH
Purchase of cars	61.0	3.88% of MoH
Purchase of motorbike	108.0	6.86% of MoH
Supply of vaccine (hepatitis)	40.0	2.54% of MoH
Renovation of Pharmacy Storehouses	66.0	4.19% of MoH
Others:		
Supply of utensils for basic health care	157.0	9.98% of MoH
Red Cross Funding	100.0	6.35% of MoH
Monitoring and Evaluation	25.0	1.59% of MoH
Management and Operational	79.0	5.02% of MoH
Reserve for Hospital Claims	110.0	6.99% of MoH
Child Delivery in *Puskesmas*	135.0	8.58% of MoH
Total MoH	**1,573.8**	40.6% of Total Health
JPK MM (PT Askes)		
Social Assistance	1,000.0	
Operational Cost	0.1	
Additional Budget (Revision)	1,300.0	
Total JPK MM	**2,300.1**	59.4% of Total Health
Total PKPS BBM for Health Sector	**3,873.90**	

Source: Calculated from Ministry of Health

V. COMMUNICABLE DISEASES PREVENTION: POLIO, TUBERCULOSIS AND HIV/AIDS PREVENTION PROGRAMS

Other than socio-economic problems, Indonesia's burden to alleviate poverty increases with the prevalence of some communicable diseases. Even though illness does not belong exclusively to poor people, yet more than ample evidence suggests some correlations between health and poverty. The data shows that globally, most of tuberculosis patients, for instance, are from poor countries, with the majority of them are from poor families and other vulnerable groups like homeless (Nhlema et al.; 2003). It is also found that the disease may cause or worsen poverty.[24] Its impact is more severe on poor patients than rich ones. While the latter may get medical treatment quite easily, either from his own pocket or medical insurance he participates, the poor often has no resource to cure his illness. The occurrence of such diseases thus may lead to impoverishment of poor patients and their households. At national level, it may increase the number of people living under poverty.

For Indonesia, the newest report states that the tuberculosis alone adds to the country 485.000 new patients every year. This is not to account the impacts of many other communicable or infectious diseases like malaria, polio or HIV/AIDS. Epidemical data clearly shows, for example, that the spread of HIV in Indonesia since 1995 has become increasingly serious, with a drastic increase in the number of new cases of people infected with HIV. Therefore, in order to eradicate the high incident of poverty in the country, it is necessary for the country to combat such diseases. Focusing on polio, tuberculosis and HIV/AIDS, this paper will analyze as how far such effort has been done and its impact on the reduction of the prevalence of the diseases in the country in general.

5.1 Background and Brief Details of the Programs

The threat of communicable diseases in Indonesia is still alarming. Other than 'old' diseases like malaria or tuberculosis, the country also has to combat the spread of new diseases like HIV/AIDS or avian influenza. For the HIV/AIDS, for instance, the UNGASS report 2006 2007 states that even though the aggregate prevalence of the disease is as low as 0.16 percent, and the incidence is concentrated in certain regions, but the spread of the disease in the country is categorized the fastest in Asia region (UNGASS report, 2006 2007: 10). Other than that, there is also possible threat from diseases from which the country had been previously free like polio. The second outbreak of polio disease in 2005, as well as other threats, warns the country to strengthen the existing programs on communicable diseases.

Polio and its prevention program

Polio (*Poliomyelitis anterior acuta)* is caused by the wild poliovirus infection. There are various symptoms of polio disease, from a light symptom to paralysis. Usually infecting young children by attacking the nervous system, the disease causes paralysis and muscular atrophy. Unfortunately, there is no cure for the disease. Therefore, since it will cause permanent physical disablement to individuals and have a significant socio-economic impact on society, the poliovirus has to be eradicated. Data shows that Indonesia is still subject to polio threat.

[24]B. Nhlema et al., 2003, A Systematic Analysis of TB and Poverty, available on ….

Even though it was declared that Indonesia had been free from polio virus since the last case was reported in 1995, wild polio virus attack was found again in the country in 2005. Indonesia was even ranked number two after Yemen in terms of the number of new cases found (p. 4).

Before this outbreak, based on AFP (Acute Flaccid Paralysis=*Lumpuh Layuh Mendadak*) surveillance to monitor paralysis, there were indications that cases of wild poliovirus no longer existed in Indonesia since the last wild poliovirus case was reported in Magelang, Central Java Province in 1995. Through an extensive and systematic polio immunization program, the number of polio cases in Indonesia had been reduced by 97% in 7 years from 773 cases in 1988 to only 30 cases in 1993.

In 6 May 2005, however, the World Health Organization reported a total of four new confirmed cases of poliomyelitis in Indonesia. The first case was confirmed on 2 May 2005 in Giri Jaya Village, Sukabumi District, West Java. Two further cases have occurred in the same village as the index case and a third from a neighboring village. All cases have occurred in previously unvaccinated children (Nathnac, 2006). These are the first cases of wild type polio in Indonesia since 1995. This has attracted attention and was reported as a second polio outbreak in Indonesia. By mid-June 2005, the number of polio cases was reported to have reached 46 and by September to have grown to a total of 236 people. While most of the initial cases occurred in West Java (newsVOAcom, 2005) cases have been reported in Central Java, Lampung, Banten, DKI Jakarta, and North Sumatra. In November, ten days after the second round of 2006 PIN[25]), 9 polio cases were still found in 6 provinces (MoH, 13 September 2006). When the fourth round of the 2005/2006 PIN was conducted on 27 February 2006, the cumulative total of polio cases was reported to have reached 304 cases in 10 provinces and 40 districts (MoH, 27 February 2006).

In order to prevent and eradicate wild poliovirus, the Government of Indonesia (GoI) has taken several steps as follows: (1) Conducting high dosage routine immunization with a minimum of 3 rounds of polio immunization vaccine; (2) Conducting '*Pekan Imunisasi Nasional* (PIN)' (the National Immunization Week) over three consecutive rounds; (3) Conducting AFP Surveillance with laboratories check-up; Conducting mopping-up; and (4) Polio Free Certification.

In practice, the Government of Indonesia regulates that all infants under 5 (*bawah lima tahun or 'balita'*), including newborn babies, who live in Indonesia have to take certain immunizations, including polio. This systematic routine immunization has been in place for a long time. The vaccine includes BCG, polio, DPT, measles, hepatitis B, and influenza. The vaccine is available from all health providers, hospitals, *Puskesmas* [26] as well as private medical practitioners and midwives. Even though it is regulated and obligatory, access to the vaccine is voluntary and not free. The socialization of these systematic immunizations is conducted through doctors, midwives, nurses, *Posyandu*[27], health cadres, families and other members of the community. It has been so effective that most community members acknowledge the importance of the immunizations and the negative impact of not taking the immunizations. A few community members are, however, sometimes reluctant to access the vaccine for 3 main reasons; the cost, lack of access to the vaccine, and afraid of being ill after the immunizations.

[25]PIN: *Pekan Imunisasi Nasional*: National Immunization Week.

[26]*Puskesmas: Pusat kesehatan masyarakat:* Community healthcare centers.

[27]*Posyandu: Pos pelayanan terpadu:* Integrated health posts.

More specifically, the GoI conducted what is called Pekan Immunisasi Nasional (PIN, National Immunization Week). It is a special week when all *balita*, including newborn babies, who live in Indonesia, are given a free polio immunization, irrespective of their previous immunization status. The immunization was given twice with 2 drops of vaccine on each of 2 occasions at an interval of 2 months. It is hoped that a mass polio immunization for target groups (*balita*) will speed up the disruption to the wild poliovirus lifecycle since it is believed that poliovirus can live for only 48 hours in open air. PINs are conducted because of indications of the existence of wild poliovirus and to strengthen systematic routine immunization activities that might not effectively reach all members of the community.

The program was successfully conducted in the months of September and October in the consecutive years of 1995, 1996 and 1997. As recommended in the New Delhi meeting,[28] Indonesia conducted another PIN in 2002 with support from WHO, UNICEF, Rotary International and UNDP. Finally, because of the second polio outbreak that broke out in May 2005 (even though the poliovirus comeback was recorded in year 2003), the government took action by conducting another PIN in 2005 and 2006 over 5 rounds, (August 2005, September 2005, November 2005, February 2006, and round 5 will be in April 2006). Additionally, as there are areas at high-risk to polio and the fact that the targeting performance of the 2005 PIN rounds 1, 2 and 3 were not optimum (90%), another Sub-PIN was conducted on 30 January 2006 in 57 districts in the province of NAD, North Sumatra, South Sumatra, Lampung, Banten and East Java. Sub-PINS were also undertaken in the aftermath of the economic and political crisis in 1997 as the crisis was thought to have weakened the routine immunization program performance, and thus has created opportunity for the re-emergence of wild poliovirus, which potentially enters Indonesia from neighboring countries like India, Bangladesh and Myanmar.

Tuberculosis and its prevention program

Tuberculosis (TBC/TB) is caused by the *mycobacterium tuberculosis*. The bacterium, which mostly attacks the lung, is spread by a positive BTA TBC[29] carrier who coughs and spills the droplet into open air. People can be infected if the droplet is inhaled into their lung. According to the WHO, around 3 million people in the world die annually because of tuberculosis or around 5,000 people every day with Indonesia has the third highest incidence of TB after India and China. The WHO Global Surveillance and Monitoring Project 1999 estimated the incidence in Indonesia to be around 583,000 new cases and 262,000 new smear positive cases per year. The prevalence of smear positive cases is estimated to be 715,000, with 140,000 patients dying annually of TB. Based on the National Household Health Survey (NHHS) (*Survei Kesehatan Rumah Tangga/SKRT*) 1995, tuberculosis is the third major cause of mortality in Indonesia, accounting for 10 per cent of the total mortality rate, after cardiovascular disease (19 per cent) and respiratory system illnesses (16 per cent). The Annual Risk of Tuberculosis Infection (ARTI), which measures the number of people infected by TBC annually per 1,000 people, is considered high for Indonesia. The NHHS 1995 also indicated that tuberculosis is ranked 7th in morbidity with a rate of 4.2 per 1,000 people.

[28]The Eight Technical Consultative Group on Vaccine Preventable Diseases in SouthEast Asia Regional Office (SEARO), 22-25 October 2001 which identified SEARO areas were vulnerable to polio.

[29]*BTA: Basil tahan asam*: Acid-fast (tuberculosis) bacillus (AFB).

Table 1. Tuberculosis Cases in Indonesia (1997-2006)

Year	Pulmonary Tuberculosis			Extra Pulmonary Tuberculosis	Total
	Smear-Positive		Smear Negative		
	New	Relapse			
1997	25,420	497	3,125	4,174	33,216
1998	29,781	1,177	8,217	382	39,557
1999	49,333	2,205	20,792	1,105	73,435
2000	52,338	2,478	28,225	1,550	84,591
2001	53,965	2,708	34,547	1,818	93,038
2002	76,230	3,731	72,219	3,008	155,188
2003	92,566	4,086	77,561	4,047	178,260
2004	128,981	4,429	76,981	4,267	214,658
2005	158,640	4,446	85,373	6,142	254,601
2006	175,320	4,227	91,029	7,013	277,586

Source: Ministry of Health and Bakti Husada and Stop TB Partnership (2007), Report of the Joint External TB Monitoring Mission

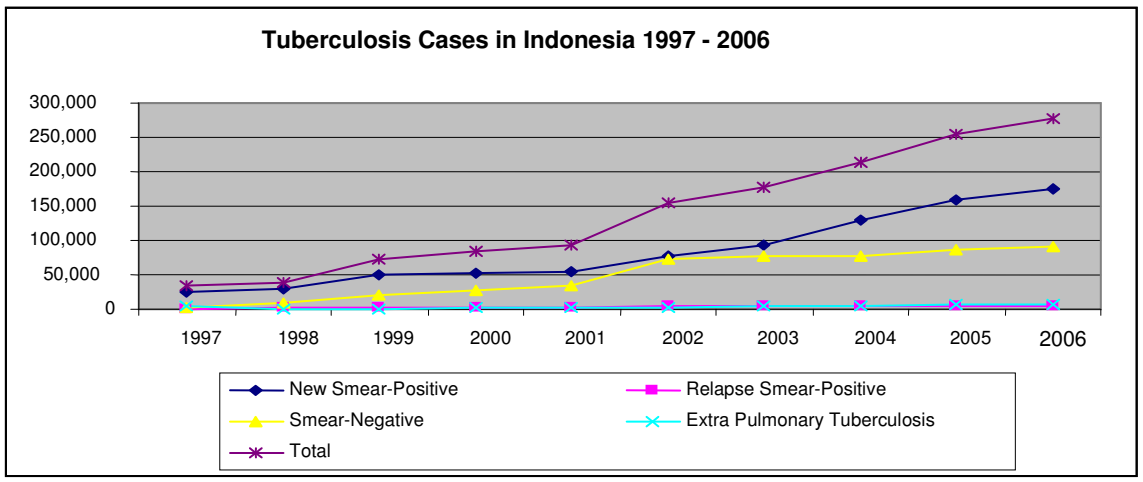


Figure 1. Tuberculosis cases in Indonesia 1997 - 2006

The National TB Control Program has been in place since 1969. Initially the program was based in the health centers (*Puskesmas*) using standard drug regimens with a treatment duration of 1-2 years. The objective of NTP is to decrease the TB morbidity and mortality rate through interrupting the transmission of TB infection until the tuberculosis is no longer a public health problem. The short-term goals of the NTP are to: (1) cure at least 85 per cent of all new smear-positive cases detected in each year from 2002 until 2006; and (2) detect at least 40 per cent of all new smear positive cases by the year 2002, with 50 per cent detection by 2003, 60 per cent (2004) and 70 per cent (2005).

The program is aiming to achieve a conversion rate of at least 80 per cent at the end of intensive treatment, a cure rate of at least 85 per cent of the AFB (+) patient, and an error rate of slide cross check at a maximum of 5 per cent. The program activities include: (1) conducting high level advocacy at provincial and district levels; (2) conducting training of related staff and sectors; (3) improving the quality control of laboratory examination by creating a laboratory network at all levels; (4) conducting routine and problem solving

meetings and regular coordination to improve surveillance data and program management; and (5) providing better community-based services through COMBI (Community Based Initiatives).

In 1993, the DOTS (Directly Observed Treatment, Short-course chemotherapy) strategy was adopted with a pilot project in 4 provinces of Sulawesi. DOTS consists of five (5) components: political commitments, microscopic diagnosis, short-term drug treatment with direct drug intake monitoring (*Pengawasan Menelan Obat*=PMO), guarantee on drug availability, and an effective and uniform recording and reporting system. The DOTS strategy piloting proves that the strategy has contributed to a high cure rate. The World Bank also claims that the DOTS strategy is cost effective and a WHO study showed that every US$1 used for a TB prevention program will save around US$55 in 20 years references. Due to the success of the pilot program, DOTS was expanded to two other provinces in 1995. Since then the DOTS strategy has been expanded to all provinces in the country (DG CDC EH[30]?, 2004).

