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RESEARCH REPORT

Qualitative Impact Study for PNPM Generasi and PKH on the Provision and the Utilization of Maternal and Child Health Services and Basic Education Services in the Provinces of West Java and East Nusa Tenggara

Vita Febriany

Nina Toyamah

Justin Sodo

Sri Budiyati

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The SMERU Research Institute
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ABSTRACT

Qualitative Impact Study for PNPM Generasi and PKH on the Provision and the Utilization of Maternal and Child Health Services and Basic Education Services in the Provinces of West Java and East Nusa Tenggara

Vita Febriany, Nina, Toyamah, Justin Sodo, Sri Budiyati

This study aimed to examine the impact of PNPM Generasi and PKH on the provision and the utilization of maternal and child health (MCH) services and basic education services. The study was conducted in 24 villages in two provinces, West Java and East Nusa Tenggara (NTT), which were divided into treatment and control areas. The qualitative panel method was used by comparing the results of the impact study with the baseline study conducted in 2007. Overall, the study found an increase in the provision and utilization in the sample areas, especially in PNPM Generasi treatment areas. PNPM Generasi contributed to the provision of services via building physical and supporting facilities of MCH and basic education as well as incentives for service providers. Contributions to improvement of utilization took the form of direct aid to households, including aid to cover childbirth expenses, supplementary feeding, scholarships, transport and dormitory allowances, and school equipment. On the other hand, PKH contribution to the improvement in service utilization was evident only in NTT Province. Improvements were indicated by the increase in mothers' attendance at *posyandu* (integrated health service posts)[i] and of students attendance in class. These increases were encouraged by the role of PKH facilitators in motivating the beneficiaries, the possible consequences of PKH fund deduction or fund withdrawal, and the relatively large proportion of beneficiaries in each village. However, a number of problems regarding the provision and the utilization of MCH and basic education services were still evident, especially in NTT. The problems included geographical and economic barriers, unavailability of service providers (of village midwives and teachers), and the villagers' beliefs in traditional customs.

[i]A *posyandu* or an integrated health service post is a medium for a village/*kelurahan*/*RW* community to provide basic health services for its own members. The main objective is to help reduce Under-five and maternal mortality rates. The services, provided by local cadres assisted by a *puskesmas* medical staff member, include immunization, weight measuring, and general health checks for children under the age of five as well as general health checks for mothers and the elderly.

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EXECUTIVE SUMMARY

Introduction

In mid 2007, the Government of Indonesia (GoI) launched two pilot Conditional Cash Transfer Programs: PNPM Generasi Sehat dan Cerdas (PNPM Generasi) and Program Keluarga Harapan (PKH) in an effort to reduce poverty rates and maternal and infant mortality rates as well as to ensure basic educational attainment for all. Despite similar objectives, the two programs used different approaches. PNPM Generasi fund was managed at the village level, while the PKH fund was managed directly by the beneficiaries.

The SMERU Research Institute, in cooperation with the World Bank, conducted a qualitative study to examine current conditions, tendencies and change dynamics related to the provision and the utilization of MCH and basic education services from 2007 to 2010 and to study the impact of PNPM Generasi and PKH on these changes. This study employed a qualitative panel method by comparing the findings of this study with those of the 2007 baseline study. Three approaches were used: (i) structured interviews; (ii) focus group discussions; and (iii) direct observation of villages/*kelurahan*,[ii] schools, and integrated health service posts (*posyandu*). The study was conducted in West Java and East Nusa Tenggara (NTT) provinces and covered 24 villages/*kelurahan*—the same ones visited during the 2007 baseline study. The impact study was conducted from January to August 2010.

Characteristics of Study Areas

The study areas in West Java were relatively accessible by public transportation. However in NTT, only two sample *kelurahan* were easily accessible. The other sample areas were difficult—if not very difficult—to access, due to their considerable distance from the *kecamatan* (subdistrict) capital, poor road condition, undulating terrain, and limited public transport. Most sample areas in West Java were less than 500 hectares in size, whereas a sample area in NTT could cover more than 1,000 hectares of land, so the distance between *dusun*[iii] (hamlets) was significant and some *dusun* were simply inaccessible during the rainy season. Compared to 2007, some roads within the villages had been improved with funds from local government, PNPM Mandiri Perdesaan, and the Urban Poverty Alleviation Program (P2KP).

Most villagers in the study areas made their living from farming—except for four sample areas of the urban PKH, where the majority of the villagers were traders and labors and a few were civil servants. Since 2007, there had been an increase in the number of sources of income and in the participation in some non-farming jobs such as trading, providing *ojek* (motorcycle taxis) services, and mining manganese (in NTT). In West Java, clean water was supplied by the Local Water Company (PDAM), while electricity was made available by the State Electricity Company (PLN). In NTT, people obtained clean water from streams and wells which dried up during the dry season and they provided themselves with light at night with kerosene lamps. There were no significant changes in these condition since 2007.

[ii] A *kelurahan* is a village level administrative area located in an urban center.

[iii] A *dusun* is an administrative area within a village, consisting of a number of *RT* (neighborhood units).

PNPM Generasi Study Findings

Implementation of PNPM Generasi

Community, village elite, and services providers considered PNPM Generasi more beneficial to MCH and basic education than other programs because (i) it offered a wide variety of aid, (ii) almost everyone obtained the fund, (iii) and it could complement other existing programs. PNPM Generasi was also regarded as having better fulfilled participant aspirations compared to other programs since the type of aid and the list of beneficiaries were determined at the village level.

PNPM Generasi funds were used in accordance with the program's guidelines, all uses were directly related to MCH and basic education. The fund for education was mostly allocated for direct assistance to students, whereas the fund for MCH was mostly used in the form of incentives for service providers and support facilities at *posyandu/polindes*. This triggered a public perception that PNPM Generasi provided more benefits to the education sector than to the MCH sector. **The modest allocation of PNPM Generasi funds for the improvement of school buildings and facilities were thought to be influenced by the fact that representatives from schools (principles/teachers) were not among the program implementers at the village level. In contrast, in relation to MCH, there were many *posyandu* cadres among the program implementers.**

Community members' contribution to the program implementation varied between West Java and NTT. In West Java they contributed money, food, and services. In contrast, only one village in NTT gave in-kind contributions. People in the other villages did not want to contribute because they thought that PNPM was an assistance program, meaning that they should receive, not give. They were also worried that their contribution would only benefit the program implementers.

Village facilitators and TPMD undertook the task of routinely monitoring the program's 12 achievement indicators. However, as recognized by program implementers, monitoring had not been effectively implemented. This was mainly due to technical reasons such as forgetting to tear off coupons when mothers visited the *posyandu* and the distant location of junior high schools (SMP). SMP were generally located outside the village, hence making it difficult for program implementers to monitor student attendance. Low operational budgets for program implementers added to this obstacle, particularly in NTT.

The availability of MCH Services

Compared to 2007, there was no change in the type or number of MCH services in the sample villages. However, **PNPM Generasi** had improved the condition of the existing MCH services by constructing *posyandu/polindes* posts, adding *posyandu/polindes* equipment, and providing incentives for the *posyandu* cadres. According to the baseline study, the absence of incentives was among the reasons why some cadres did not conduct their tasks and why it was difficult to recruit new cadres.

Factors that hindered the provision of MCH services, especially for communities in remote areas in NTT, were the same, although less intense than in 2007. These factors included, (i) some village midwives living outside the village or frequently being unavailable; (ii) limited supplies of medicine; (iii) large sparsely populated areas; (iv) bad road conditions; (v) limited means of transportation; and (vi) people's belief in traditional practices such as *naketi* (traditional medication), *sei* (exposing one's body to heat), *tatobi* (putting a compress on a

woman's body parts(s) after giving birth), and a belief in traditional birth attendant (*dukun beranak*). Large, sparsely populated areas resulted in inhabitants having no access to *posyandu* and village midwives. **Establishing new *posyandu* or increasing the number of village midwives in each remote area was hindered by the small target number, and the limited number of existing *posyandu* cadres and midwives**.

The services of *dukun beranak* in helping with birth processes were becoming less favored. In NTT, this occurred because of the treatment in the form of money incentives allocated from **PNPM Generasi** to mothers who give birth with the help of a midwife and punishment from the village/*kecamatan* apparatus for those who give birth with the help of *dukun beranak*. In West Java, it occurred because there were no younger generations of *dukun beranak* and because the local government discouraged the use of their services. However, just as in 2007, the services of *dukun beranak* in helping with pre- and postnatal care were still in demand. They provided massages to fix the position of a fetus and to reduce fatigue or helped take care of the baby and/or the mother after delivery.

The requirement for community involvement through consultative meetings and discussions in the formulation of programs for PNPM Generasi, Desa Siaga and NGO aid formally enhanced the role of community in the formulation of MCH services. However, the final decision makers were mostly the village elite. Different levels of education and economic status between village elites and the rest of the villagers, especially in NTT, were thought to be one of the reasons explaining why the elites still dominated the decision making process.

Utilization of MCH Services

PNPM Generasi contributed to increasing utilization of MCH services (*posyandu* and village midwives) for it provided subsidized costs for childbirth, transport for pre- and postnatal health checks, supplementary foods, and transport to visit *posyandu*. Other factors that boosted the utilization of MCH services in the treatment and control areas were the increased awareness among the villagers of the importance of MCH as well as supporting programs such as Desa Siaga in West Java, Revolusi KIA (Revolution on MCH), from various NGOs, and the intensification of fine punishments in NTT.

The main reason that some women did not use of midwife services was expensive childbirth costs. In the treatment villages, this obstacle was overcome with subsidies on childbirth expenses from PNPM Generasi. Other impeding factors were the unavailability of midwives when needed and, in some communities, feelings of shame for having many children, for premarital pregnancy, and, especially in NTT, for having to show women's genital organs to a midwife.

Actors that influenced the utilization of MCH services were village officials, village midwives, *posyandu* cadres, neighbors, and, especially in NTT, religious leaders and NGO staff. The roles of village officials, among others, were being present at the *posyandu*, reminding the mothers to attend at the *posyandu*, and, in West Java, picking up mothers and their under-five children who were not present at the *posyandu*. In NTT, religious leaders helped by reminding their followers of the *posyandu* schedule during church gatherings. The NGOs played a role in providing advice and raising awareness of the importance of MCH services.

In general, most villagers' knowledge and awareness of the importance of MCH has improved, encouraged by the Revolusi KIA program and the Desa Siaga program, elucidation from NGOs, and aid from PNPM **Generasi**. The improvement was also

promoted by the easy access to information concerning MCH through printed and electronic media. The women's increased awareness was indicated by the growing attendance at *posyandu* and the FGD participants' improved knowledge regarding MCH and their reasons in choosing midwife services. As women were the main target of MCH services, women's awareness increased more than men's.

Availability of Basic Education Services

Since 2007, the number of primary schools (SD) in every sample village has been adequate. There is no change in the number of SD, but one primary school in NTT had a change of status, from a small primary school (*SD kecil*)[iv] to an independent one (*SD mandiri*). In addition, in all sample villages in West Java and NTT, there had been at least one institution running early childhood education programs (PAUD) funded by the local government, PNPM Mandiri Perdesaan, NGOs, and the communities themselves.

Junior high schools in all the sample areas in West Java were sufficiently accessible and relatively easy to get to. In NTT, the availability of junior high schools was still an issue due to long distances and high transportation costs. Compared to 2007, one junior high school was established in a control village in NTT.

Compared to 2007, there had been physical improvements to schools including addition and renovation of buildings (classrooms, libraries, school clinics, laboratories, and auditoriums) and addition of teaching and learning support facilities (such as furniture, books, audiovisual aids, and extracurricular equipment). Most of the funds for the improvement were from the Special Allocation Fund (DAK), Dutch Grant (DBEP), and Plan International, especially in NTT. **The role of PNPM Generasi was more focused to providing school support facilities, especially desks and chairs for students**.

A number of barriers to the provision of basic education services still existed. In West Java, the obstacles included the lack of specialized teachers in junior high school, the limited number of teaching aids, and the uneven number of students because of parents' preferences for particular schools. In NTT, the obstacles faced by schools were more serious, such as teachers' low levels of education and attendance, the temporary status of many teachers, the lack of teaching aids, and the unavailability of electricity and clean water in schools. These barriers, both in West Java and in NTT, were made worse by the parents' low participation following the implementation of the School Operational Assistance (BOS) program.

In NTT, school committees contributed to PNPM Generasi by actively voicing the schools' need to receive funding from the program. It was also an incentive for school committees, village apparatus, and the villagers to motivate students to attend school by reinforcing punishment for absentees. On the other hand, in West Java, due to the busy schedules of the committee leaders, the role of the committee in implementing **PNPM Generasi** was limited to acknowledging the program and distributing aid.

Utilization of Basic Education Services

[iv] A small primary school (*SD kecil* or additional classrooms) is a primary school affiliated with an existing primary school. Additional classrooms are constructed in a remote *dusun* so that the children from that *dusun*, especially first to third graders who are too young to travel long distances, can study there.

The participation level of primary-school-aged children in West Java and NTT was already high and did not changed significantly since 2007. Parents' high motivation in sending their children to primary schools was followed by their enthusiasm in sending their children to PAUD or preschools. Some primary school administrators even required that prospective students have a PAUD or preschool certificate. This resulted in the improvement of the quality of primary school students and reduced the number of primary school dropouts, especially in NTT.

Participation of junior-high-school-aged children increased because of their parents' improved awareness of the benefits of education. This is also in line with the fact that some jobs require at least a junior high school certificate (to be a migrant worker, the head of a *dusun*/RT/RW, a factory worker, or a driver). Other reasons were feeling shame for not attending school, the availability of open junior high school programs (*SMP Terbuka*), and the active roles of teachers, school committee members, and village apparatus.

Economic problems were the main reason that some junior-high-school-aged children did not enroll at schools or dropped out of school, these included school expenses (transport cost, pocket money, uniform and other school equipment) and children having to help their parents earn money to meet households' needs. Other reasons for girls were because they were forced to get married, got pregnant out of wedlock, or became migrant workers abroad; whereas other reasons for boys were because of the negative influence of their environment. In NTT, the distant location of junior high schools, up to 7 km away, and the high cost of transportation and of living in a dormitory were the causes behind why some children did not enroll at or dropped out of school. In some cases, due to various factors (environment, information media, etc.) there tended to be an increasing role of children in deciding whether to continue their studies or in selecting a junior high school without parents' influence.

PNPM Generasi prevented school dropouts. This was possible because Generasi's aid (including uniforms, school equipments, school fee subsidies, as well as transport and dormitory allowances) helped lessen parents' burden of school expenses. **PNPM Generasi helped lower the absentee level of primary school/junior high school students** because the direct assistance improved the students' spirit and motivation to attend school and, in NTT, the program also encouraged the reinstatement of fines for absent students.

The actors who played roles in the utilization of education services were the same as those in 2007, namely the village apparatus, teachers, school committee members, and religious leaders, as well as—specifically in NTT—NGO staff and *kecamatan* apparatus. However, the roles of these groups were still limited to giving formal advice. The roles of **PNPM Generasi** implementers in influencing the utilization of basic education services were evident in only one treatment village in West Java. In other villages, the implementers were only active in taking care of the aid.

PKH Findings

Implementation of PKH

The village apparatus, service providers, and the communities were not very familiar with PKH. The village elites did not pay attention because they felt they were not involved in the program implementation. At the community level, due to the small number of beneficiaries and for fear of social envy/conflicts, the program was treated as secretively,

including during the targeting process. Some FGD participants and key informants complained about the under-coverage of targeting and miss-targeting.

In general, the decisions regarding how to manage PKH funds were in the hands of the mothers or women in the family. **Most of the PKH funds were used for daily consumption**, or for education expenses if the time of the fund disbursement coincided with that of the new school year. The fund was not generally used to pay for MCH. Most PKH beneficiaries did not prepare for childbirth expenses. In addition, many beneficiaries in NTT used the fund to buy assets, such as livestock, with the assumption that if they needed money for education or health expenses, they could sell it.

The function of monitoring PKH beneficiaries' compliance with the program's 12 achievement indicators was not properly fulfilled. School teachers/principals, midwives, and *puskesmas staff* did not understand how to fill out the verification forms, which were distributed and collected by the post office. Some of the facilitators claimed to have filled out the forms themselves after getting the required information from the schools, midwives, and *puskesmas*. However, most providers of the health and education services said that they had never been interviewed by the facilitators.

PKH beneficiaries' compliance with the program requirements was strongly influenced by the facilitators' active roles and the number of beneficiaries in each village. In West Java and in the urban areas of NTT, most of the facilitators were not active because of the relatively large coverage area (several villages/*kelurahan*) and because the beneficiaries were residents of a number of villages/*kelurahan*.[v] In contrast, in the rural areas in NTT most of the facilitators oversaw beneficiaries in just one village and they actively engaged and motivated the beneficiaries to comply with conditions.

The Availability of MCH Services

The availability of MCH services in some treatment and control villages increased through the addition of midwives, of *posyandu* and *polindes* posts, and of rooms and equipment at the village health post (*poskesdes*)/secondary health services *puskesmas*/*polindes*, due to the funds and the initiatives from the local government. In one treatment village and one control village in NTT, the availability of the services did not change.

Obstacles still faced by most of MCH's service providers were lack of incentives for *posyandu* cadres, limited support facilities, unavailability of village midwives, sparse population coverage, poor road conditions, lack of transportation facilities, and the influence of the rainy season. The unavailability of midwives in two villages in NTT were due to a lack of midwives and the fact that the available midwives did not want to live in a remote village.

The provision of MCH services still had difficulty reaching a small group of villagers in NTT who lived far from the facilities and who still believed in *dukun beranak* and traditional customs **and groups of fishers in West Java**. However, compared to 2007, this number had decreased.

The role of *dukun beranak* in assisting with childbirth tended to decline. In West Java the decrease was due to no additional younger *dukun beranak* and the local government's appeal to *dukun beranak* to not provide childbirth delivery services. In NTT the decline was further influenced due to the Revolusi KIA program that prohibited *dukun beranak* from

[v]The PKH Facilitator Pocket Book mentioned that each PKH facilitator is in charge of around 375 beneficiaries.

providing MCH services. However, in two villages in NTT, where there were no village midwives, the role of *dukun beranak* in assisting childbirth was still prevalent. In addition, in all sample villages *dukun beranak* still provided services during pregnancy, such as massage (to fix the location of the fetus and reduce fatigue during pregnancy), postpartum (taking care of babies and mothers after childbirth), and the holding of traditional ceremonies.

The decision making process regarding the provision of MCH services were still conducted entirely by the government (local) and MCH service providers. However, since 2007 community involvement in decision making related to MCH services tended to increase, particularly in rural areas. In rural NTT, the increase was influenced by the Revolusi KIA program, while in West Java, the increase only occurred in the sample villages that had been actively implementing the Desa Siaga program, as the implementation of this program involved community participation and contribution.

Utilization of MCH Services

PKH increased the level of mother's attendance at *posyandu* in rural areas in NTT. This increase was due to the threat by PKH facilitators that funding would be cut if mothers did not go to *posyandu*. In West Java and urban areas in NTT, PKH had no effect on the level of mothers' attendance at *posyandu*. In West Java, the use of *posyandu* had not changed significantly as in most villages mothers' presence in *posyandu* was still influenced by the number of women who become migrant workers. Some residents in urban areas, both in West Java and NTT, did not use *posyandu* because alternative MCH services were available and easy to access.

Barriers to service utilization of midwives were due to remoteness, village infrastructure constraints, unavailability or absence of village midwives, as well as the strong belief in *dukun beranak* and traditional customs, especially in NTT. In general all of these obstacles were the same as in 2007.

PKH facilitators and PKH group heads became new actors in motivating the utilization of MCH services. In two treatment villages in rural NTT, the role of facilitators was encouraging the beneficiaries to use the MCH services and threatening to cut off PKH funding if they did not. However the role of the group head was merely to inform members of when aid would be dispersed. Other actors that played a role in increasing the utilization of MCH services were village officials, midwives, *posyandu* cadres, community leaders, neighbors and especially in NTT religious leaders and NGO staff.

PKH influenced the awareness of women and men regarding MCH issues, especially in rural areas in NTT due to the motivation and the threat of sanctions from PKH facilitators. Other factors that increased people's awareness about the importance of MCH services were the Desa Siaga and Revolusi KIA programs, information on MCH via printed/electronic media, reminders from neighbors, and, specifically in NTT, motivation from NGO staff.

Availability of Basic Education

Availability and coverage of primary schools in each sample village was adequate. Compared to 2007, the only change that occurred was the status of one primary school in NTT (from a "small" SD into an independent SD) at the initiative of the community and teachers. Almost all treatment and control villages in West Java and NTT had PAUD (early childhood education). PAUD was funded by communities, NGOs, local government, and PNPM Mandiri Perdesaan.

The availability of secondary schools in the sample villages did not change compared to 2007. Availability remained a problem, especially in some villages in NTT. This was because junior high schools were generally located in *kecamatan* and public transportation was not available hence schools were difficult to reach from some of the villages.

Infrastructures and supporting facilities in primary and secondary schools in all sample villages improved. Types of improvements in NTT included the addition and renovation of classrooms and toilets and improvements in West Java included improvements to libraries, laboratories, furniture, computers and teaching aids. Source of funding originated from central, provincial, and district governments and, particularly in NTT, from NGOs.

The various programs that were available have not solved all barriers to the provision of basic education services faced in 2007. In West Java and urban areas of NTT some schools that were considered favorites experienced overcapacity and did not have enough classrooms. Another problem was a decline in parents' participation following the implementation of the BOS (*Bantuan Operasional Sekolah*) program. In rural areas of NTT, schools faced harder obstacles including low levels of teacher education. Most teachers still had temporary status. Furthermore, there was an absence of libraries and laboratories, a lack of teaching aids, and lack of electricity and clean water in schools.

The role of school committees in decision-making regarding basic education services differed between urban and rural areas. In rural areas school committees were more active. Their roles included monitoring BOS funds, engaging in the construction of school facilities, and, in NTT, participating in supervising the attendance of students and teachers. In urban areas, committees only attended meetings at school and generally did not know about the existence of **PKH** recipients at their schools.

Utilization of Basic Education

Implementation of PKH did not increase the participation levels at primary school because participation was already high in 2007. The **role of PKH in increasing participation at junior high school was only visible in rural areas in NTT** due to the relatively large number of PKH beneficiaries, the active role of facilitators, and the sanctions applied if children were not enrolled or dropped out of school. In one sample village in NTT, at the beginning of the implementation of PKH, some children who did not continue on to junior high school were asked to attend as a condition of their family receiving PKH.

Similar to 2007, economic barriers were the main reason behind some children failing to enroll or dropping out of junior high school. Other reasons were that girls were forced to get married, became pregnant out of wedlock, or became migrant workers. Reasons for the non enrollment or drop out of boys was generally due to the negative environmental factors. In NTT the distant location of junior high schools caused students to often not attend school and eventually forced them to drop out of school.

PKH contributed to the increased attendance level of primary and secondary school students, especially in rural NTT, due to the threat of **PKH** funding cuts for students who were absent. Another factor that contributed to the decrease of absentee rates was tighter control of absenteeism, including fencing around schools and hiring of security staff .

The reason that some students were absent, both at primary and secondary schools in rural NTT, was due to rain, harvest time, and market days, as well as student fatigue and laziness. In urban NTT and West Java, reasons for absence were due to negative environmental factors, laziness, lack of pocket money, and fear of arriving late or not having completed home work. Several students were absent because they had to help their parents earn money (for example catching fish). Boys were more likely than girls to be absent due to delinquency.

PKH facilitators became influential actors influencing the utilization of basic education services in rural areas in NTT. This was because one facilitator was only responsible for handling beneficiaries in one village, and they actively raised awareness of the importance of education. Other actors in the village who played a role in encouraging parents to send their children to school were school teachers/principals, heads of school committees, village officials, and neighbors. In NTT, religious leaders and NGO staff also served to motivate many parents to send their children to school.

Parents' awareness of the importance of education increased in both West Java and NTT. Employers' requirements for high school graduates and the encouragement of village officials, community leaders and NGOs have influenced this increase. Indications of increased awareness were reflected in the responses of FGD participants who expressed hope of a better future through education, and the serious efforts of parents to keep their children in school, even if assistance is stopped. During the baseline study FGD participants generally regarded the benefits of education to be limited to improving children's basic skills.

Conclusions and Recommendations

PNPM Generasi

Community generally considered **PNPM Generasi** to be beneficial for them due to the many types of assistance and high number of recipients which allowed the program to be enjoyed by almost all the villagers (both male and female). Although the poor benefited from this program, the increased utilization of MCH and basic education was still constrained by household economic factors, customs, parents' education levels, and negative environmental factors which influenced the willingness of children to attend school. Therefore, to improve the utilization of MCH and basic education services among the poor, increased guidance and counseling is needed to raise the parents' and children's awareness and to increase the economic capacities of families.

The study identified two misunderstandings regarding the program by village officials and program implementers that caused less than optimal implementation of the program. Firstly, the notion that **PNPM Generasi** assistance in education was intended only for students enrolled in primary or junior high school caused children who were not enrolled or who had dropped out of school to receive no assistance. Secondly, **PNPM Generasi** assistance in all sample villages was spent entirely on material assistance, in the form of either money or goods. The study did not find any instances of non-material assistance that aimed to increase awareness. This evidence raises the concerns of service providers and village officials that if material assistance is stopped people will return to the pre-treatment conditions because the increases in service utilization had merely occurred due to people's the desire to gain material assistance. To address both of these misunderstandings it is recommended that efforts be taken to raise the awareness of program implementers and village officials regarding the program's objectives and types of aid allocation.

PNPM Generasi is not aimed at improving village infrastructure, however the benefits of this program should be optimized through central and local government efforts to improve:

- The availability and quality of rural infrastructure including roads, bridges, electricity and clean water for the community to more easily access MCH and education services.
- The availability and quality of MCH and education services including village midwives, the availability of drugs in *polindes*, teacher education, and the employment status of contract teachers.

PKH

PKH was not very effective in increasing the utilization of MCH and basic education services because of: (i) the lack of MCH services and junior high schools; (ii) poor or no basic infrastructure such as roads, bridges, electricity and clean water, especially in remote areas; (iii) the lack of support for **PKH** from schools, midwives and *posyandu* cadres; (iv) the weak role of facilitators in guiding and overseeing beneficiaries' compliance; and (v) the potential for jealousy and conflict of non-recipients especially in villages with a relatively small number of **PKH** recipients. In order to improve the benefits of the program, it is necessary to:

i. Increase the availability of MCH services and junior high schools so that they are adequate and easily accessible by all communities.

ii. Improve rural infrastructure including roads, bridges, electricity, and clean water.

iii. Renew the awareness raising efforts of **PKH** to village officials, service providers, and recipient and non-recipient households. Schools, midwives, and *posyandu* cadres should also be involved in the monitoring of program beneficiaries.

iv. Improve the relationship between facilitators and beneficiaries by defining facilitator's regions, not only on the number of beneficiaries, but also taking into account the geographical area and number of villages assisted.

v. Ensuring transparency in the targeting of beneficiaries and renewing awareness raising efforts amongst program recipients and non-recipients.

I. INTRODUCTION

1.1 Background

In an effort to achieve the MDG's targets by 2015, the Government of Indonesia (GoI) launched two conditional cash transfer programs in mid-2007. They were the National Program for Community Empowerment Healthy and Smart Generation (PNPM GSC/PNPM Generasi)—also known as the Community Conditional Cash Transfer (Comm-CCT)—and the Hopeful Family Program (PKH)—also known as the Household Conditional Cash Transfer (HH-CCT). Both programs were designed to reach the same objectives: (i) To reduce poverty; (ii) To reduce maternal mortality rates; (iii) To reduce infant and under-five mortality rates; and (iv) To ensure basic educational attainment for all.

Two and a half years after the programs were launched, the SMERU Research Institute, in cooperation with the World Bank, conducted a qualitative study to monitor the conditions relating to the objectives and the changes in the provision and the utilization of maternal and child health (MCH) and basic education services from 2007 to 2010. In 2007, SMERU, together with the World Bank, also conducted a baseline qualitative study on the same issues. The findings of both studies were then compared to determine the impact of PNPM Generasi and PKH on the provision and utilization of MCH and basic education services.

1.2 Study Objectives

The study aimed to examine the impacts of PNPM Generasi and PKH on the provision and the utilization of MCH and basic education services. This research specifically answers the major question: How has the access to maternal and child health facilities and the education facilities changed since the programs were launched in 2007? The changes could be monitored using two approaches, from the provision (supply) and the utilization (demand). Derivative questions from the two major questions are presented in Table 1.

Table 1. Research Questions

Maternal and Child Health Services	Primary and Junior High Education Services
Supply ▪ How has the provision of the maternal and child health services changed since 2007? ▪ What are the limitations in providing the maternal and child health services? ▪ How have PNPM Generasi and PKH impacted the provision of the maternal and child health services?	**Supply** ▪ How has the provision of the primary and junior high education services changed? ▪ What are the limitations in providing the primary and junior high education services? ▪ How have PNPM Generasi and PKH impacted the provision of the primary and junior high education services?
Demand ▪ How has the access for females to the maternal and child health services changed since 2007? ▪ What are women's reasons for deciding to use or not use the maternal and child health services? ▪ What are the impeding factors for women to access the maternal and child health services? ▪ How have PNPM Generasi and PKH impacted the utilization of the maternal and child health services?	**Demand** ▪ How has participation in the primary education systems changed since 2007? ▪ What are the reasons for children not registering or dropping out of primary and junior high schools? ▪ How have students' attendance levels changed since 2007? Is it different between girls and boys? ▪ How have PNPM Generasi and PKH impacted the utilization of the primary and junior high education services?

