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# IMPLEMENTING FAMILY HOPE PROGRAM IN INCREASING HEALTH AND EDUCATION FOR THE VERY POOR HOUSEHOLD

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**Abstract.** *The Indonesian Family Hope Program (PKH) is both a Conditional Cash Transfer program (BTB) and a Social Protection Program, and is among the first cluster of modern poverty alleviation strategies implemented in Indonesia. The PKH has been able to meet some of the needs of the poor for access to health care and for education. Such services in Indonesia are difficult to obtain, especially by Very Poor Households (RTSM/KSM) in Umbulharjo District, Yogyakarta City. This study examines implementation of PKH for RTSM/KSM families and assesses effectiveness of PKH toward improving maternal health and children's education. Qualitative descriptive research collected in-depth information about, and from, seven PKH participants living in the Umbulharjo District of Yogyakarta City. These informants were selected by purposive sampling as representative of health care needs, educational issues, and reliability of information about services. Using their documented observations, the subsequent analysis consisted of data reduction, data presentation, and data inference techniques. Results documented characteristics of the program and experiences of the participants, as follows. (1) These seven PKH recipients were of productive age, but had a poor quality of formal education; were part of an extended family structure, but also had poor housing conditions; and were living amid overall poor economic conditions, while having very low income. (2) All of the participants were in the RTSM/KSM sector. (3) They were among the 42.86% of recipients having family conditions below Regency Minimum Wage (UMK) in 2018, and the 57.14% of recipients having women supporting the family. (4) Implementation of the Family Hope Program effectively improved marital health and medical health for these RTSM/KSM families, with a reduction of burdens and an increase in education.*

**Keywords:** *Family Hope Program, health, education, poverty.*

**Abstrak.** PKH merupakan program Bantuan Tunai Bersyarat (BTB) dan perlindungan sosial yang termasuk dalam klaster pertama strategi penanggulangan kemiskinan di Indonesia. Program ini sudah mampu menjawab kebutuhan dan akses masyarakat miskin terhadap kesehatan dan pendidikan yang masih sulit diperoleh, khususnya oleh RTSM/KSM di Kecamatan Umbulharjo Kota Yogyakarta. Penelitian ini bertujuan (1) mengetahui pelaksanaan PKH bagi keluarga RTSM/KSM di Kecamatan Umbulharjo Kota Yogyakarta (2) mengetahui efektivitas PKH ini dalam meningkatkan kesehatan ibu hamil dan pendidikan anak. Penelitian ini adalah deskriptif kualitatif, yang dirancang untuk mengumpulkan data dan informasi secara mendalam tentang peserta PKH di Kecamatan Umbulharjo, Kota Yogyakarta DIY. Informan dipilih secara purposive dan bukan pada jumlah yang banyak atau acak melainkan lebih pada keterwakilan masalah dan keterandalan informasi dan observasi terhadap tujuh peserta PKH sebagai informan. Teknik Analisis Data menggunakan (1) Reduksi data (2) Penyajian data (3) Penyimpulan data. Hasil penelitian menunjukkan bahwa: (1) karakteristik peserta PKH berusia produktif, kualitas pendidikan formal rendah, menganut sistem keluarga besar, dengan kondisi hunian rumah kurang layak, kondisi ekonomi kurang yang ditandai penghasilan rendah; (2) 100% peserta PKH di Kecamatan Umbulharjo adalah RTSM/KSM. (3) 42,86% kondisi keluarga peserta PKH di Kecamatan Umbulharjo berada di bawah Upah Minimum Kabupaten/Kota (UMK) DIY tahun 2018 sebab dalam keluarga RTSM/KSM yang menjadi tulang punggung keluarga adalah perempuan (57.14%); (4) pelaksanaan program keluarga harapan (PKH) di Kecamatan Umbulharjo merupakan salah satu program yang efektif dalam meningkatkan kesehatan ibu hamil, kesehatan keluarga RTSM/KSM, mengurangi beban hidup, dan meningkatkan pendidikan.