The Government of Indonesia considers TB control to be a high priority within the health system and it is not only the responsibility of the public sector but also the private sector and others. For that reason, in March 1999 the Minister of Health established "*Gerdunas TB*" (*Gerakan Terpadu National Penanggulangan TB*/A National Integrated Movement for TB Control) with the objective of strengthening the partnerships among these sectors and the NTP (DG CDC EH, 2004). To rapidly scale up the DOTS program, the government has involved donors, including among others, the Dutch Government, the Global Fund for AIDS, Tuberculosis and Malaria (GFATM)[31], Tuberculosis Coalition for Technical Assistance (TBCTA), KNCV, and CIDA (Canadian Development Aid).

HIV/AIDS and its prevention program

Since 1987, there have been worrying developments in HIV (Human Immunodeficiency Virus)/AIDS (Acquired Immunodeficiency Syndrome) in Indonesia in terms of numbers and mode of transmission. Epidemiological data clearly shows that the spread of HIV in Indonesia since 1995 has become increasingly serious, with a drastic increase in the number of new cases of people infected with HIV. There were three distinct periods that can be identified: 1985-1989, 1989-1994, and 1994-2002 (NAC, 2003). Looking at the way the patients are infected, currently, the two most common modes of transmission are unsafe sex and intravenous drug use. Table 1 and 2 and Figure 1 and 2 below (as well as Annex 1) show data on the HIV/AIDS cases in Indonesia until June 2004.

In response to the outbreak of the HIV/AIDS pandemic in Indonesia, a number of steps have been taken. In 1985, the National Institute for Research and Development, Ministry of Health formed a working group to monitor the global development of HIV/AIDS, particularly its progression in Southeast Asia and to gather information on the epidemiology of HIV/AIDS. In 1988 the Minister of Health established a Working Group (WG) of HIV/AIDS Prevention.[32] The primary task of the WG was to manage communication and coordination, as well as to gather and disseminate information to alert all sectors to the

[30]DG CDC EH: Directorate-General for Communicable Disease Control and Environmental Health.

[31]The GFATM is an independent public-private partnership working to increase funding to fight AIDS, Tuberculosis, and Malaria in countries with the greatest need and contributing to poverty reduction as part of the Millennium Development Goals (MDG). The fund will support efforts in prevention, treatment, care, and support of those infected and directly affected by complementing existing programs and/or activities.

[32]Later, in 1989, this WG was reorganized and expanded to bring multi-sectoral and NGO representatives as members.

problem of HIV/AIDS. In the same year, the Ministry of Health issued a regulation making it mandatory to report all cases of AIDS, and appointing certain laboratories to carry out HIV testing.

Table 2. Cumulative HIV/AIDS Cases in Indonesia by Region (until June 2004)

Region	HIV		AIDS		Total	
	No of Cases	%	No of cases	%	No of cases	%
Sumatra	369	12.9	175	11.5	544	12.4
Java/Bali	1,655	57.8	824	54.0	2,479	56.5
Kalimantan	141	4.9	50	3.3	191	4.4
Sulawesi	36	1.3	30	2.0	66	1.5
NTB/NTT/Maluku	30	1.0	42	2.8	72	1.6
Papua	632	22.1	404	26.5	1,036	23.6
Indonesia	2,863	100.0	1,525	100.0	4,388	100.0

Source: Ditjen PPM & PL Ministry of Health: *Statistik Kasus HIV/AIDS di Indonesia,* 2004

More developed than the previous period, the government responses in 1989-1994 included: (1) HIV surveillance in certain sub-populations such as sex workers and screening by the Blood Transfusion Unit of the Indonesian Red Cross (PMI); (2) increasing the number of laboratories with HIV testing facilities to enable all provincial health laboratories to participate in HIV/AIDS surveillance; (3) capacity building for health workers on HIV/AIDS through education and training programs and sending several officials from both health and non-health sectors for further training and experience; (4) Intensifying information, education, and communication (IEC) on HIV/AIDS through seminars for journalists, medical faculty staffs, the private sector and business community; (5) publishing, reproducing, and distributing a range of IEC aids including books, brochures, and leaflets; and (6) establishing the National AIDS Commission (KPA/*Komisi Penanggulangan AIDS*) by virtue of Presidential Decree No.36/1994 chaired by the Coordinating Minister of People's Welfare which later published the 1994 National HIV/AIDS Strategy as well as various other edicts.

In the 1994-2002 period, the government further continued the previous efforts by: (1) the establishment of Regional AIDS Commission (*KPAD/Komisi Penanggulangan AIDS Daerah*); (2) the formation of working groups on AIDS prevention at both the AIDS Commission and a number of Ministries and related sectors; (3) bilateral, regional, and international cooperation efforts; and (4) adoption of the output of the international meetings on HIV/AIDS prevention in which Indonesia participated. In 2002, the MoH, with support from international experts, created a national estimation method for HIV infection in Indonesia. This process resulted in an estimate of between 90,000 and 130,000 people living with HIV/AIDS in Indonesia (NAC, 2006).

Recently, a number of initiatives have also been taken in the area of HIV/AIDS Prevention. These include: (1) Cabinet Meeting – Special Session on HIV/AIDS which was held in March 2002 with the objective of increasing the commitment of national leaders to HIV/AIDS Prevention and to improve and to decide policy strategies on HIV/AIDS Prevention in Indonesia; (2) '*Gerakan Nasional Stop AIDS*' to prevent the national HIV/AIDS disaster in Indonesia; and (3) the National Strategy on HIV/AIDS 2003-2007 which was formulated by the National AIDS Commission with the support of UNDP, AusAID, and UNAIDS.

The National Strategy HIV/AIDS 2003-2007 identifies seven priority programs: (1) HIV/AIDS Prevention; (2) Care, Treatment and Support for people living with HIV/AIDS (PLHA); (3) HIV/AIDS and STI Surveillance; (4) Operational Studies and Research; (5) Enabling Environments; (6) Multi-stakeholder Coordination; and (7) A Sustainable Response. Additionally, as follow up to the National Strategy, the National AIDS Commission also formulated The National Action Framework 2005-2007. The goals of the action framework are to prevent and limit the spread of HIV and improve the quality of life for people living with HIV/AIDS so as to alleviate the socio-economic and health impact of the epidemic on the people in Indonesia. The purpose of the 3-year National Action Framework is to increase capacity to halt and begin to reverse the spread of HIV/AIDS infection among core transmitters and in areas of concentrated epidemic transmission (NAC, 2005).

The five priority areas of the Action Framework are to: (1) reduce the individual risk of sexual transmission of HIV; (2) reduce the individual risk of HIV transmission among injecting drug users and sexual transmission to their partners; (3) increase the awareness of the general population, particularly young people, of their vulnerability to HIV/AIDS infection and discriminatory behaviors toward PLWHA (People Living With HIV/AIDS); (4) improve access and quality of care, treatment, and support for PLWHA with a focus on increasing Voluntary Counselling and Testing (VCT), treatment for Opportunistic Infections (OI) and community based care and support; and (5) strengthen the capacity to prioritize and allocate resources for HIV/AIDS at national, province, and district levels.

The goal of all prevention programs is to ensure that everyone can protect her/himself against HIV infection, avoid transmitting the virus to others, and reduce the socio-economic impact caused by HIV/AIDS. Program activities include: (1) intensifying IEC (Information, Education and Communication); (2) reducing vulnerability; (3) increasing condom use; (4) increasing the supply of safe blood; (5) stepping up efforts to reduce the prevalence of sexually transmissible infections; (6) improving measures to prevent mother-to-child transmission; (7) improving the application of universal precautions; and (8) stepping up efforts to prevent HIV transmission among the IDU. In line with the program, the cost of ART (Anti Retroviral Therapy) has been subsidized since 2004 and 25 hospitals have been appointed to provide ART. Schools and teachers also received training on life skills-based HIV/AIDS education (LSE). Each school has two trained teachers who taught the subject during the academic year.

To anticipate the negative effects of HIV/AIDS in the workplace, the government passed Ministerial Decree of Manpower and Transmigration No.Kep.68/Men/IV/2004 on HIV/AIDS prevention in the workplace. The Decree stipulates, inter alia, that: (1) the company (management and/or owners) should conduct HIV/AIDS prevention activities at work places; (2) workers living with HIV/AIDS have the right to receive health services equal to other workers; (3) the government provide guidance about HIV/AIDS prevention programs at work places; (4) the government, the company, and workers, individual or together, should support the HIV/AIDS prevention in work places; (5) the company should not demand an HIV test as a requirement of job recruitment or routine health check-up; and (6) the test is only conducted on a voluntary basis and the test should be conducted by medical doctors with certain expertise.

Other than the government program, donors and many NGOs are also working hand in hand on the HIV prevention program. Between January and July 2004, UNICEF, in collaboration with the Ministry of National Education trained master trainers, teachers and peer educators for LSE and peer education in Papua. Teaching and learning materials in the form of a

teacher's manual, student booklets, flipcharts, and two sets of posters on LSE for HIV/AIDS were printed and distributed to 123 schools in Biak, Jayapura, Manokwari and Sorong districts.

5.2 Coverage and Targeting Performance

Different targeting systems are applied to reach the target group of every health program. While the polio eradication program targeted all the children eligible for the immunization, that zero case must be achieved for a country to be declared free from polio, TB and HIV/AIDS programs are assessed on the bases of either the percentage of standard or minimum treatment should be received by those infected, might be infected or affected by the diseases, or the minimum percentage of people or patients covered by the programs.

As for the polio eradication program, it appears that except for the period of 2000 and 2002, the target of PINs increased year by year (see Table 1). While the program targeted 17.9 million children in the first round of the PIN 1995, the number of children targeted increased by 4 million in October 1997, which is the second round of the PIN 1997. After decreasing significantly in the late nineties, due to the economic crisis faced by the country, the program targeted nearly 21 million children in 2002. The second outbreak of wild poliovirus in the country in 2005 increased the target of the program rather significantly to 23.6 million infants under 5 for every round of the 2005 and 2006 PINs.

Table 3. PIN (and Sub PIN) 1995-2006 and the Target

Year	Program	Date/month conducted and Target (infants under 5/*balita)*				
		Round 1	Round 2	Round 3	Round 4	Round 5
1995	PIN	September 17.9 million	October 19.2 million			
1996	PIN	September 21.1 million	October 21.7 million			
1997	PIN	September 21.3 million	October 21.9 million			
1998						
1999	BIAS Polio In Schools	n.a				
2000	Sub PIN (5 provinces)	August to November 1.3 million				
2001						
2002	PIN	12 Sept 20.8 million	9 Oct 20.8 million			
2003						
2004						
2005	PIN	30 August 23.6 million	27 Sept 23.6 million	30 Nov 23.6 million		
2006	PIN				27 February 23.6 million	12 April 23.6 million
	Sub PIN (6 provinces)	30 January 4.5 million				

Source: Subdit Imunisasi, Ministry of Health

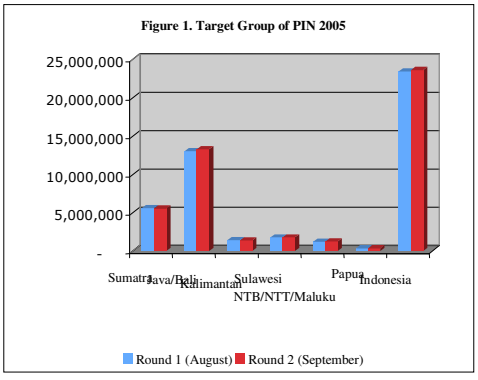
However, despite the increase in the number of children targeted after the second outbreak of the disease in 2005, it is apparent that the implementation of the program was not as good as before. While before 2005 the program could reach more children than targeted, ranging from 101.8 percent in the first round of 1995 to 107.7 percent or the highest in the second round of 1996, since 2005 the achievement of the PIN program was on average below the target. At best, it reached 98.1 percent of the target in the third round of the 2005 PIN.

Table 4. Targeting Performance of 1995-2006 PIN and Sub PIN

Year	Program	Targeting performance				
		Round 1	Round 2	Round 3	Round 4	Round 5
1995	PIN	101.8%	106.4%			
1996	PIN	105.5%	107.7%			
1997	PIN	104.9%	106.8%			
1999	BIAS Polio In schools					
2000	Sub PIN (5 provinces)	94.2%	92.8%			
2002	PIN	107.0%	na			
2005	PIN	95.0%	97.4%	98.1%		
2006	PIN				97.1% (preliminary)	Will be conducted in April
	Sub PIN (6 provinces)	95.8%				

Source: Subdit Imunisasi, Ministry of Health

A closer look at the intra-region differences in the program implementation reveals, however, that the performance of the targeting varied from region to region. For the first and second rounds of the 2005 PIN, for instance, many regions could reach the target and even more, but many others could not. As a result, the target performance of these two rounds could only achieve 95.0 and 97.4 percent respectively. As shown in the tables 3 and 4 below, Papua had the worst performance in terms of target achievement despite its tiny target compared even to Sulawesi and Nusa Tenggara-Maluku islands. Most of the target was certainly in Java and Sumatra where most of Indonesian populations live. However, for the 2005 PINs, in terms of targeting performance, Sulawesi and Nusa Tenggara-Maluku islands performed better than Java and Sumatra (see Annex 1 for more detailed picture of target coverage of PIN 2005).



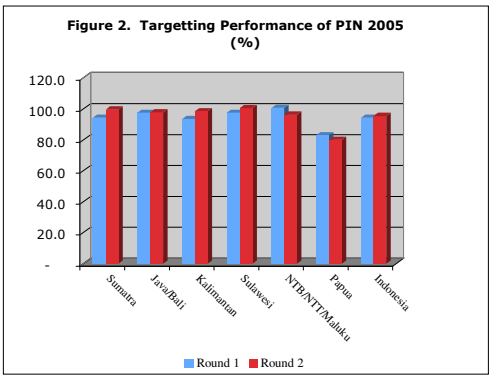


Figure 2. The target group of PIN 2005 and its performance by regions

Unlike polio prevention program, in order to overcome TB, WHO requires a detection rate of at least 70 per cent and a cure rate of 85 per cent. As of 2005, data shows that the Indonesian TB cure rate is 85 per cent[33] but the coverage is still less than 70 per cent, with an estimated coverage of only around 47 per cent even though some provinces have reached the WHO recommended level.