Maternal and Child Health Services	Primary and Junior High Education Services
Involvement of Other Actors (Village Administration, NGOs, etc.) ▪ What roles do other actors play in influencing women to access the maternal and child health services?	**Involvement of Other Actors (Village Administration, NGOs, etc.)** ▪ What roles do other actors play in influencing parents to send their children to school and not to let their children skip school?
Interactions between the Service Users and Providers ▪ How has the community's involvement in the decision making process regarding the provision of the maternal and child health services changed?	**Interactions between the Service Users and Providers** ▪ How have the school committees' involvement in managing schools—for both primary and junior high schools—changed?

1.3 PNPM Generasi and PKH in a Nutshell

PNPM Generasi and PKH are conditional cash transfer programs targeted very poor households (RTSM). As a condition of participation in the project, households/communities are required to work towards improving the following indicators:

MCH indicators include:
1. Pregnant women attend four checkups at a health facility during their pregnancy
2. Pregnant women receive and consume supplemental nutrition tablets (Fe)
3. The process of childbirth is assisted by a medical aide
4. Postnatal mothers (and their babies) attend two health checkups
5. Babies receive complete immunization
6. Babies gain weight each month
7. Children of 0–59 months old are weighed once a month
8. Children of 6–59 months old consume supplemental vitamin A twice a year

Basic education indicators include:
1. All children aged 7–12 are registered in primary school
2. Attendance level of primary school students is not less than 85% of the total number of school days
3. All children aged 13–15 are registered at junior high school
4. Attendance level of junior high school students is not less than 85% of the total number of school days

The distinction between PNPM Generasi and PKH lies in the program implementation approaches and the implementing institutions. PNPM Generasi is a conditional cash transfer for communities and is implemented by the Ministry of Home Affairs under the Directorate General of Village Community Empowerment (Ditjen PMD). Basically, the program adopted the activities and capacities established by the *kecamatan* (subdistrict) development program (PPK). The program beneficiary villages receive direct community fund (BLM), the amount of which depends on the number of beneficiaries in a village, namely pregnant women, children under-five, and primary- and junior-high-school-aged children. The use of the funds is decided by agreement among the villagers, and must be aimed at improving the provision and utilization of maternal and child health and basic education services in order to achieve the 12 required indicators. The BLM is transferred to a collective bank account at the *kecamatan* level. Program implementers at the village level comprise of village facilitators/village community empowerment cadres (FD/KPMD), and a team from the village meeting council (TPMD).[1]

[1]The FD consisted of community members who were willing to participate and were chosen by the villagers to support the PNPM Generasi. The TPMD was a team established and trusted by the villagers to design activities during the implementation of the program.

PNPM Generasi pilot involved two approaches: one with incentives and one without incentives. With the incentive system, PNPM Generasi recipient villages that succeeded in achieving the 12 indicators be entitle to additional BLM. Until 2010, the program has been tested in five provinces, comprising 20 *kabupaten* (districts), 129 *kecamatan*, and 1,625 villages.

PKH is a conditional cash transfer program for very poor households, managed by the Ministry of Social Affairs under the Directorate of Social Welfare Assurance. This program adapted similar programs that have been implemented for more than ten years and are considered successful in Latin American countries, such as the *Oportunidades* in Mexico and the *Bolsa Familia* in Brazil. Selection of PKH recipient households was done in two stages. First, the determination RTSM through household surveys in village beneficiaries of the program by using multidimensional poverty indicators. RTSM data is then filtered again under the PKH requirements, namely households with children aged 0-15 years or 15-18 years of children who have not completed the nine-year basic education, and or pregnant women. PKH recipient households must meet the program's indicators in accordance with the requirements for each household. Households with basic education aged children (7-15), for instance, must register their children at the primary/junior high schools with attendance rates of more than 85%. The amount of PKH funds received by a beneficiary depend on the household composition, with a minimum amount of Rp600,000 and a maximum amount of Rp2,200,000 per year (see table 2). The PKH fund was transferred via the post office in three installments a year

At the central level, PKH is managed by the Ministry of Social Affairs through the Directorate of Social Assistance and Social Insurance. At provincial, district and sub-district (*kecamatan*) were established PKH implementation unit (UPPKH). To ensure program effectiveness beneficiaries were supervised by facilitators, each of whom facilitated a maximum of 375 beneficiaries. To ensure the program implementation and coordination between facilitators and beneficiaries, groups consisting of 25 beneficiaries were formed and one member of each group became the leader. Up to early 2010, the PKH had been implemented in 20 provinces, comprising 90 *kabupaten/kota*, 781 *kecamatan*, and 816,000 very poor households.

Table 2. Amount of PKH Funds for Each Household

Aid Scenario	Amount per Household per Year[a]
Fixed amount	Rp200,000
For household with:	
a. Under-six children	Rp800,000
b. Pregnant/breastfeeding female member	Rp800,000
c. Primary school children	Rp400,000
d. Junior high school children	Rp800,000
Average amount per household	Rp1,390,000
Minimum amount per household	Rp600,000
Maximum amount per household	Rp2,200,000

Source: PKH General Guidelines, 2008
[a]transferred every four months

1.4 Research Methodology

The study on the impact of PNPM Generasi and PKH used the qualitative panel method by comparing the changes in the treatment areas (PNPM Generasi or PKH beneficiaries) with the control areas (non-beneficiaries). The analysis of changes were conducted by comparing the conditions in 2007 (the baseline study findings) with those in 2010 (the impact study findings). This study also analyzed how and why the changes took place and how the two programs contributed to the changes.

The data collection methods used in the impact study (and the baseline study) consisted of three approaches: (i) structured interviews with key informants at the *kecamatan* and the village/*kelurahan* levels; (ii) focus group discussions (FGDs) with the program beneficiaries and non-beneficiaries; and (iii) observation of the conditions of the village/*kelurahan*, schools (primary and junior high), and *posyandu*. The in-depth interviews, FGDs, and monitoring of facilities were conducted using structured instruments prepared for each key informant/FGD/facility. The key informants interviewed included the *kecamatan* and village/*kelurahan* apparatus, maternal and child health and basic education service providers, school committee members, and community leaders at the village/*kelurahan* level. For the impact study surveys interviews were also conducted with PNPM Generasi and PKH program implementers at the *kecamatan* and village/*kelurahan* levels. There were 16–18 key informants interviewed in each village.

In every village, FGDs were conducted with eight different groups; four groups discussed the maternal and child health services and the other four discussed basic education services. Each FGD group consisted of 8–10 program recipients and non-recipients randomly chosen from poor households. Women and men were deliberately allocated to separate groups in order to obtain more detailed information and clear indications of each gender's perception. Observation activities were conducted regarding the village conditions, *posyandu* facilities and activities, and the facilities and teaching activities at the most accessed primary school and junior high school. Observation of the *posyandu* could not be conducted in every village/*kelurahan* due to the schedule of the *posyandu* activities which were conducted once a month, and did not always coincide with the study dates. The list of key informants/FGDs/observation can be seen in Table 3.

Table 3. List of Key Informants, FGD Groups, and Monitoring

Interviews with key informants	*Kecamatan* level:	
	Head of *kecamatan*	1
	Head of *kabupaten/kota* education agency	1
	Head of *puskemas*	1
	Principal of junior high school/Islamic junior high school	1
	Teaching staff of junior high school/Islamic junior high school	1
	Head of junior high school/Islamic junior high school committee	1
	PKH advocate/PNPM Generasi facilitator	1
	Village/*kelurahan* level:	
	Head of village/*kelurahan*	1
	Community leaders	1
	Midwives	1
	Dukun beranak (traditional midwife)	1
	Posyandu Cadres	1
	Principle of primary school/ Islamic primary school	1
	Teaching staff of primary school/ Islamic primary school	1
	Head of primary school/ Islamic primary school committee	1
	Head of PKH/PNPM Generasi groups	1
	Total:	**16**

Focus group discussions (FGDs)	Mothers of primary school children (8 persons)		1
	Fathers of primary school children (8 persons)		1
	Mothers of junior high school children (8 persons)		1
	Fathers of junior high school children (8 persons)		1
	Areas with *posyandu*:		
	Mothers of under-five children (8 persons)		1
	Fathers of under-five children (8 persons)		1
	Areas without *posyandu* (remote *dusun*):		
	Mothers of under-five children (8 persons)		1
	Fathers of under-five children (8 persons)		1
		Total:	**8**
Observation	*Posyandu*		1
	Primary school/Islamic primary school		1
	Junior high school/Islamic junior high school		1
	Village conditions		1
		Total:	4

For the impact study, the plan was to interview the same informants who were interviewed during the baseline study and observe the same facilities visited in 2007. However, over half of the informants could no longer be contacted—because they had already retired, had changed jobs, or were not available at the time of the study—so researchers interviewed other informants in the same positions. In addition, some facilities visited were also different from the ones visited during the previous study, such as the *posyandu* (to adjust for the *posyandu* schedule) and some primary/junior high schools (because those visited during the baseline study were considered not representing the most accessed school by communities). Overall, the study in each village/*kelurahan* took 8–9 days and involved three researchers (one coordinator and two local researchers). The names of all researchers can be seen in Appendix 1.

To avoid biased answers from the key informants and the FGD participants during information gathering, the study team did not reveal the actual objective of the study, which was to measure the impact of PNPM Generasi and PKH. Instead, they said that the objective was to monitor the changes of provision and utilization of maternal and child health and basic education services. Questions asked during the in-depth interviews and the FGDs did not directly address the implementation and the impact of both programs, except during interviews with the program implementers on the last day of the study.

1.5 StudyAreas

The areas visited in the impact study were the same as those visited during the baseline study, namely West Java Province and East Nusa Tenggara (NTT) Province. In West Java, the study was conducted in Kabupaten Sumedang, as the recipient area of PNPM Generasi, and Kabupaten Cirebon, as the recipient area of the rural PKH and the urban PKH. In NTT, the study was conducted in Kabupaten Timor Tengah Utara (TTU) as the recipient area of PNPM Generasi, Kabupaten Timor Tengah Selatan as the recipient area of the rural PKH, and Kota Kupang as the recipient area of the urban PKH. In each *kabupaten/kota*, the study was conducted in 2–3 treatment and control *kecamatan*. In each *kecamatan*, the study was conducted in 1–2 villages/*kelurahan*. Overall, the study was conducted in 2 provinces, 5 *kabupaten/kota*, 14 *kecamatan*, and 24 villages/*kelurahan* (see Table 4).

Table 4. Study Areas

No.	Province – *Kabupaten*/*Kota*	*Kecamatan*	Category	Village/*Kelurahan*
	Jawa Barat			
1	**Sumedang**	Rancakalong	PNPM Generasi -Treatment with Incentive	Nagarawangi
2				Pamekaran
3		Buahdua	PNPM Generasi- Treatment without Incentive	Buahdua
4				Bojongloa
5		Darmaraja	PNPM Generasi-Control	Sukaratu
6				Neglasari
7	**Cirebon**	Gegesik	PKH-Treatment Village	Gegesik Kulon
8				Jagapura Kidul
9		Susukan	PKH-Control Village	Susukan
10				Tangkil
11		Gunung Jati	PKH-Treatment *Perkotaan*	Mertasinga
12		Mundu	PKH-Control *Perkotaan*	Mundu Pesisir
	Nusa Tenggara Timur (NTT)			
13	**Timor Tengah Utara (TTU)**	Biboki Utara	PNPM Generasi- Treatment without Incentive	Taunbaen
14				Hauteas
15		Insana	PNPM Generasi- Treatment with Incentive	Sekon
16				Susulaku A
17		Bikomi Tengah	PNPM-Control	Oenenu Induk
18				Kuanek
19	**Timor Tengah Selatan (TTS)**	Kie	PKH-Treatment Village	Oenai
20				Falas
21		Molo Selatan	PKH-Control Village	Bisene
22				Biloto
23	**Kota Kupang**	Alak	PKH-Treatment *Perkotaan*	Fetufeto
24		Kelapa Lima	PKH-Control *Perkotaan*	Tode Kisar

Note: The highlighted sections represent new/replacement villages/*kelurahan*.

During the study, three PKH control villages/*kelurahan* in NTT were replaced since they had become recipients of the PKH. They were Kelurahan Naikolan in Kecamatan Maulaffa, Kota Kupang, that had formerly been an urban PKH control area, and Desa Boentuka and Desa Oehela in Kecamatan Batu Putih, Kabupaten TTS, that had formerly been rural PKH control areas. The study team had difficulties in finding a replacement for Kelurahan Naikolan since there were only two *kelurahan* left in Kota Kupang that did not receive the PKH funds. They were Kelurahan LLBK and Kelurahan Tode Kisar (both are located in Kecamatan Kelapa Lima). The characteristics of the two *kelurahan* (number of inhabitants, number of very poor households, and the area size) were not similar to those of Kelurahan Fatufeto, which was the PKH treatment area in Kota Kupang. Finally, the team chose Kelurahan Tode Kisar, considering that it had more very poor households than Kelurahan LLBK did.

In contrast, it was relatively easy to find replacements for the rural PKH control areas. Of the 32 *kecamatan* in Kabupaten TTS, only 13 *kecamatan* had received the PKH funds. That left 19 *kecamatan* as alternative replacements. Considering the proportion of poor households, types of livelihood, and access to the location that resembled the treatment villages, the team selected Kecamatan Molo Selatan as the replacement. In this *kecamatan*, two villages were chosen; one that was easily accessible, Desa Biloto, and the other which was difficult to access, Desa Bisene.

In addition to the replacement of the three villages, a village/*kecataman* division had changed the administrative area of one study *kecamatan*/village. Desa Oenenu and Desa Kuanek (PNPM Generasi control areas) in Kabupaten TTU were parts of Kecamatan Miomafo Timur during the baseline study. After the *kecamatan* was divided in 2007, the villages became parts of

Kecamatan Bikomi Tengah. Moreover, Desa Taunbaen in Kecamatan Biboki Utara, Kabupaten TTU, was undergoing the process of being divided into two villages. One of the *dusun* in the village, that was inhabited by 136 households, was going to become a new village.

There were distortions in the design of the study areas since two villages that were in the category of PNPM Generasi treatment areas had received the PKH fund since 2007. They were Desa Nagarawangi and Desa Pamekaran in Kecamatan Rancakalong, Kabupaten Sumedang, West Java. These two villages remained as PNPM Generasi treatment areas, but the existence of the PKH was taken into consideration.

1.6 Report Organization

This report consists of five chapters. Chapter I presents the introduction, comprising details of the study background, objective, methodology, and study areas and schedules. Chapter II discusses the characteristics of the study areas, including location and access, inhabitants, conditions of houses and supporting facilities, and natural and economic resources. Chapter III describes PNPM Generasi, including the implementation aspects and the provision and utilization of the maternal and child health and basic education services in the program treatment and control areas. Chapter IV depicts the PKH, including the implementation aspects and the provision and utilization of the maternal and child health and basic education services in the program treatment and control areas. The analysis of chapters III and IV focus on the changes, the causes of the changes, and the impact of PNPM Generasi or PKH on the changes. Chapter V states the conclusions and recommendations.

1.7 Study Schedule

Overall the study was conducted over ten months, from January to October 2010. In January, preparation for the study was made, including preparing the field study instruments, recruiting local researchers, and obtaining field permits. The field study in West Java was conducted between 2–21 February 2010, followed by the field study in NTT between 9–28 March 2010. The report draft writing was conducted from April to mid-June 2010, and the report finalization process was completed by October 2010.

II. CHARACTERISTICS OF RESEARCH AREAS

2.1 Location and Access

The study locations were distinguished based on their accessibility—the distance and whether they were reachable or not—from the center of the *kecamatan*/subdistrict (see Appendix 2). The *kecamatan* center was set as the reference point because, generlly, health facilities (*puskesmas*) and secondary education facilities (junior and senior high schools) were located there. Six villages in West Java which were easily accessible were located near or adjacent to the *kecamatan* capital. It was easy to access public transportation in the six villages because they were located along the provincial or *kabupaten* (district) road. Six other villages in West Java which were difficult to access were located seven kilometers, at most, from the *kecamatan* capital. The roads to the six villages were in relatively good condition since they were asphalted. Only some *dusun*[2] in the villages were difficult to access. Most people's preferred means of transportation was the intra-city shuttle van because of its relatively low fare. Another alternative was *ojek* (motorcycle taxis), especially for traveling between *dusun*. Since 2007, there had been road repairs and improvements, mainly funded by PNPM Mandiri Perdesaan.

In NTT, of the six villages in the category of easily accessible, only two villages—located in Kota Kupang—were very easy to access. The four other villages—in Kabupaten TTU and Kabupaten TTS)—were less than two kilometers away from the *kecamatan* capital, but the poor road conditions and the limited public transportation made the villages less easy to access. Six villages, which were difficult to access, were located six kilometers, or more, away from the *kecamatan* capital. This condition was worsened by the damaged roads, undulating roads, and the limited public transportation to the villages. Four of the villages had already been accessed by public transportation, although only one or two times a day. Two other villages in Kabupaten TTS, Falas and Bisene, were still not accessible by public transportation, so the villagers had to walk 7–9 km (or for around 90 minutes) to reach the *kecamatan* capital. The size of each village (generally more than 1,000 hectares) created large distances between *dusun*. Large rivers, forest areas, and rugged terrain in some of the villages made it more difficult to access some of the remote *dusun*. During the rainy season, some *dusun* could not be reached even by a motorcycle. This condition greatly affected the villagers' access to MCH and education facilities.

> *"The question is how midwives can cross the river when it's high, or if they can, the baby cannot wait to get out, that is the problem"* (FGD Male-NTT).

> *"When the river is high, we help carry our kids to get across. When the school is over, we wait for the kids on the other side and help them cross again and go home together "* (FGD Male-NTT).

There had not been much improvement in the condition of the road to the sample villages. since 2007. However, there had been some in the village road improvement funded by the *kabupaten* budget and community contributions. *Ojek* had been available since 2009, but the fare was relatively high (Rp25,000 one way). Cellular communication facilities were also accessible in several villages. "*In 2007 we were not able to contact the midwife because there were no ojek and no mobile phones*" (FGD Female-NTT).

[2]A *dusun* is an administrative area within a village, consisting of a number of *RT* (neighborhood units).

2.2 Population

In general, compared to 2007, the population in almost all research areas had grown with the population in NTT growing relatively higher than that in West Java (see Appendix 3). In all sample villages/*kelurahan*, there were no significant movements of people (into or out of the villages). A significant number of villagers from West Java travel to Jakarta to find jobs (mostly men) or work in Saudi Arabia and Malaysia as *TKW* (female migrant workers), this had occurred since 2007.

There was no significant difference in the proportion of females and males in all study areas. The average number of family members was 3–4 people in West Java and 4–5 people in NTT. The average proportion of female heads of households in each village was approximately 15%, mostly widows of deceased husbands. Based on the level of education, both in West Java and in NTT, most of the villagers completed primary school, some others graduated from junior or senior high school, and a few others were primary school dropouts (grade four or five). These conditions had not changed much since 2007.

2.3 Conditions of Housing and Supporting Facilities

The houses in the sample villages in West Java were in relatively good condition, with tiled roofs, cemented walls, and tiled, cemented, or ceramic floors. These conditions had not changed significantly since 2007. In the study areas in NTT, most houses had thatched or aluminum roofs, wooden or bamboo walls, and dirt floors. Compared to their condition in 2007, some houses in NTT were in better condition and more houses had cemented walls and floors.

Most households in West Java obtained clean water from the regional state water company (PDAM), wells, and springs. During the dry season, when their wells dried up and were contaminated by sea water intrusion, some villagers in Kabupaten Cirebon had to buy water at Rp1,500 per jerry can. Most houses had toilets and some others used public toilets or took advantage of a river. Electricity from PLN was used as the source of lighting in houses. Changes that occurred since 2007 were that a greater number of homes had taps and a toilet. Increased ownership of latrines was mostly due to improvements made by individual households and assistance from WSSLIC (Water Supply and Sanitation for Low Income Communities) program.

In NTT, except in two sample villages in the city of Kupang, the condition of clean water facilities, toilets, and electricity was still an issue. Households' clean water sources were generally wells, both personal and public, and rivers. In the dry season most of the households experienced water shortages and had to walk 3-4 km to fetch water from springs or rivers. Some households already possessed a toilet in their yards. Provision of clean water and toilets in NTT were assisted by many international agencies such as Plan International, WVI and the CWS, so that compared to 2007 access to clean water and toilets were a little better. Most households still used kerosene lamps for lighting. Three villages in TTS had no access to electricity, whereas in seven other village a small portion of household obtained of electricity (from PLN and generators). Poor facilities adversely affected the availability and utilization of MCH and basic education services.

> "*The midwife did not want to live in the village because here there is no electricity and no water" (FGD Female-NTT).*
>
> "*There is no water at school, so children should bring water to school. Every week there are two classes that always bring water for the school toilet "(Principal-NTT).*

2.4 Natural and Economic Resources

The livelihoods of most households in the study areas, both in West Java and NTT were based in agriculture. In rural areas in West Java most famers cultivated rice, vegetables, cassava and corn. Yields were generally sold to the market (rather than as subsistence farmers). Average cultivated land area per households was generally less than 1 ha with a ratio of the number of farmers as owners and tenants (farm laborers) being almost equal. The involvement of women (wives) in agriculture included helping the men (husbands) during planting and harvesting seasons. In rural NTT, dry land food crops (corn, sweet potatoes, cassava, and peanuts) were favored due to the land conditions. The average cultivated land area per household was 5 ha. Yields were used partly for consumption and the remainder was sold on the market. Some households also gathered forest products such as tamarind, areca nut, cashew nut, and candle nut. In agricultural work, women had the same workload as men. Outside of the farms women also worked as weavers, and woven products were either used or sold on the market.

Besides agriculture, some households in the coastal regions of Cirebon Regency and Kupang City also worked as fishers. In this area men went in search of fish, shellfish, and crabs in the sea, while the women helped to peel the shells, clean the fish and sell them on the market. The work of fishers often involved school-age children, both boys and girls. In some villages in West Java (especially in Cirebon), many women worked as migrant workers with the main destinations being Saudi Arabia and Malaysia. Many men also migrated to Jakarta to work as construction workers, drivers, domestic helpers, or traders. In contrast to the other sample villages, in two urban PKH samples in NTT, the majority of community members worked as traders and laborers, and some as civil servants, particularly teachers and local government employees.

Compared to 2007, there were additional sources of livelihood and increased participation in several types of non-agricultural employment. In West Java, the number of *ojek* drivers, laborers and traders increased, whereas the number of farmers (mainly peasant owners) decreased. In several villages in NTT, *ojek* drivers and manganese quarry workers became new forms of livelihood since 2008/2009. Manganese quarrying involved not only parents but also children of school age.

III PNPM GENERASI

3.1 Implementation of PNPM Generasi

Of the 24 sample villages, eight villages received **PNPM Generasi** since 2007. In those eight villages, **PNPM Generasi** was well known among both officials and communities. FGD participants, who were mostly from poor households, were generally familiar with the name **PNPM Generasi**, some called this program 'GSC', others referred to it as Generasi or just PNPM. Communities generally knew of PNPM Generasi from the socialization conducted by the facilitators when the program was launched in 2007, and from when a family member (child or wife) received assistance from the program.

> "*I know about PNPM from the facilitator in this village" (FGD Female-NTT). "PNPM we know, most others program we do not know*" (FGD Male-NTT).

Benefits of the program received positive acknowledgement from the village elite, MCH service providers (midwives, health centers, cadres), education service providers (school principals and teachers) and communities. The program was considered more useful than other MCH/education programs because it offered many types of assistance and was received, not only by most of the villagers, but also by service providers via the *posyandu* cadre and teacher allowances and subsidies provided directly to midwives for assisting with childbirth. The program was also considered to complement similar programs that already existed in the village including the BOS program, Jamkesmas, and various health and education programs run by NGOs in NTT (Plan International, WVI, CARE, WFP, GMIT, Dutch Aid, Sanggar Suara Perempuan, etc.). The program was also considered more aspirational than BOS or Jamkesmas because the type of assistance and the beneficiaries were determined at the village level.

> "*GSC could solve the main problems of the mothers during pregnancy, childbirth and postpartum (nifas). Before the program the community had difficulties in paying the cost of accessing those three services "(FGD* Male-NTT*).*
>
> "*PNPM had direct impacts since we directly received the benefits. BOS is too restricted* "(FGD Male-NTT).

Although formally the type of assistance was determined at the village level, decision-making was still largely determined by program implementers and the village elite. Women's involvement in determining the type of assistance provided by **PNPM Generasi** was also still relatively low because, although women were represented formally, men were generally more talkative in village discussions. In addition the village elite were generally men.

> "*In meetings, bureaucratic intervention is still high. Especially when encouraging participants to better prioritize infrastructure* "(Facilitator-West Java).
>
> "*Targeting of PNPM beneficiaries involved hamlet officials, RT and village officials. There were always village officials, head of dusun and RT that targeted their relatives to be the program beneficiaries* "(Midwife-West Java).
>
> "*PNPM implementers 'walk alone'. The type of assistance from PNPM were set solely by PNPM implementers* "(Midwife-NTT).
>
> "*So the musdus (discussion at hamlet level) was dominated by women (almost 90%), with male participants consisting solely of village officials. By contrast, musdes (discussion at village level) was dominated by men* "(*Posyandu* candre -West Java).

"*On average, mothers did not know because they were not invited to the meetings. Meetings were attended mostly by men. If women participated, men were more talkative* (FGD Female-West Java).

In terms of the use of funds, the study did not find any allocation of **PNPM Generasi** funds that deviated from the program guidelines. All spending was related to MCH and basic education. Within a year villages had generally allocated funds for at least eight types of usage, for both MCH and education. Uses of funds could be divided into three categories: direct assistance to households, incentives for service providers, and construction of infrastructures and the provision of supporting facilities for MCH and basic education.

Conceptually, **PNPM Generasi** is an open menu program, the funds could be allocated to various activities related to MCH and basic education. The Study found that in sample villages **PNPM Generasi** funds for MCH were mostly allocated in the form of incentives for service providers (*posyandu* cadres and village midwives) and support facilities at *posyandu*/*polinde*. Direct assistance to households was generally in the form of transport allowances for checkups during pregnancy, supplementary food for malnourished children, and subsidies for the cost of childbirth where funds were transferred directly to a midwife. **Beginning in 2009 the increased allocations for each village encouraged communities to allocate most of their funds to infrastructure developments, particularly building *posyandu* posts**. In one village in West Java for example, 96% of Rp 90.8 million allocated in 2009 spent on the construction of six *posyandu* posts.

For education, **PNPM Generasi** funds were mostly allocated in the form of direct assistance to students, i.e. for uniforms, school equipment, transportation, photo copying and dormitory allowances, and scholarships for poor students. Allocations to education providers were only found in three villages in NTT taking the form of payment for contract teachers. The vast majority of funds allocated for school facilities was spent on chairs and desks for students. **The relatively limited allocation of funds to education service providers and to the improvement of school facilities was likely due to the absence of program implementers from schools (teachers/principals). This was contrary to in MCH services where many program implementers were also *posyandu* cadres.**

Table 5. Fund Allocation of PNPM Generasi in 2009

Village	Total Funds (Rp)	Education	Maternal and Child Health
West Java			
Nagarawangi	90,809,700	4%	96%
Pamekaran	66,953,700	41%	59%
Buah Dua	210.508.000	55%	49%
Bojong Loa	167,257,000	46%	34%
NTT			
Taunbaen	293,328,419	71%	29%
Hauteas	298,000,000	68%	32%
Sekon	111,897,901	37%	63%
Susulaku	128,000,000	33%	61%

Source: Interviews with program implementers

There were differing allocations of **PNPM Generasi** funds between MCH (which were generally allocated to service providers and for *posyandu/polindes* improvement) and education (which were generally in the form of direct assistance for students, hence the greater visibility of benefits at the households level). **As a result of these allocations there was a perception amongst sample villages, particularly in NTT, that PNPM Generasi provided greater benefits to the education sector than to the MCH sector.**

> "*PNPM is divided fairly and everybody gets the benefits and the amount is big, especially for education*" (FGD Female-NTT).
>
> "*As for health is only limited and not evenly distributed*" (FGD Mother-NTT).
>
> "*PNPM Generasi benefited education more. There was an impact of PNPM Generasi on health, but this impact was minimal* "(Village Head-NTT).

The level of community contribution to the implementation of **PNPM Generasi** tended to be higher if infrastructure construction was involved. Moreover, there was a significant difference in community contributions between West Java and NTT. In West Java communities in the three sample villages contributed money or, in the case of one village, food and services. In contrast, in NTT of the four sample villages, only one village community contributed in-kind support (see Table 6). In other villages communities were reluctant to contribute because they thought that the term 'program assistance' meant that they should be receiving rather than giving. There were also fears that their contribution would disproportionately benefit the program implementers.