**Kata kunci:** Program Keluarga Harapan, kesehatan, pendidikan, kemiskinan.



## INTRODUCTION

Indonesia has the fourth largest global population, with more than 260 million people. Furthermore, the Indonesian people are geographically widely dispersed within their oceanic multi-island nation. Indonesia comprises 17,508 islands, of which about 6,000 are populated. The nation has 34 provinces, which in total comprise 503 regencies and 98 cities. The nation has 300 indigenous ethnicities and there are 742 languages and dialects overall. With such demography, poverty issues are challenging. There are 25.95 million resident Indonesians currently categorized as poor, based on poverty criteria (BPS, 2018), and this number constitutes nearly 10% of Indonesia's total population. For comparisons, the number of poverty-stricken Indonesians equals the entire population of the Australian continent, and it is more than five times the population of Singapore (World Bank, 2018).

Indonesia is considered a developing country, where poverty continues as a significant concern. Indonesia's governmental program to alleviate national poverty includes stabilizing prices, providing cash transfers as a societal aid, and distributing village funds; however, the program has so far been seen as ineffective. Lessening poverty in a developing country is an admittedly complex issue; nonetheless, some such countries have succeeded in increasing their national production and per capita income. According to Zakaria (2018) and Rubio-Sanchez et al., (2021), poverty must be addressed as a multidimensional phenomenon, being not only a condition of lacking food, shelter, and clothes, but also a condition of having low access to the productive assets and resources required to benefit from science and technology. Poverty typically correlates also with poor access to education and low availability of jobs, and thus creates a gap in instilling citizens' pride and honor.

The term 'poverty' emerges as applicable in a country when persons or groups fail to attain a national economic prosperity level, as the minimum requirement for specified living standards (Azizah, 2018; Rubio-Sanchez et al., 2021). Social scientists study poverty using various concepts and metrics (Subandi, 2016, p. 91). Poverty is discussed in national and international forums, yet poverty has continued over the centuries. Modern development of national economies has not overcome an increase of poverty rates globally, particularly in developing countries. Westra (Kusnaeti, 2016, p. 11) explains that implementation for improvement requires focused efforts to prepare the plans and policies, and that this should include the details of who will carry

out the plan, where it will be done, and when it will be started.

Starting in 2007 the Indonesian government implemented the Family Hope Program known as *Program Keluarga Harapan*, PKH. PKH is intended to assist alleviation of poverty and to expand social protection policies. Within the PKH provision of many services is a conditional cash transfer program, known in Indonesia as *Bantuan Tunai Bersyarat* (BTB) (Sofianto, 2020). BTB is similar to programs undertaken in countries such as Brazil, Colombia, Nicaragua, and Mexico (Desmiwati, 2018; Rubio-Sanchez, 2021).

The Indonesian government set 2019 as a target for 7-8% poverty reduction, as stated in RPJMN 2015-2019. PKH is expected to decrease both the percentage of needy people and the overall income inequality (Gini Ratio), while increasing the Human Development Index (IPM). The government expects to operate PKH until reaching targeted commitments for millennium development goals (MDGs). Afterward, the PKH beneficiary base is planned to be gradually enlarged until it covers all RTSM/KSM (Very Poor Households). In the initial plan, the Ministry of Social Affairs, Republic of Indonesia, set the scope of the beneficiaries to be served based on funding available in 2007 and projected continuance up to now. In going forward currently to expand the beneficiary scope, the PKH program development plan continues implementation as suitable to each city/regent setting, according to the poverty level in each, and as directed by the Ministry of Social Affairs' PKH guidelines (2018, pp. 15-16).

The Special Region of Yogyakarta (Daerah Istimewa Yogyakarta, or DIY), has widely implemented a PKH outreach program throughout the district, but has also seen some gaps emerging. This district's PKH participant rates were high in 2018 by comparison to other districts in Yogyakarta City. Yet PKH subsidy amounts and number of participants were falling short of meeting the needs there. The situation led to our selection of the Umbulharjo District as the focal area for this research. This study examines participant experiences with PKH implementation, looking for evidence of success and/or gaps in fulfilling people's daily needs and in enhancing access by the poor to health care and to education. Participant experiences are documented and described herein to inform and to guide poverty alleviation programs in Indonesia.

As far as the authors have observed, there has been minimal prior research to explicitly document details of PKH effects on improvement of both RTSM health and RTSM education. Some evaluation of PKH implementation for health has been discussed; and for the education aspect, separate research observed

relationships between facilitators and RTSM children. This study cites such references and literature in relation to the writers' research.