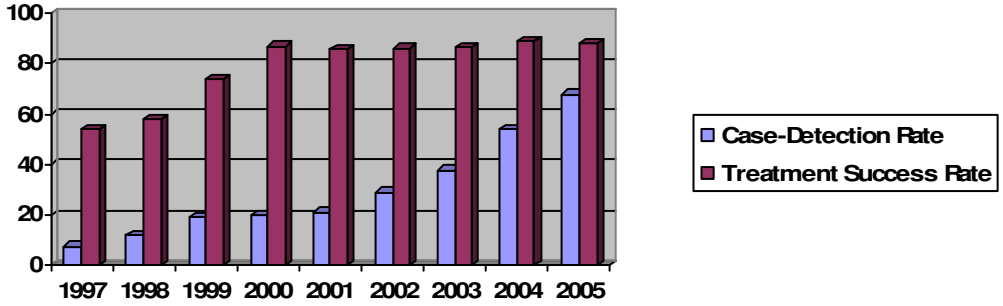


Figure 3. Case-Detection Rate and Treatment Success Rate 1997 - 2005

In the period 2001-2003, the population coverage of DOTS was 98 per cent and the case detection rates were 21 per cent, 29 per cent, and 41.6 per cent respectively.[34] It was claimed that the success rate was 86 per cent. USAID reported (USAID, 2004) that the DOTS population coverage in 2002 was 70 per cent with a detection rate in the same year of 73 per cent, and a DOTS treatment success rate in 2001 of 83 per cent. However, despite the positive performance, the TBC Prevention Program with DOTS Strategy has not reached all *Puskesmas*, hospitals and other health providers.

For the HIV/AIDS programs, not until recently has the GoI (through the NAC) set up the target to be achieved so that performance of the targeting in the previous years was not well known or documented. Furthermore, it also became very difficult to assess the targeting performance of that period. Previously, they only state their goals and target qualitatively that they would like to address the problem by both preventing the spread of the disease and curing those already infected. There are three target groups of these programs:

1. Vulnerable groups. These are people who, because of the nature of work, their environment, low level of family support and welfare or health status, are vulnerable to HIV. These groups may include highly mobile people, women, youth, street children, poor people, pregnant women and blood transfusion recipients;
2. Infection-risk groups. These are people who are linked to high-risk behavior, such as sex workers and their clients, injecting drug users, and people detained in correction/detention centers; and
3. Infected groups. These are people who are already infected with the HIV (PLWHA) who need a special approach because of their potential to transmit disease to others.

[33]WHO defines the cure rate as the proportion of new cases of smear-positive TB that were cured through treatment; this rate is routinely measured by treatment registers.

[34]The case detection rate is the number of reported cases per 100,000 persons per year divided by the estimated incidence rate per 100,000 per year or the proportion of incident smear-positive TB cases detected through a TB program. TB incidence is uncertain and not measured but estimated; therefore, the case detection rate is uncertain. The case detection rate is defined as the notification rate of new cases of smear-positive TB divided by the estimated incidence rate.

It is only in the updated version of the HIV/AIDS National Strategy 2007-2010 that the government stated clearly target to be met year by year. Focusing on three key issues, which are (1) prevention and reduction of the number of new HIV/AIDS infections, (2) the quality of life of those already infected, and (3) social and economic impacts for those with HIV/AIDS, their families and societies,[35] the government states some key targets to be met by 2010. These targets include:

1. 80% of most-at-risk-populations (MARPs) have access to a comprehensive prevention program
2. 60% of MARPs reached with behavior change intervention
3. 80% of those who are eligible can access ARV and CST as needed
4. 60% pregnant women who are HIV positive can get ARV prophylaxis
5. 50% reduction in new infections, or 35,000 new infections instead of the 70,000 new infections projected in 2010 if program coverage remains at current level.

Unfortunately, data of the program implementation is still rarely available that it is difficult to state quite precisely as how these targets have been fulfilled so far. So far, there are only two reports that could be used to evaluate the performance of this targeting, namely the UNGASS reports and the KPA annual report. Yet both of these two reports are not free from their own weaknesses. While the former is produced on occasional bases, which is not available every year, the latter is not complete either. Not all points stated as target to be met in the National Strategy are reported in the KPA annual report. On certain points, it seems that the 2007 KPA Annual Report only reproduced the same data used by the UNGASS report so that it is quite difficult to asses the all the targets mentioned above.

From both of these reports, it appears that while Indonesia could make a quite significant progress in the prevention programs, on the curative aspect the country should work harder to reach its target in stopping the spread of HIV/AIDS. On the prevention side, the KPA's data reveals that the total number of IDUs, female sex workers, MSM and other target groups reached by the prevention program was higher that the targeted in the 2007 National Strategy. Yet on the curative aspects, some indicators show that many problems are still persistent. While the 2007 National Strategy mandated that 80% of those who are eligible can access ARV and CST as needed, the UNGASS report reveals that drugs are available only in big cities. As of December 2006, only 24.8 percent of people with advanced HIV infection received ART. Other than that, still related to ARV, laboratory tests and medications for those possibly infected, in which most patients have to pay themselves as such tests and medication are not covered by insurance, are quite expensive. This problem is exacerbated by the fact that many staffs in health service location are not well informed with the services needed by these people.[36] The picture is even worse if we look at the program for pregnant women who are positive HIV. Far below the target, 60 percent of pregnant women who are positive HIV could get ARV, data per December 2006 show that the program performance could reach not more than 3.5 percent.[37]

5.3 Impact and Outcomes

Of the three diseases discussed here, it is apparent that polio program shows the most significant result. Despite the emergence of a number of new cases during the implementation of PINs, yet after several years of the program implementation, the emergence of new cases

[35]UNGASS Report 2006, p. 24.

[36]UNGASS report, 34-35.

[37]UNGASS report, 35.

could be eradicated gradually and finally no longer found. As previously mentioned the incidence of polio cases continued until the fourth round of the 2005/2006 PIN on 27 February 2006. However the number of cases is expected to decrease. Before the second round of 2005 PIN conducted in September 2005, the number of recorded polio cases had reached a total of 236 people or an average of around 60 new cases per month. In November, ten days after the second round of 2006 PIN, 9 polio cases were found. Until February 2006 the cumulative total of polio cases was reported to have reached 304 cases or an additional 12 cases per month since October 2005. Yet 2006 also marked the period when the last polio case was reported with the province of Nangroe Aceh Darussalam as the region reporting the case. Finally, Indonesia was declared free from polio after a year reporting no new polio cases since the last case was reported in 2006.

With different standard of achievement, DOT system in TB program is considered successful as well. Other than high rate of treatment success also continuously decreases. Yet it is also worth noticing that the implementation of the NTP program is not free from some problems either, namely the weak management capacity in some provinces, insufficient commitment at some provincial and district levels for the contribution of local resources, and only 60 per cent of staff has been trained at the health unit level. At present, DOTS are implemented only at health center level. Other health care providers (lung clinic) have been included in the DOTS system very recently. Hospital and public private clinics are not fully on board as yet. TB patients do not always go to the *Puskesmas* where the DOTS program is mostly based. It is necessary for the service to be expanded to the hospitals and private medical practices to cover wider TB patients.

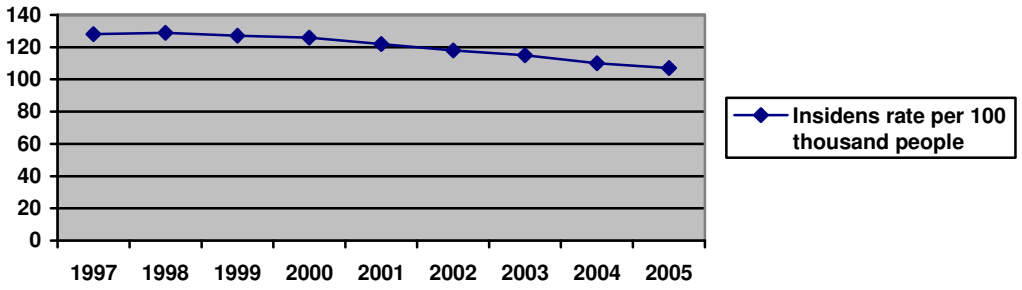


Figure 4 TB incidence rate per 100 thousand people

Source: Program nasional penanggulangan TBC Indonesia

Unlike the polio eradication and the TB programs, the impact and outcomes of the government HIV Prevention Program alone is not easily detected. To respond to the HIV/AIDS problem, many programs have been conducted, not only by the government but also by donor funded projects, such as IHPCP/AusAID, FHI/USAID, and GFATM, and many NGOs, with or without support from international initiatives and communities. Collectively, they have improved the program performance as well as those reached by the program. UNGASS report 2006 2007 notes that other than the provision of ART freely since 2004, by the end of 2007 there were 267 VCT clinics, plus 153 hospitals that provide free ART, and 19 hospitals that had Prevention of Mother to Child Transmission (PMTC) programs. Other than that, there have developed 20 referral networks for Integrated Management Adult Illness (UNGASS report 2006-2007, 34)

As for the program implemented, data from various sources cited by UNGASS reports 2004 and 2006-2007 indicate that the programs have increased significantly the number of those vulnerable to the infection of HIV/AIDS receiving prevention programs. While it has doubled the number of sex workers covered by the prevention programs, rising from 18.3 percent in 2004 to 39.6 percent in 2007, the impacts of the program on men having sex with men (MSM) and injecting drug users (IDUs) were even more significantly higher. As the table shows, the points for these two indicators rose drastically from 1.9 and 5.7 percent in 2004 to 40.1 and 44.7 respectively in 2007. Similarly, significant improvement also takes place in the percentage of female and male sex workers reporting the use of condom with their most recent clients. While in the female group the percentage rose by 11.5 points, from 56.2 percent in 2004 to 67.7 percent in 2006/2007, the percentage in the male group rose even more highly from 47.5 percent in 2004 to 72.0 percent in 2006/2007. Yet unfortunately, this improvement is not followed by the rise of knowledge about the disease, especially the transmission of the disease among the vulnerable group. Data shows that knowledge indicator rose by only 4.5 percent among sex workers, and even slightly dropped from around 43 percent in 2004 to 41.6 percent in 2006/2007 among MSMs.

Other indicators show that generally the impact of the programs on the 'curative' side has not been as significant as those on the prevention or prevention-led activities. Even though the programs could double the number MARPs having received HIV test, yet still the achievement is generally lower than the above mentioned indicators. At best, it raised the number of IDUs having received HIV test from 18 percent in 2004 to 35.9 percent in 2007. Other indicator even shows a slight drop in the program performance. While there were 35 percent patients receiving ART in 2004, the number decreased quite significantly to 24.8 percent in 2007.

Table 5. Program Impact Indicators

Indicators	2004*	2006/ 2007**
Percentage of MARPs reached with HIV Prevention Programs		
a. Sex Workers	18.3	39.6
b. MSM	1.9	40.1
c. IDUs	5.7	44.7
Percentage of MARPs that have received HIV test		
d. Sex Workers	14.0	30.8
e. MSM	15.0	31.9
f. IDUs	18.0	35.9
Percentage of HIV positive pregnant women who received ARV to reduce the risk of MTCT	n.a	3.5
Percentage of patients receiving ART	35.0	24.8
Percentage of MARPs could correctly identify ways of preventing sexual transmission of HIV		
g. Sex Workers	24.0	28.5
h. MSM	43.0	41.6
i. IDUs	na	58.3
Percentage of female and male sex workers reporting the use of a condom with their most recent client		
a. Males	47.5	72.0
b. Females	56.2	67.7
c. All	n.a	68.6

* UNGASS Indicators Country Draft Report 2003 2004
*** UNGASS country report 2006 2007

5.4 Efficiency and Administrative Costs

The budget for the 2005 PIN was Rp227 billion from APBN and international support (WHO, UNICEF, Rotary International). The Government of Japan decided to support the PIN 2005 by providing an Emergency Grant (*Bantuan Hibah Darurat*) to the GoI through the UN International Children Fund (UNICEF) for an amount of US$ 1.8 million or around Rp18.6 billion. This grant was based on a request from the GOI via UNICEF to support the availability of polio vaccine and the dissemination process. In general, the budget for the PIN 2005 increased considerably from the previous budgets. For the PIN 2000, it spent 104 billion. The 2000 Sub-PIN budget for the 5 provinces covered was Rp26.5 billion. Approximately Rp11.3 billion of this came from the APBN, another Rp11.5 billion was a grant from UNICEF, and Rp3.6 a grant from USAID through WHO. The 2002 PIN Budget for 2 rounds was Rp104 billion, Rp43 billion of which was from the APBN and APBD and the balance were grants from WHO and international donors. Table 3 below shows the overall PIN and Sub PIN budget of 1995-2006.

Table 6. PIN and Sub-PIN Budget 1995-2006

Year	Program	Budget in rupiah (Rp)				
		Round 1	Round 2	Round 3	Round 4	Round 5
1995	PIN	Na	Na			
1996	PIN	Na	Na			
1997	PIN	Na	Na			
1999	BIAS Polio In schools	Na				
2000	Sub PIN (5 provinces)	26.5 billion				
2002	PIN	104 billion				
2005	PIN	225 billion International Aid + APBN		120 billion Intl Aid+ APBN		
2006	PIN				230 billion APBN	
	Sub PIN (6 provinces)	14.5 billion UNICEF				

Source: Subdit Imunisasi, Ministry of Health; Note: data is not available

Similar to polio prevention program, funding for TB control has also improved substantially since 2002, when the NTP reported a funding gap exceeding 50 per cent of the total budget requirement and expenditure amounting to US$18 million. The total budget for 2002 was US$34 million with an available government budget of less than US$10 million. A small funding gap remained in 2003 when the total budget was US$32 million. Around US$20 million was covered by the government and US$10 million came from grants. The available funding in 2004 was doubled and the budget of around US38 million was fully funded, around US$22 million from the government, US$3 million in grants, and US$13 million from GFATM. The 2005 NTP budget was estimated at US$43 million (WHO, 2005). The budget is mainly used for first-line drugs, dedicated NTP staff, buildings/equipment, initiatives to increase case detection and cure rates, second-line drugs, TB/HIV, and others.

Around 34 per cent of the 2005 NTP budget is funded by GFATM. The additional funds from GFATM allow for increases in the anti-TB drug budget, as well as more spending on initiatives to improve detection and cure rates (WHO, 2005). The first GFATM grant

agreement was signed for 2 years. Activities commenced in 8 provinces in the 2nd quarter of 2003. Meanwhile, between 2000 and 2004, USAID funds for TB programming in Indonesia averaged US$1.7 million per year (USAID, 2004). Figure 2 below shows total TB control costs, budgets, available funding and expenditures.

