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TRANSFORMATION OF COMPLIANCE IN THE FAMILY HOPE PROGRAM: A STUDY OF THE SHIFTING OF CONDITIONAL SOCIAL ASSISTANCE MECHANISMS IN CIPAYUNG DISTRICT, EAST JAKARTA

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Abstract:

The Family Hope Program (*Program Keluarga Harapan* – PKH) is a conditional cash transfer program designed to improve the quality of human resources among poor households through enhanced access to health, education, and social welfare services. In recent years, however, the compliance verification mechanism that constitutes the core of PKH has no longer been strictly implemented. This study aims to examine how beneficiary households continue to comply with program obligations despite the absence of formal verification, using a case study conducted in Cipayung District, East Jakarta. This study employs a qualitative descriptive approach. Data were collected through in-depth interviews, focused group discussions, field observations allowing unobtrusive observation of beneficiary behavior, and document analysis. Informants consisted of PKH administrators, social facilitators, and beneficiary households. The findings reveal that although PKH has gradually shifted toward a quasi-unconditional assistance scheme, beneficiaries' compliance in accessing health and education services remains relatively well maintained. This condition is influenced by the internalization of program values, long-term participation experience, the mediating role of social facilitators, and the availability of adequate urban service

infrastructure. The study concludes that social and normative mechanisms rooted in awareness, habituation, and moral commitment can partially substitute formal compliance verification, particularly in urban contexts. Nevertheless, the re-strengthening of monitoring and evaluation mechanisms remains essential to ensure the sustainability of PKH's long-term objectives in improving human capital and breaking the intergenerational cycle of poverty.

Keywords: Family Hope Program; conditional cash transfer; beneficiary compliance; social assistance; poverty.

Introduction

The Family Hope Program (PKH), a conditional cash transfer program, is a program that has been widely implemented in various countries, known as Conditional Cash Transfers (CCTs). Launched in 2007, PKH has become a flagship program of the Indonesian government. It has proven to be a national priority, with its budget and targets increasing significantly year after year.

In the initial design of PKH, one of the most novel aspects and a major challenge was verifying the compliance of each beneficiary within a Beneficiary Family (KPM) to determine whether assistance could be continued, sanctioned, or terminated. This is called commitment verification. The consequence of this regulation is the need for a large-scale, real-time information technology platform and social assistance for each KPM. Each Facilitator is required to assist 250 to 300 KPM, depending on the circumstances of the assisted location. Facilitators ensure that each beneficiary utilizes health and/or education facilities according to established protocols. After 16 years, PKH has undergone numerous changes in design, targets, and budget. If in 2007 the number of recipients was 382,000 KPM, then by 2025 it will

be 10,000,000 KPM (Directorate of Social Security, Ministry of Social Affairs of the Republic of Indonesia, 2025).

Starting in 2025, another component, in addition to Health, Education, and Social Welfare (for the disabled and elderly), was added: the Gross Human Rights Violations component (Decree of the Director General of Social Security and Social Welfare No. 59/3.4/Hk.01/1/2025 concerning the 2025 Family Hope Program Social Assistance Index).

Verifying the commitment of PKH recipients is considered the heart of this program. Intensive, ongoing, and information-technology-based commitment verification allows for tracking the compliance of each recipient. Furthermore, the use of aid funds can be monitored, including for the needs of pregnant women, toddler food, and school support. Cash transfers to the poor through conditional social assistance programs like the Family Hope Program (PKH) are contingent on recipients meeting verifiable requirements, such as regular school attendance or visits to health clinics, as Fiszbein & Schady (2009) argue. "Conditional cash transfer programs (CCTs) provide money to poor families contingent upon certain verifiable actions, generally minimum investments in children's human capital, such as regular school attendance or visits to health clinics."

Proper commitment verification will have a positive impact on improving health and education facilities, which are the responsibility of other ministries, namely the Ministry of Education, the Ministry of Religious Affairs, and the Ministry of Health, as well as regional governments, particularly district/city governments. Verification is conducted monthly and reported through a hierarchical information technology system from the village to the central government or the Ministry of Social Affairs. Subsequent assistance will be provided based on

the results of the commitment verification. Recipients who fail to comply with obligations will be subject to sanctions, including reductions or termination of assistance, depending on the level of non-compliance. PKH recipient commitment verification is a key differentiator among social assistance programs in Indonesia. Thus, PKH (CCT) as conditional assistance is aimed at changing the behavior of poor recipient families so as to improve human resources and break the chain of poverty across generations (Fiszbein & Schady, 2009).

Commitment verification is not without debate. Some view it as a controversial measure because sanctions imposed on recipients are not due to wrongdoing but rather to issues beyond their control. "Conditionality is controversial because it involves penalizing poor people for non-compliance with behavioral requirements, which may be beyond their control" (Devereux, 2009). Furthermore, monitoring and enforcing requirements increases administrative costs and complexity, which does not always lead to better results. Some even state, "Conditionality requires strong administrative systems and an adequate supply of services; otherwise, it risks excluding the most vulnerable" (Samson, EPRI, 2009).