> "*They have a belief that the aid means they have to receive assistance, and not to give assistance. So if anyone was asked to contribute, people thought that the officers were conducting corruption or misappropriation. It's been like this since long ago.* "(PK PNPM Generasi-NTT).

Table 6. People's Contribution to PNPM Generasi in 2009

Village	Community 's Contribution	
	Type of Contribution	Amount
West Java		
Nagarawangi	Money	Rp11,400,000
Pamekaran	Money	Rp 3,500,000
Buah Dua	Money	Rp 8,839,800
Bojong Loa	Food and services	Brought food and drinks from home, lent their vehicles
NTT		
Taunbaen	None	-
Hauteas	None	-
Sekon	None	-
Susulaku A	Energy and materials	In building the *posyandu*, the villagers contributed construction materials such as board, wood, time, and energy. In providing supplementary food, women cooked the food voluntarily.

Source: Interviews and FGDs

Based on the operational technical guidelines (*juknis*), *kecamatan* facilitators/FK with village facilitators/FD/KPMD and TPMD were obligated to conduct monthly monitoring of village achievements towards the 12 indicators. This occurred via the redemption of coupons for MCH and via class attendance records for education[3]. FD interviewed claimed to have routinely collected data from schools, *posyandu*/cadres and village midwives. **Nevertheless, as acknowledge by FK/FD, particularly in NTT, monitoring had not been conducted effectively**, for example coupons were often forgotten when mothers visited *posyandu* and the monitoring of junior high school student attendance was difficult to conduct as students from one village often studied in several junior high schools which were generally located outside of the village. **Low salaries were also an obstacle for program implementers (especially in NTT) when monitoring the attendance of students in junior high schools.**

> *"For MCH, KPMD refered to data documented by midwives and posyandu cadre, as well as examining available coupons. Coupons in particular were often not torn off, hence were no longer accurate"* (KMPD-NTT).
>
> "*As for junior high school students the only way was to collect data from students' parents. Most people here know for certain which children attend school in junior high. We did not check directly to the school because it required high transportation costs if we had to go directly to the school*" (FD-NTT).

The distinction between PNPM Generasi with incentives and with no incentive was not fully understood at both village and *kecamatan* level. Of the four sample villages that received **PNPM Generasi** with incentives, three FDs did not understand the incentive system. Only in one village in NTT had an FD who understood the incentive system and explained that: "*In 2009, out of 128 million of PNPM GSC funds, Rp108 million is the core fund and Rp20 million is bonus/incentives (20% of the core funds). The amount of incentive will be reduced if the achievement of the indicators is less than the established benchmark, such as student attendance less than 85%.*" At the village official and community level, the terms incentives and non-incentives were not recognized. **In addition, this distinction was difficult to recognize, because the amount of PNPM Generasi funds received in all sample villages was increasing every year. This increase occurred for both the villages with incentives and those without incentives.** For example, Hauteas village in Kabupate TTU received **PNPM Generasi** without incentives. In 2007 the village received funds amounting to Rp60 million, yet in 2008 the amount rose to Rp160 million, and again in 2009 to Rp298 million.

The most frequent complaint by FDs regarding barriers to program implementation was the delays in aid disbursement. For example, assistance for school uniforms or school fees were needed by parents at the beginning of the school year (June-July), but such assistance was distributed in November or December. In addition, the small operational budgets for FDs were also criticized, particularly in rural areas in NTT, as villages were so far away that operational funds barely covered transportation costs: "*In 2009, our incentive was Rp115,000/month. The cost for one trip by ojek to the village was Rp20,000 and in a month we had to conduct six visits so the cost was Rp120,000* "(FD- NTT).

3.2 Availability of MCH Services

Although there were no additions to the types of MCH services or personnel in both the treatment and control areas, in general, studies found various improvements in the existing MCH services since 2007. These improvements refer to the improvement of infrastructure and supporting facilities, increased performance of service providers, and the decreased use of

[3]The use of coupon books should have not been used following May 2009, because they were considered ineffective and inefficient. However, when the survey was conducted, coupon books was still used, particularly in NTT.

dukun beranak services. Sources of funds for the improvements were from local and central governments, including from **PNPM Generasi** and PNPM Mandiri Perdesaan, and from various NGOs. However, these changes were not able to reach all poor people especially those living in remote areas because MCH services still had to deal with physical or geographical barriers, lack of MCH service providers, limited infrastructure and supporting facilities, no access to electricity and clean water, widespread populations, and *dukun beranak* who continued to assist with childbirth.

The study also found that PNPM Generasi had caused the improvement of MCH services in treatment villages to be generally higher than in the control villages. Contributions of PNPM Generasi towards the improvement of MCH services included additional/improved infrastructure and supporting facilities and incentives for MCH service providers.

3.2.1 Conditions and Changes in the Availability of MCH Services and Identified Problems

In general, the types of MCH services and health personnel available in most sample villages had not changed compared to 2007. This included midwives, village maternity posts (*polindes*), village health posts (*poskesd*es)[4], and integrated service posts (*posyandu*), including its cadres. Some villages had secondary *puskesmas* (*pustu*) and in all *kecamatan* capital there were *puskesmas*. Likewise, the number of MCH services and health personnel available in each sample village did not increase. There was only one instance of an additional *posyandu* post being established in one control village in NTT and this coincided with the division of a hamlet (see table 7). The following section describes the conditions and obstacles faced by each type of service and the changes compared to 2007.

Posyandu were available in each hamlet or RW in all sample villages in West Java, whereas in NTT the number of *posyandu* was still limited and did not cover isolated hamlets. Just as in the baseline study in 2007, *posyandu* were the primary health post for children under five. *Posyandu* provided a five service system for children under five years old which included registration, weighing, recording, nutritional counseling, and health services (immunization, vitamin A supplements, and the handling of child malnutrition and poor nutrition). Each *posyandu* operated routinely every month and was managed by an average of 5 cadres coordinated by the village midwife. Changes to the services of *posyandu* since to 2007 were improvements to the construction or renovation of some *posyandu* in both treatment and control villages (see table 8).

[4] *Polindes* provide pregnancy and maternity services, whereas *poskesdes* provide services for general health treatment. In line with the Desa Siaga Program, all *polindes* in West Java have been upgraded to become *poskesdes*.

Table 7. Type of MCH Services Available In PNPM Generasi Treatment and Control Villages

Category	Village	Number of *Posyandu*		Village Midwife[b]		The Availability of Other MCH Facilites			
		2007	2010	2007	2010	Polindes	Poskes-des	Pustu	Puskes-mas[c]
West Java - Treatment	1. Nagarawangi	8	8	Available	Available	-	√	-	√
	2. Pamekaran	5	5	Available	Available	-	√	√	-
	3. Buahdua	4	4	Available	Available[d]	-	-	-	√
	4. Bojongloa	4	4	Available	Available	-	-	√	-
West Java - Control	1. Sukaratu	4	4	Available	Available (not lives in the village)	-	√	-	-
	2. Neglasari	4[a]	3	Available	Available	-	√	-	-
NTT-Treatment	1. Taunbaen	3	3	Available	Available	√	-	√	√
	2. Hauteas	4	4	Available	Available	√	-	-	-
	3. Sekon	2	2	Available (does not live in the village)	Available	√	-	-	-
	4. Susulaku A	2	2	Available	Available (does not live in the village)	√	-	-	-
NTT-Control	1. Oenenu Induk	1	2	Available	Available	√	-	-	-
	2. Kuanek	1	1	Available (does not live in the village)	Available (does not live in the village)	√	-	-	-

Notes :
a) One *posyandu* post in one of the hamlets became a separate village area.
b) (Available) means that a midwife lives inside the village
c) (–) *Puskesmas* access is outside of the village or at the *kecamatan* capital.
d) No longer served by a *puskesmas* midwife
Source: Summarized from in-depth interviews, FGDs and observations.

In the treatment villages, construction of all *posyandu* posts were funded by PNPM Generasi. In some of sample village **PNPM Generasi** also provided a variety of *posyandu* equipment such as scales, blood pressure monitoring tools, tables, chairs, beds, children toys, and stationery. Services at *posyandu* were also enriched by supplementary feeding (PMT), especially for children who were malnourished or poorly nourished. In some control villages, the construction of *posyandu* posts were funded by PNPM Mandiri Perdesaan (see table 8), but this program did not provide *posyandu* equipment, PMT, or incentives for cadres. The construction of *posyandu* posts meant that *posyandu* services no longer used village office space or the houses of *posyandu* cadres or village officials. Thus the operations of *posyandu* no longer interfered with or disrupted other activities. Moreover, mothers and toddlers felt more comfortable in *posyandu* and services could be provided over more flexible and longer hours.

> *"We are pleased with PNPM Generasi because the neighborhood health center in the village can be built" (FGD male-NTT).*
>
> "*Children are now more comfortable in the posyandu because there are games and toys provided by PNPM Generation*" (Posyandu Cadre -West Java).

Table 8. Number of MCH Facilities Built in 2008-2010

Treatment Villages		Control Villages	
Name of village	**Number of facilities funded by PNPM Generasi**	**Name of village**	**Number of facilities funded by PNPM Mandiri Perdesaan**
Jawa Barat:			
1. Nagarawangi	6 *posyandu* out of 8 *posyandu*	1. Sukaratu	2 *posyandu* out of 4 *posyandu*; 1 poskesdes
2. Buahdua	3 *posyandu* out of 4 posyandu		
3. Pamekaran	2 *posyandu* out of 5 *posyandu*	2. Neglasari	1 *poskesdes*
4. Bojongloa	4 *posyandu*		
NTT:			
1. Sekon	2 maternity rooms at *polindes*	1. Oenenu Induk	1 *polindes*
2. Hauteas	1 polindes		
3. Susulaku A	1 *posyandu* out of 2 *posyandu*	2. Kuanek	1 *posyandu* out of 1 *posyandu*
4. Taunbaen	1 posyandu out of 3 *posyandu*; 1 *polindes*		

Source: Data summarized from interviews, FGD, and observations

PNPM Generasi also provided allowance for *posyandu* cadres. During the baseline study in 2007, the absence of incentives for *posyandu* cadres were criticized by midwives as they experienced difficulty in recruiting new cadres who were required to work voluntarily. The existence of allowances became an incentive and a reward as well as motivation for *posyandu* cadres. For example cadres in some villages become more active in visiting the houses of pregnant mothers and toddlers who didn't visit the *posyandu*. Midwives also claimed that these allowances made it easier for them to recruit *posyandu* cadres. The allowances in West Java were between Rp15,000 - 25,000 per month. In NTT allowances of between Rp 5,000 - 10,000 per month were provided in two treatment villages. The frequency of allowance dispersal differed between villages. There were village that had provided allowances regularly since the inception of **PNPM Generasi** and other villages that only provided allowances at a certain periods of the year.

> "*Now there is PNPM Generasi which is very beneficial for pregnant mothers and those who have toddlers, and* ***posyandu cadre are also motivated*** *because there is allowance though it is small*" (Midwife-West Java).

Efforts to improve *posyandu* (including efforts by **PNPM Generasi**) were only conducted in some *posyandu* and could not fully solve the problems faced by *posyandu*. Some *posyandu* still did not have important equipment such as desks and chairs. In some control villages, *posyandu* activities still ran at cadres' house or village offices. In addition, the cadres' lack of knowledge presented an obstacle since the cadre training programs were not organized specifically or regularly. The limited support and attention from the village apparatus regarding activities at *posyandu* was still an issue in some sample villages, both treatment and control.

Similar to *posyandu*, the physical condition of some *polindes/poskesdes* and their equipment had been improved[5]. In the treatment village *polindes/poskesdes* construction or improvements and additional equipment were financed by **PNPM Generasi**, whereas in control villages these were funded by PNPM Mandiri Perdesaan (see table 8). However, the number of MCH facilities funded from **PNPM Generasi** tended to be greater than those funded by PNPM

[5]Prior to improvements, *polindes* in the sample villages were generally too small and some still had nonpermanent walls and roofs, thus were prone to leaking. During the survey, the construction of *posyandu* and *polindes* in some treatment villages were in the stage of completion or awaiting the official handover from program implementers to the community.

Mandiri Perdesaan. One of the *polindes* in a treatment village also received assistance in the form of electricity from the Village Allocation Fund (*Alokasi Dana Desa/ADD*), and a well from Plan International. In one of the control villages in NTT, a *polindes* also received equipment from the health district office including beds, medicine cabinets, tables and chairs, scales, and blood pressure measurement tools. There was a tendency in NTT for **PNPM Generasi** to focus more on building and providing equipment in *polindes* than in *posyandu*, whereas in West Java the reverse occurred. This happened because treatment villages in West Java generally had more adequate *polindes/poskesdes* to begin with. As efforts to improve the services of *polindes/poskesdes* were not comprehensive, some *polindes/poskesdes* still faced the same problems as in 2007, namely: the absence of midwives, the lack of available equipment, and especially in NTT, the difficulty in reaching remote hamlets.

Village midwives become the primary providers of antenatal and post-natal checks, childbirth, and immunization, as well as general health care providers for villagers. Similar to the conditions in 2007, all sample villages had a midwife, although not all midwives lived in the village. Compared to 2007, changes in service quality was influenced by whether the village midwives lived in or outside the village, the extent to which midwives owned adequate equipment, and the duration that the midwives had worked. In some treatment villages in West Java and NTT, midwifery services increased because the village midwives were no longer sourced from *puskesmas* and because the midwives now lived in the villages and did not frequently leave the *polindes* as they had in the past. Especially in West Java, there had been an increase in the types of services offered by midwifes due to the provision of additional equipment such as ultrasonography (USG) machines. **In NTT, village midwives' services in some treatment villages expanded to include pregnancy testing and the detection of fetal heart rates (doppler). These changes occured as a result of PNPM Generasi**.

Problems and barriers related to village midwives' services were higher in the sample villages in NTT. Midwife service limitations did not pose much of a problem to communities in sample villages in West Java due to the availability of midwives in private practices outside the village that were within easy reach. In remote areas of NTT where access was difficult (poor road conditions, minimal transportation facilities, and vast distances between hamlets), not all village midwives were willing to live in the villages, so *polindes* frequently did not operate. Other reasons for midwives choosing not to live in the villages included the fact that midwives' official houses were damaged, houses had no access to clean water and electricity, or because midwives did not want be away from family or had to take care of family members who lived in another village. The absence of midwives often resulted in mother's giving birth unassisted, especially at night or in times of emergency. Midwives who lived in the villages also often failed to provide optimal services at *polindes* due to the wide coverage area and sparse, widespread population which meant that *polinde*s had to be closed when the midwife visited remote populations. In addition, midwives had to leave the village if there were activities/meetings in *puskemas* or the district health office. Another obstacle involving the provision of MCH services was the limited supply of medication at polindes/poskesdes and the fact that services is still experienced difficulties in reaching some small communities that still believed in traditional customs, such as *sei/tatobi* (compression/smoke applied to the body) after giving birth or communities who regarded *dukun beranak* as more trustworthy than midwives or *puskesmas*.

Infrastructure and facilities in *puskesmas* accessed by communities in the sample villages had generally been improved, provided with new rooms, and received additional equipment. In one treatment *kecamatan*, *puskemas* occupied a new building which was more spacious and well-equipped than prevously. This improvement was fully funded by the central government

under the *DAK* (Specific Allocation Fund) and the APBD (local government budget). Nevertheless, for communities in some samples villages in NTT the existence of *puskesmas* did not have a significant effect on MCH and were not accessible to many residents due to remoteness and limited means of transportation. In West Java and in relatively non-isolated areas in NTT, mothers experiencing complications during pregnancy or childbirth that could not be handled by village midwives or doctors/midwifes at *posyandu* were still able to access public hospitals located nearby in the capital district.

Specific Groups Unreached by MCH Services

In general, MCH service providers were able to reach almost all groups in the community, except for small groups of the population in NTT which were still difficult to access. The overall number of these populations tended to reduce since 2007. These groups included: (i) communities that lived far from the center of the settlement, and (ii) some households that still believed in traditional customs, such as *sei* and *tatobi*. In the baseline study, households (including children) that moved to farmlands during the harvest season were found to have not accessed MCH services, especially *posyandu*. In the impact study these groups were no longer identified as problematic as they generally returned to the village to attend the *posyandu*. **In addition, interventions such as the enforcement of fines and assistance from PNPM Generasi have encouraged the behavioral changes.**

Establishment of new *posyandu* or the addition of village midwives in every remote region (mainly in NTT) was constrained in terms of demand and availability. Constraints from the demand side were the number of MCH targets per region, ie the small number of pregnant women and children under five years old were too few (in some cases less than 10 mothers/children). This was due to the pattern of settlements in rural areas in NTT which were scattered and far from the center of the village with some households even living on the slopes of mountains. The barriers related to availability included limited numbers of cadres and midwives who provided services at *posyandu*. Both of these factors were likely reasons explaining why assistance from PNPM Generasi was used more frequently for physical improvements of the existing *posyandu* rather than the establishment of new *posyandu* posts.

3.2.2 Availability of Traditional MCH Services (Dukun Beranak)

Dukun beranak services were still available in all sample villages. In one village in West Java, despite the fact that there were no longer *dukun beranak* in the village, women still accessed *dukun* in other villages. Training for *dukun beranak* was no longer provided by the health office since prior to 2007, both in West Java and NTT. The reason behind the termination of training was to avoid counterproductive efforts in improving midwife/medical services. As mentioned by a midwife coordinator in one of *puskesmas* in NTT *"The existence of training encourages dukun beranak to provide delivery service and further enhances community beliefs in dukun beranak because they can provide proof of training.*"

Compared to 2007, both in West Java and NTT, **the role of *dukun beranak* in assisting childbirth had decreased, whereas their services during pregnancy and postpartum were relatively unchanged.** In West Java there were decreases in the number and role of *dukun beranak* due to absence of regeneration, and *dukun beranak* were generally old and frail (see table. 9). The appeal from provincial government for women to not use *dukun beranak* without midwife supervision contributed to reducing the role of *dukun beranak*. This appeal often took the form of legal threats to *dukun beranak* if they assisted women with childbirth without the presence of a midwife. In NTT, the number of *dukun beranak* who were still providing services

remained relatively unchanged, except in one treatment village where the number decreased because one *dukun beranak* died. In most of the sample villages, *dukun beranak* still assisted in childbirth, although their role was gradually being replaced by village midwives.

Table 9. Number of *Dukun Beranak* in PNPM Generasi Treatment and Control Villages

Category	Village Name	Number of *Dukun Beranak*		Notes
		2007	2010	
West Java-Treatment	1. Nagarawangi	3	3	-
	2. Pamekaran	2	1	One *dukun* had died
	3. Buahdua	None	None	Access *dukun* from outside villages
	4. Bojongloa	4	2	Two *dukun* had died
West Java - Control	1. Sukaratu	1	1	Suffered from stroke
	2. Neglasari	3	2	One *dukun* had died
NTT-Treatment	1. Taunbaean	6	6	One *dukun* was untrained
	2. Hauteas	6	4	Two *dukun* had died
	3. Sekon	1	1	-
	4. Susulaku A	3	3	-
NTT-Control	1. Oenenu Induk	2	2	Both *dukun* did not provide services in the village, one was untrained
	2. Kuanek	3	3	Two *dukun* were untrained

Source : Summary of data from FGD

Subsidy funds provided by the PNMP Generasi to midwives for childbirth services contributed to the decline in the role of *dukun beranak*. *Dukun beranak* who were interviewed also stated that their role in assisting childbirth decreased following the implementation of **PNPM Generasi,** because there were no subsidy funds for delivery by *dukun beranak*. The decrease in the role of *dukun beranak* was also influenced by the application of sanctions by the village and district officials for mothers who give birth with the help of *dukun beranak*. These sanctions were intensified following the implementation of the Revolusi KIA (a program belonging to Provincial Government of NTT) and **PNPM Generasi**. Education on health issues provided by NGOs such as Plan International also played a role in raising community awareness of the risks of childbirth with a *dukun beranak*. A case of maternal mortality with a *dukun beranak* in a treatment village reduced the trust of some residents towards *dukun beranak* services.

> "*According to the program (PNPM) there should be no trained dukun assisting with birth, only midwives can help, there were no subsidy for the dukun beranak*" (*Dukun Beranak* -NTT).
>
> "*Anyone found to be still using dukun beranak will never received any health treatment from the midwife anymore. In addition, since the Revolusi KIA program, it has been made a village regulation* "(Village Midwife-NTT).

In all sample areas *dukun beranak* still provided services during pregnancy and after childbirth. During pregnancy *dukun beranak* gave massages to fix the location of the fetus and reduce maternal fatigue, whereas after birth *dukun beranak* took care of mothers and babies. *Dukun beranak* also helped to organize ceremonies during pregnancy and after childbirth. The demand for *dukun beranak* services continued because of traditional customs, comfort felt by the mother and her family, and because these services were not offered by midwives.

"*I am often called to massage the mothers and bathe the babies after giving birth. It has become a tradition for 40 days after delivery and has continued until now*" (*Dukun Beranak* -West Java).

"*Now they mostly use dukun beranak only for massage. At birth they must use the services of midwives and even during home births dukun beranak and midwives usually work together. But they still use the services of dukun beranak if the midwife is away* "(Village Head-NTT).

3.2.3 Community Involvement in Decision Making Concerning the MCH Services

Only small number of communities had been involved in making decisions about basic services at the village level (including MCH services). Others were not directly involved because they were too busy with their work and livelihoods. In NTT community involvement was also constrained by the distance to the meeting locations. **PNPM Generasi**, PNPM Mandiri Perdesaan, the Desa Siaga program and NGOs programs, which required community involvement in activities did increase community involvement in decision making about basic services at the village level, although most decisions were still made by village elites and program implementers. Different levels of education and economic status between village elites and ordinary citizens, especially in NTT, were suspected to be one cause underlying the dominant role of elites in decision-making.

In West Java, before **PNPM Generasi** was implemented, the Desa Siaga Program was implemented in both treatment and control villages. The Desa Siaga program focused on community participation in decision making and financing of health. One of the main achievements of the Desa Siaga program was increasing the role *posyandu* cadres. **PNPM Generasi** also required the involvement of communities in decision making related to MCH services, including via meetings at the hamlet level (*musdus*) which were then incorporated at village level meetings (*musdes*). In the control villages PNPM Mandiri Perdesaan utilized community meetings/discussions between villages in its process of determining activities.

In NTT, the implementation of **PNPM Generasi** was supported by the Revolusi KIA program that began in mid-2009 and encouraged community involvement in agreeing to the implementation of sanctions and fines for mothers who did not access *posyandu*. In two treatment villages, agreement and implementation of sanctions were formulated in the *Musrenbang* forum and in the process of making *perdes* (village law). Similar conditions took place in two control villages, but more significant roles in decision making were still limited to village officials and midwives.

> "*.... There is a consensus that pregnant women should have checkups every month and children under five have to go to posyandu. If they do not participate, then what they are entitled to through PNPM GSC program will not be granted and when they are due to deliver, childbirth will not be attended by a midwife*." (Village Head-NTT).

PNPM Generasi specifically requires the involvement of women in the formulation of its activities. Both in West Java and NTT, women were formally represented in decision-making programs. Discussions are held exclusively for women for the purpose of capturing women's ideas. However, when men and women participated together in a village meeting (*Musdes*), men still did most of the talking, a condition made possible as generally the village elite were men.

3.3 Utilization of MCH Services

In general, the study found an increased utilization of MCH services in both treatment and control villages. **Increased utilization was generally higher in the treatment villages as PNPM Generasi provided various assistance and incentives.**

However, there were a number of other obstacles to increasing the use of MCH services which were unresolved by **PNPM Generasi** or by other government and non-government programs. Constraints were mostly associated with the limited number of MCH services, geographical conditions, reliance on *dukun beranak,* economic issues, and mothers' psychological problems.

3.3.1 Changes in the Utilization of MCH Services

MCH services accessed by the community included antenatal care, childbirth services, postpartum examinations, immunizations, weighing, and treatment of malnutrition of infants and toddlers. For antenatal care and post delivery, communities accessed both midwife and *dukun beranak* services, as these roles were complementary. For childbirth most women accessed the midwives' services, whereas the role of *dukun beranak* was limited to assisting midwives. Midwife services were obtained in *polindes/poskesdes, posyandu* or at private practices. Immunization and weight measuring services were obtained in *posyandu* from a midwife and *posyandu* cadres.

In the sample villages in West Java, all the under five children were immunized and weighed regularly in the *posyandu* and almost all pregnant women and postpartum mothers visited a midwife and obtained medical help at the time of delivery. As the utilization of MCH services had been high since 2007, the increase in MCH service utilization in West Java was not too visible, **however the increasing utilization of MCH service was higher in the PNPM Generasi treatment villages compared to the control villages**. PMT and better *posyandu* facilities from PNPM Generasi motivated mothers to visit *posyandu* more routinely.

> "*The rapid increase and a strong motivation occurred in 2008 and 2009 in the presence of the supplementary feeding of PMT activities at posyandu funded by PNPM Generasi*" (Cadre-West Java).
>
> "*The participation of mothers and children increased since the incentive PMT from PNPM*" (Cadre-West Java).

In NTT, the increase in the utilization of MCH services was more noticeable especially considering the increasing number of mothers who give birth with assistance from a midwife compared to 2007. The intensity of the increase in the utilization of MCH services in NTT was different among sample villages depending on the availability and coverage of MCH services, especially village midwives, as well as other factors such as remoteness of the region and the existence of assistance from **PNPM Generasi**, PNPM Mandiri Perdesaan, and NGOs.

> "*Compared to 2007, more babies and toddlers came to posyandu. In 2007 the participation rate was about 80% while in 2010 it rose to 95% of the total of children aged under five years. The remaining 5% that did not routinely visit the posyandu were mothers of babies or toddlers from remote hamlets or those who had gone to the farmlands*" (Village Midwife-NTT).

PNPM Generasi contributed to improving the utilization of MCH services both at *posyandu* and midwives in *polindes/poskesdes*. The contributions of PNPM Generasi to the improvement of *posyandu* utilization was through the distribution of PMT and, specifically in NTT, the transport allowance for mothers to access *posyandu*. In some treatment

villages, PMT was only provided to malnourished children, whereas in other villages it was given to all infants in *posyandu*. PMT was generally managed directly by the program implementers at the village level which included *posyandu* cadres. In West Java PMT was generally provided in the form of biscuits and milk which amounted to Rp1,500 to 2,000 per child. In NTT it was provided in the form of a prepared meal consisting of rice and side dishes. The transport allowance for mothers to access *posyandu* was provided in only one village in NTT and amounted to Rp10,000 for 12 visits for mothers from the remote hamlets.

> "*.... There was also a contribution from PNPM Generasi and PKH because if (they) were not present at the posyandu there was a fear that assistance would be terminated* "(Posyandu Cadre-West Java).
>
> "*..... If there is supplementary food (PMT) more are present. If not, only few have come* "(Posyandu Cadre-NTT).

PNPM Generasi contributed to the increased utilization of midwives' services via subsidized childbirth expenses, and transport allowances for checkups during pregnancy and postpartum. The amount of subsidies provided for childbirth expenses reached Rp200,000 in West Java and between Rp200,000 - 250,000 in NTT. Subsidies in West Java, covered approximately 30-60% of the cost of giving birth with assistance from a midwife, while in NTT the subsidy could cover the entire cost of giving birth with assistance from a midwife (see table 10). Women also received Rp25,000 in transport allowances for examinations four times during pregnancy and twice following childbirth.

> "*Since PNPM GSC women no longer used trained dukun beranak, because they were not paid for by the program" "Only those who gave birth with assistance from midwives were paid*" (FGD Mother-NTT).
>
> "*Prior to 2007, midwives and dukun beranak worked together, then the program PNPM only paid the midwives, so we only went came to a midwife, we no longer accessed dukun beranak.*" (FGD Mother-NTT).
>
> "*If they did not receive PNPM there was a chance they would give birth assisted only by their husband*" (PHC-NTT).

Tabel 10. Delivery Cost and PNPM Generasi Subsidies

Province	Delivery cost for midwives	Subidy of Delivery Costs from PNPM Generasi	% subsidy
West Java	Rp400,000-Rp700,000	Rp200,000	30-60%
NTT	Rp150,000-Rp250,000	Rp200,000-250,000	100%

Source: Recapitulation from FGD

Other factors that encouraged the increased utilization of MCH services were the increased community awareness and the existence of programs related to MCH such as the Desa Siaga program, in West Java, the PMT assistance from WFP and the implementation of fines and the penalty of not receiving assistance if children did not routinely visit the *posyandu* or childbirth assisted by *dukun beranak* in NTT. In control villages, in addition to the improvement of health facilities funded by PNPM Mandiri Perdesaan, another driving factor, especially in NTT, was PMT assistance and education regarding MCH from CARE and WVI, and fines for mothers who did not attend *posyandu*.

> "*In addition, there is also the rule if they are not present at posyandu activities they will be subject to a fine of Rp5,000* "(*Posyandu* Cadre-NTT).