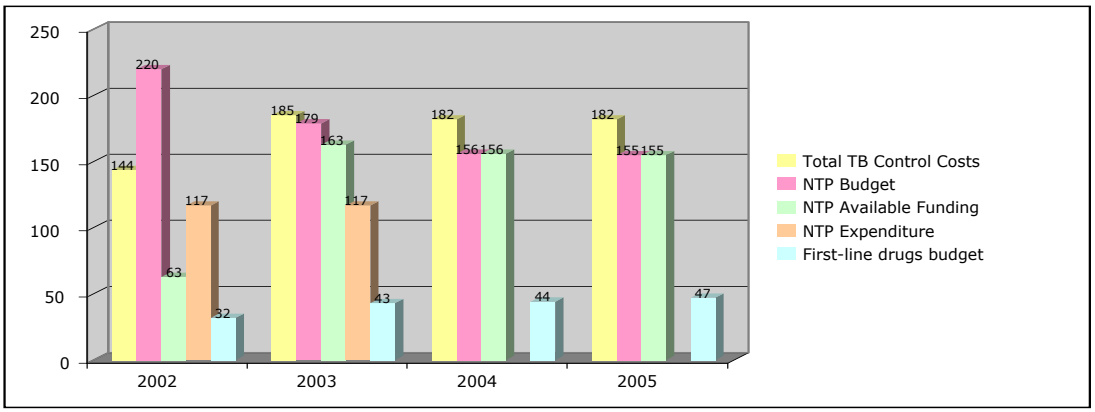


Figure 5. Total TB Control Costs, Budgets, Available Funding and Expenditures (2002-2005)

Table 7. Estimated HIV/AIDS International Funding for 2003-2005 (in US$)

Agency	2003	2004	2005
Total government	6,315,000	8,766,990	13,000,000
DFID	-	-	18,000,000
USAID	9,600,000	8,800,000	9,000,000
AusAID	4,760,000	4,760,000	4,760,000
GFATM	1,000,000	1,000,000	12,000,000
DKT/KFW	1,000,000	3,000,000	3,500,000
UNICEF	800,000	1,000,000	1,500,000
UNFPA	665,555	638,032	654,250
UNDP	146,518	746,518	555,000
WHO	-	400,125	233,375
ILO	-	200,000	150,000
UNESCO	-	12,000	4,000
UNV	-	216,000	309,000
World Bank	-	50,000	75,000
UNHCR	-	65,000	-
UNAIDS	329,000	588,000	685,000
MSF Belgium	-	150,000	150,000
Cordaid	239,835	206,657	75,000
Church World Service	-	-	100,000
Save the Children US	35,000	35,000	35,000
Save the Children UK	-	-	100,000
Total	24,890,908	30,634,332	64,885,625

Source: NAC, 2006 and NAC, 2005

For the HIV/AIDS, the government allocated US$13 million to respond to the epidemic of the disease in 2005. Around US$11.4 million was from the central government and US$1.6 million from local government. This 2005 budget was a 40% increase over the amount disbursed in 2004, which was around US$9.3 million (NAC, 2006).[38] The 2005 local government budget was an increase of 100% from the 2004 budget of US$0.8 million. This indicates a high commitment of local government to respond to the HIV/AIDS problems. Table 3 below shows the government budget for 2003 and 2004.

More than all of these, the budget for the National AIDS Commission in 2003 was around Rp700 million and Rp800 million in 2004. The highest proportion of 2004 government budget funds was used for program development and coordination (44.6%) and prevention programs (41.7%). Other proportions of the 2004 budget were used for treatment and care (12.5%), incentives of human resources (0.1%) and vulnerability reduction (women), around 0.3% (NAC, 2006). Recently the government has promoted '*Gerakan Nasional Stop AIDS*' to prevent a national HIV/AIDS disaster in Indonesia with an annual budget around Rp200 billion (look at annexes).

In addition to the budget provided by the government, donors also provide funds for the HIV/AIDS program, delivered through their own programs or with the government and NGOs. Table 4 below shows the budget of all donors involved in HIV/AIDS programs. Current funding from programmable sources available for the HIV/AIDS response over the period of the Framework (2005-2007) is about US$45 million per year. Household and private sector expenditure is estimated to add about 50% more, giving a total estimate of US$65-70 million per year for HIV/AIDS services. The funding gap for the National HIV/AIDS Action Framework is estimated to range from US$50 million in 2005 to US$150 million in 2007. Table 5 is the estimated budget/funding required for the National HIV/AIDS Action Framework 2005-2007 (NAC, 2005).

Table 8. Estimated funding for the National HIV/AIDS Action Framework, 2005-2007 (US$)

	2005	2006	2007
Total need	120,000,000	150,000,000	210,000,000
Total Government and Donor Resources	44,000,000	47,000,000	45,000,000
Estimated Household and Private expenditure (50%)	22,000,000	24,000,000	23,000,000
Estimated funding gap	54,000,000	79,000,000	142,000,000

Source: NAC, 2005

5.5 Institutional Structure and Incentive Effects

Even though all of these programs are focused on the same sector, namely health, the government uses different institutional structures to deliver the programs. The polio vaccine is given at 'Pos PINs' located in *Posyandu*, *Puskesmas*, *Puskesmas Pembantu*, hospitals and other health providers, including private services. Other strategic public facilities are also used for 'Pos PIN', for example airports, seaports, bus terminal, train station, market, kindergarten, playgrounds, orphan services, and others to capture a wider target and those who are traveling.

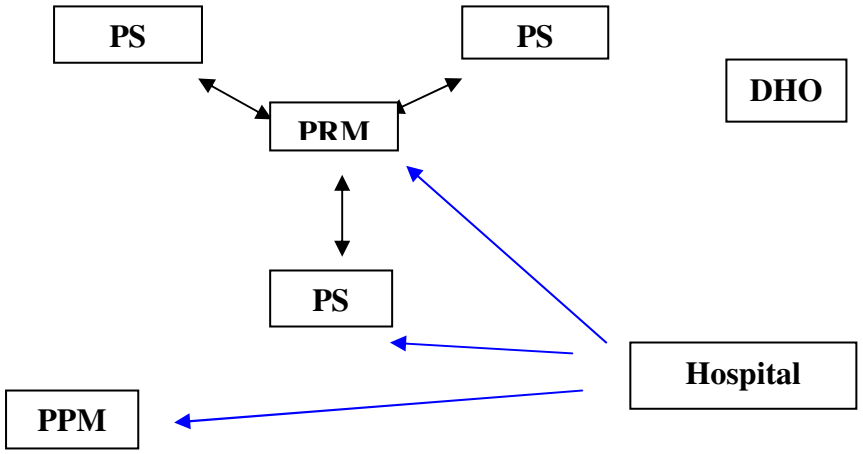
[38] This information is based on Baseline Survey of National Response to HIV/AIDS 2003-2004 (IHPCP-NAC/Indonesia HIV/AIDS Prevention and Care Project - National AIDS Commission).

Every Pos PIN services around 60-100 infants (2002) and 100-150 infants (2005/2006) under 5 depending on the population.

The PIN operational staff are medical and non-medical staff (cadre, teacher, squad, youth group, youth red cross, and others). Every Pos PIN requires around 3-4 staff including 1 staff member responsible for immunization, 1 note-taker, and 1 line-manager.

The PIN institutional structure starts from the center and goes down to village level. The PIN program at the national level is headed by the Director General of Communicable Disease Eradication (*Pemberantasan Penyakit Menular*) and Community Sanitation (*Penyehatan Lingkungan*), Ministry of Health. The operational responsibility is held by the Head of Immunization, under the same institution. Similarly, *Bupati/Walikota* and the Health Agency Head are the persons responsible for the implementation of PIN at the district level. The head of the sub-district (*kecamatan*) working with the head of *Puskesmas* coordinates the implementation of PIN in villages under the sub-districts. The village head, village midwives (and midwives) and *Puskesmas* staff play the most important roles in the implementation of PIN and are fully responsible for its success.

Unlike PIN, the National Tuberculosis Program (NTP) uses all health facilities within the national health care structure. Health centers have been clustered into a Health Center Group (*Kelompok Pusat P/KPP*) consisting of 1 Microscopic Health Center and 3-4 Satellite Health Centers. The group covers 50,000 to 150,000 people. The district level health services can be regarded as the "basic unit" for TB control in Indonesia. The organization of the NTP at the district level is shown in Figure 3 below.



Note:
DHO = District Health Officer: supervision-recording-reporting
PRM = *Puskesmas Rujukan Mikroskopis* (Microscopic Reference *Puskesmas*): diagnosis-treatment-referral
PS = *Puskesmas Satellite* (Satellite *Puskesmas*): smear preparation-treatment
PPM = *Puskesmas Pelaksana Mandiri* (Independent Implementing *Puskesmas*): diagnosis-treatment

Figure 6. Organization of National Tuberculosis Program (NTP)

The role of NTP Staff is as follows:

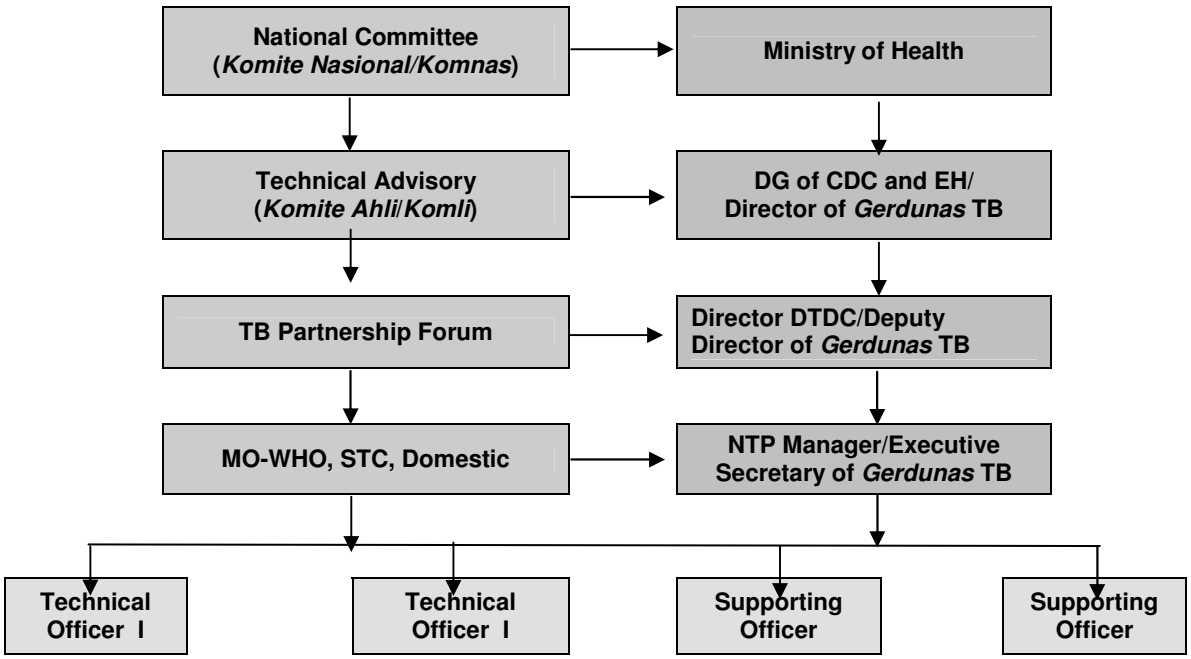
Facility	Staff	Role
District Hospital	Doctor	To conduct diagnosis and Treatment.
	Staff	To maintain the registration. To fill out patient treatment card. To inform WASOR.
	Laboratory technician	To conduct sputum smear test.
District Health Services	District TB Coordinator (WASOR)	To supervise HC's and hospitals. To maintain district TB register. To report and update TB status and condition.
Health Center	Doctor	To conduct diagnosis and treatment.
	Staff	To maintain patient register. To fill out patient treatment card. To inform WASOR.
	Laboratory technician	To conduct sputum smear test.
Community	Family members	To ensure and monitor the drug intake by patient under supervision. To monitor the side effects. To record the patient's condition.

According to the structure, TB control is decentralized to the district level in accordance with the policy of the Minister of Health. It is implemented in health center units, government and private hospitals, lung clinics, and is fully integrated with community participation. Unfortunately, it has had a negative effect on human resource capacity and development. The links between TB laboratories and the NTP remains weak. Based on the analysis result conducted by a graduate student on the implementation of TB Treatment with DOTS in 10 *Puskesmas* in Medan (Sawaluddin, 2004), the impact of decentralization was considered 'good' by 6 *Puskesmas* and 'poor' by the remainder. The indicators to measure the performance of the *Puskesmas* are human resources, equipment, infrastructure, combination of medicines adherence to the prescribed medication and support of a supervisor in taking the medication. Based on multivariate test, the most significant variable in the success of TB treatment is equipment.

The tasks of *Komnas*, which is responsible to the Minister of Health is to provide input to the Ministry of Health in formulating TB control policy in Indonesia and provide input in developing method and technology of TB control. Meanwhile, *Komli's* function is to provide input to the DG of CDC and EH in deciding policy and strategy and developing program implementation of the TB control program.

In 2001, *Gerdunas* TB also established a forum called 'TB Partnership Forum Indonesia', which tries to gather those local NGOs, international NGOs, donor agencies and individuals who are working in the TB field. Currently around 48 institutions and individuals have become members of the forum.

The institutional structure of the *Gerdunas TB* program at the national level is as follows:



Different institutional structure is also built for the national HIV/AIDS program. At national level, the National AIDS Commission (NAC/KPA/*Komisi Penanggulangan AIDS*), as a multi-sectoral coordinating authority, has been established by virtue of Presidential Decree No.36/1994 and is chaired by the Coordinating Minister of People's Welfare. The principal functions and tasks of the commission are:

1. To formulate a national HIV/AIDS policy and strategy;
2. Policy advocacy to the executive and legislative branches of government to gain support for the HIV/AIDS program;
3. To coordinate the HIV/AIDS prevention efforts nationally;
4. To draft and/or make a study of the regulations, guidelines, and other legal aspects needed;
5. To develop an information center on HIV/AIDS prevention program;
6. To collaborate with the UN system, donor agencies and other international agencies;
7. To raise funds from various sources;
8. To provide technical guidance to related agencies at the central level and regional AIDS commissions; and
9. To monitor and evaluate the implementation of the National HIV/AIDS Strategy.