Rohmatunisa's (2012) research stated that evaluation of PKH implementation in Baros Regent, Banten, in 2020, found it to be effective at 66.4%. Similar to that, Permana (2012) reported that PKH implementation in Saruni Subdistrict has worked well. Calculation yielded  $t_{count}$  as larger than  $t_{table}$  ( $5,885 > 1,657$ ). The study concluded that PKH in the Saruni subdistrict of Banten reached a 69.90% rate, which was significantly above the hypothesis rate of 60%. Nainggolan et al. (2012) reported PKH as an effective medium to help the poor in regard to decreasing individual vulnerability, improving family behavior, and preventing poverty transmission between generations. Nurdiansah's (2017) research study on PKH, as part of the Implementation of Family Hope Program Unit (UPPKH) in Cipaku District, Ciamis Regent, found that out of 13 indicators, 11 exhibited proper implementation and two did not.

Isdijoso et al. (SMERU, 2018) showed that PKH does cover many of the recipients' costs for education and health services, for daily consumption, and for a more satisfactory life. Beside its use for education and health, PKH helped recipients to pay for house rental, electricity, and clean water. The study also found that the selection criteria for each PKH beneficiary were on target, but also that the aid amount was smaller than the need. Several aspects were seen to be needing improvement, most notably the overall transparency of implementation, in order to ensure against inappropriately reducing the funding or sharing funds with a program officer or facilitator. Also, the overall societal awareness of the PKH program needed improvement by means of information being more thoroughly and widely distributed to the public. The PKH allotments, mainly for medical health, were deemed to need increases, and the benefit distribution schedule was found to need better coordination with the timing of costs associated with the school calendar.

Retrospective assessment of programs also needs attention. Saraswati's (2018) research on PKH in Pekon Pandansurat showed that PKH assistance to the poor, for costs of education and health, decreased the overall poverty incidence by 8.3%. Caution is needed, however, such as when distribution decisions or amounts are not correctly targeting the most needy. This has happened when beneficiaries were actually relatively prosperous and therefore should not have qualified for aid; also, when a beneficiary family successfully reached a prosperous

status, yet continued to receive aid; and even when a beneficiary family was not only not needy, but also was one of the village officer families.

Research by Azizah (2018) showed that education has a significantly beneficial role on economic well-being. Similarly, research by Purnama (2017) showed that positive overall economic growth is also significantly beneficial. However, prior research on the Family Hope Program (PKH) has not yet examined improvement of RTSM participants' health or education. Prior research primarily has discussed effects of PKH implementation on overall health and education in a community. This research study differs in its focus on subject, method, place, and time. It is a qualitatively descriptive study with a view to theoretical discourse, but also with the underpinning of interview data gathered directly from recipients. This research thereby examines the extent of the implementation and benefits of PKH and the improvement factors for RTSM health and education.

## METHOD

This study presents qualitative field research, which, according to Richie as quoted in Moleong (2013, p. 6), is the effort to present a perspective on the social world and the research subjects, and to do so in terms of concepts, behavior, outlooks, and issues on an overall topic. In addition, the research was designed to be short-term, intended to provide a snapshot of contemporary conditions, and implemented with consensual agreement between researchers and the participants being studied (Moleong, 2013, p. 44).

This research on the PKH Family Hope Program's effects, toward improving health and education of very poor households (RTSM), was conducted in Umbulharjo district, Yogyakarta City, DIY. This district was chosen because it was the most prominent PKH distributor in Yogyakarta in 2018 and in the Umbulharjo district as well. The participant base was drawn from publicly available resources for obtaining relevant data. Participants were being served by Suparmiatun, A.Md., which is both a PKH facilitator and a RTSM provider in the district. Observation, documentation, and interviews were the methods of data collection. Synthesis and analysis of, and conclusions drawn from, the data were the final part of the study.

The Family Hope Program (PKH), which started in 2011, was observed in this study to have had positive impact on the Umbulharjo community by improving educational access and healthcare access for participants. This program is different

from other cash aid and other security programs because PKH participants have obligations to use the support funds for health and education. Importantly, PKH distributions are more successfully targeted to ensure such usage, as compared to other social aid programs. As an example, any participant, when utilizing health care, is accompanied by a facilitator; thereby distributions are being monitored as to appropriate usage.