3.3.2 Reasons for Choosing Modern and Traditional MCH Services and Barriers to Accessing MCH Services

Communities chose modern MCH services, especially midwives, both in treatment and control villages, because of the assurance of the mother's safety as midwives were supported with expertise, medicines, and medical equipment. Midwives could also provide referrals to hospitals in emergency situations involving pregnant women or childbirth. In addition, midwives provided birth certificates as an additional service included in the cost of delivery.

Conversely, the reason why some people continued to utilize *dukun beranak* services especially during childbirth, was because midwives were inaccessible, *dukun beranak* were cheaper or closer, cultural and belief factors, and reasons of emotional closeness (peace of mind) associated with *dukun beranak*. Especially in NTT, both in treatment and control villages, difficulties in accessing midwives were mainly due to the long distances from services, poor road conditions, difficult passes during the rainy season, and a lack of transportation. In addition, midwives were often not in place because they did not live in villages or because they had to cover an extensive area. Other remaining barriers in both West Java and NTT were the trust and closeness associated with *dukun beranak,* the shame of having many children or being pregnant out of wedlock, and specifically in NTT, women's shame of showing genitals to the midwife. In the control villages, both in West Java and NTT, access to midwives was constrained by the high cost of childbirth services provided by midwives. **In the treatment villages, both in West Java and NTT, the economic barriers of poor families in obtaining midwife services were partially alleviated by funds from PNPM Generasi subsidy paid directly to the village midwife by program implementers.**

> "*If the government wants all pregnant women to give birth in a neighborhood health center, with a midwife, or in a health center, first they must lower the cost*" (*Posyandu* Cadre-West Java).
>
> "*Because she was due to give birth and there were no midwives, we were forced to call the dukun beranak*" (FGD Male-NTT).

The main reason women accessed *dukun beranak* during pregnancy was because they believed that *dukun beranak* had expertise in determining the age of the fetus and adjusting the location of the baby. For postpartum care, the role of *dukun beranak* was to help mothers in taking care of themselves and their babies as well as providing massage services and prayers to provide a sense of security for the mother.

> "*Since the time of our ancestors we used a dukun beranak, so this has become a habit*" (FGD Male-NTT).
>
> "*... this is our tradition from a long time ago so we can't change it. We were once born with the assistance of a dukun beranak and we are still living healthy today*"(Community Leaders-NTT).

In relation to the constraints on *posyandu* utilization, 1-2 cases of under five children who were not fully immunized were found in some of the sample villages. The reason for this was that parents feared that their children would experience fever. Likewise, a small proportion of mothers had not routinely taken their babies for weighing at the *posyandu* because of children's' illnesses, boredom with *posyandu* activities, a failure of their children to gain weight, or personal reasons such as a death or illness in the family. In addition, mothers with 2-3 children, especially in NTT, faced difficulties in bringing all their children to *posyandu*. In all sample villages in West Java, the distance to a *posyandu* and *polindes/poskesdes* and the burden of domestic and paid work were no longer barriers to pregnant women and children accessing MCH services. Conversely, in some sample villages in NTT the burden of domestic work still posed a barrier to some mothers visiting *posyandu* regularly. The culture of *se'i*, which requires

mothers and their babies to stay home in the 40-days following childbirth also presented a barrier to them accessing *posyandu* and midwifery services.

> "*.... their reluctance to come to posyandu was because the services provided at posyandu were always the same, besides the weight of their children was not increasing so why come to the posyandu ...* "(*Posyandu* Cadre -West Java).
>
> "*Domestic work is mandatory, but attending the posyandu is also mandatory, one does not inhibit the other*" (FGD Female-West Java).
>
> "*The main point is that we know that every 15th we go there (posyandu), if my child's weight increases I smile, if it does not increase I am grim* " (FGD Female-NTT).
>
> "*.. There are women who due to the close interval between births experience a little trouble taking care of their children .... sometimes they are late in attending the posyandu, but they still always come* "(FGD Male-NTT).
>
> "*... We all grew up practicing the sei and this tatobi ....*" (FGD Male-NTT).

3.3.3 Actors that Influence the Utilization of MCH Services

The actors who influenced the utilization of MCH services, both in treatment and control villages were village officials, village midwives, *posyandu* cadres, and neighbors. In NTT religious leaders and NGO staff (CWS, WVI, WFP and Plan) were also influential. There was no significant change in these actors compared to 2007. The role of village officials (village chief, hamlet chief, the RT/RW) who were mostly men was generally not to engage directly with MCH services. Rather, their role was to monitor and remind the mothers to come to the *posyandu* or occasionally to visit the *posyandu*, and in West Java, to collect mothers and toddlers who had failed to attend the *posyandu*. In NTT village officials were directly involved in creating village policy (*perdes*) regarding penalties for mothers who did not use the service of midwives or attend the *posyandu*. Religious leaders reminded mothers about *posyandu* schedules during church gatherings at the church. NGOs did not only provide in kind assistance, but also provided education and awareness about the importance of MCH services. **PNPM Generasi did not generate additional actors to influence the utilization of MCH services at the village level** as the program implementers were generally *posyandu* cadres and local community leaders who had previously been involved in influencing the utilization of MCH services.

Table 11. Actors that Motivated the Utilization of MCH Services at PNPM Generasi Treatment and Control Villages

Category	Village Name	Actors at the Village Level
West Java-Treatment	Nagarawangi	*Puskesmas* head, cadres, village officials
	Pamekaran	Cadres, midwives, village officials
	Buahdua	Cadres, midwives, *puskesmas* staff, , village officials (RT, RW), neighbours/friends
	Bojongloa	Midwives, cadres, neighbours
West Java-Control	Sukaratu	Cadres, women's groups (PKK), neighbours
	Neglasari	Midwives, cadres, village officials, women's groups (PKK)
NTT-Treatment	Taunbaean	Village officials, cadres, midwives, *puskesmas* staff, NGOs (Plan)
	Hauteas	Cadres, midwives, doctors, village officials (village head), neighbours
	Sekon	Village officials, cadres, midwives, *puskesmas* staff
	Susulaku A	Cadres, midwives, village officials, *puskesmas* staff, NGOs
NTT-Control	Oenenu Induk	Midwives, cadres, village officials (village head), churches, CARE and WVI, neighbours
	Kuanek	Cadres, midwives, WVI and CARE, village officials

Source: Summary of FGD data

At the household level, the decision to access *posyandu* services depended entirely on wives. The decision to access other MCH services generally resulted from the wife asking for her husband's permission, especially in relation to cost. Decisions and initiatives were more likely to have been initiated by wives in West Java, whereas in NTT decisions were more likely to involve consensus between husband and wife with consideration of the opinions of parents and other relatives. For example, among the Dawan ethnic group in NTT, there was a tradition for "Atoin Amaf" (maternal uncles) to play a central role in the decision making process within the household.

> "*The mother already has confidence to decide what is best for the health of herself and her babies, usually the fathers just agree* " (Posyandu Cadre-West Java).
>
> "*Wives tend to be afraid of their husbands ... for example when a child is suddenly ill at home and his or her father is in the fields, the mother would not dare to bring the child to the hospital or clinic without permission from the father* "(Village Head-NTT).

3.3.4 Changes in Women's and Men's Awareness of MCH Issues

In general most people's knowledge and awareness of the importance of MCH was improving. The existence of various forms of assistance and education on MCH from NGOs, PNPM Generasi and the Revolusi KIA program in NTT, and the Desa Siaga program and PNPM Generasi in West Java, have contributed to increased awareness of both women and men regarding MCH issues. Increases in awareness were also due to the increasing number of young mothers who were relatively more educated and had easier access to information about MCH via print and electronic media. Women tended to have higher levels of increased awareness compared to men as women were the direct targets of MCH programs, whereas fathers were more dominant as breadwinners.

> "*Awareness of the importance of health for women has existed for a long time,... Changes in the awareness of men have also occurred over a long time, they would take their children to immunization, they also now want to take birth control* ...." (Posyandu Cadre-West Java).
>
> "*There is PNPM so the community changed*" (Community Leaders-West Java).
>
> "*PNPM Generasi had a great influence on community behavior. Now if they are sick they go directly to a health center ";"This assistance made the community start to realize how to have a healthy life*." (FGD Male-NTT).
>
> "…*But not 100% of community awareness of health issues here is influenced by PNPM because there are also other programs such as those from Plan and the Health Office … There are also rules and policies in the village*." (Village Midwife-NTT)

Women's increasing awareness was indicated by the increasing regularity of mothers in attending the *posyandu*, pregnant women's decision to have checkups with midwives, and the increased knowledge of FGD participants regarding MCH. Indications of increased awareness were reflected in the reasons provided by FGD participants for utilizing the services of the village midwife, namely that midwives possess more comprehensive knowledge and tools that make them safer options than *dukun beranak*. The fear of reprisal from midwives if childbirth was assisted by *dukun beranak* was no longer a reason cited by many participants. However, there were still mothers with lower levels of awareness who felt it was more important to work in the fields, or who could not be bothered walking long distances to the *posyandu*, especially in some sample villages in NTT. The increased awareness of men could be seen from their moral support to wives in the form of reminding mothers of *posyandu* schedules, and sometimes accompanying their wives to the *polindes* or their children to the *posyandu*.

"...., *Mothers are more aware. Now the fathers encourage their wives to attend posyandu, previously they did not care* "(Community Leader-West Java).

Although FGD participants emphasized that access to MCH services would not be affected if the assistance was stopped, the key informants at village and district levels were still doubtful. They believed that people attended the *posyandu* primarily to obtain PMT and were assisted by a midwife during childbirth due to the subsidy allowance.

3.4 Availability of Basic Education

In general, the study found various improvements in the availability of basic education services in all sample areas with sources of funding from local and central governments or from NGOs. Improvements included the addition of one junior high school and improvements to infrastructure and facilities for teaching and learning activities at primary/junior high schools in the sample areas.

PNPM Generasi caused improvements in the treatment villages to generally be more substantial than in the control villages. Most of the changes in the availability of basic education due to **PNPM Generasi** were in the form of additional furniture in classrooms, however one school experienced the addition of classrooms.

Yet, despite all changes in availability that occurred since 2007, not all obstacles faced by schools had been fully addressed. These include the limited number and quality of teachers, the lack of infrastructure and learning facilities, declining support and participation of communities and parents following the BOS program, and specifically in NTT, geographical barriers and the unavailability of electricity and clean water in schools.

3.4.1 Conditions and Changes in the Availability of Basic Education

The number of primary schools (SDs) in the sample villages, both in West Java and NTT, had been sufficient since 2007. In every village there was at least one SD, and all available SDs were able to accommodate all students who registered. In NTT the availability of primary schools was assisted by the establishment of small SD or additional classrooms (*Tambahan Ruang Kelas/TRK*) which were part of an independent SDs in the same village. The establishment of TRK were initiated by communities, village officials, and schools in order to reach students who lived in remote areas. When the number of students was relatively sufficient and classes were available to the sixth grade, TRK increased their status by becoming independent SDs following approval from the District Education Office. Compared to 2007, there were no additional SD in sample villages, but one TRK became an independent SD in NTT.

The availability of junior high schools (SMP) differed between West Java and NTT. **In West Java, the availability of SMP were relatively adequate, their locations were quite evenly spread, and they were relatively easy to reach**. The existence of open junior high schools which provided free education, school equipment, and more flexible schedules increased the accessibility of educational services, particularly for the poor. **In contrast, in NTT the availability of SMP in some villages was still an issue due to the distance of SMP which were generally located in the capital of the *kecamatan*, and the high cost of transportation which only consisted of motorcycle taxis.** One of the efforts made to overcome these problems was the establishment of junior high schools under one roof (SATAP). The name 'one roof' referred to the fact that initially these schools were attached to, and used the space, facilities, and teachers of existing primary schools.

Table 12. The Number of SD and SMP Accessed at the Sample Villages

Category	Village Name	SD		SMP	
		Inside the vllage	Outside the village	Inside the vllage	Outside the village
West Java-PNPM Treatment	Nagarawangi	3	-	2	2
	Pamekaran	3	1	1	7
	Buahdua	3	1		5
	Bojongloa	2	1	-	5
West Java –PNPM Control	Sukaratu	3	1	-	4
	Neglasari	2	-	1	3
NTT-PNPM Treatment	Taunbaen	2	-	1 (satap)	-
	Hauteas	2	2	-	4
	Sekon	1	-	-	4 (1 Satap)
	Susulaku	1	-	-	4
NTT-PNPM Control	Oenenu	1	2	1	2
	Kuanek	1	2	-	3

Source: Summary of FGD data

Compared to 2007, there was one addition of SMP Satap in the control villages (SMP Satap Oenenu) which was established in 2008. The establishment of this Satap was motivated by the distance from this village to an SMP, poor road access, and the unavailability of public transport, which prompted many children to cease study or drop-out at junior high school level. The establishment of this SMP SATAP was entirely at the initiative of the community with the help of local government. Rooms for this SMP were still composed of three unused rooms that belonged to the existing SD. However, the provision of one SMP (SATAP) in every village in NTT was constrained by the relatively small number of junior high schools students per village and limited infrastructure, facilities and teachers.

Non-formal education providing an equivalent level of education to SD (*Kejar Packet A),* SMP (*Kejar Paket B),* and SMA (*Kejar Paket C)* were not available in all sample villages. These services were generally only located in the *kecamatan* capital. Participants in this form of education were generally not school aged children but rather village or *kecamatan* officials who required a higher school diploma for certain work positions. In West Java almost every village had access to a form of religious non-formal education called *Madrasa Diniyah* (MD). MD were generally accessed by primary and junior secondary students after school hours. In addition, all treatment and control villages in West Java and NTT had access to early childhood education (PAUD) located at the *posyandu* or adjacent to the SD.

The availability of teachers in all sample schools was relatively unchanged. Nevertheless, the level of teacher education had increased mainly as a result of the teacher certification program. In West Java, the majority of primary school teachers held a minimum of a graduates diploma (D2) while many if the junior high school teachers held a graduate degree (S1). The status of most teachers in West Java was as civil servants, with only 1-3 teachers in each school employed as contract teachers. In NTT there were many primary and junior high school teachers who had only graduated from senior high school (SMA) and at some schools there were still many contract teachers. **In two treatment villages in NTT, PNPM Generasi contributed to the availability of teachers via the allocation of funds for the payment of contract teachers at SMP.**

Although there had been only one additional SMP since 2007, in most existing SD and SMP there had been improvements in infrastructure and additional school facilities, both in the treatment and control villages. Improved infrastructure included additions or renovations to classrooms, libraries, laboratories, school fences, school health rooms (UKS) and school toilets (see appendix 4). Infrastructure development was mostly funded by the district budget (APBD), the specific allocation fund (DAK), and, particularly in NTT, also by the Dutch Grants (DBEP) and the NGO Plan International.
The allocation of PNPM Generasi funds for school infrastructure development was only found in one SD in a sample village in NTT, namely for the construction of two classrooms in 2009. **In addition, in one village in West Java PNPM Generasi, improved the road** (alley) to the school. In this village two alleys to the school were cemented with funds from the PNPN Generasi 2009. Previously the roads had been very muddy and slippery when it rained.

Improvements in school facilities included additional text books and reading materials, furniture, teaching aids, laboratory equipment, sports and art equipment, computers and audio visual equipment, as well as clean water facilities (see attachment 5). The sources of funding for improvements to school facilities included the BOS program (both national and provincial), Decontration funds (managed by provincial governments), specific allocation funds (DAK), **PNPM Generasi,** and, especially in NTT, funds from Plan International and the Dutch Grants. Nevertheless, additional high-tech facilities such as CD players or audiovisual equipment, were not optimal in most schools due to a lack of teacher expertise. In some schools in NTT, the use of electric-powered facilities, such as computers, laptops, and musical instruments were constrained due to a lack of electricity.

Contributions of PNPM Generasi to improving school facilities were almost entirely in the form of furniture, especially student chairs and tables in classes. Furniture was regarded as the most necessary facility required in primary and junior high schools so many parents and schools proposed that its procurement be funded by **PNPM Generasi**. The study only found one sample school in NTT where **PNPM Generasi** also allocated funds for other facilities, namely reading books for primary school students. These reading books were provided to fill the newly built library which was funded by a Dutch Grant in 2009. "*Since the school was established, just this year we have a library complete with books, book shelves, chairs, and desks*" (Teacher SD-NTT).

3.4.2 Barriers to the Provision of Basic Education Services

Improved infrastructure and school facilities did not solve all the problems faced by schools. The limited allocation of improvement funds received by each school caused some schools to continue to face the same problems as in 2007. Schools (especially in NTT) faced obstacles including geographical remoteness, the lack of basic infrastructure, and low socio-economic conditions of communities in which the schools were situated.

In West Java, both in treatment and control villages, the obstacles faced by primary and junior high schools generally related to **the lack of supporting facilities such as school textbooks, reading books, supporting facilities for extra-curricular lessons, and, especially for junior high school, limited computer and multimedia equipment**. In addition, schools also faced the problem of low participation of parents in school funding as a result of the public opinion that the BOS program had replaced funding for entire schools' expenditure.
In NTT, the obstacles faced by primary and secondary schools were related to teachers, a lack of school infrastructure and supporting facilities, and the large geographical area serviced by

schools. Problems related to teachers included a lack of teachers, low levels of education and training for teachers, and teachers who were often late to class. The main reasons behind teacher lateness were that teachers' houses were too distant from schools, public transportation was limited, and the fact that many teachers were busy continuing their studies at college. Schools also complained about the lack of textbooks which meant that one book had to be shared between five students. Some secondary schools (especially in the control region) also still lacked tables and chairs. Two SMP samples still lacked rooms as they had to share space with other schools. One SMP had to share with an SD, while the other SMP had to share with an SMK (senior vocational school).

> "*The distribution of teachers here is unequal. In the city, civil servant teachers are plentiful, one study group is taught by 7-8 teachers based on the fields of study. While here we cannot even have one teacher for one class* "(Teacher SD-NTT).

Access to schools also remained a problem in some villages in NTT. Even though SD were available in every village, the large areas serviced by schools caused difficulties for poor communities living in remote areas and away from public housing to access the nearest available SD. SMP which were generally located in the central *kecamatan* district were difficult to access by students who lived in rural and remote hamlets. In some SMP there were dormitories with very minimal amenities and limited capacities available at a monthly fee which was burdensome for some parents. Some parents overcame problems of distance by sending their children to live with a relative closer to the nearest secondary school. In one village, an open SMP had been established in 2006, however it failed because there were no available teachers and facilities were inadequate. This school only lasted for a year. The establishment of (open) SMP in each village were also hindered by the small number of junior high school-aged children per village, as a result of low population levels scattered over large rural areas.

Other barriers which affected the availability of adequate educational services both in West Java and NTT were the delays of BOS fund disbursement. The BOS program was important as a major source of school financing. School principals complained about delays in BOS funds when they had to pay for school operations. On many occasions the headmaster in one sample school had to use the school's petty cash or students' savings to temporarily settle school operational costs, whilst waiting the disbursement of BOS funds. In addition to the delay problem, the tight regulation of BOS usage also presented difficulties for schools in allocating the BOS funds.

In both West Java and NTT, PNPM Generasi did little to solve the problem of limited school infrastructure and supporting facilities except for furniture (tables and chairs in the classroom). This occurred as the PNPM Generasi funds in sample villages were more focused on direct assistance to students.

3.4.3 The Role of School Committees Regarding Basic Education Services

In general, the activity level of committees depended heavily on the individual capacities of the committee's chairperson and the school principal as well as the economic and social conditions of the community in which the school was located. In West Java, in both treatment and control villages, the committees were generally less active. The committees generally functioned as merely a liaison between parents and schools and only attended the regular meetings held by the school. "*They only come to school, If there is an invitation*," (school principal-West Java). However, the committee of one sample SMP was

very active due to an active chairperson. The committee at this school made proposals to the District Education Office for additional classrooms and improved sports facilities in schools. The committee was also involved in financing a student try-out (preparation for the national exams).

In NTT school committees generally played a role in overseeing student attendance at schools and in school development projects. One of the sample SD in a control village had received an award for the best district committee, because the committee had been considered successful in improving the quality of schools and overseeing student attendance. Committees in some schools had also partnered with NGOs to establish facilities in schools, such as dormitories and school halls. However, as noted previously, the activity level of committees was very dependent upon individual committee chairs. In one sample SD in NTT the committee did not function at all due to an inactive chairperson. This inactive committee received complaints from the principal and the teachers. "*They never even visited the school to meet us, let alone tried to monitor absent students"* said of the primary school teachers.

The role of school committees in PNPM Generasi in NTT was actively voicing the school needs to receive funding from PNPM Generasi. **PNPM Generasi** also provided a motivating reason for village officials, communities, and committees to encourage student attendance at school by intensifying the re-enforcement of sanctions for absent pupils. These actors reasoned that if the school received assistance from **PNPM Generasi**, there were no reasons for students to be absent except for illness or if the school had otherwise granted permission for non-attendance. The intensification of sanctions involved increasing fines and strengthening the legal basis of sanctions via the drafting of village regulations (perdes). In contrast, in West Java, due to committee chairs' busy schedules, committees' roles in the implementation of the **PNPM Generasi** were limited to during distributing assistance. According to some committee chairs, the management of PNPM Generasi was implemented entirely by program implementers and village officials, while schools and committees' involvement was limited.

3.5 Utilization of Basic Education

Overall, the study found an increase in the level of school attendance rates of primary and junior high school students, community participation, and the level of parental awareness of the importance of education in all sample villages. **The study also found that the increased utilization was generally higher in PNPM Generasi treatment villages.** Nevertheless, there were still some obstacles to improving the utilization of basic education services that had not been fully resolved either by government (including PNPM Generasi) or non-government programs. Constraints were generally associated with costs, geographical conditions, problems related to individual children, and the lack of parental and other actors' involvement.

3.5.1 Changes in the Participation Rates of Primary and Junior High School-Aged Children

In general the participation rates of primary school-aged children had been high since 2007, and the junior high school aged children's participation rates had increased in all sample villages. **In West Java, in both treatment and control villages, the reason for the increased attendance levels of junior high school aged children was that both parents and children desired that the children obtain a job that required a junior high school certificate.** For example, two years ago migrant workers (TKW/TKI) only required primary

school education, however now they are required to have graduated from junior high school. The existence of an open SMP also increased the participation rates of children from poor families because, in addition to it being free of charge, students at this school also received assistance in the form of stationery and uniforms. Furthermore school attendance hours were fewer and scheduled in the afternoon and evening, which allowed children to work or assist prior to attending school each day.

> "*The reason for choosing the Open SMP, were because everything was free including the uniforms and school equipment* "(FGD Male-NTT).
>
> "*Most of the students in Open SMP are those from very poor households* " (FGD Male-NTT).

In NTT, in addition to increases in the enrollment rates of junior high school-aged children, primary school dropout rates declined. One cause of this decline in school dropout rates was the existence of early childhood education (PAUD) attached to primary school locations. **The utilization of PAUD could have helped to improve the quality of primary school pupils. One of the main reasons students dropped out was because they could not read and write, and were subsequently asked to repeat lower grades several times before eventually dropping out of school.** "*With PAUD, children became accustomed to their teachers, were familiar with the classroom earlier, were already familiar with the learning environment, and in particular, had learnt to recognize letters and numbers from an early age* "(Primary Principal NTT).

Similarly to West Java, increased participation rates in SMP in NTT was also driven by the increasing educational requirements for employment. Professions requiring junior high school certificates included heads of the villages/hamlets/RT/ RW, factory workers, and even drivers. Increased participation in junior high schools was also triggered by the presence of a new junior high school. In one control village school participation increased dramatically after an SMP Satap had been built in this village in 2008. Previously, the location SMP was too far away and could only be accessed by people who were relatively rich. Various tutoring programs and assistance provided by World Vision International (WVI) and Plan International also affected the attitudes the awareness of parents regarding the importance of school. In the two control villages WVI provided assistance to households (students) in the form of school fees, uniforms, books, and other school equipment. In treatment villages, Plan International provided direct assistance to students in the form of uniforms and stationery in addition to assistance directly to schools in the form of infrastructure and facility upgrades.

Participation in primary schools

> "*To my knowledge, there are no primary school-age children who do not attend school, even before that age they are already in school, as there is PAUD.*" (FGD Male—West Java)

Participation in junior high schools

> *"... junior high school graduates can become cadre, village chiefs, or LKMD, even RT and RW need a school certificate*" (FGD Female-NTT).
>
> "*Now there is not work for junior high school graduates, let alone for those who only completed primary school*" (FGD Female-West Java).
>
> "*Parents tend to be embarrassed if their children do not go to junior high school*" (FGD father-West Java).
>
> "*In the year 2007 there were many (junior high school-aged children) who did not attend school due to costs because there were no Open SMP*". (FGD Female-West Java).

In both in West Java and NTT, parents generally did not differentiate between basic education for girls and boys. **Differential treatment did occur when children continued their**

education to high school or college level. Boys tended to gain priority because they were still regarded as the main source of support to their family following marriage. In addition, especially in NTT, there were strong patriarchal cultural beliefs that viewed men as the successor and protectors of their family's dignity and good name.

PNPM Generasi had prevented school dropouts and improved the students' motivation and diligence to school. This was possible because the assistance of **PNPM Generasi** (uniforms, stationery, tuition fee, transport and dormitory allowances) overcame some of parents' burdens for school expenditures. Direct assistance to students also reduced some students' sense of inferiority due to their lack of uniforms, shoes, and stationery.

> "*Children were so excited to go to school because their clothing was better and cleaner. They were more confident because their clothes were just as good as their friends so they were no longer teased by friends*" (FGD Female-NTT).
>
> "*We are pleased that all school children are now in uniform. Previously the school children were able to wear anything, so parents who could afford it dressed their children really nicely, but now they all wear the same uniform*" (FGD Male_ NTT).
>
> "*My son is now in the first grade of junior high school. I am very grateful that he receives transport allowances from PNPM*" (FGD Female-NTT).

In sample villages, PNPM Generasi assistance was only allocated to children who were enrolled at schools. The study did not find evidence of allocations for school-aged children who were not enrolled or had dropped out of primary/junior high school in order to entice them back to school. It was suspected that this occurred because program implementers and village officials believed that **PNPM Generasi** assistance for education was only intended for students currently are enrolled at school. When data were collected at the beginning of the program, the data regarding the number of target beneficiaries for each village was based upon the number of students who attended school, not the number of school-aged children in the village.[6] In addition, parents whose children dropped out of school were generally from very poor households whose voices were not represented in discussions determining the type of assistance from **PNPM Generasi**.

> "*Because PNPM-GSC is not focused on the community, but rather on school children, pregnant women and children under five years old*" (TPK-NTT).
>
> *"Children who were absent or dropped out of school did not receive assistance, but in 2009 there were no dropouts'* (FDMale-NTT)
>
> "*Initial data was based on the number of students as determined by school principals*" (TPK-NTT).

3.5.2 Barriers to the Utilization of Basic Education Services

Barriers to parents sending their children to primary school were relatively few compared to junior high school. This was because the locations of SD were easily accessible and the school fees that parents be paid were relatively cheap. At the junior high school level, the reasons that parents did not enroll their children, or that children dropped out of school were generally the same as in 2007. These reasons included economic problems, children's delinquency or lack of motivation, and, in NTT, because of the distance and difficulty in accessing schools. Compared to 2007, economic constraints and school access due to distance remained similar whereas the delinquency and lack of motivation of children tended to increase due to the negative influences of environments and technological developments.

[6]Even though in 2008, program implementers at the village level were instructed to identify primary/junior high school aged children who did not enroll or almost dropped out.

In West Java, economic problems were the main reason that parents did not register their children at school. Economic reasons included the cost of transport and children's pocket money, school related expenses, and household economic necessities. Pocket money, and transportation costs for school children were typical costs covered by parents. Many parents complained that their children did not want to go to school if they were not given pocket money. The amount of school expenses that parents had to pay differed across schools. Expenses included textbooks, student worksheets, photocopies, field trips, and various extracurricular activities (see table 13). **Although primary and junior high school students in the treatment villages received various kinds of assistance from PNPM Generasi, the amount and types of assistance were inadequate to cover all school related expenses that parents were required to pay**. In addition, limited household incomes necessitated that some children work to support households. Consequently, some of the children who were enrolled in school also worked after school to assist their parents to earn money . This situation often resulted in school dropout. In the sample villages many parents took their primary or junior secondary school-aged children to work in Jakarta, hence local village officials were unaware of these children's educational status.

Table 13. Illustration of the Type and Amount of School Related Expenses (SMP)

Type of Expenses	SMP (PNPM Generasi Treatment)	SMP (PNPM Generasi Control)
Registration Fee	Rp 30.000	
Uniforms (National, *batik*, sport, school attribute)	Rp 75.000	Rp112.000
Books/Student worksheets/Photocopies	Rp 76.000	Rp1.000/rented book
Tests/Final Examinations		Rp 500/test
Sports		Rp11.000-15.000
Class Petty Cash		Rp2.000/month
Farewell Fee		Rp15.000
Charity (Mosque, Festivites etc)	Rp2.000/month	
Pocket money/transport		Rp4.000/day

Note: * This table is only an ilustration, the type of expenses that were mentioned by FGD participants is not complete
Source: Summary of FGD data

Other reasons for student dropout, especially for girls, were marriage, or parents forcing them to get married, or pregnancy out of wedlock. In addition to the shame experienced by girls due to pregnancy, schools did not allow students who were pregnant or married to continue their studies. For boys reasons included a lack of motivation and delinquency, especially due to negative environmental influences and the lack of parental supervision. In some villages many parents migrated to Jakarta or became TKI/TKW and thus entrusted their children to grandmothers or other relatives. This resulted in the child's schooling receiving less attention. In one sample village, up to 30% of students had absent parents. The headmaster and teachers complained that students who were left by their parents lacked motivation in learning, tended to be more mischievous, were often absent, and had to repeat the same classes or even drop out of school.