Starting in 2002 and in line with the decentralization process, Regional AIDS Commissions (*KPAD/Komisi Penanggulangan AIDS Daerah*) were also established in all provinces and many districts, especially in areas with a high incidence of HIV/AIDS. While at the provincial level the KPADS are led by the governor, at the district level they are led by the *Bupati/Walikota*. The main tasks and functions of KPADs are:

1. To lead, manage and coordinate the HIV/AIDS prevention efforts in the regions;
2. To identify locations/areas where there is potential for HIV/AIDS to spread;
3. To collect, mobilize and/or exploit the resources from central, local, community, and international organizations;
4. To develop an information center on HIV/AIDS prevention program;
5. To encourage the establishment of local AIDS NGOs;
6. To provide technical guidance on HIV/AIDS prevention to related agencies and NGOs at the regions; and
7. To monitor and evaluate the implementation of the National HIV/AIDS prevention program.

Other institutions who also play important roles in the HIV/AIDS efforts are (1) NGOs that play a key role by reaching people or groups; (2) private sector/business community in accelerating and expanding the coverage in the work environment and providing funds, facilities, specialists; (3) professionals for their input into policy formulation, research and evaluation; (4) the general community by supporting the HIV/AIDS efforts; (5) PLWHA for doing outreach through peer education, mentoring others, or becoming role models, and to prevent the transmission of HIV to their partners or other people; and (6) international cooperation.

Since 1989, a number of NGOs concerned with AIDS have been established in recognition of the growing awareness within the community of the part they could play in HIV/AIDS prevention. AIDS NGOs are now established in every province in Indonesia. Working groups on AIDS prevention have also been formed by both the National AIDS Commission and a number of Ministries and related sectors (please see Table 3 above which shows the related Ministries). Based on the budget allocation (85% in 2004), it seems that the Ministry of Health plays the biggest role in controlling the HIV/AIDS in Indonesia. The main technical focus of the Ministry of Health is care, support and treatment. Other ministries focus more on prevention.

Besides those related sector Ministries, the National HIV/AIDS strategy also nominates several Ministries which can play important roles, those being the State Ministry of Information and Communication, Ministry of Tourism, Ministry of Foreign Affairs, Ministry of Finance, Ministry of Industry and Trade, and Ministry of Agriculture. The National Strategy explains the roles and responsibilities of each Ministry in controlling HIV/AIDS.

All of the HIV/AIDS management efforts being made that have been mentioned above have resulted in the National Composite Policy Index increasing from 65% in 2003 to 75% in 2005.[39]

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[39]Information gathered by The National AIDS Commission from the NCPI Workshop. The index indicates the level of support related to the HIV/AIDS response. The NCPI questionnaire sought responses from 2 different groups (Group A and B). Group A responded that the strategic plan had increased from 6 (2003) to 7 (2005), political support (no increase, 6), prevention 6 to 7, care and support 6 to 7, monitoring and evaluation 5 to 6. Group B responded that human rights policies, law and regulations increased from 3 to 4, efforts to enforce existing human rights policies, laws and regulations 5 to 6, civil society participation 6 to 7, prevention programs 6 to 7 and care and support 6 to 7.

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Annex 1: HIV/AIDS Cases in Indonesia (Until June 2004)

Province	HIV	AIDS	Total	AIDS IDU	Deaths
NAD	1	-	1	-	-
North Sumatra	35	51	86	17	18
West Sumatra	9	2	11	1	1
Riau	204	87	291	2	41
Jambi	17	5	22	1	3
South Sumatra	74	21	95	9	11
Bangka Belitung	-	3	3	1	1
Bengkulu	10	3	13	2	1
Lampung	19	3	22	3	1
DKI Jakarta	861	358	1,219	167	102
West Java	131	117	248	60	30
Banten	12	4	16	2	1
Central Java	76	25	101	4	15
Yogyakarta	30	18	48	7	7
East Java	282	213	495	79	66
West Kalimantan	75	43	118	14	12
Central Kalimantan	27	-	27	-	-
South Kalimantan	4	3	7	2	2
East Kalimantan	35	4	39	3	3
Bali	263	89	352	32	25
West Nusa Tenggara	6	7	13	5	2
East Nusa Tenggara	8	20	28	3	4
North Sulawesi	1	26	27	1	11
Central Sulawesi	3	2	5	1	1
South Sulawesi	32	2	34	-	1
Southeast Sulawesi			-		
Maluku	16	15	31	5	11
Papua	632	404	1,036	2	149
Not mentioned	1	-	1	-	-
Total	2,864	1,525	4,389	423	519

Source: National Aids Commission. National HIV/AIDS Strategy, 2003-2007. Office of Coordinating Minister of People's Welfare. 2003

Annex 2. Target Coverage of PIN 2005 as of 17 Oktober 2005 at 12:00

Province	Target		Under Five Received Polio Immunization			
			1st Round		2nd Round	
	1st Round	2nd Round	ABS	%	ABS	%
NAD	548,699	536,699	475,835	86.7	495,623	92.3
North Sumatra	1,478,620	1,478,620	1,386,679	93.8	1,464,773	99.1
West Sumatra	480,390	480,390	477,438	99.4	492,016	102.4
Riau	599,992	617,800	617,800	103.0	635,920	102.9
Kepri	160,744	149,164	149,045	92.7	149,233	100.0
Jambi	328,453	320,857	298,967	91.0	305,228	95.1
South Sumatra	845,501	846,331	846,331	100.1	861,052	101.7
Bangka Belitung	124,952	111,789	110,716	88.6	118,827	106.3
Bengkulu	170,220	170,220	166,717	97.9	167,319	98.3
Lampung	856,386	825,594	781,660	91.3	815,429	98.8
DKI Jakarta	757,197	922,963	852,669	112.6	880,084	95.4
West Java	4,337,474	4,494,725	4,100,337	94.5	4,261,746	94.8
Banten	1,176,113	1,176,113	1,023,290	87.0	1,078,597	91.7
Central Java	3,103,478	3,103,478	2,816,731	90.8	2,864,189	92.3
Yogjakarta	229,543	228,240	227,207	99.0	234,916	102.9
East Java	3,164,679	3,059,019	3,059,019	96.7	3,153,700	103.1
West Kalimantan	513,422	489,250	455,733	88.8	475,644	97.2
Central Kalimantan	232,213	232,213	214,586	92.4	229,798	99.0
South Kalimantan	357,404	352,182	332,612	93.1	343,355	97.5
East Kalimantan	313,552	313,552	313,404	100.0	316,043	100.8
Bali	297,604	305,607	305,607	102.7	321,456	105.2
West Nusa Tenggara	428,833	470,609	470,609	109.7	495,149	105.2
East Nusa Tenggara	502,545	522,117	522,117	93.6	534,918	102.5
North Sulawesi	198,338	221,331	221,754	111.8	223,852	101.1
Gorontalo	110,650	110,650	102,133	92.3	105,051	94.9
Central Sulawesi	274,107	278,925	278,925	101.8	287,980	103.2
South Sulawesi	805,769	805,769	751,128	93.2	792,000	98.3
West Sulawesi	112,363	112,363	109,144	97.1	115,126	102.5
Southeast Sulawesi	264,662	241,470	237,680	89.8	249,649	103.4
Maluku	181,122	171,256	170,445	94.1	153,476	89.6
North Maluku	97,406	97,406	102,874	105.6	85,970	88.3
Papua	286,151	286,151	197,168	68.9	214,045	74.8
West Papua	87,574	87,574	85,212	97.3	74,818	85.4
Total	23,426,156	23,620,427	22,261,572	95.0	22,996,982	97.4

Annex 3. Indonesian Government HIV/AIDS Budget 2003-2004 (US$)

Agency	2003	2004	2006
Ministry of Health	4,951,538	7,479,062	12,543,092
Ministry of National Education	827,777	800,000	116,206
Coordinating Minister of People's Welfare	110,979	109,065	
Ministry of Religious Affairs	111,045	99,423	
National Narcotics Board	100,000	90,000	
Ministry of Social Affairs	49,399	71,600	188,490
National Family Planning Board	47,019	47,604	23,033
Ministry of Defense	75,182	13,121	162,645
Armed Forces			48,478
Ministry of Home Affairs	21,380	13,418	25,992
Ministry of Law and Human Right			9,626
Ministry of Women's Empowerment	8,333	21,800	19,651
Ministry of Transport	8,333	9,402	24,457
Ministry of Manpower and Transmigration	4,444	12,495	17,793
Total	6,315,429	8,766,990	13,179,462

Source: NAC, 2006

VI. PKPS-BBM FOR RURAL INFRASTRUCTURE AND CLEAN WATER

As a complement to the Government of Indonesia (GoI) policy to reduce subsidy of oil-based fuel (*bahan bakar minyak* – BBM), GoI has created several programs to compensate this subsidy removal, called PKPS-BBM (*Program Kompensasi Pengurangan Subsidi Bahan Bakar Minyak*). These programs were primarily aiming at reducing the burdens of the community, particularly the poor, by providing basic services and employment opportunities. Infrastructure development program is one of these PKPS-BBM programs. The first infrastructure type program under PKPS BBM was implemented in the end of 2000. This was followed by the provision of clean water that last from 2001 to 2004. Later, in 2005 the government modified the programs to PKPS-BBM *Infrastruktur Perdesaan* (Rural Infrastructure). Focusing on the PKPS BBM rural infrastructure and clean water this paper would like to analyse the performance of the program as well as its impact on the infrastructure development.

6.1 Program Evolution in Brief

The first infrastructure type program was a community empowerment programs generating employment opportunities by supporting the development of infrastructure projects or was known as *PPM Prasarana*. The three programs under the 2000 fuel subsidy removal programs[41] were implemented over a 3-month period, between October and December, including planning, execution and evaluation. However, due to some delay in the execution process, the implementation of the *PPM Prasarana* program was extended until March 2001.

PPM-Prasarana, aimed to generate employment opportunities through a community empowerment program and the development of general infrastructure in rural and urban areas. The program targeted rural communities with low levels of income and gave priority to communities outside Jawa, especially the eastern Indonesian provinces. The recipients of the funding were various community groups, including those with existing project proposals for local infrastructure development which had previously been discussed at village meetings, those who had been assisted by existing community empowerment programs (for example the Kecamatan Development Program), other working groups who had not yet been targeted by poverty alleviation programs, and those regions classified as "special territories". The allocation of funding per *kecamatan* could be used for projects with unrestricted or 'open menus', within a framework of maintaining, rehabilitating, and developing local infrastructure development. The wages paid to the workers involved in the program were set at a level that did not exceed the official minimum wage in each locality. The PPM-Prasarana program was managed by Department of Settlements and Regional Infrastructure.

The *PPM-Prasarana* was only implemented once and the government decided to focus the infrastructure type programs to the provision of clean water. According to BPS data, there were 2,808 kelurahan and 5,910 desa that did not have adequate clean and save water. The primary objective of this program was to reduce the burden of the poor who live in areas where clean and save water is scarce by assisting the development of adequate, usable and healthy water provision. This program was managed by Ministry of Public Works,[42] complemented with central coordination team and teams at regional level.

[41]There were three programs implemented: cash transfer, revolving funds, and the *PPM-Prasarana*.

[42] Previously was the Department of Settlements and Regional Infrastructure which also managed the PPM Prasarana program in year 2000

In 2005, the government of Indonesia modified the programs that are included in the PKPS-BBM, and the clean water program is expanded to include other rural infrastructure called PKPS-BBM *Infrastruktur Perdesaan* (Rural Infrastructure) or was also known as PKPS BBM IP. The primary objective of the PKPS BBM IP is to reduce the burden of living costs of the poor community in rural areas, specifically in the fulfillment of needs for transportation, drinking water, and irrigation through community empowerment approaches which are expected to increase the growth and development of economics, social, and cultural activities in the rural areas. The implementation of rural infrastructure development in isolated/backward rural areas covers the following:

- Infrastructure and facilities that support accessibility and reduce isolation, such as: village roads, village bridges, and boat mooring, boat and titian;
- Infrastructure that supports activities in increase of food production, namely rural irrigation, such as artesian well, irrigation canals, and dams.
- Other infrastructures that fulfill basic needs of the community, namely rural clean water.

This program is also managed by the Ministry of Public Works and the central coordination team consisted of Ministry of Finance, Ministry of Public Works, Bappenas, Ministry of Home Affairs, and State Ministry for the Acceleration of Development in Left-Behind Regions.

6.2 Targeting Performance

The estimated target for the 2000 PKPS BBM rural infrastructure program of *PPM-Prasarana* was 14,685,000 working days across 5,097 villages, 250 *kecamatan* (sub district*)*, 55 *kabupaten (*district*)*, and 14 provinces. The program was meant to help accelerate infrastructure development in some least developed regions, especially those outside Java. The official guidance states that there are two main criteria as to which sub-district the budget would be disbursed. Other than the proportion of the poor in the sub-district, the condition of local infrastructure or the remoteness of the area became the main indicator as how eligible a certain sub-district was. Nevertheless, due to the time constraint, it appeared that some sub-districts were chosen not because they really needed infrastructure development, i.e. in remote areas or physical isolation, but often because the national coordinating team saw them institutionally ready to implement the program. In many cases, the national coordinating team simply chose those regions that had been included in the PPK program.

The allocation of funding per sub-district ranged from Rp750 million to Rp1.1 billion. (Look as Table 1 below for rough picture of how the budget was disbursed in every villages/sub-districts). This difference, however, does not necessarily indicate that a bigger amount a village received more or bigger projects that the village developed. Presumably, the allocation of funding was dependent upon not only the number and the size of projects being proposed, but also on the proportion of the poor people living in the area. But in practice, SMERU study in two districts in Kalimantan in 2001 revealed that the final decision on the amount of money disbursed and which districts given the programs appeared to be the authority of the central government. In two districts in Central and South Kalimantan, 10 of 24 *kecamatan* in Kabupaten Kapuas and 5 from 16 *kecamatan* in Barito Kuala received the programs. Most of management team member at both districts was not sure about the criteria used by the *Tim Pusat* (National team) to select the kecamatan and budget allocation per kecamatan. They assumed that the criteria used to select the kecamatan and to allocate the budget was the proportion of poor people in the areas. In fact Kabupaten Kapuas had actually been selected because it categorized as a "special region" due to the problems resulting from the Development of Peat Soil Lands (PLG) project, which is still unresolved. However, although

it was widely perceived that this program was planned to curb social unrest, the PPM-Prasarana program was not intended as a substitute for the PLG compensation being demanded by the local community. Meanwhile, the 5 kecamatan in Kabupaten barito Kuala also received Kecamatan Development Program (out of 8 kecamatan which received KDP).