## RESULT AND DISCUSSION

All PKH participants in the Umbulharjo district are classified as RTSM/KSM. Household condition rates 42.86% of these PKH participants as having less than the DIY regional/city minimum wage (UMK). This particularly reflects the high cost in the Umbulharjo district for daily life necessities, including clothing, food, housing, and education. For such situations, it is naturally seen that RTSM/KSM households are vulnerable to poverty. Also, among the district's RTSM/KSM families, there are 57.14% whose family income is provided by women (wives). In this study, four of the seven informant households were supported by women whose husbands were unemployed due to termination of employment or due to acute illness. PKH aid accordingly was helping participants to have access to free health care and to defray costs of education and to provide children with pin money.

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From the interview with Mrs. Suparmiatun as the PKH facilitator in Umbulharjo district, this study learned that the Family Hope Program (PKH) process for soliciting and adding RTSM/KSM families started in 2011 and ended in 2016. Due to the saturation level reached for any further expansion, PKH implementation then ended in 2020. Some participants had exited automatically; for example, when eventually there were no more kids still in Elementary or Junior High School level in a PKH family. Year by year, when a family was no longer qualified for benefits, they no longer participated in the study. PKH participant households being studied

originally numbered 245; then in 2011, this number decreased to 183; and in 2012, to 183; then in 2013, to 170; and in 2014, to 163 (UPPKH Secretariat, 2018).

PKH participant data was based on information from the Badan Pusat Statistik (BPS). Criteria for selecting participants partially relied on these national averages, although exact conditions differ from region to region. Accordingly, the village or subdistrict government often selected participants according to criteria more applicable to their regional conditions. The facilitator stressed that Family Hope Program (PKH) criteria for participant selection used RTSM, as obtained from Badan Pusat Statistik (BPS) data. As the selection process proceeds, the facilitator undertakes data collection again and organizes a meeting to provide information to the public. PKH meetings in the Umbulharjo district are conducted by the Neighborhood Chief (RT/RW); subsequently, the information is distributed widely to the local community. The PKH implementation process for RTSM families then starts by invitation and by seeking addresses for conducting family-by-family validation of their qualifying data. Lastly, the officer checks and validates which children in each family are in Elementary School or Junior High School.

The funds are then distributed by the Ministry of Social Affairs according to the amounts requested by the PKH facilitator who completed the family validations. Fund usage reaches 100% because none of the funds used for any purpose other than the verified actual needs of the recipients and thus the actual costs borne by each RTSM on behalf of the recipients.

Activities conducted in Umbulharjo for information, qualification, and implementation proceeded in eight settings: (1) group meetings, based on division of seven sub districts into ten groups, and with any relatively small village considered as a single group, or sometimes as two groups when prominent participants in a village are involved; (2) tutoring sites; (3) cooking competitions; (4) welcoming Ramadan, usually by holding morning exercise; (5) social gatherings; (6) savings and loan sites; (7) congregational groups for women, which occur in a special program supported by Office of Religious Affairs (KUA) for learning Quran recitation; and (8) sessions for learning to write and count (Calistung).

The Department of Health was also instrumental, based on its basic level health monitoring service. The department provides reports through the midwife coordinator in every district. And before the Department of Health conducts monitoring, every village midwife has reported firstly to their coordinator. This process

was utilized to find out the health services carried out by the village midwife and the usage of health insurance funding.

Participation from PKH recipients in the program was deemed "very good," as explained by the facilitator. The participants were requested to compile the required qualification information, and they responded swiftly in order not to miss out on the program benefits. All participants were enthusiastic. Monitoring was conducted by the facilitator in every meeting, such as reviewing a child's school evaluation or a pregnant mother's condition. A home visit was conducted when a recipient could not attend a meeting, so that the facilitator could ask about the reason for absence; for example, illness or heavy workload.

Two main obstacles in distribution of PKH in Umbulharjo district of Yogyakarta city were: (1) the circumstance that many PKH participants lacked information about using PKH cards and the advantages available for gaining medical service in Hospital or Public Health Center or for children's schooling; and (2) the occurrences of mismatched, outdated, or incorrect data when current and accurate information was not available to qualify for PKH implementation. The second situation could occur when a needy household had not been correctly categorized if their individual circumstances amid certain regional conditions did not align with the exact national criteria.

The data gathered enabled evaluation for the health and education benefits in the PKH program, on the basis of nine output indicators and seven outcome indicators.