In NTT the main reasons that parents did not register their children in junior high school, both in treatment and control villages, **were school expenses**. These included the costs of photocopying textbooks, transportation, and dormitories. The assistance provided from

PNPM **Generasi and Plan International (in three treatment villages) and assistance from WVI and PNPM Mandiri Perdesaan in control villages did reduce the financial burden of children's education on parents. However it was not sufficient to fully overcome the economic barriers.** Other obstacles that prevented parents from registering their children in secondary schools were the **accessibility of SMP**. In three treatment villages and one control village there were no secondary schools in the villages so students had to board in dormitories or walk long distances to school. Facilities and supervision in the dormitories were limited and student tiredness was also a cause of school dropout. Additionally, **the transition from a rural culture to an urban culture** that occurred in both treatment and control villages had a negative influence on the children's motivation to study in school. Some children (especially boys) chose to become motorcycle taxi drivers or a bus conductors in order to earn money and buy consumer goods such as mobile phones or DVD players. **Many parents expressed the view that the decision to attend school or not was the decision of the child themselves**, and if the child decided to quit school, sometimes parents could not prevent it.

Economic Barriers

> "*School means additional pocket money expenses and transport expenses for parents to their children*" (FGD Male-West Java).
>
> "*I prefer school in the old days, books were free. Why do we now have to buy them? The subjects also keep changing as well as the books* " (FGD Male-West Java).
>
> "*My children work after school, they help in the furniture workshop. In a week they can earn up to Rp50 thousand*". "*My son works as ojek driver after school for his extra pocket money*" (FGD Female-West Java).

Childhood delinquency

> "*The computer screens in the multimedia lab are scribbled with markers. Computer tables have been rocked back and forth. Finally, the monitor was broken. We also built a high wall that was meant to prevent students from running away* "(Head of School-West Java).
>
> "*If they do not go to school, boys generally play, supervise grazing goats, or collect some grass*" (FGD Male-WestJava).
>
> "*But if the child does not want to go to school, we cannot force them* " (FGD Female-NTT).

PNPM Generation assistance Helped to ease the economic burden

> "*Suddenly I was going to have to sell chickens to buy school uniforms for my child, but it didn't happen because we got school uniforms from PNPM*" (FGD Male-NTT).
>
> "*If there are students who have not paid the school fees, this will be covered by PNPM Generasi funds*" (Committee of BC-NTT).
>
> *"My son is now in the first grade of junior high school. We get transport allowances from PNPM, I feel grateful, but even if PNPM no longer existed my children's schooling must continue ....* "(FGD Mother-NTT).

School Registration Fees Still Hamper Access to School

In one village in NTT, a group of children from minority families were forced to enroll their children in school which was 3 km from their residence. This occurred because they were unable to pay the registration fee of Rp80,000 for one of the nearest public primary schools (SDN). Another school, which was not too far from that SDN, was also inaccessible because it did provide the religious teachings of these minority family groups. Therefore, they were forced to choose another SDN located 3 km from their house because of cheaper registration fee of Rp25,000 and the provision of appropriate religious lessons. There were no risks posed by choosing a school with a cheaper registration fee. However, the distance that must be travelled every day over steep and poor quality roads with no means of transportation, could pose risks to children's punctuality, energy levels, and safety. Compare this risk with the extra cost of only Rp 55,000 required to register at the nearest public primary school.

3.5.3 Changes in the Levels of Absenteeism and Reasons for Students Absence

Compared to 2007, the overall levels of student absence from primary and junior high schools in all sample villages in West Java and NTT had declined. However, there were 1-2 students who were absent for an average period of 1-3 days in one school semester. **In West Java the decreased absenteeism, both at primary and junior high schools, was driven by the increasingly strict rules of the schools, increased monitoring of schools and parents, and improved school facilities**. Some schools, for example, built a fence around the school so that students could not easily 'escape'. **In NTT in both treatment and control villages, reduced student absenteeism was also due to increased parental awareness of the importance of education which made them more concerned about their children's attendance at school**. Educational assistance and guidance provided by Plan International and WVI also helped to raise parents' awareness of the importance of children's education.

Assistance from PNPM Generasi contributed to the decreased absenteeism of students through two mechanisms: direct assistance to students and increased attention of village officials and communities to student attendance at schools. Direct assistance to students from the PNPN Generasi lowered the level of absence through:

- The provision of umbrellas and additional uniforms overcame some obstacles in rainy season which caused student absence in NTT.
- Transport allowances for poor students overcame barriers of transport costs, In NTT the transport allowance was not actually used for transportation because of the unavailability/infrequency of public transport, but it could motivate students to be more diligent in attending school.
- Uniforms, shoes, bags and stationery, increased students' spirit and motivation to go to school and reduced any sense of inferiority due to the lack of such goods.

As previously explained, **the existence of PNPM Generasi in NTT was a driving force behind village officials/*kecamatan* intensifying penalties for student absence.** Fines have existed for a long time, but they were intensified in conjunction with the implementation of PNPM **Generasi**. The fines charged for each day of absence differed between villages and fines for junior secondary school students were larger than those of primary schools (see table 14). Although penalties were considered effective in reducing the level of student absences, they also led to primary school students dropping out of school as fines did not solve the reasons for absence, namely the distance between student's homes and schools.

> "*My son has also been absent two times so I had to pay a fine equal to that of Mr Min, Rp 20,000*" (FGD Male—NTT).

Table 14. The Fines for Absent Students in PNPM Generasi Treatment Villages

Name of Village	SD/SMP	Fine	Policy Makers	Notes
Sekon	SD	Rp5,000/day or Rp25,000/three days in a row	Village, & Committee	Fine was increased in 2009, previoulsy Rp1.000
Taunbaen	SD	Rp5,000/day		
	SMP	Rp10,000/day	School & Parents	
Susulaku A	SD	Rp1,000/day		
	SMP	Rp2,000/day	School & Parents	
Hauteas	SD	Rp5,000/day	School	Fine was increased in 2010, previoulsy Rp1.000
	SMP	Rp10,000/day	Parents	

Although in general the level of absence has been declining, there were still primary and junior high school students who were absent. In West Java, the main cause was delinquency, lack of motivation, and bad environmental influences. Students who were absent generally told their parents that they were going to school, but on their way they stopped at a Playstation rental point or hung out in a kiosk with their friends. In addition, **some students were absent due to accompanying their parents to visit relatives** outside the village. As noted earlier, pocket money was an important motivating factor to students attending school. Therefore the absence of pocket money could cause them to 'strike' and not attend school. In some villages in West Java, junior high school student absence rates increased at harvest time because the students had to help their parents with the harvest or look after younger siblings at home when both parents were busy in the fields.

When Sanctions for Absence Became the Cause of Dropout

Implementing sanctions for the purpose of encouraging students to attend school became counterproductive. A situation experienced by a student at one of the sample areas in NTT provides some empirical evidence. The child's house was located in the foothills, 5 km from school. As a grade 2 primary school student, the child stayed in the house of a relative who lived not far from the school. The reason for her moving to the relatives house was to ensure that she would not be late or absent from school. However due to the child's age and her need for love and attention from parents, she was often absent and found to be living in her parents' home in the foothills. Over several months the parents became less concerned with their daughter's absence from school because of busy work on the farm. However, her parents were summoned by the school and village officials to account for their child's absence. According to the rules she and her family had to bear the penalty of IDR500,000 and a goat. Being obedient, the poor parents were willing to pay these penalties, yet they begged to be allowed to withdraw their child from school. Her parents said that if they let their daughter continues her study, they would not be able to ensure that their daughter attended school and therefore they decided it was better to withdraw her. The school and the village apparatus approved this request after all the fines been paid. The sanction of a fine didn't solve the real problem of distance to school.

"*.. If they are absent from school it is normally because they couldn't do their homework. They are afraid of their teacher because didn't do the homework* "(FGD Male-NTT).

"*They often just hang around playing PS(Play Station), so they forget to do homework* " (TeacherSMP-West Java).

"*.. As long as my children gets their pocket money they are diligent in attending school*" (FGD Female-West Java).

In NTT the main reason for student absence was fatigue as a result of walking long distances to school. Although SD already existed in each village, the fact that some villages had large populations spread sparsely over a wide area meant that schools may have been located as far as five kilometers from remote sections of villages Absenteeism also increased in the rainy season and on market days. The rainy season restricted school attendance because road conditions were muddy and the water levels in rivers increased and made it difficult to pass where there were no bridges. **On market days many students assisted their parents in the market or just went with friends rather than attending school**. Similarly, in West Java, **the main reasons for junior high school students' absence were a lack of motivation and delinquency caused mainly by the influence of bad environments**. Male students were absent more frequently than girls because boys tended to be less motivated and mischievous. Absences due to child delinquency increased in intensity compared to 2007 and had begun to worry parents in both treatment and control villages.

3.5.4 Actors Influencing the Utilization of Basic Education

At the household level in all sample villages in West Java, the decision to send children to school, and the choice of school was generally decided by agreement between husbands and wives. **Wives generally had more influence over non-financial decisions whereas husbands were more influential when financial decisions were required**. In addition, there was a tendency for the wishes of children to be included in decisions regarding the continuation of study school selection, especially at the junior high school level.

> "*... Her mother generally provides the motivation, because her father is rarely at home. He works outside*" (FGD Male-West Java).
>
> "*Obviously his mother, because mothers are more often at home so they know more about the children, whereas the father's job is to search for a living. Mothers are also the ones who help children with their homework. Fathers never do because in the evening they are tired after work*" (FGD Maler-West Java).
>
> "*Before (making a decision) we have to ask our children, would you like to continue studying?, Because if our children are willing, they will surely go to school, but if we force them, they will not attend, they will leave the house but they won't reach the school.* " (FGD Male-West Java).

Outside of the family, actors who played a role in encouraging households to send their children to school were village officials, teachers, principals and committees. The role of these actors was merely to advise and provide information to parents regarding sending their children to school. In addition, there was the role of neighbors, especially to warn parents if their children were not going to school or were truants. In treatment villages, PNPM **Generasi's program implementer also played a role in encouraging residents take advantage of basic education services**, such as through educating and motivating parents to pay attention to their children's education.

> "*There is a Kadus (hamlet head). Every two months he travels to the community to encourage residents to send their children to school*" (FGD Male-West Java).
>
> "... such *as PNPM explains that parents should send their children to school so that children are not illiterate* "(FGD Male-West Java).
>
> "*There was a neighbor talking to my child: "You should go to school, you can see that your parents are poor, who knows, maybe you will be more prosperous* " (FGD Male-West Java).

In NTT, at the household level both parents played a role in deciding upon their children's schools. However, it was not uncommon to consider the wishes of the children themselves. "*With Dad and Mom. But if the child does not want to go to school, we cannot force them* "(FGD Female-

NTT). In addition to the nuclear family, the decision to send children to school was also influenced by other, highly educated family members. They motivated parents and children and explained the benefits of education. They were also commonly used as an example for parents in motivating their children to attend school. Influential actors outside of the family included the head of the village who provided briefing during village meetings or meetings at schools. In the treatment villages agreements of village head regarding student absences provided strong evidence of the role that village officials played towards the utilization of educational services. Additionally, in two control villages WVI staff, in addition to providing assistance, also advocated the importance of education. Table 15 below describes the actors who promoted the utilization of educational services in all sample areas.

Table 15. List of Actors who Influnced the Utilization of Basic Education Services in PNPM Generasi Treatment and Control Villages

Category	Village Name	Name of Actors	
Treatment – West Java	**Nagarawangi**	-Hamlet head -Religious leader	-Teachers
	Pamekaran	-Community leader -School Committee	-Teachers
	Buahdua	-Village officials	-PNPM Generasi's implementer
	Bojongloa	-Village head -Community leaders	-Family/relatives
Control–West Java	**Sukaratu**	-Village head -Teachers	-School Committee -Family/neighbors
	Neglasari	- Village head - Teachers	- School committee
Treatment -NTT	**Taunbaean**	-Village Officials	-Religious leaders
	Hauteas	-*Kecamatan*	-Village officials
	Sekon	-Village head -*RT*	-Hamlet head. -Teachers
	Susulaku	-*Kecamatan* -Village head -School committee	-Community leader -Teacher -School principle
Control -NTT	**Oenenu**	-Village head -Religious leader -NGOs (CARE & WVI)	-Village head -*Kecamatan* -Teacher
	Kuanek	-Village head -Teacher -School Committee	-Between parents -NGOs (WVI) - PNPM Mandiri Perdesaan - *Kecamatan*

Source: Summary of FGD data

3.5.5 Changes in Parent's Awareness of Children's Education

In general, in West Java, awareness of the importance of education among parents was high. **Parents did not differentiate between the importance of education for girls and boys in primary and junior high school.** However some parents prioritized higher education for boys due to fund limitations.

> "*We must send (all) our children to junior high school, even if we have to borrow money... but for continuing to senior high school we prioritize boys over girls. I think boys will have more responsibilities, so they should not be like me who only have muscle as my capital, work is really tiring*"(FGD Male-West Java).

> "*The benefits (of education) for boys (are important) as they will be responsible for supporting their wives. Yet girls will be provided for by someone else(her huband)* "(FGD Female-West Java).

Similarly, in all sample areas in NTT parents' awareness of the importance of sending their children to school had increased compared to 2007. This increase was evident from the expressions FGD participants used to describe the benefits of children's education, for example: "*In order to get a certificate from primary to senior secondary school" "... so our children can go to college* " (FGD Femala -NTT) "*So they will be able to work in offices, companies or become migrant workers"* (FGD Male-NTT). Increased awareness was also evident from the statements that reflected the experiences of parents who lacked education: "*School is very important for our children. We've felt how difficult life is without education* " (FGD Female-NTT). **Increased awareness was influenced by the existence of educational programs such as PNPM Generasi in the treatment villages and WVI in treatment and control villages.** In in addition to providing material assistance, also provided awareness raising within communities regarding the importance of education.

IV KELUARGA HARAPAN (PKH)

4.1 Implementation of PKH

Of the 24 sample villages, **PKH** was implemented in eight villages. Six villages included in the study were delegated **PKH** treatment villages since 2007.The other two villages were delegated PNPM Generasi treatment villages that subsequently also received **PKH** meaning that these two villages received both PNPM Generasi and PKH. This study did not investigate the issue of **PKH** in depth in those two villages. Therefore the following discussion is derived from data collected on the six villages that were originally delegated as **PKH** treatment villages. Of the six **PKH** treatment villages, four were rural and the other two were urban.

At the community level, especially in West Java and in urban areas in NTT, the presence of **PKH** was not too well known. **Due to the small number of beneficiaries and the subsequent potential for jealousy and conflict to arise between beneficiaries and non-beneficiaries the program was implemented almost as if it were a secret**. Non-PKH beneficiary FGD participants in West Java and in urban areas in NTT generally gained awareness of the existence of **PKH** in their villages as a result of participating in the focus group.

> "*..Promotion of the program was conducted secretly so as to not cause conflict within community*" (PKH Facilitator -West Java).
>
> "*PKH beneficiaries were limited in number so facilitators asked beneficiaries to not inform their neighbors (of the program) because of fears that this would lead to jealousy*" (Head of PKH Group -West Java).
>
> "*Maybe it is there but it (has been operating) secretly, we have just discovered that there are households who received PKH. Why did they receive it while we didn't? Our level of welfare is the same, or even lower than them* "(FGD Female-NTT Urban).

The village/hamlet apparatus and MCH and basic education service providers tended to be dissatisfied with PKH because they were not involved. In five PKH treatment villages, all midwives interviewed complained that they were not involved in PKH. **One midwife did not even know about the existence of PKH in her village.**

> "*Fortunately, the PKH money was directly transferred to beneficiaries through the post office, so we can say that the village officials were not involved in PKH. It was via the village office so there could be conflicts in the community* "(Head of Village-West Java).
>
> "*The only people who know about PKH in this village are the beneficiaries because the implementation of the program is done secretly*" (Head of Village -NTT-Urban).
>
> "*There should be coordination with midwives regarding the issues of pregnant women in posyandu, but there was none*" (Midwife-NTT).
>
> "*... Is our only task to collect data? Even the district health office was not informed, how were we supposed to know* " (Midwife-NTT).

The number of PKH recipients in each of the sample villages were relatively small. In both West Java and NTT the urban recipients composed of only about 2% of total households. In the two villages in rural NTT the proportion was more significant at 25% and 33% of total households (see table 16). **In both in NTT and West Java, FGD participants and key informants complained about the existence of household economic conditions equal to or poorer than the PKH recipients who did not obtain PKH**

(undercoverage). There were also some recipients who were considered to be undeserving (miss targeting). Both beneficiary and non-beneficiary FGD participants and key informants claimed that they were unaware of how PKH recipients were selected.

Table 16. Number and Proportion of PKH Beneficiaries

Village Name	Number of Households	Number of PKH Beneficiaries	Proportion
West Java			
Gegesik Kulon	1.819	45	2%
Jagapura Kidul	2.612	57	2%
Mertasinga	2.000	25	1%
NTT			
Oenai	740	184	25%
Falas	576	191	33%
Fatufeto	935	22	2%

Source: Summary of village level data

PKH funds were mainly used for household daily consumables. If PKH funds were disbursed at the beginning of the new school year, then some of the funds were allocated to school expenses such as uniforms, shoes, bags, stationery, books, and tuition fees for junior high school children.

> "*But if the fund disbursement was far from the new school terms, the funds were usually spent on other household needs*" (Chairman of t PKH Group-West Java).
>
> "*There were even some beneficiaries who pawned their PKH card to borrow money for consumption, so when the funds were disbursed they were used directly to repay debt*" (PKH Facilitator-West Java).

Using PKH funds for MCH utilization was rare, almost non-existent because the timing of payments were often not at the same time as the funds were needed (for example during childbirth). Therefore mothers tended to ignore aspects of MCH despite receiving **PKH** funds for infants or pregnant women. Midwives who served the villages complained that of **the pregnant women who received PKH, most were not prepared for the cost of childbirth**. In addition, in one village the use of PKH for MCH was hampered due to the lack of a village midwife. In this village the majority of PKH recipients had no access to midwifery services for childbirth.

> "*Funds provided before delivery were gone. There were no more funds to give birth*" (Midwife-NTT).
>
> "*At the time of labor, mothers do not have anything because the money had been spent*" (Midwife-NTT).
>
> "*The PKH fund is not enough for health, just for education*" (FGD Female-NTT).

Many PKH recipients in NTT used the funds to buy assets in the form of livestock such as chickens, pigs, or even a cow. They reasoned that if the need for education or health expenditures arose, livestock could be sold. Whether this had occurred in practice could not be verified.

"*If the fund is enough, we can buy one pig at Rp150,000 in order for it to be sold again for the children's education*" (FGD Female-NTT).

"*The PKH assistance is targeted correctly but it is not appropriately used. Beneficiaries do not focus on education and health but rather use it to pay for debts, parties, liquor, and customary ceremonies*" (Village head-NTT).

Although overall PKH funds were not used appropriately, in terms of management the funds were mostly in the hands of mothers or women in the family. Mothers withdrew funds directly from the post office and usually they spent some of that money directly at the market. In one village in NTT the fact that **PKH** funds were managed by the women lead to jealousy by the men. These men hoped that the unconditional cash transfer (BLT) could be dispersed again and be managed by the head of the family.

"*Hopefully that BLT will again be disbursed, so that I will receive it. How come the aid is only for women, nothing for men?"* (PKH Facilitator-NTT).

"The PKH fund is managed by mothers and they are the ones who spend it. This is because mothers are closer to their children and better understand their day to day needs as they monitor children at home. There are only 1-2 households where PKH funds were managed by the husband because the wife was still subordinate to the husband or because the wife had died."(PKH Facilitator-NTT).

"*... PKH funds are handled by mothers. Husbands are not allowed to interfere*" (FGD Male-NTT).

The presence and activity of **PKH** facilitators played an important role in motivating the recipients to comply with the 12 indicators of achievement in the allocation of the **PKH** funds. Facilitators often instructed recipients to comply with the conditionality of the program and use the funds for MCH and educational purposes. One of the ways in which facilitators emphasized or encouraged this was to threaten to cut or even revoke the **PKH** funds if recipient pregnant women or infants and toddlers did not go to *posyandu* or if students were often absent from school. This method was considered quite effective in encouraging recipient compliance in rural areas in NTT.

"*I explained to the PKH recipient that if they did not come to the posyandu they would be fined 50,000 and if they were not present at posyandu on 3 occasions they would be banned as a recipient.*" (PKH Facilitator-NTT).

"*There was an effort to make children go to school, namely via PKH. If students were absent the funds were cut by Rp50,000, therefore parents monitored their children to ensure that they were not absent. Faithfulness to the school was due to fear of fines.*"(FGD Male-NTT).

However, **PKH facilitators were not always available and active in all treatment villages. The number of villages to be monitored was one cause of facilitators being neither focused nor active**. The small number of **PKH** recipients per village in West Java and in urban areas in NTT resulted in facilitators having to facilitate several villages. In fact, there was a facilitator who was responsible for facilitating up to seven villages. In addition, in one sample village in NTT, one facilitator resigned in 2009, so facilitation for that village was covered by a facilitator from other village.

Leaders of PKH groups were chosen by recipients and were responsible for an average of about 20–25 program recipients. They acted as liaisons between the facilitators and the recipients. If the facilitators had information they needed to convey to members, such as the date for a meeting prior to disbursement of funds, usually they would simply send a text message to the group leader with instructions to convey that information to all other members of the group.

Monitoring the compliance of **PKH** recipients in achieving the12 indicators of the program did not run properly. **Some teachers, principles, midwives, and *puskesmas* staff did not understand the process of completing verification forms which were sent and collected by the post office because they were never informed of the purpose of the forms or how to fill them out**. To overcome this, some facilitators admitted to filling the verification forms on their own after obtaining information from schools, midwives or health clinics to fulfill the administrative requirements. However, some teachers, principals, midwives and *puskesmas* staff interviewed claimed that facilitators had never asked for data.

> "*At first the entire verification process was using a form sent by mail, but since shipping was often too late, and forms were not completed at the school, eventually facilitators took the initiative to monitor all such activities* ...." (PKH Facilitator-West Java).

4.2 The Availability of MCH Services

The study found an increased availability of MCH services compared to 2007. This increase was partly driven by the existence of government (central and regional) and non-government programs and aid.

Despite improvements to the availability of MCH services, a number of barriers to the availability of modern MCH services in both treatment and control villages still existed. Barriers included the limited number of cadres and midwives, limited MCH support facilities, difficult geographical access, and the lack of electricity and clean water. Some small communities of women were difficult to reach with modern MCH services due to the nature of their work, such women in West Java who went to sea, women in NTT who had strong beliefs in *dukun beranak,* and women who lived in remote areas.

4.2.1 Conditions and Changes in the Availability of MCH Services and Barriers

The types of MCH services available in **PKH** treatment and control villages included *posyandu* and *polindes*/*poskesdes*. Service providers also included village midwives and *posyandu* cadres. Some villages also had *pustu* and in *kecamatan* capitals *puskesmas* were accessible (see table 17). In most villages/*kelurahan* in urban areas general practitioners, pediatricians, and gynecologists were available.

In all sample villages in West Java, *posyandu* services were available in every hamlet or RW. **In NTT *posyandu* services were still difficult to access from remote areas or villages, one control village had only one available *posyandu*. The limited number of *posyandu* was due to the small number of targeted beneficiaries (pregnant women and infants) and the vast spread of populations. In addition there were a limited number of *posyandu* cadres and village midwives to provide services at *posyandu***. As found in the baseline study of 2007, *posyandu* were the primary healthcare facility servicing children under the age of five. Almost all *posyandu* ran actively every month providing the five basic services. However, in some sample villages, the number of cadres available were still less than the required minimum of five cadres. This was due to the difficulty of recruiting cadres who were willing to work voluntarily.

Compared to 2007, there were an additional three *posyandu* services: one in a treatment village in West Java and two in control villages in NTT. The additional *posyandu* in West Java intended to make services more readily available to the communities as the number of households

serviced had become too great for a single *posyandu*. The addition of two *posyandu* in the control villages in NTT occurred due to administrative divisions of hamlets. In some other sample villages, in both rural and urban areas in NTT, *posyandu* were equipped with various support facilities such as desks, chairs, beds, cupboards, shelves, medicines, books, and scales. These were funded by the assistance of the Church World Service (CWS).

Table 17. Type of MCH Services Available In PKH Treatment and Control Villages

Category	Village	Number of *Posyandu*		Village Midwife [b]		The Availability of Other MCH Facilites			
		2007	2010	2007	2010	Polindes	2007	2010	2007
West Java-Rural -Treatment	Gregesik Kulon	5	5	Available	Available	√	√ [c]	-	-
	Jagapura Kidul	7	8	Available	Available	-	√ [c]	-	-
West Java-Rural - Control	Susukan	8	8	Available	Available	-	√	√	√
	Tangkil	6	6	Available	Available	-	-	√	-
West Java-Urban -Treatment	Mertasinga	6	6	Available	Available	-	-	-	√
West Java-Urban -Control	Mundu Pesisir	5	5	Available	Available	-	√	-	-
NTT-Rural -Treatment	Oenai	3	3	Available	Available	√	-	-	-
	Falas	3	3	Not available	Not available	-	-	-	-
NTT-Rural -Control	Bisene	1	1	Not available	Not available	-	-	-	-
	Biloto	2	4	Available (Did not live in the village)	Available (Did not live in the village)	-	√	-	√
NTT-Urban -Treatment	Fatufeto	4	4	Available	Available	-	-	√	-
NTT-Urban -Control	Tode Kisar	2	2	Available (Did not live in the village)	Available (Did not live in the village)	-	-	-	-

Notes :
a) One *posyandu* posts in one of the hamlets became part of a separate village division.
b) (Available) means that the midwife lived inside the village
c) (–) *Puskesmas* were accessed outside the village or at the *kecamatan* capital.
d) No longer serviced by a *puskemas* midwife
Source: Summary of data from in-depth interviews, FGDs and observations.

Although there were some improvements in some sample villages, both treatment and control, ***posyandu* services were constrained due to the frequent turnover of cadres. The main cause of this turnover was the lack of adequate incentives for the cadre**s. In West Java, the former cadres preferred to become laborers or maids. **The substitution of cadres was also directly related to the change of village heads.** In one control village in West Java, each *posyandu* was run by 2-3 cadres as it was difficult to recruit cadres. In fact, the five platform service system should involve a minimum of 5 cadres for every *posyandu*. **Other problems in the *posyandu* services were the lack of permanent buildings dedicated to *posyandu* in some sample villages. This meant that the delivery of services were still conducted at cadres' houses or village offices.** As a result, mothers and children felt less comfortable during their visits to *posyandu*. "*A constraint is that communities still do not feel comfortable when in poyandu, polindes, and puskesmas, because children are not comfortable and feel uneasy*" (Village Midwife-West Java). In addition, households who lived in remote RT had to walk for hours to access the nearest *posyandu*

The reason for cadre turn over:

> "*There are people who claim that it is better for them to work as crab skin peeler rather than as a posyandu cadre. There are no incentives and it is just tiring* "(village midwife-West Java).
>
> "*Cadre activeness was influenced by the change of the village head or the cadre's husband's position at the village office, and because some cadres chose to be migrant workers to Saudi Arabia*" (Village Midwife-West Java).

Services in *polindes/poskesdes* or *pustu* in some sample villages also improved due to additional village midwives, additional p*oskesdes* or mobile *puskesmas* (*pusling*) and, especially in NTT, additional building and support facilities for *polindes*. In rural West Java, in one treatment and one control village, the number of village midwives on duty increased so that each village had two midwives. Additional midwives in one of these villages encouraged the availability of weekly *poskesdes* services. **In urban areas, *poskesdes* services increased with the addition of laboratory examinations**. Alternative MCH services increased due to the increasing number of private midwifery service practices within and outside the village. However, the majority of sample villages in West Java were still facing problems as there were not yet dedicated locations for *polindes* or *pusling* service posts which had been held at the village offices or in the home of village residents. In some sample villages, both treatment and control, problems were faced due to the reduced number of days the *poskesdes* services were operating and because the midwives in charge were continuing their education.