Table 1. The Allocation of Funding in Three Kecamatan in Kabupaten Kapuas

Kec. Kapuan Murung*)		Kec. Selat*)		Kec. Barambai**)	
Village	**Budget (Rp)**	**Village**	**Budget (Rp)**	**Village**	**Budget (Rp)**
Palangkau Baru	140.500.000	Pulau Kupang	168.500.000	Karya Baru	105.366.268
Palangkau Lama	140.500.000	Murung Keramat	198.500.000	Karya Tani	149.748.866
Talekung Punei	140.500.000	Sei Lunuk	168.500.000	Kolam Kiri	120.180.415
Belawang	140.500.000	Terusan Raya	214.500.000	Kolam Kanan	45.791.207
Dadahup	162.000.000			Pendalaman	118.787.589
Tambak Bajai	125.000.000			Pendalaman Baru	143.923.695
Palingkau Baru	110.000.000			Handil Barabai	118.181.717
Palingkau Lama	141.000.000			Sungai Kali	121.244.499
				Bagagap	106.940.326
				Barambai	69.205.500
Total	1.100.000.000		750.000.000		1.099.370.082

Sources: *) Report of budget realization of PPM Prasarana Kabupaten Kapuas
**) Report of UPK Kecamatan Barambai
Note: This amount does not include 'dana gotong royong Rp 5 juta' collected in every village.

Unfortunately, a more comprehensive study of the implementation of the program is not available yet. National survey conducted to evaluate the distribution of Social Safety Nets as the model of such a program had been taken one year earlier, so that there is no information available on the targeting of the 2000 PKBS BBM rural infrastructure program. Yet as the program was modeled after the Social Safety Nets program, especially those of the employment creation program (*program padat karya*) conducted in the previous year, the evaluation of the later program may provide some insights as how successful the targeting performance of the 2000 PKPS BBM rural infrastructure program was. Later in the sub-section of the 2005 PKPS BBM rural infrastructure program, it is evident that in terms of targeting performance, the trend shown in the Social Safety Nets program has not undergone any significant changes.

Based on the 100 Village Survey (Survei Seratus Desa, SSD) conducted by Indonesian Central Agency of Statistics (Biro Pusat Statistics, BPS) in 1998, Suryahadi et. al., found that in terms of targeting, i.e. what fraction of the program went to the poor, most of the districts surveyed had the value of the targeting ratio quite close to one. With the targeting ratio defined as the proportion of the participants in the program who are non-poor divided by the overall non-poor population, the targeting ratio 1 indicates that the program has no targeting. It might be distributed randomly across income groups. As could be seen more clearly in the coverage rate, i.e. how many of the poor participated in the program, the highest coverage was found in Kupang where 49 percent of the poor were involved in some padat karya programs. In most of the districts, the coverage rate ranged from 6 percent to less than 30 percent. Meanwhile, out of ten sampled districts, 3 districts reported no significant participation of the poor with less than 1 percent of the poor having participated in the program (Suryahadi, et, al., 1999: 12-4).

As for the PPM-Prasarana in particular, though the exact data on the targeting ratio of the program is not available, SMERU qualitative study in 2002 in two districts in Central Kalimantan revealed quite similar story, and to some degree explained some problems faced by program implementers in reaching the poor. Despite the official guidance given by the Ministry of Public Works (PU) in identifying the target area or executing the program, it was evident that local variations could influence the implementation of the program. Even though the official guidance states that one of the main goals of PPM Prasarana was to create employment opportunities for poor or low-income households, SMERU study in two villages in district Kapuas found that not all of those working for the projects under the program came from poor families. Many of them were from middle or even high-income households (Rahayu, et, al., 2001: 81). The problem here was that due to the scarcity of people around the project site, or difficulty in accessing it, the village coordinator had to involve all the people in the area, regardless their economic condition, to complete the works. This could be clearly seen, for instance, in village Terusan Raya in which people are scattered in many different parts of the village. Another case indicated that the opportunity to work was evenly distributed among the villagers. In one village in Kabupaten Kapuas, SMERU team found each neighborhood association (RT) received a quota for workers that resulted in most of workers only being able to work no more than 3 out of 15 working days. Meanwhile, in other villages, including those officially classified as "disadvantaged" (IDT) areas, community groups were formed and they used a contract system to carry out the projects.

Apart from this, the GoI decided to replace the PPM Prasarana with the Clean Water Program since 2001. The program was planned to be completed in 4 years period with the estimated target 3,258 villages across the country. According to BPS data, there were approximately 8000 villages that did not have clean water facilities in 2001. Partly because of this, the provision of clean water was prioritized by the President Susilo Bambang Yudhoyono.[43] For the first year, the program targeted 859 kalurahan in 249 kabupaten/kota in 30 provinces and would serve approximately one million people (Dept. Kimpraswil, 2001). The number of villages targeted for the program increased in the next years as the funding allocated also developed bigger. In 2004, which was also the final year of the program, 1250 villages in 347 kabupaten/kota were targeted to receive the benefits of the program.

Village status, i.e. poor or very poor, and the condition of clean water facilities as well as the clean water project already received became the criteria on which a village was chosen as beneficiary of the program. Other than that, the program also considered the number of poor people that would receive the benefits of the program. The 2003 clean water program, for instance, targeted 1,250,000 poor people. The number decreased slightly in 2004 when the program targeted 1,000,000 people. Yet a study by Coordinating Ministry for Social Welfare in cooperation with 35 universities revealed that the coverage rate of the program was only 72,60 percent (in Purna, 2005).

In 2005, the GoI proposed another program focusing primarily on the development of rural infrastructure (Infrastruktur Perdesaan). The estimated target of the program was 12,834 poor villages in 427 districts in 33 provinces that still had bad infrastructure facilities. Based on the 'indeks ketertinggalan desa' set up by the BPS, those scoring below the average would be chosen as the beneficiaries of the program. Presumably, most of these villages would be chosen from eastern part of Indonesia, as many part of this region was still isolated and really needed infrastructure development. They would receive Rp 250 million per villages for funding the proposed projects, including for hiring the workers. As stated in the official guideline, the project aimed not only to improve the quality of rural infrastructure, but also to streghthen people's purchasing power, especially those of poor people.

[43] http://www.pu.go.id/index.asp?link=Humas/news2003/PPW2906041.htm (8 February 2008)

As such, there are two criteria that can be used to assess the accuracy of the targeting, namely the condition of the village beneficiaries and the number of poor living in the village. According to survey conducted by the LP3ES Jakarta in 2006, 71.1 percent of targeted villages were correctly matched with the index of 'ketertinggalan desa', while the rest was unfortunately not. The study reveals that out of 930 villages in 21 districts surveyed, 250 villages or 29.9 percent scored over the average. Similar assessment, and even worse, was also given by the monitoring team from the Ministry of Finance. According to the evaluation of this team, which monitored the implementation of the program in 7 different districts, the 2005 PKPS BBM rural infrastructure had bad targeting performance. The village beneficiaries of the program often showed no characteristic 'least developed' villages, such as in poor condition, located in remote areas, or had bad local infrastructure as specified in the official guideline of the program.

Table 2. Estimated Target Villages for the 2005 PKPS BBM *Rural Infrastructure*

Area and Targeted Village	Number of Village in Remote Areas	Number of Village in Non-remote Areas	Targeted Village
Western part	2,925	2,907	5,832
Eastern part	5,821	1,181	7,002
Total	8,746 (68.2%)	4,088 (31.8%)	12,834 (100.0%)

Why could be mistargeted? According to LP3ES study, some evidence indicates that it resulted from elit's intervention in deciding which villages might receive the grants. Even though the district is allowed to nominate villages matched with the criteria of the program, in practice it was the central administration at national level that finally decided to which villages the grants would be allocated. It happened that villages chosen by the central government were not those nominated by the district officials. Some times these villages chosen by the central administration were under the category of 'least developed villages' –district government nominated wrong villages?--, but could be also the case that these villages were categorized as the least developed ones. In every district surveyed, the LP3ES team found various mistargeting practices, which, put in percentage point, ranges from 10 percent until nearly 50 percent at worts. The choosing of village recipients was best undertaken in district TTU, East Nusa Tenggara in which only 10.3 percent receiving villages were not categorized least developed ones. In contrast, the worst performance was shown by district East Lampung as 48.1 percent recipient villages were mistargeted.

Other than misselecting recipient villages, LP3ES study also indicates another weakness in targeting workers to be involved in the construction projects. According to the main goal of the project, which was to create employment opportunities for poor people, the chances generated by the program should be prioritized for those people. However, LP3ES survey indicates that poverty was not always used as the main criteria in recruiting the potential workers. Out of 100 villages surveyed, it was only 10 villages that used poor people as the main criteria in choosing those to be employed in the project. Similarly neglected was 'unemployment' category as only 7 percent local implementers prioritized those without jobs to work in the project. Instead of poor or unemployed people, fellow villagers or those living surrounding the site became the main criteria in recruiting the potential workers. According to local administrators, this resulted from the fact that they had difficulty refuting the interest or request of fellow villagers to work in the project that would be or was being undertaken.

6.2 Impact and Outcome

The direct impact of the program of the 2000 PKPS BBM *PPM Prasarana* for the community member is wages received during the construction of the infrastructures, even though there were variation on the wage system and the level of wages in different locations. The system applied was either daily hire or contract arrangements with no difference in wages for men and women. Despite the stipulations in the project guidelines, the wages paid were higher than the official minimum wage for the region and the wage rates that were usually being paid in any particular village. For example, the wage paid for road maintenance work on a PPM-Prasarana project in one village was (in 2000) Rp19,400 per day (from 7am to 12pm), while skilled construction workers in the same village only received Rp 35,000 for a full working day of eight hours, and for contract work the rate was Rp 60,000 per square meter of completed construction. In another village, the rate for contract workers on a PPM-Prasarana was Rp 40,000 a day**,** while the local daily wage rate was Rp 20,000.

According to the Department of Settlement and Regional Infrastructure report, nearly half of development projects undertaken by societies was road construction or rehabilitation (45.57%). The rest of the grants were spent on irrigation system (24.85%0, clean water facilities (13.62%) and public toiletes (MCK) (10.60%). Besides these four main projects, however, other infrastruture projects were also found, particulalry in South and Southeast Sulawesi (to exclude Maluku and Papua due to data availability).

Nevertheless, as to what extent the implementation of this program has met its objective of alleviating poverty is still questionable. Many found that not all poor people could participate in the work. In contrast, many non-poor people were involved. Perhaps, the fact that the lump sum offered by the project was quite high became one of the factors that attracted not only the poor but also non-poor people to also participate in the project (Maxwell and Perdana). In addition, SMERU study in two districts in Kalimantan in 2005 also revealed that not all the projects carried out by the program were basic infrastructure needed to break the remoteness of the village or to improve local production. Other than village roads and bridges, some communities used the money to rehabilitate religious buildings such as mosques or churches.

For the clean water program, it is reported that by 2003, the program had built clean water facilities that served around 2.75 million people in 1509 villages. The number of villages supported by the program increased significantly in the following year, the fourth year, which is also the final year of the implementation of the program. The government claimed that it had build clean water facilities in 3500 villages across the country in 2004.[44] Unfortunately, detailed information or evaluation of the program is not available yet so that it is very difficult to measure the impact of the program precisely. So far, assessment or evaluation of the program could only be read in fragmented reports from different regions. Some evidence indicate that even though the program was aimed at helping urban poor, in certain urban areas, not all poor people in the area could have access to the facilities built. In practice, village people could not insist that they were provided particularly for poor people. Many non-poor people also used the facilities. Yet as how far such practices happened cross-regionally, or affect the perfoemance of the program in general, or conversely how significant the program helped or even reduced the number of poor people, more comprehensive study is still needed.

[44] http://www.pu.go.id/index.asp?link=Humas/news2003/PPW2906041.htm (8 February 2008)

From the central government, Department of 'Permukiman dan Regional Infrastructure' as the program implementor has only once published a report of the implementation and the monitoring of the clean water program, namely that of fiscal year 2003. Even though the report clearly explained the budget allocation and the achievement of the program in every region, it was generally limited to the budget absoprment and spending. Issues like social dimension of the program, especially as how far the project and the facilities built were really for the poor, or help them reduce their difficulties and vulnerabilities are of little concern.

Nevertheless, in spite of these weaknesses, still the report provides some valuable information of the program. Generally speaking, there were four main components concerned in developing clean water facilities. First was public hydrant. This facility was built by using the existing PDAM pipe line. It was meant to provide clean water for those living within 3 km distance from the nearest PDAM pipe line. For 2003, the project provided 3.233 water tanks distributed in all 30 provinces that received the grant. Out of this number, Kalimantan and eastern part of Indonesia (Nusa Tenggara, Sulawesi, Maluku and Papua) built 1581 water tanks. While the rest was shared between Java and Sumatra with each developed 773 and 869 tanks respectively.

Especially for houses under the reach of PDAM services, the 2003 clean water project also successfully built 15.622 'Saluran Rumah Langsung Murah'. Unlike the development of public hydrants, most of 'Saluran Rumah Langsung Murah' developed were located in Java and Sumatra. While the latter could build not less than 5.136, the former could develop even more Saluran Langsung Rumah (6.545). In Kalimantan, the project could build 2.235 'Saluran Langsung Rumah', and the rest was shared by Bali, Maluku (including Maluku and North Maluku) and Papua with each region built 160, 501 and 200 Saluran Langsung Rumah respectively.

Other than public hydrants and *saluran langsung rumah*, which used the existing PDAM pipe line, the 2003 clean water program also developed *'Sistem Penyediaan Air Bersih Sederhana'* (SIPAS). This project was particularly designed for those living far from the reach of PDAM pipe line. Through the project, the government developed or rehabilitated water facilities like deep well (25 – 100 m), natural spring and other simple clean water facilities in accordance with the local condition or agreement. For 2003, there had developed 384 new SIPAS units. Out of this total number, Java and Sumatra received the most, 123 and 111 units for each island respectively. Some other 41 units were built in Kalimantan. For eastern part of Indonesia, Sulawesi was the region to build the most. While the island developed 48 SIPAS units, other islands namely Nusa Tenggara, Bali, Maluku and Papua built 20, 7, 17 and 14 units respectively.

Finally, included in the clean water program was the provision of 'truck tanki air', especially for those living in the areas more than 3 km away from the existing PDAM pipe line. Interestingly, data for the implementation of this project is quite abundant. For 2001 – 2003, through the clean water project the government of Indonesia bought 594 trucks. Out of this number, 228 units were bought in 2001, while the rest was bought the next two years, 128 trucks in 2003 and 228 ones in the next fiscal year. Seen from its distribution, as could be seen from the table below, most of the trucks went to urban poor of Sumatra (230 units or 38.7 percent). Even though the number of trucks provided for central part of Indonesia was greater (261 units or 43.9 percent), on the average the urban poor in this region received less as the region, consisting of Java and Kalimantan, is considerably larger than Sumatra. For 2003, Kalimantan alone received 50 trucks out of 103 trucks provided for the central region. Meanwhile, for eastern region, which consists of Bali, Nusa Tenggara, Sulawesi, Maluku and

Papua, by the end of 2003 there had been bought 103 trucks. Looking at the 2003 data, it seems that Sulawesi received the most. Out of 45 trucks provided for the eastern region, nearly ¾ went to Sulawesi.