PKH output indicators are: (1) complete immunization for infants less than a year age according to the city/regent, the district, and the Public Health Center; (2) distribution of Vitamin A for infants less than a year old, according to city/regent, district, and Public Health Center; (3) child's expected growth for infants less than one year old, according to city/regent, district, and Public Health Center; (4) Fe (ferric/iron) medicine tablet distribution to pregnant women according to city/regent, district, and Public Health Center; (5) antenatal care in the first through fourth visits (K1-K4) by pregnant women, according to city/regent, district, and Public Health Center; (6) the birthing process, as helped by a professional health facilitator, according to city/regent, district, and Public Health Center; (7) postnatal care service for women, according to city/regent, district, and Public Health Center; (8) percentage of children who attended

school; and (9) percentage of children who quit their schooling. (PKH General Manual 2018, p. 88)

PKH outcome indicators are based on: (1) decreasing rate of poverty for PKH participants after two to four years of participating in the program; (2) decreasing malnutrition cases in infants after four years of the program implementation; (3) increasing nutritional and protein food consumption after two years of program implementation; (4) increasing the amount of children's schooling after three to four years of the program implementation; (5) increasing school participation rate after two to four years of program implementation; (6) diminishment of children's working hours, including zero working hours, for children at work after two to four years program implementation; and (7) the ability of at least 60% of people in the lowest income category to utilize the program benefits.

In this research, the writers use the first set of indicators, namely PKH output indicators. Based on the per-village payment data of RTSM PKH in Yogyakarta, there were 5 pregnant women as PKH participants in the Umbulharjo district. However, the researchers could only meet with one woman during this study who had received PKH aid all throughout pregnancy and until giving birth. Mrs. Tri, an informant in Warung Boto sub-district, stated that she "routinely went to the Integrated Health Center, and that once a month for five months, she got medical checkups and obtained vitamins to add blood cells."

The effectiveness of PKH in enhancing maternal health in the Umbulharjo district was shown in the records documenting that 14.29% of respondents who were pregnant routinely got four antenatal care checks and obtained additional blood supplement (Fe) and Tetanus Toxoid Immunization (TT). A trained health officer assisted the giving birth process, helping 100% of respondents who were giving birth. After the births, the health officer conducted a medical check of their conditions, and subsequently the PKH participants in the Umbulharjo district had three health checks, namely in their First, Second, and Fourth Postpartum Weeks. After giving birth, there were checks of the respondents' health conditions, and the newborn babies (neonates 0-28 days of age) had health checkups three times, namely two times before one week of age (KNI, KN2) and one time at the age of 7 to 28 days (KSN). In the general population, only 14.29% of the infants below one year of age are routinely weighed monthly and get complete immunizations. The mothers and children monitored in this study all got their full health care during the

first year, including infants 6 to 11 months of age getting one Vitamin A 100, 000IU capsule supplement and being weighed every three months. Children one to five years of age had check-ups twice a year. Children five to six years of age were monitored by routine weighing every three months. The study indicates that 100% of respondents did their health checks at the health center.

In the interview with Mrs. Suparmiatun, PKH facilitator in Umbulharjo District, she stated: "For infants, from 2011-2018, it has improved, and every stage had decreasing cost. The 2018 deduction reduction is zero Rupiah, the stage 3 and 4 is zero Rupiah, and every pregnant woman has been examined because they had their trust, although some believed that immunization is unnecessary, and some were too ashamed to come because they have too many kids, when the Health officer once asked them to join in family planning, but they were reluctant."

PKH effectiveness in improving education of PKH participant RTSM families was seen by most respondents considering that the program increased their family's education. The PKH facilitator in Umbulharjo District said, "Children can get their education easily; also, children who have no bicycle can save money now so that they can buy one, and get uniform and Worksheet books, and pay their tuition fees. This program motivates children to go to school, thanks to the allowance of 2000 IDR each day."

Facilitator and RTSM/KSM respondent explanations concurred that PKH effectively improved education for the children in the program. Also, with PKH aid, those without a bicycle also could save money to buy one. Furthermore, children were more motivated to attend school because the facilitator monitored the absence reports. Attendance encouraged more diligence in study habits. PKH aid also helped for the cost of uniforms, worksheet books, and additional allowance money for students. With this help, they did not feel inferior to their friends, as compared to previously having torn shoes and not having any worksheet books or enough money for snacks or lunch. With the PKH aid, needs could better be fulfilled.