In NTT, improvements of MCH services did not occur in all sample villages. In some sample villages, both rural and urban, construction and repairs had been carried out on *poskesdes* buildings. This had created additional examination and delivery rooms in *pustu*. Additional equipment for *poskesdes*, such as tables and chairs, beds, cupboards, shelves, medicine, books, and scales had also been provided. Increased MCH service facilities were funded through the district and provincial budget. In one control village there were additional *poskesdes* services provided to the farthest hamlet as people in this hamlet had experienced difficulties in accessing MCH services available in the center of the village. Yet the availability of MCH services in another treatment village and a control village remained relatively unchanged. In these two villages there were no village midwives and in the treatment village *pusling* services had been terminated since 2008 due to a lack of operational funds. In the treatment village no midwives had been available since 2002. In addition to the shortage of midwives, it was difficult to find midwives willing to live in the villages. Reasons for this were that midwives did not want to live in the villages because there was no clean water or electricity and locations were far from health centers and only accessible via damaged roads and severe (mountainous) terrain. Midwifery services were also limited by the sparse population spread over vast areas, the lack of rural infrastructure which was exacerbated in the rainy season, and the continued lack of service facilities (buildings and equipment for *posyandu/polindes*).

Puskesmas services in treatment and control areas in West Java and NTT increased as a result of *puskesmas* building renovations, the addition of nursing and delivery rooms or special units of midwifery, as well as additional staff and other supporting facilities funded by provincial and district budgets. However, these improvements were only implemented partially, and as a result the problems faced by *pusksesmas* were yet to be fully overcome. In West Java, some centers still faced barriers including limitations to the types of services provided, limited numbers of midwives and staff, limited medical equipment, and no allocated room for hospitalization of patients. In NTT the obstacles faced by *puskesmas* included reduced numbers of nutritionists, especially in urban areas. This negatively impacted efforts to monitor and detect cases of child malnutrition. Another problem was the late delivery and limited

supply of various equipment, including disposable equipment. However, in every district capital there was one or more local government-owned or private hospitals to which patients could be referred if their condition was such that it could not be handled by a village midwife or midwives and doctors at a *puskesmas*.

PKH required the commitment of local governments to ensure the availability of MCH services in the region. Based on the information obtained at the village and district level, there was no relationship between the increase of MCH services and PKH. The increased availability of MCH services occurred in both treatment and control villages with funding and assistance from local budgets and NGOs. **There was no proof that the availability or anticipation or response rate of MCH services to PKH recipients occurred. For example, in one PKH treatment village, midwifery services were still unavailable although the village had been receiving PKH since 2007.**

Specific Groups Unreached by MCH services

MCH services still experienced difficulties in reaching some small groups of communities due to distance factors, customs and the occupations of targeted beneficiaires. Compared to 2007, the number of populations unreached by MCH services decreased. In NTT several households living in remote locations still found it difficult to reach midwives and *posyandu* cadres. Likewise midwives and cadres were still having difficulty reaching some people who believed in cultural customs such as *sei* (heating the body for 40 days following birth) or households who had more faith in *dukun beranak*. In West Java *posyandu* services were not able to reach mothers (and children) who helped husbands at sea (fishers). In addition, many mothers went to work in the fields during harvest time and this hampered the implementation of *posyandu* activities which had to be postponed due to limited numbers of mothers being able to attend.

4.2.2 The Availability of Traditional MCH Services

In general, the number of *dukun beranak* in most sample villages, both in West Java and NTT, since 2007 tended to be similar. In two treatment villages the number of *dukun beranak* were reduced but in the two control villages the number increased due to the addition of new *dukun beranak* (see table 18).

The role of traditional midwives in assisting childbirth in West Java tended to decrease. Even if they were involved in the childbirth process, the role of *dukun beranak* was only to assist the midwife. This decreased role was due to the government's appeal to *dukun beranak* to cease delivering babies. In addition, some *dukun beranak* were so old that they could no longer actively provide services. There were also no new young *dukun beranak*.

> "*Most mothers in labor will invite dukun beranak and a midwife to assist in the delivery process*" (Posyandu cadre-West Java).

Table 18. The Number of *Dukun Beranak* in PKH Treatment and Control Villages

Category	Village Name	Number of Dukun Beranak		Notes
		2007	2010	
West Java-Rural -Treatment	Gegesik Kulon	1	1	Community accessed *dukun* from ouside the village
	Jagapura Kidul	3	2	One *dukun* has died and the community accessed *dukun* from outside the village
West Java-Rural -Control	Susukan	5	5	Two were untrained
	Tangkil	3	4	Two were untrained including one new *dukun*
West Java-Urban -Treatment	Mertasinga	2	2	One *dukun was* inactive because of aging
West Java-Urban -Control	Mundu Pesisir	2	2	One was untrained
NTT-Rural -Treatment	Oenai	9	9	Five were untrained
	Falas	6	6	-
NTT-Rural -Control	Bisene	1	5	Four new *dukun beranak*
	Biloto	n.a	3	All were untrained
NTT-Urban -Treatment	Fatufeto	5	3	-
NTT-Urban -Control	Tode Kisar	2	2	One of them was too old to provide any services

Souces: Summary of data from FGDs and In-depth Interviews

In contrast, in NTT, there were still numerous *dukun beranak* in each sample village. Some had not been trained, yet were still delivering babies, particularly in two villages (one treatment and one control). In these two villages the roles of *dukun beranak* were still relatively high as there were no midwives. For this reason the Revolusi KIA program could not prevent mothers from accessing *dukun beranak* services, as women did not have any access to alternative services. In addition, the cultural practice of *naketi* was still implemented in one control village meaning that *dukun beranak* still played a prominent role.

> "*There is no midwife in the village, so we chose dukun beranak , midwives are too far away from at Kecamatan Kie*" (FGD Female-NTT).
>
> *"... because their beliefs are still strong (Naketi culture) and because there is no midwife who stays in the village, they cannot use a midwife at the time they would give birth. They also never experienced problems with the services of dukun* "(*Puskesmas* Midwife-NTT).
>
> "*In Fatufeto in almost every neighborhood there is a dukun beranak that we women use. Here we still use dukun beranak for massage and delivery, if there is a problem we then go to the midwife or public hospital, but this rarely happens*"(Community Leader-NTT)
>
> "*.. there are still pregnant women and mothers who accessed the services of dukun beranak. However, dukun beranak who are still active also always bring their children if assisting with childbirth "(Village Midwife-NTT).*

Other services provided by *dukun beranak*, both in West Java and NTT, included massage services during pregnancy (to fix the location of the fetus and reduce fatigue) and postpartum care (care of the baby and mother). *Dukun beranak* also helped mothers by conducting traditional ceremonies, such as a ceremonies during pregnancy (at 4 months and 7 months), *puputan* (a ceremony after 7-days as signalled by the release of the baby's umbilical cord) and *matang puluh dinaan* (the 40th day following the baby's birth). Therefore,

some FGD participants emphasized that *dukun beranak* were still relevant to complementing to the midwife services and played an important role in making mothers and their families feel more comfortable and content.

> "*... For the mothers who have given birth, usually up to 40 days following the birth I massage three times.* (*Dukun Beranak* -West Java).
>
> "*The services are still there, they usually come to the midwife for a massage when 8-9 months pregnant. In addition they also ask for dukun beranak to help with nursing after delivery "(Village Midwife -West Java*).
>
> "*.. They were massaged by a dukun beranak to strengthen the womb* "(*Posyandu* Cadre-NTT).

4.2.3 Community Involvement in Decision Making Concerning Health Services

The decision making process regarding the provision of MCH services was still entirely conducted by the local government and service providers. However, compared to 2007 community involvement in decision making related to MCH services tended to increase, particularly in rural areas.

In the rural sample areas in NTT, the presence of the Revolusi KIA program motivated *kecamatan* and village officials to involve the community (especially mothers in *posyandu*) to make compromises or rules which required mothers to deliver babies with assistance from midwives at the *polindes*. All of the sample villages in NTT enforced the agreements and, if violated, women were subject to large fines. The existence of these penalties were considered quite effective because communities still needed "pressure" for women to give birth with the assistance of medical personnel. However, the agreement was difficult to implement in villages where midwives were not available.

> "*... There is an agreement between the cadres, midwives and pregnant women (agreed early March 2010), that if women give birth unassisted by health workers then they have to pay Rp250,000", "The value of this penalty is smaller than that specified by the kecamatan (Rp500,000) because there is no midwife in Desa Falas* "(Midwife *Puskesmas*-NTT).

In West Java, increased community involvement only occurred in the sample villages who were actively implementing the Desa Siaga program. The implementation of this program in the Cirebon district formed an early commencement of direct community involvement in decision making regarding MCH services at the village level. In one control village, for example, the community agreed that a vehicle belonging to households could be used if there were members of the community who needed transport to the hospital.

> "*In 2010, the Desa Siaga program was implemented with the main activities of developing a Maternity Savings Fund (Tabulin) and the Solidarity Fund of the Community (Dasolin), so that communities themselves could be well prepared to face childbirth expenses*" (Village Midwife-West Java).
>
> "*The deal was that each household that owned a vehicle was expected to participate by lending out their vehicle every time there was a poor household who need transport to the hospital to access health care services . The cost of gasoline and other expenses will be temporarily covered by the village cash fund, from private assistance or from me* "(Head of Village-West Java).

In urban areas, both in NTT and West Java, no direct involvement of communities in decision making related to MCH services was observed. Communities were merely clients of available MCH services. The Implementation of the Desa Siaga program in urban areas in West Java, was still at the stage of promotion and the formation of a committee. In NTT, the Revolusi KIA program was also not widely known among urban communities.

4.3 Utilization of MCH Services

In general, the study found an increased utilization of MCH services, increasing community participation, as well as increased awareness of women and men about the importance of access to MCH services. Despite an increase in utilization, barriers to the utilization of MCH services had been relatively unchanged since 2007, i.e., physical/geographic barriers, seasonal factors, limited number of MCH services, reliance on *dukun beranak*, household economic conditions, and mothers psychological problems.

PKH's contribution to increasing the utilization of MCH services, namely the presence of mothers in *posyandu* only occurred in rural areas within NTT samples, because of the large number of PKH recipients and the active roles of PKH facilitators in motivating recipients.

4.3.1 Changes in the Level of Modern MCH

MCH services that were utilized by communities in the **PKH** treatment and control villages were the same as those used in PNPM Generasi treatment and control villages. For antenatal and postpartum care mothers generally utilized the services of midwives and *dukun beranak*, while for childbirth most women were already using the services of midwives. For the health of children under five years old including immunization, weighing, and the treatment of malnutrition, the majority of communities accessed *posyandu* services. Changes in the level of utilization of MCH services (*posyandu* and village midwives) differed between West Java and NTT, between rural and urban areas, and between treatment and control villages.

In some villages in West Java, *posyandu* service utilization rates tended to increase. The increase was affected by the provision of vitamins and PMT from the village budget. However, in several other villages *posyandu* service utilization was influenced by the number of women who become migrant workers, and those who were busy working in paddy fields during the harvest season. While many returning migrant workers caused a visible increased in the use of *posyandu* facilities, a decline was evident during the rice harvest season when *posyandu* activities were often delayed or cancelled. In urban areas, the utilization of *posyandu* services tended to remain low and there were even parents who rejected children's immunization. All of these factors meant that midwives still had to keep reminding people to be present at *posyandu*.

> *"Their behavior, such as not feeling the need to know the increasing of their baby's weight"; "Midwives and cadres should be around more for 'rounding up' or 'sweeping', and sometimes posyandu should be held two times in a month* " (Village Midwife-West Java).

In general All sample villages in West Java already had a high level of utilization of midwifery services. However, in the farthest hamlet in a treatment village, some births were still assisted by *dukun beranak*. Similarly, in the villages located in coastal areas, despite urban conditions and many available options for modern MCH services, there were still a few mothers who give birth with the help of *dukun beranak* because their level of awareness regarding MCH was still relatively low.

Unlike in West Java, in rural areas in NTT there was a significant increase in the utilization of *posyandu*. Factors driving the increase were the supplementary food assistance provided at *posyandu* (rice, cooking oil, instant noodles) from WFP and CWS, fines issued by cadres/villages (Rp5,000 for women who did not attend or Rp1,000 for late attendance), and the existence of village regulations requiring childbirth to occur at *polindes/puskesmas*.

PKH contributed to the increased use of *posyandu* in rural areas in NTT because there were a more significant number of PKH recipients and facilitators threatened to cut Rp50,000 of PKH funding to recipients if they did not routinely attend *posyandu*.

> "*I explained to the PKH recipient that if they do not come to posyandu they will receive a fine of Rp. 50,000, if they are not present at posyandu three times in a row they will be terminated as a PKH beneficiary* "(PKH Facilitator-NTT).

The utilization of midwifery services during childbirth differed between the two treatment villages in NTT. **In one treatment village, the use of midwives increased significantly because of *perdes* which required mothers to give birth in *polindes*. If they did not they were subject to fines of Rp500,000. Conversely, in the other treatment village, despite fines amounting to Rp250,000, midwife services utilization rates were unchanged as there was no village midwife. Consequently most of the PKH recipients still gave birth assisted by *dukun beranak*. The same occurrence happened in one of the control villages. Most of the mothers gave birth assisted by *dukun beranak*** because there was no village midwife. In a remote hamlet in another control village the community's level of trust and confidence in *dukun beranak* was still high, so they continued to rely on *dukun beranak* even though midwives were available.

> "*Dukun beranak are close, whereas midwives are far away, midwives do not exist in Falas"; "We need a midwife but midwife is too far away*" (FGD Female-NTT).

> "*In 2007, almost all (women) used dukun beranak. in 2008 and mid 2009 they accessed village midwife, but now because the village midwife have moved away they go back to dukun beranak*" (*Posyandu* cadre-NTT).

In urban areas in NTT, the level of *posyandu* service utilization in the treatment and control villages did not change and tended to remain low. The number of mothers and children who routinely visited the *posyandu* were estimated to be only half of the target population. **The low utilization of services was influenced, among other factors, by the implementation of early childhood education (ECD/PAUD), that meant children aged 3-4 years are were longer routinely weighed at *posyandu* because they followed the activities of PAUD. Another factor was that working mothers (traders and domestic helpers) were unavailable to take children to *posyandu*.** Mothers were also reluctant to go to *posyandu* because they felt embarrassed that their children had not gained sufficient weight. There were also mothers who no longer went to *posyandu* after their children had received measles immunization because they thought that their children had received complete immunizations.

> *"Those who came to posyandu had Jamkesmas. Those who were busy working at the office, or traders, did not come "*(FGD Female-NTT).

> "*Shame, because the child was malnourished or was underweight*" (FGD Female-NTT).

> "*More mothers were carrying babies to posyandu, while children under five years were brought less often to the posyandu. There was a tendency that if the child had already been immunized, they were reluctant to bring it to the posyandu just to weigh it* "(Community Leaders-NTT).

> "*The rich were embarrassed to go to the posyandu, they went to the doctor*" (FGD Female-NTT).

4.3.2 Reasons for Choosing Modern and Traditional MCH Services and Barriers to Accessing MCH Services

The reason for using midwifery services were to better ensure women's safety with proper expertise, medicines, and medical equipment. Midwives could also provide a referral to the

hospital when pregnant women or mothers faced emergencies during childbirth. Midwives also provided birth certificates. Especially in rural areas in NTT, prohibitions and penalties for women giving birth with assistance from *dukun beranak* encouraged mothers to utilize the services of midwives.

> "*Because people are afraid of the sanctions that have been set by the village head at Rp200,000 if they do not use a midwife to deliver the baby*" (FGD Female-NTT).
>
> *"Immunization with a midwife in the posyandu," "Because midwives are experienced in delivering babies," "For the full equipment and sterile facilities, and available medicines* (FGD Female-West Java)

The main reasons that women gave birth assisted by the *dukun beranak* were cultural or economic, and particularly in NTT because of the remoteness of the region and the unavailability of a village midwife. Another reason was because *dukun beranak* were closely related to the women giving birth, or because parents instructed their daughters to use *dukun beranak*. **In one treatment village and two control villages in NTT midwifery services were not available so most women, including PKH beneficiaries, gave birth assisted by *dukun beranak*.** In fact, there were instances where births were only attended by husbands or parents. In both villages public confidence in the expertise *dukun beranak* was still high, and cultural traditions such as *sei* (postpartum) and *naketi* were still practiced. Some mothers also accessed a *dukun beranak* because they were ashamed of already having many children, a close interval between pregnancies, or pregnancy out of wedlock. Some women were also ashamed, or believed it taboo to show their genitals to the midwives. In urban areas in NTT, some mothers reasoned that using the services of *dukun beranak* had not caused problems and that both mothers and babies were safe and healthy.

> "*Being unable to call the midwife at midnight" "Because the dukun beranak helps with prayers" "Because they are closer*" (FGD Mother-NTT).
>
> "*All were delivered by dukun beranak, because dukun beranak are near here*" (FGD father-NTT).
>
> "*... My stomach pain started and I immediately give birth without a midwife, just a dukun", "because of the cost to be borne, and also due to distance. The midwife lives too far away*. (FGD Female-NTT).
>
> "*If my child is sick I naketi first and after that prayer, I take them to a posyandu or to a health clinic*" (FGD Male-NTT).
>
> "*Shame because I'm pregnant out of wedlock", "Expensive (in hospital/midwife's practice) including the cost of hospitalization, eating, drinking*" (FGD Female-NTT).

The cost of giving birth with assistance from a midwife was quite expensive, especially in West Java and in urban areas in NTT (see table 19). **For this reason some women used the services of *dukun beranak*. PKH did not reduce the cost barriers for women in accessing midwifery services. This was partly because the dispersal of PKH funds often did not coincide at the time that funds were needed (for example during childbirth).** Therefore, PKH funds were generally used for other purposes deemed more urgent such as the fulfillment of daily household consumption.

> "*We just go to dukun, mothers are fine,", "The cost of delivery by a midwife was about Rp500 thousand, while a dukun beranak does not specify the cost and can be paid with a cloth and about Rp100 thousand*" (*Posyandu* cadre-NTT) .

Table 19. Delivery Cost Comparison between Midwives and *Dukun Beranak*

Sample Areas	Delivery Cost	
	Midwives	Dukun
West Java	Rp400,000-Rp700,000	Rp100,000-Rp200,000
NTT Rural	Rp150,000-Rp200,000	Rp10,000-Rp50,000 or betel nut
NTT Urban	Rp500,000-Rp800,000	Rp50,000-Rp100,000

Sorce: Inteviews and FGDs

4.3.3 Actors that Influenced the Utilization of MCH Services

Just as in the treatment and control villages of PNPM Generasi, the actors who played a role in influencing the utilization of MCH services in the **PKH** treatment and control regions were village officials, midwives, *posyandu* cadres, community leaders, neighbors, and, especially in NTT, religious leaders, NGO staff, *puskesmas* staff, and in treatment villages, **PKH** facilitators. (see table 20). The role of village officials was not to directly affect aspects of MCH, but more to monitor and remind the mothers to go a *posyandu*. They also sometimes took time to attend the *posyandu* personally. **Particularly in NTT village officials were directly involved in village policy-making** (*perdes*) **that stipulated sanctions or penalties for mothers who did not use the services of midwives and did attend the *posyandu*.** Religious leaders played a role in reminding communities of *posyandu* schedules when residents gathered at churches. NGOs also provided guidance and awareness raising regarding the importance of MCH in addition to other forms of support.

> "*For that we received assistance from village officials. If during posyandu opening hours people did not attend, the village head went to their houses and dragged them out to the posyandu. Because of this everyone became wary and attended the posyandu diligently.*" (Posyandu cadre-NTT).
>
> "*The village head called on the village to be diligent in attending the posyandu." "The village head and the PKH facilitator also said we must go to the posyandu, children must be delivered by a midwife, and if not PKH money will be cut*" (FGD Male-NTT).

In urban areas, both in West Java and NTT, village officials typically did not play an influential role in MCH services. *Posyandu* cadre were the main actors that FGD participants mentioned in many urban areas (see table 21).

PKH facilitators' roles in influencing the use of MCH services was only visible in two rural sample villages in NTT. This was because the facilitators in these two villages were only in charge of one village and the facilitators were active in providing direction and pressure regarding the importance of MCH. **In contrast, in rural areas in NTT and urban areas in West Java, the small number of recipients per village caused the work area of facilitators to cover many villages. Consequently these facilitators were more preoccupied with administrative tasks and less able to focus on mentoring**. The role of PKH group heads was only to convey information (especially the date of disbursement) from the facilitators to group members. In fact, in some areas forming the group was only a formality and did not provide activities that benefited members.

At the household level the decision to access *posyandu* services was entirely the wife's decision and initial ideas to access other MCH services (midwives, health centers, hospitals, doctors) were initiated by the wife seeking approval from her husband, mainly because of associated costs. Only in one treatment and control village in NTT were husbands more dominant in deciding what types of MCH services were to be accessed.

Table 20. Actors that Motivated the Utilization of MCH Services at the Rural PKH Treatment and Control Villages

Cateogry	Village Name	Actors at The Village Level
West Java-Treatment	Gregesik Kulon	Cadres, midwives, village officials
	Jagapura Kidul	Midwives, village officials
West Java-Control	Susukan	Midwives, village officials
	Tangkil	Midwives, cadres, village officials
NTT-Treatment	Oenai	Cadres, village officials, *puskesmas* staff, midwives, community leaders , religious leaders /Churches, NGOs (WFP), neighbors, PKH facilitators
	Falas	Cadres, village officials , midwives, NGOs (CSW, Plan, WFP), PKH facilitators
NTT-Control	Bisene	Cadres, village officers, midwives, doctors, neigbors
	Biloto	Cadres, villages officials (*kadus*), midwives, *puskesmas* staff, NGO (CWS)

Sources: Interviews and FGDs

Table 21. Actors that Motivated the Utilization of MCH Services at the Urban PKH Treatmen and Control Villages

Cateogry	Village Name	Actors at The Village Level
West Java-Treatment	Mertasinga	Midwives, Hamlet head, cadre, village head
West Java-Control	Mundu Pesisir	Cadres
NTT-Treatment	Fatufeto	Cadres, Midwives, neigbors
NTT-Control	Tode Kisar	Cadres

Sources: Interviews and FGDs

4.3.4 Changes in Women's and Men's Awareness Concerning MCH

The general knowledge, understanding, and awareness of most people in the sample areas regarding the importance of MCH services, especially the services of *posyandu* and midwives had increased. **Increased awareness in all areas of the samples, both treatment and control, were driven by the Desa Siaga program and the Revolusi KIA program**. MCH information was also obtained through print and electronic media and reminders from neighbors. Especially in rural areas in NTT, increased awareness was also triggered by regulations stipulating that childbirth must be assisted by midwives to avoid fines. Assistance and education regarding health from NGOs such as Plan International and WFP, and the active role of village officials and health workers also raised public awareness of MCH.

The presence of PKH also influenced the awareness of women and men regarding MCH issues especially in rural areas in NTT. This was due to education and awareness raising by facilitators and the threat of Rp50,000 sanctions from PKH funding if recipients did not access services or take their children to visit *posyandu*.

Increased awareness was reflected in the increasing regular attendance of mothers at *posyandu*, increased knowledge of mothers regarding MCH, and fathers reminding mothers of *posyandu* schedules and even providing transport or taking children to the *posyandu* themselves. In the treatment villages in urban areas of West Java, family planning awareness and practice had increased, especially among mothers despite associated costs. In one treatment and one

control village in NTT where there were no midwives, women's raised awareness had resulted in increased efforts to access midwives via the *puskesmas*. "*I recently reported to the puskesmas and requested that they assign a midwife in this village because people here have it difficult*" (Community Leader-NTT). Increased awareness of women tended to be more dominant than men because women were subjected to various MCH programs. However, there were increasing numbers of husbands who accompanied wives to pregnancy checkups and brought them to *posyandu.* There were no longer any husbands who prevented their wives from accessing MCH services.

> "*... All the programs that exist are a health lesson for us*" (FGD Male-NTT).
>
> "*... husbands sometimes reminded to us to immunize. When husbands were at home they would do the housework such as cooking and frying tofu when there was an activity at the posyandu* "(FGD Female-West Java).
>
> "*The level of fathers' awareness is the same compared to 2007. They have already allowed their wives to go to the posyandu and they also help by reminding the mothers to go to the posyandu*" (*Posyandu* cadre-West Java).
>
> "*Husbands did not say anything, but when their wives went to Saudi Arabia they wanted to come to the posyandu*" (FGD Female-West Java).

The level of community awareness in urban areas in NTT was not as high as the level of awareness in rural areas regarding accessing services of *posyandu* and midwives. In the control *kelurahan* some women, especially from middle to high economic classes, preferred other more 'expensive' MCH services to the *posyandu*. Some low income women diligently went to *posyandu* if assistance was provided. Domestic or work duties caused some mothers in the two *kelurahan* to neglect weighing their children.

> "*Lack of awareness, irregular attendance in the absence of assistance. Currently everyone is coming to the posyandu because there is assistance from BLM P2KP*" (Posyandu cadre-NTT).
>
> "*Due to busy work at home, I did not go to the posyandu", "I have a kiosk so could not come to posyandu* " (FGD Female-NTT).

Some service providers and authorities (village/*kelurahan* and *kecamatan*) still associate the high awareness among mothers and the the use of MCH services to the presence of aid. They felt pessimistic about the sustainability of changes. They felt that if the various aid programs, including **PKH** were abolished, poor communities would no longer have the level of awareness necessary to continue visiting posyandu or for checkups with the midwife during pregnancy. In contrast, **PKH** recipients confirmed that if aid, including PKH were stopped, they would continue to utilize MCH services.

4.4 The Availability of Basic Education

During the period 2007 to 2010 there was no additions of schools in sample areas, except for a change in status of one primary school. Yet there were various improvements in infrastructure and support facilities in nearly all existing primary and junior high schools sampled, both in treatment and control areas. However, various improvements had not yet fully overcome a number of obstacles faced by schools, namely: the limited infrastructure and facilities to support teaching and learning processes, the limited number and poor quality of teachers, geographical barriers, electricity and water problems, especially in NTT, and the lack of school committees' roles, especially in urban areas. In general, the constraints to the availability of basic education services in the rural areas in NTT were higher compared to urban NTT and West Java.

4.4.1 Changes in the Availability of Basic Education

In terms of quantity, the availability of primary schools in all sample areas in both West Java and NTT had been sufficient since 2007. In each village there was a minimum of one primary school. In West Java, because of the easy access in terms of distance and transportation, communities did not only access schools that were in the village, but also schools that were outside the village, especially if they were considered to be good schools. In NTT, the availability of primary schools had been assisted by the establishment of small primary schools or TRK (additional classrooms) in remote hamlets. The establishment of TRK were generally due to the initiative of communities, schools, and village officials with the aim to increasing the participation of primary school students from the farthest hamlets. TRK could then become independent schools if the classrooms, number of students, and availability of teachers was adequate and the school obtained support from local government, especially for operational costs and teacher wages. In comparison to 2007, in the sample areas only one TRK-turned into an independent SD in 2008.

At the junior high school level, the number of schools in the village had not changed compared to 2007. Some villages still did not have secondary schools in the villages (see table 22). **In West Java, the lack of secondary schools in the villages was not a problem because schools outside the villages were generally easily accessible. Conversely, in NTT the unavailability junior high schools in the villages were still an issue because of the distance of schools (mostly junior high schools were located in the capital *kecamatan*) and the unavailability of public transport.** Additionally, using a motorcycle taxi service to access schools was very expensive. One method to overcome the problem of availability of secondary schools in NTT was the establishment of SMP Satap (one roof schools). These schools were referred to as 'Satap' because they were located under the same roof as existing primary schools, some of the rooms and teachers were also shared with the primary schools. However, due to limited resources, especially teachers and the small number of junior high school students per village, not all villages in NTT could create a SMP Satap.

Table 22. Number of SD and SMP Accessed at the Sample Villages

Category	Name of Village	Primary Schools		Junior High Schools	
		In the Village	Outside the Village	In the Village	Outside the Village
West Java-Rural Treatment	Gegesik Kulon	4	-	-	5
	Jagapura kidul	2	2	-	3
West Java-Rura Control	Susukan	2	3	1	4
	Tangkil	3	1	-	5
West Java-Rural Control	Mundu Pesisir	5	3	2	4
West Java-Urban Treatment	Mertasinga	2	1	1	2
NTT-Rural Treatment	Oenai	3	1	1	-
	Falas	3	-	1(Satap)	2
NTT-Rural Control	Biloto	4 SD (1 TRK)	-	1	4
	Bisene	1	-	-	6
NTT-Urban Treatment	Fatufeto	2	-	-	7
NTT-Rural Control	Todekisar	-	7	-	9

Source: FGDs

The availability of non-formal education was generally only at the district level and was not often accessed by communities in the study areas. Schools of this type were generally more frequently accessed by adults, such as the village/hamlet officials who were required to have a junior high school diploma. In West Java, in almost every village non-formal religious

education, namely Madrassa Diniyah (MD) were organized. MD were generally accessible to primary and junior high students after school hours. In addition, in almost all treatment and control villages in West Java and NTT early childhood education (PAUD) was available. PAUD was funded by communities, NGOs, local governments, and PNPM Mandiri Perdesaan.