Table 3. Number of Trucks Tangki Provided by the Clean Water Program

No	Region	Number of Trucks				
		2001	2002	2003	Total	Percentage
1	Western (Sumatera)	100	40	90	230	38.7
2	Middle (Java and Kalimantan)	94	64	103	261	43.9
3	Eastern (Bali, NTT, NTB, Sulawesi, Maluku, Papua)	34	24	45	103	17.3
Total		228	128	238	594	100.0

Sources: Departemen Permukiman dan Prasarana Wilayah dan PT. Indah Karya, 2003, Laporan Monitoring Pelaksanaan PKPS-BBM untuk Penyediaan Prasarana Air Bersih (Program SB-AB) TA. 2003.

Seen from the ratios of poor people (in urban areas) and its distribution, it is apparent that the government has paid serious attention for the development of outer region (outside Java). Except for cheap Saluran Langsung Rumah, the existing data indicates that the majority of clean water facilities developed by the program were located outside Java in which the proportion of urban poor did not exceed the half number of urban poor in Java. As could be seen from the table, out of 12.26 million urban poor, Sumatera accommodated 'only' 19 percent. Considerably lower percentage lived in Kalimantan, Sulawesi and other eastern islands (Bali, Nusa Tenggara, Maluku dan Papua) with 3.10, 3.02 and 5.95 percent respectively. In contrast, 68.92 percent of urban poor lived in Java. Meanwhile, by the end of 2003, out of 3.233 public hydrants that had been completed, 2.460 units or 76.1 percent was developed out of Java. While Kalimantan and eastern part (Bali, Nusa Tenggara, Sulawesi, Maluku and Papua) built 1.581 units, Sumatra could add 869 public hydrants. In total, only 773 units (24 percent) were built in Java. Similarly, most of SIPAS and truk tanki air were also provided for outer islands (out of Java). However, in order to further assess the program implementation, especially in terms its regional distribution, we also need to look at the budget allocation per region as explained in the next sub-section.

Table 4. Number of Poor People in Urban Areas in 2003

No	Island	Number of Population below the Poverty Line (Million)	Percentage
1.	Sumatera	2.33	19.00
2.	Java and Bali	8.45	68.92
3.	Kalimantan	0.38	3.10
4.	Sulawesi	0.37	3.02
5.	Pulau Lain	0.73	5.95
Total		12.26	100.00

Source: BPS, *Statistik Indonesia Statistical Yearbook of Indonesia 2005/2006*. Jakarta: BPS.

After four years of its implementation, the Clean Water Program was discontinued by the GoI and replaced with another project named PKPS BBM Rural Infrastructure since 2005. Unlike the previous program that covered urban societies, Rural Infrastructure Support Program was concentrated on rural areas with more than Rp 3 trillion was allocated for the program.

According to an evaluation study carried out by LP3ES Jakarta in 2006, most of this funding was used to develop village roads and clean water facilities. As can be seen from the Table 5 below, out of 441 projects in 100 villages surveyed in this study, --even though not all of them had been completed by time this study was conducted-- 293 projects (66,4 %) were village roads construction and 62 projects (14,1 %) were clean water facilities. Other facilities also developed by this program included 51 bridges (11,6 %) and 26 dams or irrigation systems (5,9 %). Finally, 2 percent of the program, or 9 projects were consisted of boat moorings.

Table 5. Types and Number of Infrastructure Projects Developed in the Surveyed Regions

Province	Road		Bridge		Clean Water		Irrigation/ Drainage		Boat Mooring		Total	
	Num	%	Num	%	Num	%	Num	%	Num	%	Num	%
Sumut	17	60.7	1	3.6	8	28.6	2	7.1	0	0.0	28	100
Jateng	26	84.0	3	9.7	0	0.0	2	6.5	0	0.0	31	100
Kalbar	12	21.1	30	52.6	0	0.0	6	10.5	9	15.8	57	100
NTT	10	76.9	0	0.0	2	15.4	1	7.7	0	0.0	13	100
Jatim	149	86.6	9	5.2	6	3.5	8	4.7	0	0.0	172	100
Sulsel	37	41.6	5	5.6	42	47.2	5	5.6	0	0.0	89	100
B. Lampung	42	82.4	3	5.9	4	7.8	2	3.9	0	0.0	51	100
Total	293	66.4	51	11.6	62	14.1	26	5.9	9	2.0	441	100

Source : Erfan Maryono, et al., 2007, Studi Evaluasi Pelaksanaan Program Kompensasi Pengurangan Subsidi Bahan Bakar Minyak Bidang Infrastruktur Perdesaan. Jakarta: LP3ES, p. 50

These differences or the choosing of the projects to be carried out in every village reflected the need as well as the condition of local infrastructure. In West Kalimantan, bridges dominated the implementation of Rural Infrastructure Support Program following the domination of river in the region. Out of 57 construction projects carried out in the province, there were only 12 road construction projects, or approximately 21.1 percent. In contrats, there were 30 briges developed in the province (52.6 percent). The dominant influence of river could be seen more clearly if we also take into account the number of boot moorings that amounted 9 projects of 15.8 percent. Different pictures were shown by North Sumatra or South Sulawesi. In the last province, nearly half of the infrastructural projects undertaken (47.2 percent) were devoted to the development of clean water facilities. This was due to the fact that local people, like those in Palopo village for instance, badly needed clean water. Similar problem was also faced by many people in North Sumatra, NTT and Bandar Lampung in which the development of clean water facilities absorbed 28.6, 15.4 and 7.8 percent respectively of the projects carried out in the three provinces.

Unlike briges or clean water facilities, drainage or irrigation system was more evenly distributed in every region. Even though the total number of drainage developed by the program was not so significant, only 26 projects or 5.9 percent of the total 441 projects surveyed, data indicates that every region built irrigation system. Furthermore, there were no significant differences in number of drainage developed within each region. It would be certainly too early to conclude that the drainage or irrigation systems in every region were similarly bad or broken, yet these figures implied that to certain degree every region need drainage or irrigation system development. Except for West Kalimantan, in which the number of drainage and irrigation systems developed amounted to 10.5 percent, on average the number of drainage or irrigation system developed in every province ranged from 3.9 to 7 percent.

In general, roads or transportation infrastructure became people's main priority or choices in the rural infrastructure development program. Except for South Sulawesi, in which the need for clean water was more urgent, all provinces spent most of the allocated budget on road or transportation infrastructure development. Included within this category is the development of bridges or tambatan perahu in West Kalimantan. Replacing the function of road in other regions, bridges and titian perahu in West Kalimantan facilitated the access point from/to many areas in the province. In total, road or transportation infrastructure absorbed 353 out of 441 projects in 2005 (83.9 percent). Nevertheless, to further assess the impact of the program on the condition of transportation infrastructure in every region we still need more deeper or comprehensive studies. Even though the development of road or transportation infratsruture was quite evenly distributed in every region, ranging from 47 to 87 percent of the total infrastructure projects in each region, the avalibale data does not allow us to further make general comparison among the regions as data on the local condition prior to the implementation of PKPS BBM IP was not freely available.

6.3 Efficiency and Administrative Cost

For the PPM Prasarana, the GoI allocated approximately Rp 250 billion. This amount of money came from the government budget, especially from the reduction of fuel subsidy. Following the government decision to raise the price of fuel by 12 % in the final months of 2000, the government reduced the fuel subsidy from from Rp 44 trillion to 43.2 trillion so that the government could save Rp 800 billion. It was from this money that the budget for the PPM Prasarana, as well as the budget for other subsidy removal compensation programs in 2000, was taken. The official report of the Department of Settlement and Regional Infrastructure released in March 2001 stated that Rp 243.750.000.000 was allocated for infrastructure development in 2655 villages in 255 sub-districts (in 64 districts, 17 provinces) across the country. However, not this entire allocated budget was used. Until the end of 2000, 62 villages chosen as the beneficiaries of the project in Riau and other 10 villages in East Nusa Tenggara reported no activities of spending the budget. As a result, until the end of the implementation of the PPM Prasarana, more than Rp 14 billion remained unused and was proposed to be allocated for the next PPM Prasarana II in 2001. As can be seen from the Table 6 below, out of more than Rp 243 billion allocated for the PPM Prasarana 2000, the project could manage to spend 'only' Rp. 229.670.390.000,00 or less than 95 percent.

Table 6. Budget Realization of PPM Prasarana 2000 (Rp x 1000)

No	Region	Districts	Sub-districts	Villages	Budget Allocation	Percent
1.	Sumatera	22	94	977	86.225.000	37.5
2.	Kalimantan	6	42	443	41.585.394	18.1
5.	Sulawesi	14	61	789	61.435.000	26.8
6.	NTT, NTB, Maluku, Papua	16	48	374	40.425.000	17.6
Total		58	245	2583	229.670.394	100.0

Source: Dept. Setlement and Regional Infrastructure, PPM-Prasarana 30 Maret 2001, Final Report.

If we look at the number of villages receiving the grant as well as the amount of the grant itself, it is apparent that Sumatera received the most. Out of Rp. 229.6 billion that had been used for the project, 37.5 percent or approximately Rp. 86.2 billion went to 977 villages in 94 sub-districts or totally 22 districts and 6 provinces in Sumatera. Second only to Sumatera was

Sulawesi Island in which 789 villages in 14 districts across 4 provinces in the Island absorbed nearly 27 percent of the total budget realized or Rp Rp. 61.435.000.000. Finally, the rest of the budget was shared quite equally between Kalimantan and other islands with each part took 18.1 and 17.6 percent respectively of the total realized budget. Other than this 'rough' calculation, however, there is no data available on how the budget was precisely spent in every region, as how much of the budget was used for hiring the workers, the percentage of funding allocation for materials as well as the administrative tasks. There is no information either on the monitoring of the project implementation.

With different scheme and emphasize, the GoI continued to fund infrastructure developments in village level. In 2001, another program called the Clean Water Program was launched with total budget allocated Rp 170 billion. Replacing the PPM Prasarana as 'open menu' grants for different types of infrastructure projects, the Clean Water program was concentrated on the development of clean water facilities. Implemented for the period of 4 years, the budget allocated for the program is quite huge. After slightly decreasing to Rp 150 billion in 2002, the budget allocated for the program increased significantly in the next two years as the GoI allocated Rp 250 for clean water facilities development every year. In total, for 4 years of the program implementation, no less than Rp 820 billion has been provided by the government for funding the program. Yet in practice, as can be seen from the Table 7 below, except for the first year, the realization of the program never exceeded the total allocated budget. Quite far below the funding allocation, the four-year implementation of the Clean Water program spent Rp. 789.890.000.000 or approximately 96.33 percent of the total allocated budget. The table also showed that approximately 3 to 5 percent of the budget was allocated for safeguarding activities.

Table 7. Budget for PKPS-BBM Clean Water and the Realization (x1000 Rupiah)

Year	Allocation	Realization	Safeguarding*
2001	170.000.000	174.000.000	5.623.161
2002	150.000.000	128.795.984	3.269.000
2003	250.000.000	245.955.651	13.263.802
2004	250.000.000	241.138.042	n.d
Total	820.000	789.890	22.155**

* From the budget realized
** Excluding the safeguarding allocation for 2004
Sources: taken from different sources, primarily from Departemen Permukiman dan Prasarana Wilayah, n.d., Program Subsidi Energi – Air Bersih; Departemen Permukiman dan Prasarana Wilayah dan PT. Indah Karya, 2003, Laporan Monitoring Pelaksanaan PKPS-BBM untuk Penyediaan Prasarana Air Bersih (Program SB-AB) TA. 2003; and Ministry of Finance.

In terms of regional distribution, the data confirms the above-mentioned fact that outer islands (non-Java) received considerable part of the project. Despite the high percentage of urban poverty in Java and Bali, that 7.77 million urban poor live in the region, until 2003 the region absorbed 'only' 27.32 percent of the total realized budget. In contrast, Sumatera with its 2.22 million urban poor received no less than 26.33 percent. Nevertheless, looking at the condition of poverty in eastern part of Indonesia, especially in Nusa Tenggara, Maluku and Papua, it is right that more budgets should have been dispersed in the region. Compared to Kalimantan and Sulawesi that received 16.21 and 13.33 percent respectively, Nusa Tenggara, Maluku and Papua only got 12.75 percent of the total budget. While in fact, the occurrence of

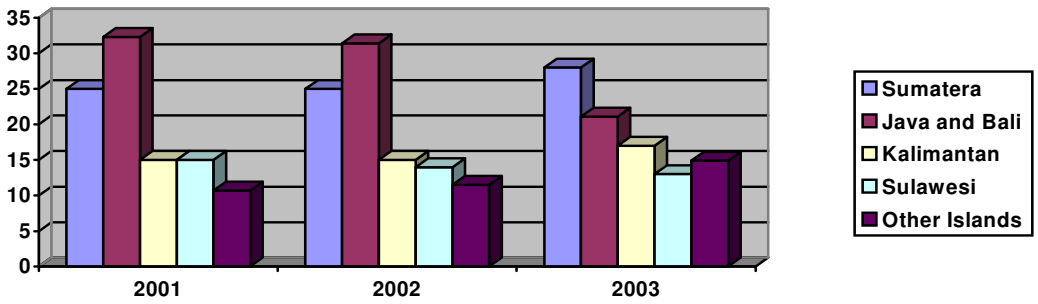
urban poverty in these islands is much higher than those in Kalimantan and Sulawesi. According to BPS, 0.73 million urban dwellers, or 22.84 percent of the population of Nusa Tenggara, Maluku and Irian lived below the poverty line in 2003. In contrast, Kalimantan and Sulawesi had 0.38 and 0.37 million urban poor respectively, or approximately 8.9 and 8.7 percent of their population.[45]

Table 8. Budget Allocation of PKPS BBM Clean Water 2001, 2002 and 2003 (x1000)

Region	2001	2002	2003	Total	Percent.
Sumatera	44.335.832	32.300.000	67.877.810	144.513.642	26.33
Java and Bali	56.231.200	40.700.000	53.012.633	149.943.833	27.32
Kalimantan	26.031.785	19.850.000	43.084.669	88.966.454	16.21
Sulawesi	23.118.180	17.850.000	32.201.438	73.169.618	13.33
NTB, NTT, Maluku and Papua	18.659.842	14.800.000	36.515.644	69.975.486	12.75
Sub Total	168.376.839	125.500.000	232.692.198	526.569.037	95.96
Safeguarding	5.623.161	3.269.000	13.263.802	22.155.963	4.04
Total Budget	174.000.000	128.796.000	245.956.000	548.752.000	100.00

Sources: taken from different sources, primarily from Departemen Permukiman dan Prasarana Wilayah, n.d., Program Subsidi Energi – Air Bersih; Departemen Permukiman dan Prasarana Wilayah dan PT. Indah Karya, 2003, Laporan Monitoring Pelaksanaan PKPS-BBM untuk Penyediaan Prasarana Air Bersih (Program SB-AB) TA. 2003.