PKH cards can be used to get pregnancy checkups at the Public Health Center or health assistance in hospitals. The cards also can be used to arrange education aid. This benefit was described in the interview with Mrs. Maimunah, one of the informants in Warung Boto. "For my husband's health check it is useful, and when I once got a toothache, I used the card. Yes, previously we did not know about this, but now that we know it, we usually use the card when we check in at the Public Health Center." Similarly, Mrs. Sri, the informant in Pandean

Village, uses the PKH card to get medicine in the Hospital or at the Public Health Center.

"Yes, we also use the PKH card to get medical service, so we do not have to pay a penny. When my husband was treated in hospital for a stroke attack twice, for his brain attack in which he could remember things only temporarily, we used the card. *Alhamdulillah* (thank God), it has been six months since the event."

Meanwhile, Mrs. Sri spoke of the education service and using a PKH card:

"For school, we receive the TUNAS program with the help of PKH and BSM, yes. And for my son in Junior High School, he also got a scholarship from the school, so it helps us a lot. We provide PKH copy, BSM, and C1 form -- that is all it takes. These PKH cards help us a lot, for education and health service."

As documented, PKH participants in the Umbulharjo district were using their PKH cards to get health checks and services, either at the Public Health Center or in Hospitals, and the card could also be used for education services to help their children's learning at school. Nevertheless, many PKH participants had not fully understood how to use PKH cards for education access and health service, as evidenced by them still using *Jamkesmas* or *Jamkesda* for medical service in Hospital/Public Health services.

For more than two and half years, PKH participants used PKH cards for health service at Hospital/Public Health sites and for family education access at schools. PKH participants felt that the process was straightforward. Similarly, schools and hospitals respond warmly. They did not make any difference in treatment between patients who pay and those who have subsidies. This was described by PKH participant Mrs. Sri in her interview, as follows:

*"When I went to Wirosaban Hospital, it was easy, and they asked me, 'What insurance, ma'am?' I said, 'PKH!', and they directly told me everything about the paper documents. By midday it finished, from 8 until 12 a.m., and we stayed in the hospital for four days, and had medical check-ups two times, yet we did not have to pay a penny. Even if we used the health service ten times, it is still free. My husband got better and better and the service was good. Also, the doctor treated us nicely and just the same as other patients, without having to know whether we used free service or paid."*

Mrs. Maimunah said that health service was good both in the hospital and at the Public Health Service, and that the process was easy. "It ran smoothly, but at first we had to provide ID card and Family Card copy; after that, they gave their services, in the Hospital and in the Public Health Center. They already know about card usage, and we do not have to pay anything; even the registration is free. We just go straight to the service; we do not need to pay anymore."

Similar to Mrs. Maimunah, Mrs. Siti also feels the same ease in both Hospital and Public Health Center services.

*"Everything went just fine, and they provide services quickly, the difference is when we take third class if we use this free facility. Nevertheless, if we want the second class, we must pay for the service, free service only for third class."*

Meanwhile, Mrs. Poniyah explains that the Hospitals did not distinguish between patients who were getting their service freely using PKH cards or patients who paid with their money. They were all given generic medicine, and the difference is only in the room.

*"No, it turns out that the hospital already knows, so we only show the card. The medicine was all equal, same generic. The difference is in the room; if there was no room available, most likely they move to other days. Maybe that is it."*

It was generally felt that most health services in hospitals and the Public Health services are pretty good. However, some PKH participants felt that their services were unsatisfactory, as explained by Mrs. Santi, the informant in Warung Boto.

*"They said PKH is inapplicable here, but in Wirosaban Hospital, it still can be used. They say, "If you have Jamkesda, it is better to use Jamkesda. In the last Ramadhan month, I wanted to get an operation for my kid's tonsils, and I wanted to use PKH, but could not. How did that happen? They said it was better to use Jamkesda, and the hospital takes the Jamkesda card, but then we still have pay for some services that are not completely free."*

Getting health service and education access, either from hospitals or schools, was relatively easy.

Nevertheless, some officers in Public Health Centers did not provide their best service to PKH participants, particularly in the Umbulharjo district, Yogyakarta City.

PKH fund aid was also found to be useful by PKH participants to help with household expenses in the Umbulharjo district. This finding is seen with the following information gleaned in this study.