The availability of teachers in all schools in the sample villages was relatively unchanged. **Nevertheless, the level of teacher education had increased. This was mainly motivated by the teacher certification program.** In West Java, the majority of primary school teachers held a graduates diploma (D2) and were civil servants. The number of contract teachers on average was 1-3 per school. In NTT most teachers were high school graduates and most teachers were contracted teachers. When studies were conducted, some junior high school teachers in the sample schools were pursuing graduate diploma programs (D2) organized by the local education office. Teachers' attendance rates were still a problem in almost all areas. **The main inhibiting factor affecting teacher absenteeism was the lack of discipline of teachers in West Java, whereas in NTT it was the distance factor, the unavailability of public transport to school, teachers' status, and the lack of clean water and toilets in schools.**

Although no additional schools had been built in the sample villages, the physical condition and facilities of existing schools had generally been improved (see appendix 6 and appendix 7). The developments in primary schools were generally in the form of improvements of classrooms and additions of toilets, while in junior high schools improvements were in the form of additional support spaces such as libraries, laboratories, and multimedia rooms. **Changes in the physical conditions of schools was more common in rural areas because the physical conditions of urban schools were generally relatively adequate. There were no significant differences in the physical improvements made to schools between treatment and control villages**. Sources of additional funds for physical improvements generally came from the school operational program (BOS), district budgets, central government block grants, school committees, DAK, provincial budgets, and co-sharing funds between central local governments. In NTT funding also came from non-government assistance such as: the GMIT Foundation, AusAID, the Sanggar Suara Perempuan Foundation, and Dutch Grants.

All primary and junior high school samples in rural and urban areas in West Java and NTT also gained additional support facilities (see Annex 8 and Annex 9). The addition of facilities at the primary level were generally more focused on increasing extra-curricular subjects such as scouting and the arts. In junior high schools the use of technology and audiovisual equipment to support teaching and learning activities was favored. Sources of funding for additional support facilities in West Java were generally derived from BOS and local budgets (APBD). In rural areas in NTT sources of funds mostly came from NGOs such as from Plan International, DBEP, and Sanggar Suara Perempuan Foundation. In urban areas in NTT sources of funding generally came from the school committees, BOS, and Provincial Budgets and there were no instances of NGO funding such as occurred in rural areas. **In general, there were no differences in the improvements to school support facilities between treatment and control areas.**

4.4.2 Barriers to the Provision of Basic Education

Although there were some additions and improvements to school infrastructure and support facilities, these were not sufficient to solve all the problems faced by basic education services. Moreover, the addition of rooms such as laboratories or multimedia rooms and the provision of supporting facilities were often not accompanied by the availability of equipment and teacher expertise. In NTT the utilization of facilities to support learning and teaching were still constrained due to the lack of electricity in the school. **In general, there were no significant differences in the types of barriers faced by schools in treatment and control villages.** The different visible barriers between schools in West Java and NTT were **based on geographical conditions, the availability of infrastructure, and the socio-economic** conditions of societies.

The main problem complained by many junior high school principles was the limited funds for school operations. BOS funds were considered inadequate as the allocation of these funds were hindered by the terms and conditions of usage, such as conditions that BOS funds could not be used tofinance the construction of new buildings. The calculation of BOS funds was based on the number of students enrolled in the school. This was problematic for schools that had small numbers of students. Limitations of school funds were also due to the low participation of parents following implementation of the BOS program. The schools complained about the prohibition of schools collecting any regular funds from the parents. *"We actually agree not to collect the funds from parents. But please ensure our needs are fulfilled, the government must cover all costs"*(Shool Principal-West Java).

In urban areas in West Java and NTT, primary and junior high schools still faced inequalities due to **the unequal number of students between schools**. Some primary and secondary schools faced classroom limitations due to the increased number of students who registered. Increasing numbers of students were a result of parental preferences towards particular schools. Some primary schools in West Java had to rent the space of local Madrasah or exceed the capacity of students in one classroom. Conversely, less desirable schools (especially primary schools) experienced a lack of students and received fewer BOS funds. Although in general the existing school facilities in urban areas were more adequate than their rural counterparts, schools faced the need for more sophisticated facilities such as computers, English language laboratory facilities, multimedia equipment, and teachers who had the specialized skills as demanded by the international school standards.

Especially in rural areas in NTT, the conditions of primary and junior high schools had improved since 2007. However the limited amount of aid meant that some schools still faced fundamental obstacles such as the lack of tables and chairs, no libraries and laboratories, and a lack of teaching aids. Some schools in rural areas in NTT also did not have clean water and electricity facilities. The absence of electricity in the school meant that teaching aids requiring electricity could not be used. The lack of clean water meant that students who already had to walk long distances to school, also had to carry water from home.

Schools in rural areas in NTT also experienced barriers as a result of inadequate numbers of teachers, the low quality of teachers, and the lack of teacher training. The low quality of teachers was expressed either by the school principals or village heads: "*We want smart kids, but we do not have enough quality teachers*" (School Principle -NTT) "*How could a new senior high school graduate teach in junior high school*" (village head-NTT). Another problem was that teachers were often late to school or absent. **The cause of teacher tardiness and frequent absences were due to the large distances between schools and teachers' homes and the lack of public transport. The low education levels and nonpermanent status of teachers also affected the poor quality of**

teaching and teachers' attendance at school, which ultimately affected student achievement. For example, in a junior high school in NTT, only one of the forty-nine students who sat the National Examination in 2008 passed. The other students had to take the remedial exam, repeat the same class, or chose not to continue to senior high school.

4.4.3 The Role of School Committees in Decision Making Concerning Basic Education Services

In general there were differences in the roles of primary and junior high school committees between in rural and urban areas. In rural areas, both in West Java and NTT, the committees' roles were relatively active, with tasks including helping to finance the construction of school facilities (such as construction of school latrines or fences) through donations of parents, contributing to decisions regarding the allocation and monitoring of BOS funds, and, especially in NTT, monitoring the attendance of students and teachers. Committee heads in rural areas, especially in primary schools, were local people from the village/hamlet where the schools were located. Committees in rural areas were also generally acknowledged and supported by parents and village officials. However, the role of committees were also highly influenced by individual committee heads and school principals. In one primary school in the rural sample in NTT, for example, the committee was inactive because the headmaster refused to allow the school committee to play a role in overseeing the use of BOS funds, a task that was considered to be the sole right of schools. **The role of school committees related to PKH were generally limited to knowing the existence of PKH beneficiaries at their schools. However the committees were not involved in the supervision of PKH recipient student attendance rates.**

In urban areas, the committees' roles was generally limited to formally attending school meetings and acting as a liaison between schools and parents. Prior to the BOS program, the role of the school committees were more focused on fundraising. Since the implementation of BOS many school committees ceased functioning optimally. School principals generally complained about the decreasing role of committees and lower participation rates of communities following implementation of the BOS program. This was believed to be due to the perception in some schools (both primary and junior high) that the extent of the committees' roles were to obtain school income from students' parents. The role of school committees in others affairs, especially overseeing of teaching and learning, were often ignored and even tended to be rejected by the schools. In urban areas the committee chairperson was generally a busy parent, so little time was allotted for committee affairs. **The committees of urban schools were generally unaware of the existence PKH recipients at their schools.**

4.5 Utilization of Basic Education

The participation rate of children in primary and junior high school, attendance rates, and parental awareness of the importance of education in general tended to increase in all sample regions. The increases were driven by various factors, such as the existence of government and NGO programs. **The effects of PKH on the increased utilization of basic education services were only visible in rural areas in NTT, particularly in relation to the level of student attendance.** Still there were some obstacles in the utilization of basic education services that had not been fully resolved either by the presence of **PKH** or by government and non-government programs. Constraints were generally associated with costs, geographical conditions, and children's individual issues.

4.5.1 Changes in the Participation Rates of Primary/Junior High School Students

The participation rates of primary school age children in West Java and NTT for both boys and girls had been high since 2007. FGD participants and informants mentioned that all normal primary school aged children were enrolled in school. In addition, the high motivation of parents to send their children to primary school had also affected their eagerness to send their children to PAUD/kindergarten in both urban and rural areas in West Java and NTT. In fact, some schools began to require PAUD certificates to enroll in primary school. **No visible differences in participation rates among primary school age children were detected between treatment and control villages.**

Junior high school participation rates increased in almost all sample villages. **The increase in participation was primarily due to the increased awareness of parents. Increased parental awareness was triggered by increased educational requirements to become migrant workers (TKI/TKW) factory employees, hamlet and village officers and neighborhood heads. All of these positions required at least the equivalent of a junior high school diploma. Especially in NTT, parents' increased awareness was also due to education-related assistance and guidance from various NGOs, mainly Plan International**. The existence of and access to SMP also determined the level of participation. The establishment of one SATAP in one sample village in NTT in 2006 increased the proportion of children who enrolled at junior high school in this village. Prior to the establishment of this SATAP, the participation rate of junior high school was less than 50% because the nearest junior high school was located in the capital district approximately 8 km from the village center. Following the establishment of the Satap in 2009, nearly all students who completed primary school in this village continued on to junior Satap. In West Java, the presence of an open school funded by local government also increased the participation in junior high school. Students who enrolled at the open junior high school did not pay school fees and were even provided with school equipment. In addition, classes were scheduled in the late afternoon and there were less contact hours. The students of poor families were greatly assisted by the existence of this open junior high school.

> "*...Those with junior high school diplomas can become cadre, village chiefs, even the head of RT and RW. For (all these jobs) we need a junior high school certificate*" (FGD Female-NTT). "
>
> "*The increased awareness is due to the demands of the workplace. People need at least junior high school education to work in factories*" (FGD Male-West Java).

In one control village school participation tended to remain consistently low. The level of junior high school enrollment in this village was less than 40%. Unlike the three other villages, there were no NGOs providing aid and special assistance for education in this village. Unfortunately **PKH** was also not operating in this village. The distance to school was an inhibiting factor influencing parents' decisions in sending children to school. The nearest secondary school was 9 km from the village center. There was no public transportation to the school and no dormitory available at the school. Some parents who were still eager to send their children circumnavigated these obstacles by placing children in the homes of family or relatives who lived closer to the school.

PKH's role towards increasing the participation of students was evident at the junior high school level, particularly in rural areas in NTT. There was no visible difference in the participation of primary school aged children as levels had already been high prior to the program. The impact of PKH was only visible in rural areas in NTT where it had an active role in providing assistance. The threat of cuts or withdrawal of **PKH** funding if children were not enrolled, or dropped out of school, was especially effective in raising participation levels.

Other factors explaining the increase were the initially low levels of participation in secondary schools in rural areas in NTT and the relatively high number of **PKH** recipient households

Studies also found that in one of the sample villages in NTT, at the beginning of PKH (2007), some children who did not continue to junior high school were asked to return to school as a condition of their families receiving PKH funds. However in following years, PKH merely prevented students from dropping out of school and ensured that those who completed primary school continued to junior high. This was due to a fixed number of PKH recipient households (no additions) from 2007-2010.

4.5.2 Barriers to the Utilization of Basic Education and Reasons that Children Failed to Enroll or Dropped Out of School

In general, there were no significant barriers for parents in sending their children to primary school. Primary schools were relatively close and generally fees and other associated costs were low. **However, there were still a few cases of primary school aged children who dropped out of school because they could not keep up with the lessons and often had to repeat classes before eventually dropping out of school (especially the case in NTT).** The lack of nutritional intake was also a problem, children often did not have breakfast before going to school, and children who were tired after having to walk to school often had difficulty concentrating in class. In addition, there were some cases of primary school children (especially grade 5 or 6 and usually male) who were negatively affected by the environment and became reluctant to attend school, eventually dropping out. **The threat of PKH funding cuts for beneficiaries if households did not enroll their children in school, could prevent children from dropping out of school, as parental supervision of children's education increased.**

The reasons that children were not enrolled or dropped out of **junior high school** in West Java and NTT were generally similar to 2007 in both the treatment and control regions. These reasons included economic factors, delinquency and idleness of children, and **in NTT, the distance and difficulty in accessing junior high school**. Compared to 2007, economic constraints and the accessibility of schools were similar (with a declining trend), whereas delinquency and idleness of children were increasing.

Economic barriers that caused students to not enroll or drop out of junior high school were the school related expenses that parents have to pay. These included monthly fees, school equipment, and student pocket money. Some junior high schools, especially private schools (some were accessible in the sample villages in NTT) were still allowed to charge monthly fees. School equipment included photocopying of textbooks, uniforms, stationary, extracurricular activities, and other costs (see Table 22). In West Java, parents were also burdened with the cost of transport and pocket money to school. Children often refused to attend school if not given pocket money. The burden of poor parents attracted growing concern with teacher's discrimination against poor students. **Teachers were regarded as providing more attention to affluent students, for example by visiting and frequently communicating the developments of the children to affluent parents. This did not occur with poor parents.**

Table 23. Illustration of the Type and Amount of School (SMP) Expenses

Type of Expense	SMP Sample 1	SMP Sample 2	SMP Sample 3
Registration fee	10.000	100.000	45.000
Monthly fee		20.000	15.000
Comuputer class /year		25.000	100.000
Additional course for grade 3		50.000	
Exam fee	25.000	75.000	
Certificate/farewell fee		50.000	100.000
Photo copy (per subject)	50.000	35.000	25.000
Uniform			
-National			75.000
-Sport	60.000		55.000
Shoes	40.000		
Bag	25.000		
Books and stationary/semester	40.000		

Note: *)Just an illustration, the types of expenses mentioned by FGD participants might not complete
Source: FGD

The presence of PKH funds reduced some of the economic burdens of parents in sending their children to school, especially if the disbursement of the PKH funds occurred at the same time as when school expenses were due. In addition, in these two treatment villages and one control village in NTT, Plan International donated school equipment and provided transportation and tuition fee subsidies for some poor students. In West Java, there was a scholarship program for poor students funded by local government and the private sector (such as Sampoerna Foundation and assistance from *zakat* (Islamic charity). Scholarships were beneficial, but the number of recipients was still limited.

Another economic barrier was that some children were required to work or chose to work because they had to help parents meet household economic needs. In the fishing areas of West Java and NTT, one reason for children discontinuing or dropping out of secondary school was that children were involved in fishing at sea or working as part of a ship's crew. In West Java, some girls were forced to become migrant workers. Although the minimum requirements for migrant workers were junior high school certificates, sometimes diplomas were falsified. In urban areas (West Java and NTT), there were many school-age children who became motorcycle taxi drivers, bus conductors, or laborers in the markets. At first they only worked after school, but then they eventually dropped out of school.

Another reason that children did not want to continue school or dropped out of school was because of **misbehavior or laziness caused by adverse environmental effects**. This factor was generally more common in boys and in urban areas. There were also several cases of children who did not continue to junior high school because their parents divorced or because parents become migrant workers (TKI/TKW) so children had less attention. Additional reasons for girls dropping out were being forced to marry by parents, or becoming pregnant out of wedlock. In addition to the social shame of having a child out of wedlock, school rules did not allow girls who were pregnant or had children to attend school.

In rural areas in NTT, **other barriers that caused parents to be more reluctant to send their children to school were the long distances to schools**. Although each of the three villages (two treatment and one control) had available SMP, the vast territory and scattered

population meant that students from remote villages had to walk for up to two hours to attend school. This distance and the length of time required caused children to be tired and often absent. In the end, some children were forced to leave school. In one control village in particular, the obstacles faced were more severe. The nearest junior high school was located 9 km from the village center. In addition, in this village there was no NGO assistance for education. This resulted in a level of parental awareness of the importance of education and consequently there were many school-age children involved in helping their parents working on farms.

The high cost of education

> "*There are children who do not want to attend schools because of economic reasons because not all expenses are free or paid by BOS*" (FGD Female-West Java).
>
> "*With BOS, the school tuition is free. But still we have to pay the cost of school books (LKS). If we did not buy LKS our children's scores would not be reviewed* "(FGD Female-West Java).
>
> "*At primary level all the children were enrolled, but at junior high it depends on parents and children. Sometimes children want to attend but parents cannot afford it, or vice versa* "(FGD Male-West Java).

Children should work

> *Many girls were 'waiting for their age' to become migrant workers in Saudi Arabia. Or even if they were old enough, junior certificates can be falsified* "(FGD Female-West Java).
>
> "*If it occurred it was because of economic factors. Usually when there are children who are not registered at school, the child helps the parents work* "(FGD Female-West Java).
>
> ". *never mind my child will go to Saudi Arabia, just because there was no financial support*" (Guru SMP-West Java).
>
> "*They were enrolled in school but they dropped out of school part way through, usually because of economic factors. In the end they chose to work* (FGD Male-West Java).
>
> "*They were not enrolled at schools but became fishers helping their parents* " (FGD Female-West Java).

Delinquency and idleness of children

> "*More boys are lazy, while girls drop out of school to work abroad (TKW) or get married*" (FGD Female-West Java).
>
> *Before there was BOS, many children dropped out of school because of poverty or economic factors. Now, if school dropout occurs it is because children are generally lazy, stubborn and do not want to go* (FGD Male-West Java).
>
> "*They are actually 100% registered in school, if their parents educate their children properly, the children would not be absent or dropping out of school*" (FGD Male-West Java).
>
> "*Girls are, on average, more obedient. If a girl dropped out it was due to pregnancy or being forced to work to Saudi Arabia by her parents* "(FGD Female-West Java).

4.5.3 Changes and Causes in the Levels of Student Absence

In general, student absenteeism rates in primary and junior high schools in both the treatment and control villages in West Java and NTT declined. Nevertheless, there were still 1-2 students per class who were absent with an average length of absence betwee1-3 days in one month. Boys were more often absent than girls. **PKH had a role in lowering the level of student absences, especially for beneficiaries in rural areas in NTT.**

In West Java (treatment and control) decreases in the level of primary and junior high student absenteeism were mainly due to increasingly strict school rules. Some schools, for example, build a fence around the school and locked it during school hours. There were also schools that recruited security personnel whose main duty was to oversee problems of student absenteeism. However, there were still students who were absent (especially at junior high school level) due to delinquency, laziness, and bad environmental influences. The presence of Playstation rental kiosks close to schools were a source of criticism by many parents and teachers, because students who were absent generally spent time playing Playstation or just *'hanging out' in the kiosks nearby'*. A father of FGD participants stated *"From home the children wore their uniform and asked permission to go to school, but they did not get to school. Usually they played at the playstation rental kiosk'* (FGD Male-West Java)

Another reason for student absenteeism was because they had to look after their younger siblings at home while the parents worked on the farm. In fishing villages, there were also children who had to help their parents go out to sea. Children who joined their parents at sea were generally male and in junior high or late primary school. **PKH influence on the level of student absences in West Java was not too visible.** This was due firstly to the low number of **PKH** recipients who were scattered in different schools meaning that teachers did not know who the **PKH** recipients were and consequently did not oversee the student's attendance. In addition, the lack of supervision from the **PKH** facilitators also reduced the potential influence of PKH towards the level of student absenteeism amongst receiving **PKH** funds.

In NTT, in almost all sample areas student absenteeism decreased, with attendance rates remaining low only in one (control) village. The cause of this decline was the increasing awareness of parents regarding the importance of education. This meant that parents were more concerned about their children's school attendance rates. Decreased absenteeism was also due to the increased control of schools and village officials. Village officials were often involved by the school in solving the problem of frequently absent students. These village officials summoned and admonished parents to better supervise their children. Increased awareness of parents and increasing roles of village officials were also due to the assistance and counseling related to education from NGOs. **PKH contributed to a significant increase in school attendance**. The emphasis of the facilitator that **PKH** funds received would be reduced by Rp50,000 per day of school absence resulted in increased parental awareness and supervision. A father said: "*There was an effort to reduce children's absence, if they were absent PKH funds would be cut by Rp50,000, so we oversaw the children so they are not absent. We were faithful to the school because we feared a fine* "(FGD Male-NTT).

Reasons why there were no changes in absence rates (especially for SMP) in one control village were that village conditions were relatively more isolated and underdeveloped compared to other sample villages in NTT. From this village the students had to walk more than 9 km to the nearest secondary school, and no public transport was available. In addition, in this village there was no education-related NGOs assistance. Consequently parents' awareness of the importance of education generally did not change much. It was unfortunate that PKH did not operate in this village.

Similarly to West Java, NTT also experienced absent primary and junior high school students, but for slightly different reasons than West Java, mainly due to geographical and socio-economic conditions. In rural areas in NTT the main reasons that students were absent were because of the rainy season, the harvest season, and market days. The rainy season was still a constraint, since road conditions were muddy, and rising rivers could not be crossed (because

there were no bridges), or because uniforms, shoes, and stationery, were wet. In the rainy season, students could be absent up to a week waiting for the water in the river to recede. At the time of the harvest and planting seasons, there were students (especially in junior high school), who had to assist parents in the fields. On market days many students had to help parents bring agricultural products to the market. Several other students were absent from school because they wanted to play and enjoy the market crowd. The distant location of houses from schools also caused students to be absent. For primary schools, although schools already existed at the village level, those living in remote hamlets still had to walk for durations of up to one hour. Consequently students were often exhausted and did not attend school. In some schools students were frequently absent due to teacher absences. In urban areas in NTT, the reasons for student absences were similar to those in West Java, namely because of delinquency and student laziness, because students played in Playstation kiosks rather than attending school, did not complete their homework or arrived late and were afraid of upsetting the teacher.

4.5.4 Actors Influencing the Utilization of Basic Education

There were a diversity of actors who influenced the utilization of basic education services in West Java and NTT. The diversity was due not only to the type of actor, but also the intensity and the type of roles of each actor played in influencing the utilization of educational services. The role and number of actors in rural areas was relatively higher than in urban areas, and this applied to both West Java and NTT. **Specially for treatment villages in rural areas in NTT there were new actors, namely PKH facilitators, who played a role in encouraging parents (PKH recipients) to pay more attention to their children's schooling.**

Table 24 List of Actors who Influnced the Utilization of Basic Education Services in PKHTreatment and Control Village

Category	Village Name	Name of Actors
West Java		
Rural Treatment	Gregesik Kulon	Teachers
	Jagapura Kidul	Teachers, village officials, school principals
Rural Control	Susukan	Teachers, village officials
	Tangkil	Village officials, hamlet head, RT head
Urban Treatment	Mertasinga	Neighbours
Urban Control	Mundu Pesisir	Friends, Neighbours
NTT		
Rural Treatment	Oenai	Village head, Hamlet head, head of RT, religious and community leaders, teachers, NGOs (Plan)
	Falas	Village officials, community leaders, school committees, school principles, , teachers , NGOs (Pidra, WFP, CWS & Plan)
Control Treatment	Bisene	Village head, school committees, community leaders, teachers, religious leaders
	Biloto	Village head, Hamlet head, school committees, religious leaders
Urban Treatment	Fatufeto	Religious leaders , head of RT
Urban Control	Tode Kisar	Neighbours, community leaders, village officials

Source: Interviews and FGD

In rural areas in West Java, both in treatment and control villages, actors who influenced the utilization of basic education services included principals, teachers, heads of the committees, village officials (especially the village heads), as well as neighbors. There were also roles for schools, for example in establishing policies to withhold students' certificates if students did not continue to junior secondary level. "*.. If they do not continue the diplomas will be held by the school so that they will continue*" (FGD Male- WestJava). The role of village officials tended to decline, their roles were limited to providing advice to parents during meetings at the village level or at schools. The reduced role of village officials was due to a perception that public awareness had increased.

> "*To capture the children who dropped out of school there was a cooperation with village and RT head at the beginning of each new school year* ***but this does not occur anymore***. " (FGD Male-West Java).

In urban areas in West Java, both in treatment and control villages, the actors who played roles in encouraging parents to send their children to school were committee and village officials. The role of these two groups were limited to encouraging and advising children and parents. Village officials in rural sample areas also played a role helping the poor obtain certificates confirming their economic status (SKM) which were a requirement to obtain a scholarship from the school. In addition. Neighbors also played a role in reminding and advising parents if their children did not diligently attend school.

In rural areas in NTT, village heads and other village officials (heads of the hamlet, RW and RT) were the actors who were most frequently mentioned, in both treatment and control villages. Compared to rural areas in West Java, the role of village officials in NTT were more prominent, they not only encouraged, but also looked after parents to pay attention to their children's education. Village officials were also often involved by the school to deal with juvenile problems such as students' frequent absence. Other important figures were pastors at churches, who regularly reminded parents and students about the importance of education during church services. The school committees (especially the heads) were also active in providing motivation to parents, both individually and through meetings at the school. In rural NTT, the role of NGOs was quite significant in motivating parents. In addition to providing assistance to schools, NGOs also provided scholarships for poor students, as well as support and guidance to parents regarding sending their children to school. In addition, **the PKH facilitators were also quite active in motivating parents to send their children to school and to continually paying attention to children's attendance at school.**

Compared to rural areas, urban areas in NTT had fewer actors concerned with education. This was true in both treatment and control areas. Actors in urban areas, included churches, heads of RT, neighbors, and community leaders. In addition, due to a high level of parental awareness of the importance of education, urban culture, and the absence of NGOs working in the field of education, educational issues in urban settings were more often regarded as the internal affairs of each household.

4.5.5 Changes in Women' and Men' Awareness of the Importance of Sending Children to School

Both in West Java and NTT, the existence of jobs requiring junior high school diplomas, and efforts by village officials, community leaders, and NGOs helped to increase public awareness of the importance of education. Indications of this increased awareness were reflected in the responses of FGD participants who expressed hopes of a better future through their

children's education. For comparison, the baseline study FGD participants found that participants generally viewed the benefits of education to be limited to improving children's basic skills (just enough to read, write and count). Parent's increasing awareness of the importance of educating their children was also reflected in their earnestness to keep their children in school, even if assistance stopped. High levels of parental awareness were also reflected in the lack of differentiation between boys and girls regarding primary school education. Yet for high school or higher education some parents still prioritized boys over girls, this was mainly due to the limited economic resources of parents.

Increased awareness of the importance of education

> "*(Children) should go to school so they are not illiterate, can get better work, and no longer work as a farm laborers. Now there are a lot of... companies. Many who work in companies have to have at least graduated from high school* (FGD Male-West Java).
>
> "*I observe, parents want to work hard as long as students seriously want to go to school. They put great expectations on their children Men and women were given equal opportunities, depending on the ability of the child's brain* "(SDN Principal-NTT).

No differentiation between boys and girls

> *There was no difference in treatment of boys and girls to attend school at all school levels. Parents now or since 3 years ago have been serious about sending children to school, both male and female* (School Principal- NTT).
>
> "*Anyone either male or female, it makes no difference, everyone should be smart* (FGD Female-West Java).

However, some parents who were unconcerned with their children's education were still found. In fishing regions in West Java, the level of awareness of some parents had not changed significantly. schools were still complaining about the lack of support provided by some parents towards their children's education. The parents' backgrounds as fishers with limited education caused them to pay limited attention to the education of their children. Parents' economic limitations meant that they did not prohibit children from going to sea and tended to ignore the school. In addition, in one control village in NTT awareness of the benefits of education amongst parents, especially mothers, was still low. In this village parents still tended to prioritize boys attending junior high school over girls and communities were still prioritizing certain traditional customs. "*They prefer boys, because they are afraid that girls get pregnant so easily, so we would have a financial loss if we sent girls to school. Boys have to go to school to continue the clan*" (Principal SD-NTT).

Awareness in coastal communities was still low

> *"..... Coastal communities tended to be more detached, there was less community support for education. Although the teachers continued to advocate, and provide advice regarding children's enrollment in schools and diligent attendance, (the communities) didn't care* "(School Principle -West Java).
>
> "*They don't want to cooperate for the good of their children ..., they protect their children even if they do something wrong. Finally, there is no solution because they do not want to cooperate ...* "(Head of Primary School-West Java).

PKH, especially in rural areas in NTT, contributed to raising the awareness of parents to send their children to school. In rural areas in NTT the PKH facilitators provided guidance or advice to parents about the importance of school. Although PKH was more focused towards wives, the information obtained was also passed on to the husbands so that both wives' and husbands' knowledge increased.

V CONCLUSIONS AND RECOMMENDATIONS

5.1 Conclusions

5.1.1 PNPM Generasi

In general, the implementation of PNPM Generasi provided benefits for most communities in the recipient villages. These included benefits in the provision of services through the addition and improvement of physical facilities, and benefits to the utilization of services through easier access to MCH services and basic educational services. The increased availability and utilization of services in control areas also occurred due to other support programs run by government (central and local) and nongovernmental organizations (NGOs and foreign aid). Despite increases, a number of barriers to the availability and utilization of services continued to exist, especially in NTT.

The Availability of MCH Services

- Although there were no additional types or quantities of service providers, the improvement of physical facilities and supporting facilities funded by PNPM Generasi and other programs resulted in improved MCH services compared to 2007.

- *Posyandu* were available in every hamlet and were actively managed by cadres each month. *Posyandu* services were increasing, especially in treatment areas, due to **PNPM Generasi** aid including the construction/renovation of *posyandu*, the provision of additional support facilities, incentives for cadres, and PMT for under five children.

- Midwives were the main providers of MCH services in the villages, but the barriers to midwifery services were not significantly reduced compared to 2007. This was a result of difficulties in access, services that covered vast areas, a lack of basic facilities, a lack of medicine, the reluctance of midwives to live in villages, and frequent midwife absences.

- There were two groups in the community that MCH services had difficulty reaching: (1) those who lived far from the center of the village, and (2) residents who still adhered to customs such as *se'i*, or *naketi*. Compared to 2007 the overall number of these groups had reduced.