Table 9. The Percentage of Budget Allocation for the Clean Water Program 2001 – 2003



Much bigger that the budget allocated for the Clean Water program, in 2005 the GoI allocated Rp 3.342 trillion or equivalent to 24.9% of the overall the 2005 PKPS BBM budget for developing rural infrastructure (PKPS BBM IP). This budget was derived from the State Budget (APBN 2005) with the condition that local governments provide administrative cost (dana pembinaan dan administrasi proyek) for every projects carried out in their regions.[46] With around 4 percent of the budget allocated for safeguarding activities, the allocation of funding per village was around Rp250 million. Diagram 1 below shows the budget allocation by regions (see also Annex 2 and 3 for provincial allocation).

[45]BPS, *Statistik Indonesia 2005/2006*, p. 567.

[46]Dept. Pekerjaan Umum, 2005, PKPS BBM Bidang Infrastruktur Perdesaan: Pedoman Umum, p. 14

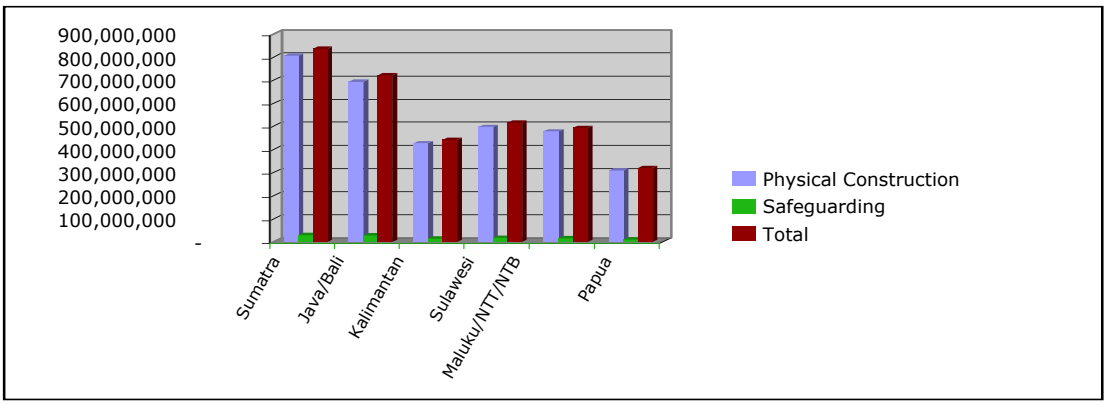


Diagram 1. Budget Allocation of 2005 PKPS BBM IP by Regions (x1000 rupiah)

The budget allocation for each district was determined by a central coordinating team using certain criteria, among others the condition of the village to obtain drinking water project, village poverty status, and the availability of clean water investments in the area. Funds was transferred directly to the person who was responsible for the construction of clean water facilities at the community level after the community decided the cost of such activities.

The fund received by the targeted villages was delay. By the end of September 2005, only 10% of targeted villages (or around 1.135 villages from 12.834 villages) have received the first trance. As regulated in the Guidelines, the fund was transferred to the village level from the Ministry of Public Works in 3 trances, 40% when the project was begun and the other 40% and 20% were transferred during the construction period. By October 2005, it was reported from the 888 targeted villages in 16 districts in NTT, only 55 villages have received the funds.

Findings of Monitoring Team of Ministry of Finance also shows there was some delays in the absorption of safeguarding fund and the revision of the budget before the second trance to adjust the fuel price escalation. It is also found that the local governments did not provide APBD for *dana pendamping* as required in the guidelines. There were questions in the field regarding the unavailability funds to covered transportation and honorarium for the district team and village officials who have been very active in conducting the program. To complete the provision of the purchase order took 2 months and this has caused the delay of the implementation of the projects. It is predicted that the program will not be completed by the end of 2005. The completion of the infrastructure projects in the village faced several problems, such as overlapping with other similar programs, queuing heavy machine for constructions, lacking of materials (cement, asphalt, others), depending on the season, such as rainy and harvest season, and distance/accessibility. Based on the Minister of Finance decision, the funds can be transferred in the fiscal year of 2006. It is also found that few villages received more than the allocation of Rp250 million regulated in the guidelines as one village also received Rp500 million.

6.5 Institutional Structure and Incentive Effects

Based on a SMERU study on the 2000 PKPS BBM PPM Prasarana the proposed activities in Kabupaten Kapuas, Central Kalimantan was resulted from only a one day meeting held in the *kecamatan,* which was attended by the *Camat***,** local village or *kelurahan* officials, and the community leaders. Meanwhile study in Kabupaten Barito Kuala in South Kalimantan, shows

that this region already had prepared a development proposal for the year 2000 under the Kecamatan Development Program (KDP). The planning process and the submission of proposals was carried out through several stages of discussion and approval, which involved the local community throughout.

The introduction and implementation of the PPM-Prasarana program in both these regions was planned to be carried out between October and the end of December 2000. Since the time frame was considered too short, the schedule was extended until the end of March, 2001. Almost all the projects in Kabupaten Kapuas were in fact completed by December 2000. However, several projects in Kabupaten Barito Kuala remained incomplete at the end of March 2001 due to environmental obstacles such as heavy rain and high tides.

The role of the Kecamatan Program Facilitator was not actually included in the design of the PPM Prasarana program, even though in reality these facilitators became one of the most important forces driving the program's success. In addition, Village Facilitators and Technical Assistants were urgently needed in the villages. However, due to limited local human resources some of those Village Facilitators who were recruited were unable to give the guidance or advice that was really needed.

The key to the successful implementation of the PPM-Prasarana program was community empowerment. Thus, the implementation of this program in Kabupaten Barito Kuala, facilitated by the KDP, was generally considered to be more successful, compared to those areas that did not have similar assistance, for the following reasons: (i) these village communities were already empowered by the previous support from the KDP, before the PPM-Prasarana program began; (ii) the project proposals were based on existing planning decisions which were subsequently verified and discussed at the UDKP II Plus Forum**,** a *kecamatan* coordination committee grouping organized especially to discuss the fuel subsidy program; and (iii) the facilitators from the KDP provided constant support for the PPM-Prasarana program.

The main aim of introducing community empowerment into the PPM-Prasarana program was not only to achieve better results in terms of the quality of construction, but also to increase community involvement in the planning and implementation process. Where KDP facilitators were involved in the implementation of the PPM-Prasarana program, better performance was achieved in both of these areas. Many consider the physical quality of buildings constructed by the community in these areas to be superior to the work by contractors.

Despite these advantages, the following problems remained evident where KDP facilitators had assisted the PPM-Prasarana program, those are: (i) the short time frame available to complete the PPM-Prasarana program was a distraction for the KDP facilitators and a disruption to the work of that program; (ii) there was an increased workload and greater responsibility for both the KDP facilitators and the Kabupaten Management Consultant, without the incentive of any adequate extra compensation; and (iii) the reluctance of many members of the community to reprimand others for poor performance.

At the same time there were also several discernable weaknesses in the implementation of the PPM-Prasarana program in those areas that were not facilitated by the KDP: (i) the promotion of the program and the collection of project proposals were carried out over a very short time period (2-4 days), and entire projects were meant to be completed in no more than 50 days. Consequently, some sections of the community were not even aware that projects were being implemented in their area; (ii) the organization of the program implementers was too unwieldy

and there was no clarity about their precise tasks and responsibilities; (iii) program proposals were based on the outcomes of meetings that included the village elite and excluded the wider community. Hence, some proposals were rejected and revised; (iv) there was no genuine process of community participation because the empowerment element had been interpreted in such a way that the community was only regarded as the workforce; and (v) monitoring and supervision were inadequate.

The strength of the PKPS BBM Clean Water is the availability of central coordinating team at the national level and the execution of the program decentralized to local governments. However, there were some weakness of the program, those are lack of proper preparation at the community level and as of other similar programs, the whole activity of the program (from design to implementation) implemented only in very short period, 3 months, and the maintenance was handed over to the community, while government officials did not properly monitor the facility resulting facilities were not functioning well due to lack of maintenance.

The Monitoring Team of Ministry of Finance views that the size of teams involved in 2005 PKPS BBM IP program is too big. The '*pendampingan*' was also not effective. The involvement of kecamatan consultant/facilitators was late so that they were not able to assist the OMS (Organisasi Masyarakat Setempat) and their role has changed from '*pendampingan*' to supervision and evaluation. Only in certain region, like in Kabupaten Banggai was the coordination among teams (Satker, TKK, kecamatan consultant/ facilitator, KPPN) of PKPS BBM IP considered good.

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Tabloid Mingguan 'Udik' Edisi No. 226, Oktober 2005

Annex 1. Budget Allocation for PKPS BBM Clean Water, 2002

	Province	Allocation (thousand rupiah)
1	NAD	3,500,000
2	North Sumatra	6,500,000
3	West Sumatra	3,500,000
4	Riau	5,500,000
5	Jambi	2,000,000
6	South Sumatra	3,500,000
7	Bangka Belitung	2,700,000
8	Bengkulu	2,100,000
9	Lampung	3,000,000
10	Jakarta	6,000,000
11	West Java	8,350,000
12	Banten	4,500,000
13	Central Java	9,500,000
14	Yogjakarta	1,850,000
15	East Java	8,500,000
16	West Kalimantan	5,750,000
17	Central Kalimantan	3,500,000
18	South Kalimantan	5,100,000
19	East Kalimantan	5,500,000
20	Bali	2,000,000
21	West Nusa Tenggara	2,200,000
22	East Nusa Tenggara	3,900,000
23	North Sulawesi	2,300,000
24	Gorontalo	1,900,000
25	Central Sulawesi	3,300,000
26	South Sulawesi	8,600,000
27	Southeast Sulawesi	1,750,000
28	Maluku	1,800,000
29	North Maluku	1,600,000
30	Papua	5,300,000
	Total	125,500,000

Annex 2. Budget Allocation for the PKPS BBM Rural Infrastructure, 2005

	Province	Targeted District	Targeted Subdistrict	Targeted Village	Physical Construction	Safeguarding	Total
1	NAD	13	103	260	65,000,000	2,738,022	67,738,022
2	North Sumatra	25	188	586	146,500,000	5,558,822	152,058,822
3	West Sumatra	19	119	286	96,500,000	3,825,366	100,325,366
4	Riau	11	96	285	71,250,000	2,829,580	74,079,580
5	Riau Archipelago	6	27	95	23,750,000	1,192,480	24,942,480
6	Jambi	10	58	236	59,000,000	2,303,133	61,303,133
7	South Sumatra	14	116	533	133,250,000	4,473,020	137,723,020
8	Bangka Belitung	7	34	146	36,500,000	1,503,553	38,003,553
9	Bengkulu	9	55	348	87,000,000	2,874,660	89,874,660
10	Lampung	10	105	348	87,000,000	3,237,080	90,237,080
11	Jakarta	1	2	6	1,500,000	28,830	1,528,830
12	West Java	25	319	573	143,250,000	6,286,370	149,536,370
13	Banten	6	68	166	41,500,000	1,814,545	43,314,545
14	Central Java	35	335	810	202,500,000	7,956,530	210,456,530
15	Yogjakarta	5	45	118	29,500,000	1,326,762	30,826,762
16	East Java	38	361	936	234,000,000	9,255,295	243,255,295
17	West Kalimantan	12	120	536	134,000,000	4,563,281	138,563,281
18	Central Kalimantan	14	71	474	118,500,000	3,806,185	122,306,185
19	South Kalimantan	13	99	351	87,750,000	3,324,075	91,074,075
20	East Kalimantan	13	82	344	86,000,000	3,144,540	89,144,540
21	Bali	9	49	166	41,500,000	1,811,845	43,311,845
22	West Nusa Tenggara	9	86	367	91,750,000	3,190,577	94,940,577
23	East Nusa Tenggara	16	175	888	222,000,000	7,055,781	229,055,781
24	North Sulawesi	9	61	210	50,250,000	2,125,680	52,375,680
25	Gorontalo	5	34	149	37,250,000	1,514,407	38,764,407
26	Central Sulawesi	10	68	404	101,000,000	3,625,335	104,625,335
27	West Sulawesi	5	40	187	46,750,000	1,738,312	48,488,312
28	South Sulawesi	23	202	680	170,000,000	6,099,127	176,099,127
29	Southeast Sulawesi	10	75	366	91,500,000	3,274,730	94,774,730
30	Maluku	8	54	362	88,000,000	2,960,147	90,960,147
31	North Maluku	8	44	302	75,500,000	2,680,002	78,180,002
32	West Irian Jaya	9	38	351	87,750,000	2,942,629	90,692,629
33	Papua	20	118	884	221,000,000	7,933,569	228,933,569
	Central					14,630,730	14,630,730
	Central Coordination Team					7,122,020	7,122,020
	Ministry of Lift-behind Regions					1,163,270	1,163,270
	Consultant for Technical Assistance					4,360,440	4,360,440
	Consultant for Monitoring and Evaluation					1,985,000	1,985,000
	Total					133,625,000	3,342,125,000

Source: Directorate General Cipta Karya, Ministry of Public Works, 2005

Annex 3. Budget Allocation for the PKPS BBM Rural Infrastructure 2005 (per region)

No	Region	Number of Districts	Number of Location	Budget Allocation (Rp.x1000)	Percentage
1.	Sumatera Island	124	3123	805.750.000	24.11
2.	Java Island	110	2609	652.250.000	19.52
3.	Bali	9	166	41.500.000	1.25
3.	Kalimantan Island	52	1705	426.250.000	12.75
4.	Sulawesi Island	62	1996	496.750.000	14.86
5.	NTB, NTT, Maluku Utara and Papua	70	3154	786.000.000	23.52
Sub Total		427	12.753	3.208.500.000	96.00
Dana Pengawasan				118.994.270	3.56
Dana Monitoring dan Evaluasi (Pusat)				14.630.730	0.44
Total Anggaran PKPS BBM Air Bersih 2003				3.342.125.000	100.00