*First, Criteria of Aid Participant:*

**Table 1.1 Criteria of PKH participant**

No	Criteria of PKH Aid Beneficiary	Kids
1.	Pregnant Women /Post-Pregnant	1
2.	/infants	2
3.	5-7 years age children who have not to get basic education (pre-school kids)	4
4.		2
5.	SD/MI/Package A/SDLB kids (7-12 years)	
	SLTP/MTs/Package B/SMLB kids (12-15 years)	
	15-18 years age kids who have not finished basic education, including children with disability	

PKH beneficiary criteria in Umbulharjo district for Elementary School children covers a majority as described in Table 1.1. Of the five criteria generally met, from the researchers' observation, all were in the Umbulharjo district.

*Second,* participants could get aid reduction. In this context, it appears that the majority (85.71%) of PKH participants did not get aid reduction for the past two years, as occurred for six people, as seen in the following table 1.2.

**Table 1.2 PKH Participants Aid Reduction**

No	Reduction Aspect	N	Percent
1.	Funding cut	1	14,29
2.	Never	6	85,71
	Total	7	100,00

Source: Interview, 2018

The finding shows that a 10% reduction within the three months of receiving was not done. Most respondents never got the reduction. The experience of the respondent who had reduction is illustrated in the following interview.

*"It occurred when my kid was in Junior High, and now he is in Senior High. When he did not study*

at school, he wrote a letter to his teacher, but his friend never passed the letter to their teacher. We were worried that if we did not write the letter, we would get a reduction by 50.000 IDR, it is because they noted not present, in the school, I was shocked, so we have 50.000 IDR of aid reduction, after that, it never occurred again, Alhamdulillah, because if my son did not go to school, we write a letter to the school directly."

Third, the aid could diminish household expenses. PKH aid had this effect for the PKH participants in the Umbulharjo district. Mrs. Poniyah explained:

"Yes, we received it. Furthermore, when we receive the aid, we use it to buy school kits, uniforms, or to replace torn shoes; alhamdulillah, it helps a lot. I saved some of it, maybe 50.000 IDR, but when my kid has needs for his school, we use the money."

Similarly to Mrs. Poniyah, PKH aid also decreased Mrs. Fatimah's household expenses in the Pandean subdistrict. "Alhamdulillah, we got it, it is relatively sufficient, we have kid, but with the government's help, we are thankful for having it. We only need to concentrate on finding earnings for the daily meal, for the school, since we got the aid. If we had not gotten it, we would be in difficult situations. Back then, it was different; we used to eat only *Tempe* and some plain veggies, yet now when we did not have anything, we could only cook eggs, or instant noodles or some milk, if he wants it; since we have the money, we just bought it, it is easier now."

Even though PKH aid is not lavish, it can reduce RTSM/KSM household expenses, such that the family can then buy a school's kit and utensils (uniform, shoes, worksheet book, and bicycle). And they can afford their daily necessities in which before receiving PKH, they ate what they had, such as tempe, tofu, and egg, but after receiving PKH, they were able to buy a different menu according to their kids wish at the time, such as fish, noodles, and milk. In fact, they can even spare some aid money to save for admission fees, for when they continue their education to Junior High or Senior High.

## CONCLUSION

According to the informants and supported by the observations, the Family Hope Program (PKH) is one of the effective programs for poor households (RTSM), by increasing maternal health, increasing health care, decreasing living expenses, and increasing children's education in Umbulharjo

district. The evidence shows that PKH, in its health aspect and its educational aspect in Umbulharjo district, is running well. It is also seen, in this case, that the implementation process is corresponding to the government expectation, even though in the beginning there were minor implementation problems in the health sector. Furthermore, the program is getting better and has improved significantly.

The PKH program success is worth maintaining and expanding with the expectation that it would create a synergy between the health and education aspects, as implemented in the Family Hope Program (PKH), which conforms to the indicators set up by the PKH itself.

Benefits were documented to show *firstly*, that the Department of Health, with PKH implementation, becomes the supervisor enabling the Public Health Service and the Village midwife to provide medical services to PKH participants. *Secondly*, the initial information dispersal to prospective PKH participants can be conducted in the beginning by the facilitator in the village/sub district hall.

Meanwhile, this study found four conditions to address for any future implementation of the program. (1) The participant data used in PKH of Umbulharjo district came from BPS central; but (2) there were some data mismatches in PKH implementation because data from 2008 was used, even though the new program continued to 2011. Also, (3) there were some difficulties encountered in PKH participants using the program, as regards the obligation of the Integrated Health Center (*posyandu*) to monitor their infant's growth. And lastly, (4) the district by itself can not propose new participants because it has been the case that only BPS can only initiate and authorize continuation.

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