- *Dukun beranak* were still present but had a diminishing role, mainly assisting the midviwes with childbirth. **The incentive funds from PNPM Generasi for childbirth services**, the absence of a new generation of *dukun beranak,* sanctions administered by authorities for mothers' whose babies were delivered by *dukun beranak*, and the appeals of local government, all contributed to a reduction in the role of *dukun beranak*.

- Community involvement in determining new MCH services occurred formally via PNPM **Generasi**, Desa Siaga, and NGO aid programs. Village elites and project staff, especially men, continued to dominate the decision making process.

Utilization of MCH Services

- Utilization of MCH services (midwives and *posyandu*) increased with increasing knowledge and awareness of women and men regarding the importance of MCH. Increased knowledge and awareness was driven by a variety of government and nongovernment aid programs, higher education levels within the community, and easier access to MCH information.

- **PNPM Generasi contributed to the increased utilization of MCH services** by providing subsidies for midwifery services during childbirth, providing transportation subsidies for pregnant and postpartum women to attend health checks, and providing PMT at *posyandu.*

- In general, women preferred to have babies delivered by a midwife rather than a *dukun beranak*. This was because midwives had more extensive equipment and drugs, midwives could provide hospital referrals, fees could be paid in installments, and midwives could provide additional services such as issuing birth certificates.

- A small number of women did not use midwifery services due to remoteness, high costs, and a higher level of trust in *dukun beranak*. Other factors included the shame of having many children, being pregnant out of wedlock, and, specifically in NTT, the shame of showing genitals to the midwife. In general, these reasons had not changed since 2007.

- Reasons for not accessing *posyandu* did not differ compared to 2007. Reasons included sick children, the completion of children's immunization, the lack of supplementary feeding (PMT), the lack of children's playground, work obligations, the lack of an escort, the shame of having many children, or flooding in the rainy season. However, the proportion of women and children accessing *posyandu* had risen compared to 2007.

- Actors influencing the utilization of MCH services had not increased due to PNPM Generasi. This was because the actors implementing PNPM Generasi were *posyandu* cadres and local community leaders.

Availability of Basic Education

- The number of primary schools in every village were sufficient and there had been no significant changes in sample areas since 2007. The availability of junior high schools in West Java had been adequate and relatively easy to reach since 2007. However in NTT, the availability of SMP still posed problematic due to large geographical distances between communities and schools and high transportation costs. The addition of a One-Roof SMP (Satap) occurred in one control village.

- Physical infrastructure and supporting facilities in primary and junior high schools had improved compared to 2007 with funding from government and nongovernment sources. **PNPM Generasi provided additional school furniture, and the payment of teachers' salaries in some junior high schools.**

- Barriers to the provision of basic education services in 2007 had not been fully resolved. This especially included the availability and quality of teachers, the attendance of teachers

in the classroom, and the status of teachers. In NTT, the barriers were greater due to the additional burdens of the lack of electricity and clean water in schools.

- In general, school committees were not functioning optimally and their level of activity were very dependent on the capacity of individual committee heads and principals as well as socio-economic conditions of the society in which the schools were located.

- There were three groups of people who were difficult to access by junior high school services: (1) the poor, (2) remote communities, and (3) juvenile delinquents and unmotivated students.

Utilization of Basic Education

- The level of participation of primary school age children had been high since 2007. The level of participation in SMP increased due to the increased awareness of parents, the demands of employment, guidance and assistance from government and nongovernment educational programs (**including PNPM Generasi**), shame for failing to attend school, the active role of teachers, committees and village officials, the availability of Open SMP, and the absence of differential treatment for boys and girls in accessing junior high school.

- **PNPM Generasi prevented school dropouts**. This was possible because Generasi's aid (including uniforms, school equipments, school fee subsidies, as well as transport and dormitory allowances) helped lessen parents' burden of school expenses. **PNPM Generasi helped lower the absentee level of primary school/junior high school students** because the direct assistance improved the students' spirit and motivation to attend school and, in NTT, the program also encouraged the reinstatement of fines for absent students.

- Factors that still caused junior high school-aged children to discontinue or drop out of school were the economic factors and geographical barriers(especially in NTT). For girls, other factors included being forced to marry or becoming pregnant out of wedlock. For boys other factors were negative environmental influences. **In treatment villages economic barriers were slightly alleviated by various kinds of assistance from PNPM Generasi.**

- Student absenteeism at SD/SMP decreased compared to 2007. **PNPM Generasi enhanced the motivation of students and, especially in NTT, encouraged the villages/*kecamatan* to intensify penalties for absent students.**

- Actors at the village level who encouraged parents to send their children to school had not changed since 2007. Most actors' roles were limited to providing formal advice.

5.1.2 The Family Hope Program (PKH)

In general, the study found that the benefits of PKH were only felt at the level of **PKH** recipient households, there were no impacts to non-beneficiaries. In addition, non-beneficiaries and some MCH and education service providers were not aware of PKH because it was implemented discretely to reduce the likelihood of jealousy and potential conflicts. However, in villages where there were a relatively large number of recipients and active facilitators, **PKH contributed to the growing attendance of women at *posyandu* and student attendance at schools**.

The Availability of MCH Services

- The availability of MCH services increased in only some sample areas. In two remote villages in NTT the availability of MCH services did not change. This was because there were no midwives and only a limited number of *posyandu*.

- Midwives were the main providers of MCH services in villages. In isolated areas in NTT, the absence of midwifery services were a result of difficult accessibility of villages, wide service coverage areas, a lack of basic facilities, and unwillingness of midwives to relocate away from their families.

- The *posyandu* services operated regularly every month and there were increased activities in some *posyandu*. However some *posyandu*, were limited by minimal or absent cadres and the lack of incentives and support facilities for *posyandu* services.

- There were several small groups of communities that were difficult to reach with MCH services, namely (1) residents who lived far from the center of villages, (2) citizens who believed in traditional or cultural customs, such as *sei*, (3) mothers who assisted their husbands at sea, and (4) mothers who went to the field during the harvest season. Compared to 2007 the overall number of these groups had decreased.

- The role of *dukun beranak* in delivering babies decreased. In West Java the decline in the role of *dukun beranak* was due to no new generations of *dukun beranak,* and local government appeals. In NTT the decline was due to a prohibition of *dukun beranak* delivering babies issued by the KIA Revolusi program. However, in all sample villages *dukun beranak* continued to provide services to pregnant and postpartum women as well as in organizing traditional ceremonies.

- Community involvement in decision making increased as a result of the Revolusi KIA program in NTT and the Desa Siaga program inWest Java.

Utilization of MCH Services

- **PKH had a positive effect on increasing the use of *posyandu* in rural areas in NTT.** This was due to the active role of the PKH facilitators and the threat of PKH funding cuts to recipients who did not routinely attend the *posyandu*. In the treatment villages in urban NTT and West Java PKH facilitators had no significant influence on *posyandu* utilization. The presence of PKH had no effect in overcoming barriers to women accessing midwifery services. This was because the dispersal of PKH funds generally did not coincide with the times that funds were needed (for example during childbirth). Additionally, in one village midwives were not available.

- **Reasons for women not utilizing the services of midwives were, limited or no midwife availability,** limited finances, and in NTT, the practice of *se'i* and belief in *dukun beranak*. There were no significant changes in these reasons compared to 2007. Reasons for women not attending *posyandu* included women's work as laborers, vendors or maids, or a preference for other widely available providers of MCH.

- Actors influencing the utilization of MCH services included village officials, midwives, *posyandu* cadres, community leaders, neighbors, and, especially in NTT, religious figures

and NGO officials. **PKH facilitators were new actors that affected the utilization of MCH services in only two of the sampled villages.**

Availability of Basic Education

- The number of primary schools in all sample villages were adequate and had not changed since 2007. The availability of junior high schools in West Java had been similarly adequate since 2007 and relatively easy to reach. However in NTT, the availability of SMP continued to pose problems due to large distances between communities and schools and high transportation costs. There had been no new schools built since 2007.

- The quantity and quality of infrastructure and supporting teaching and learning facilities in primary and junior high schools rose from 2007 with funding from government and nongovernment sources.

- Barriers to the provision of basic education services in 2007 has not been fully addressed, especially in rural areas in NTT. Barriers included the limited number, quality, and status of teachers, the lack of electricity and clean water in schools, and the limited facilities, infrastructure, and teaching aids in schools.

- Education services had difficulties reaching the following specific communities: (1) fishing communities, (2) remote villages, and (3) juvenile delinquents and unmotivated students.

- In general school committees were not functioning optimally, particularly in urban areas. In rural areas, committees played a role in monitoring BOS funds, the construction of school facilities, and, especially in NTT, monitoring student and teacher attendance.

Utilization of Basic Education

- The participation of primary school age children had been high since 2007, and the participation of junior high school aged children had increased as a result of increased parental awareness of the importance of education, increased educational requirements for jobs, and support from NGOs. The role of PKH in increasing junior high school participation was only visible in rural NTT due to the relatively large number of PKH recipients, existence of sanctions, and the active role of the facilitators.

- A number of factors caused some children to discontinue or drop out of junior high school. These included economic factors, geographical barriers, and high transportation costs. For girls, other factors included being forced to marry, becoming pregnant out of wedlock, or becoming migrant workers. For boys, other factors included negative environmental influences and juvenile delinquency.

- In general, the average school student absence was 1-3 days. There were different reasons for absences of students from rural or urban areas and for NTT and West Java. In rural NTT absence occurred due to the wet season, harvest season, market days, student fatigue, and lack of student motivation. In urban West Java and NTT absence occurred due to negative peer pressure, lack of student motivation, student's not receiving pocket money, or students assisting with their parents' work.

- **PKH improved primary and secondary school attendance**, especially in rural NTT, due to the threat of PKH funding cuts to recipients whose children were absent from school. Levels of absenteeism also fell as a result of stricter school rules, fencing around schools and the availability of school security staff.

- Actors that encouraged parents to send their children to school were school principals, teachers, committee chairs, village officials, and neighbors. In NTT, religious leaders and NGOs also played a role.

5.2 Recommendations

5.2.1 PNPM Generasi

- In general, PNPM Generasi could overcome some obstacles to the provision and utilization of MCH and basic education services. Drawing on the conclusions, the following actions are recommended for the central and local government to improve program benefits: (i) Increasing the availability and quality of rural infrastructure including roads, bridges, electricity and clean water to allow easier public access to MCH and primary education services, and (ii) Increasing the availability and quality of MCH and primary education services including village midwifes, the availability of drugs at *polindes*, teacher education, and status of contract teachers.

- To reduce barriers and simultaneously increase the utilization of MCH and basic education services additional guidance and mentoring is required, especially to increase the awareness of parents and children regarding the benefits and importance of MCH and primary education and to increase the economic capacity of households.

- The study identified two misunderstandings regarding the program by village officials and program implementers that caused less than optimal implementation of the program. Firstly, the notion that PNPM **Generasi** assistance for children was intended only for students enrolled in primary or junior high school. This resulted in children who were not enrolled or who had dropped out of school receiving no assistance. Secondly, PNPM **Generasi** assistance in all sample villages was spent entirely on material assistance, in the form of either money or goods. The study did not find any instances of non-material assistance that aimed to increase awareness. This evidence raises the concerns of service providers and village officials that if material assistance is stopped people will return to the pre-treatment conditions because the increases in service utilization had merely occurred due to people's desire to gain material assistance. To address both of these misunderstandings it is recommended that efforts be taken to raise the awareness of program implementers and village officials regarding the program's objectives and types of aid allocation.

5.2.2 PKH

- Drawing on the experience of PKH in rural areas of NTT we can conclude that the impact of PKH is largely determined by a high number of recipients in one village, the support and active involvement of community and village officials, and the active role of facilitators within the program. These findings provide valuable lessons to be applied to other PKH recipient areas. However, efforts to strengthen other factors related to the program in relation to both availability and use, are still needed.

- To increase the impact of PKH on the use of MCH and education services it is recommended to:
  (i) Increase the availability of MCH services and junior high schools so that they are accessible by all communities.
  (ii) Improve village infrastructure including roads, bridges, electricity, and clean water.
  (iii) Raise awareness of PKH amongst village officials, service providers recipients and non-recipient households. Include schools, midwives, and cadres in the monitoring of program recipients.
  (iv) Ensure that program facilitators are located close to program recipients by limiting the geographical areas covered by each facilitator and determining work boundaries based on the total area and number of villages in addition to the number of beneficiaries.
  (v) Increase transparency of the process used to determine program recipients and increase awareness of this amongst both recipients and non-recipients.

APPENDICES

APPENDIX 1

Table A1. List of Researchers

Kecamatan	Village/*Kelurahan*	Research Team	
		Coordinator	Local Researchers
Kabupaten Sumedang (West Java Province)			
Rancakalong	1. Nagarawangi	Sri Budyati	Hendra W. Wardhana Harso Yuliantena
	2. Pamekaran	Nina Toyamah	Kartawi Amah Majidah V.D.
Buah Dua	3. Buah Dua	Meuthia R.	Didi Supardi Ida Dewi Yuliawati
	4. Bojongloa	Justin Sodo	Dedi Ali Ahmad Urilawati D. A. Lihiang
Darmaraja	5. Sukaratu	Ruhmaniati	Heru P. Wardhana Sintawaty
	6. Neglasari	Adri Amiruddin	Asep Kurniawan Juliawati
Kabupaten Cirebon (West Java Province)			
Gegesik	7. Gegesik Kulon	Sri Budiyati	Hendra W. Wardhana Harso Yuliantena
	8. Jagapura Kidul	Nina Toyamah	Kartawi Amah Majidah V.D.
Susukan	9. Susukan	Justin Sodo	Dedi Ali Ahmad Urilawati D. A. Lihiang
	10. Tangkil	Meuthia Rosfadhila	Didi Supardi Ida Dewi Yuliawati
Mundu	11. Mundu Pesisir	Ruhmaniati	Heru P. Wardhana Sintawaty
Gunung Jati	12. Mertasinga	Adri Amiruddin	Asep Kurniawan Juliawati
Kabupaten Timor Tengah Utara (East Nusa Tenggara Province)			
Biboki Utara	13. Taumbaen	Adri Amiruddin	Ida Dewi Yuliawati Theo Wetangterah
	14. Hauteas	Justin Sodo	Maria HKT Sorywotun Patje Oktofianus T.
Insana	15. Sekon	Vita Febriany	Edu Mungga Timoryani Samauna
	16. Susulaku A	Nina Toyamah	Yohanes Ghewa Yakomina W. Nguru
Bikomi Tengah	17. Oenenu Induk	Hendra W. Wardhana	Ronny Modena Erlina Dangu
	18. Kuanek	Ruhmaniati	Yans Koliham Yeanny Marlina B.M.
Kabupaten Timor Tengah Selatan (East Nusa Tenggara Province)			
Kie	19. Oenai	Hendra W. Wardhana	Ronny Modena Erlina Dangu
	20. Falas	Vita Febriany	Edu Mungga Timoryani Samauna
Molo Selatan	21. Biloto	Adri Amiruddin	Ida Dewi Yuliawati Theo Wetangterah
	22. Bisene	Justin Sodo	Maria HKT Sorywotun Patje Oktofianus T.
Kota Kupang (East Nusa Tenggara Province)			
Alak	23. Fetufetto	Nina Toyamah	Yohanes Ghewa Yakomina W. Nguru
Kelapa Lima	24. Tode Kisar	Ruhmaniati	Yans Koliham Yeanny Marlina B.M.

APPENDIX 2

Table A2. Access to Sample Villages/*Kelurahan*

Kecamatan	Village	Distance from the Village to the *Kecamatan*'s Center (km)
Kabupaten Sumedang (West Java Province)		
1. Rancakalong	1. Nagarawangi	0
	2. Pamekaran	2
2. Buahdua	3. Buahdua	0
	4. Bojongloa	3
3. Darmaraja	5. Sukaratu	0.3
	6. Neglasari	2
Kabupaten Cirebon (West Java Province)		
4. Gegesik	7. Gegesik Kulon	<1
	8. Jagapura Kidul	6–7
5. Susukan	9. Susukan	0
	10. Tangkil	5
6. Gunung Jati	11. Mertasinga	6
7. Mundu	12. Mundu Pesisir	2
Kabupaten Timor Tengah Utara (East Nusa Tenggara Province)		
8. Biboki Utara	13. Taunbaen	12
	14. Hauteas	2
9. Insana	15. Sekon	6
	16. Susulaku A	6
10. Bikomi Tengah	17. Oenenu Induk	1.5
	18. Kuanek	8
Kabupaten Timor Tengah Selatan (East Nusa Tenggara Province)		
11. Kie	19. Oenay	6
	20. Falas	7
12. Molo Selatan	21. Biloto	5
	22. Bisene	10
Kota Kupang (East Nusa Tenggara Province)		
13. Alak	23. Fetufetto	0
14. Kelapa Lima	24. Tode Kisar	0

Source: Baseline study (2007) and field verification of the impact study (2010).

APPENDIX 3

Table A3. Area, Population, and Number of Households (KK) in Sample Villages/*Kelurahan*

Village	Area (Ha)	Population			Number of Households (KK)		
		2007	2010	Δ(%)	2007	2010	Δ(%)
1. Nagarawangi	436	4131	4367	6	1416	1533	8
2. Pamekaran	375	3027	3107	3	1026	1110	8
3. Buahdua	372	3332	3428	3	998	1134	14
4. Bojongloa	535	3208	3552	11	n.a.	1145	-
5. Sukaratu	130	2576	2796	9	812	789	-3
6. Neglasari	169	n.a.	2442	-	n.a.	615	-
7. Gegesik Kulon	401	n.a.	5565	-	-	1819	-
8. Jagapura Kidul	500	7411	8148	10	2248	2612	16
9. Susukan	130	6708	6711	0.04	1619	1619	0
10. Tangkil	304	6906	5822	-16	1780	1812	2
11. Mertasinga	74	6088	6323	n.a.	1271	2000	-
12. Mundu Pesisir	155	6016	5743	-5	1285	1294	1
13. Taunbaen	1,970	1432	1554	9	339	366	8
14. Hauteas	2,220	1739	1862	7	391	403	3
15. Sekon	1,800	867	994	15	223	225	1
16. Susulaku A	650	943	1041	10	225	231	3
17. Oenenu Induk	1,200	738	884	20	184	237	29
18. Kuanek	433	510	612	20	154	163	6
19. Oenai	1,800	2439	2624	8	717	740	3
20. Falas	1,650	2038	2044	0.3	535	576	8
21. Biloto	3,000	n.a.	602	-	155	176	14
22. Bisene	1,700	1684	1708	1	407	427	5
23. Fetufetto	53	4652	4445	-4	1037	935	-10
24. Tode Kisar	0.11	1039	965	-7	285	285	0

APPENDIX 4

Table A4. Changes of the Condition of Facilities of Sample SD and SMP in PNPM Generasi Treatment and Control Villages

Category	Village	SD/SMP	Type of Change	Source of Fund	Year
West Java					
Treatment	Nagarawangi and Pemekaran	SDN 1 Nagarawangi	Classroom renovation	APBD	2008
		SDN Cikeusik	Classroom renovation	APBD	2008
		SMPN 1 Rancakalong	Renovation to 4 classrooms	DAK and BOS	2009
	Buahdua and Bojongloa	SDN Buahdua	No change	-	-
		SDN Bojongloa 2	Major renovation to 4 classrooms	DAK	2008
		SMPN 1 Buahdua	Classroom renovation	DAK	2008
Control	Sukaratu and Neglasari	SDN Cakrawati	Classroom renovation	DAK	2007
		SDN Neglasari	Clasroom renovation and 2 toilets	DAK	2009
		SMPN 2 Darmaraja	Major renovation to classroom and teacher/administration's toilet	DAK	2009
East Nusa Tenggara					
Treatment	Hauteas and Taubaen	SDK Lurasik	1 new classroom, 1 library, 1 school health unit (*usaha kesehatan sekolah*–UKS)	DAK and DBEP	2008
		SDN Oeekam	2 new classrooms	PNPM Generasi	2009
		SDN Taunbaen	2 new classrooms, library, UKS	Plan International and DBEP	2008
		SMPN 1 Lurasik	New hall/praying room	Komite sekolah	2008
	Susulaku and Sekon	SDN Sekon	3 new rooms for library and teachers	Plan International	2008 & 2009
		SDK Susulaku	Renovation to 3 classrooms	DBEP	2008
		SMPK Oelolok	No change	-	-
Control	Oenenu and Kuanek	SDK Oenenu	4 new local rooms and renovation to classroom(s)	DBEP and Dekon Prov	2007
		SDN Kuanek	New classroom(s) and library	DAK	2009
		SMPN Oenenu[a]	No change	-	-
		SMPN Oelneke	No change	-	-

[a] It was established in 2008 and has been using the premises of SDK Aloysius for its activities.

APPENDIX 5

Table A5. Changes of Condition of Supporting Facilities of Sample Schools in PNPM Generasi Treatment and Control Villages

Category	SD/SMP	Type of Change	Source of Fund	Year
West Java				
Treatment	SDN Nagarawangi	Furniture, visual aid tools, CD player, laptop, computer (no operator), art supplies, laboratory tools and apparatuses, and TV	PNPM Generasi, BOS and SDSN-Dekon Provinsi	2008
	SDN Cikeusik	No addition/change		
	SDN Sukamaju	Furniture	PNPM Generasi	2009
	SDN Buahdua	2 computers	School alumni/committee	2008
	SDN Bojongloa 2	30 sets of student chair and desk, textbooks, and computer[a]	PNPM Generasi BOS DAK	2009
	SMPN 1 Rancakalong	Sport equipment, library books, musical instruments, furniture	BOS	2008 & 2009
	SMPN 1 Buahdua	Textbooks/library books	BOS	2009
Control	SDN Cakrawati	School's kitchen equipment and furniture Books	DAK BOS Provinsi	2007 2008
	SDN Neglasari	Textbooks, CD player, computers, chairs and desks	BOS DAK	2008 & 2009
	SMPN 2 Darmaraja	No addition/change	-	-
East Nusa Tenggara				
Treatment	SDK Lurasik	New chairs and desks, textbooks, computer, visual aid tools, and TV/VCD player	PNPM Generasi, DAK, APBD & Plan International	2007 & 2008
	SDK Oenali	70 sets of chair and desk and blackboard	DBEP & PNPM Generasi	2008 & 2009
	SDN Sekon	Chairs and desks, textbooks/library books, and school cupboard(s)	Plan International & PNPM Generasi	2009
	SDK Boni	Chairs, desks, textbooks, and cupboards	DBEP and BOS	2010
	SMPN 1 Lurasik	School fence, art supplies, and resource books for teachers	BOS & DBEP	2008 & 2009
	SMPK Oelolok	2 computer	APBD & PNPM Generasi	
Control	SDK Aloysius, Oenenu	Learning media/VCD, computer, and printer[b]	APBD	2008, 2009 & 2010
	SDN Oefui	No addition/change	-	-
	SMPN Oenenu	5 desks and chairs	BOS	2008 & 2009
	SMPN Oelneke	Textbooks, library books, TV, and generating set[c]	BOS Buku, DBEP, WVI, and APBD	n.a.

[a]The computer is kept at the school principal's house because they are afraid that the computer will be stolen.
[b]They cannot be used since there is no electricity supply.
[c]They cannot be used since there is no electricity supply and the generating set is lack of capacity.

APPENDIX 6

Table A6. Changes of Condition of Facilities of Sample SD and SMP in Rural and Urban PKH Treatment and Control Villages in West Java Province

Category	Villages	SD/SMP	Type of Change	Source of Fund	Year
Rural Area					
Treatment	Gegesik Kulon and Jagapura Kidul	SDN 2 Gegesik	Classroom renovation and building additional toilets	BOS	2009
		SDN 2 Jagapura Kidul	Classroom renovation	APBD	2009
		SMPN 1 Gegesik	New classroom(s) and laboratory	block grant and committee	2008
		SMPN 2 Gegesik	New classroom(s) and laboratory	DAK	2007
Control	Susukan and Tangkil	SDN 1 Susukan	Renovation to 3 classrooms	APBD Provinsi	2008
		SDN Tangkil	New library and renovation to classroom(s)	DAK	2008
		SMPN 1 Susukan	Renovation to 5 classrooms and 2 laboratories	Co-sharing (the central government and local government (*kabupaten* level))	2009
Urban Area					
Treatment	Mertasinga	SDN 1 Mertasinga	Renovation to 2 classrooms	Co-sharing	2008
		SMPN Mertasinga	Building laboratory and multimedia room	APBD Provinsi	2007
Control	Mundu Pesisir	SDN 3 Mundu Pesisir	Renovation to 3 classrooms	DAK	2009
		SMPN 1 Mundu	New laboratory, multimedia room, and 3 classrooms	APBN	2008 & 2009

APPENDIX 7

Table A7. Changes of Condition of Facilities of Sample SD and SMP in PKH Treatment and Control Villages in Rural and Urban Areas of East Nusa Tenggara Province

Category	Villages	SD/SMP	Type of Change	Source of Fund	Year
Rural Areas					
Treatment PKH	Oenai and Falas	SD GMIT Oenai	Classroom renovation	BOS	2008/2009
		SDN Fatubia	Renovation to 3 classrooms	Yayasan GMIT	2010
		SMP Satap Fatubia	Building a library	Bantuan Australia	2009
		SMPN Oenai	New classroom[a]	-	2008
Control PKH	Biloto and Bisene	SD GMIT Biloto	Toilet renovation	Sanggar Suara Perempuan	2009
		SD Inpres Bisene	1 new classroom and renovation to 7 rooms	DAK and DBEP	2008 & 2009
		SMPN Siso	3 new classrooms	APBD	2008 & 2009
Urban Area					
Treatment	Fatufeto	SD Inpres 2 Fatufeto	No change	-	-
		SMPN 6 Kupang	No change	-	-
Control	Todekisar	SDN Oeba 2	No change	-	-
		SMPN 2 Kupang	Renovation to classroom(s) and the teacher's room[a]	BOS	2008

[a] The classroom was previously used as a teacher's room.

APPENDIX 8

Table A8. Changes of Condition of Supporting Facilities of Sample Schools in PKH Treatment and Control Villages in Rural and Urban Areas of West Java Province

Category	SD/SMP	Type of Change	Source of Fund	Year
Rural Area				
Treatment	SDN 2 Gegesik	Computer/printer, visual aid tools, and equipments for boy/girl scouts	BOS	2008
	SDN Jagapura Kidul	Student desks and chairs	BOS	2007 & 2008
	SMPN 1 Gegesik	Multimedia tools, books, sport equipments, art supplies, and marching band instruments	Block grant, APBD, and BOS	2009
	SMPN Gegesik 2	Textbooks for national examination (*ujian national*–UN) preparation	BOS and APBD Provinsi	2008
Control	SDN 1 Susukan	Sport equipments and marching band instruments	School committee and BOS	2008 & 2009
	SDN Tangkil	Desks/chairs and computer	BOS	2009
	SMPN 1 Susukan	Audiovisual tools, library, parabola, TV, and books	SSN-Depdiknas[a] BOS	2009
Urban Area				
Treatment	SDN 1 Mertasinga	Library books, textbooks, visual aid tools	BOS	2008 & 2009
	SMPN Mertasinga	Practicum equipments, visual aid tools, and computer	APBN	2008 & 2009
Control	SDN 3 Mundu Pesisir	120 chairs, 60 desks, books	BOS	2008 & 2009
	SMPN Mundu	Textbooks for UN preparation	BOS	2008 & 2009

[a] SSN (*Sekolah Standar Nasional* or National Standard School) is a school qualification set by the Ministry of National Education.

APPENDIX 9

Table A9. Changes of Condition of Supporting Facilities of Sample Schools in PKH Treatment and Control Villages in Rural and Urban Areas of East Nusa Tenggara Province

Category	SD/SMP	Type of Change	Source of Fund	Year
Rural Area				
Treatment	SD GMIT Oenai	Visual aid tools, *bangun data matematika* (mathematics' two-dimensional objects), musical instruments (organ)[a], sport equipments, textbooks, cupboars, desks, and chairs	DBEP, Plan International, and BOS	2008 & 2009
	SD Fatubia	Textbooks, musical instruments[a]	Plan International	2010
	SMP SATAP Fatubia[b]	No addition/change	-	-
	SMPN Oenai	Cupboars, desks/chairs, computer[a], and visual aid tools	DBEP	2008 & 2009
Control	SDN Biloto	Fresh water/waterworks (*perusahaan air minum*–PAM), and textbooks	Sanggar Suara Perempuan and Plan International	2009
	SD Inpres Bisene	New chairs and desks	DBEP	2007
	SMPN Siso	Biology laboratory equipments	DBEP	2008
Urban Area				
Treatment	SD Inpres 2 Fatufeto	Waterworks (PAM) & mobile library	School committee	2008
	SMPN 6 Kupang	Textbooks, visual aid tools, and chairs and desks	BOS and school committee	2007 & 2008/2009
Control	SDN 2 Oeba	No change	-	-
	SMPN 2 Kupang	Desks, chairs, laboratory equipments, learning media (TV, LCD, computer), printed and electronic textbooks	APBD Provinsi and BOS	2008 & 2009

[a] The supporting facilities have not been used since there is no electricity supply.
[b] SMP SATAP Fatubia was established in 2008; there has been no additional supporting facilities yet.