Given the dynamics of national policy, the discontinuation of commitment verification raises concerns about the achievement of this conditional social assistance program's original mission. In other words, there is an urgency to determine how the Family Hope Program (PKH) can continue to improve the human resources of the poor, particularly in terms of behavioral change and access to health and education facilities, without strict oversight of compliance with assistance requirements. Behavior change, as PKH's primary mission, should be demonstrated by recipients' willingness to consciously and voluntarily fulfill their obligations. Regardless of the view

that commitment verification is mandatory, or the view that commitment enforcement is unnecessary due to its high cost and burden on recipients, this study aims to describe how the Family Hope Program (PKH) is implemented after the absence of commitment verification for compliance. Therefore, the objectives of this study are to (a) provide an overview of the basis for cash assistance payments to beneficiaries at each stage, (b) describe whether beneficiaries continue to fulfill their obligations to access health and education even though they are not required to do so, (c) describe the assistance tasks involved in ensuring access to health and education services, and (d) describe whether there has been a transformation in the behavior of PKH recipients in utilizing health and education facilities.

This research is expected to be both academically and practically beneficial. Academically, it is expected to develop concepts in social work, specifically social protection, social assistance, and social assistance. Practically, it will be useful to assist the government, particularly PKH administrators at the central and regional levels, in improving, sharpening, and enhancing the performance of conditional social assistance programs at the grassroots level.

Furthermore, to analyze the level of compliance of PKH beneficiaries with fulfilling their obligations, the theory of Compliance Theory, developed by Amitai Etzioni (1961), is used. According to Etzioni, compliance is not solely determined by the mechanism of sanctions or material incentives, but rather by the fit between the type of power used and the form of individual involvement in an organizational system. Etzioni divides the forms of organizational power into coercive, utilitarian, and normative power, and distinguishes member involvement into alienative, calculative, and moral. Stable and

sustainable compliance, he argues, occurs when normative power is used and responded to by moral involvement, that is, when individuals comply with rules because they internalize values and goals that are considered legitimate and important. Therefore, sustainable compliance is more likely to occur when individuals comply with rules out of moral awareness and commitment, rather than out of coercion or considerations of profit and loss alone. Effective compliance occurs when there is a fit between the type of power used and the form of member involvement.

In the context of the PKH social program, compliance, which initially tended to be built through a coercive, utilitarian, and normative approach, was later abandoned. PKH recipients were entrusted with fulfilling their obligations without compliance verification. This policy change proved to be effective, as it transformed the behavior of beneficiaries (KPM) to fulfill their obligations in accordance with PKH requirements. The provision of educational programs and social campaigns through the P2K2 (P2K2), including support from various central and regional institutions, and NGOs, has contributed to the internalization of the program. The mentoring that is a hallmark of the program also contributes to maintaining its sustainability. As the program enters its 18th year, it has been discovered that the strict PKH protocol through compliance verification is no longer a focus in both policy and implementation at the grassroots level. A transformation in compliance has occurred among beneficiaries, with beneficiaries carrying out their obligations without supervision from their mentors and reporting obligations by beneficiaries. PKH implementation in the field is no longer based on coercive rules and intensive supervision from mentors. KPM compliance is driven by the awareness, values, and morals inherent in PKH recipients. Within Etzioni's theoretical

framework, this companion role represents the use of normative power aimed at building legitimacy and moral commitment, not simply monitoring or sanctioning.

Methodology

This research was conducted using a descriptive qualitative approach. Data were collected from various institutions or parties as research informants, namely officials and experts in charge of PKH at the Indonesian Ministry of Social Affairs, officials and staff who manage PKH at the East Jakarta Social Service Sub-Department, the District Coordinator, the Sub-District Coordinator, the PKH Facilitators of the Cipayung Sub-District and Village, and the KPM. After data and information were collected from each relevant institution, intensive discussions were held through FGDs and interviews with informants, including conducting visits to KPM homes. Overall, there were 11 key informants in the study as shown in the following table:

Tabl2 1
Informant Data

No	Initial	Age/LP	Title/position	Data obtained
1	AR	45/L	Kemensos RI	PKH policies, programs, data
2	Stw	48/L	Kemensos RI	PKH policies, programs, data
3	IN	50/P	Kemensos RI	PKH policies, programs, data
4	BWQN	23/P	Kemensos RI	PKH policies, programs, data
5	ATH	35/L	Korkot	East Jakarta City PKH Data

6	HA	34/L	Korcam	PKH Data for Cipayung District
7	Fik	30/P	Pendamping	Data on PKH implementation in the field
8	Vv	28/P	Pendamping	Data on PKH implementation in the field
9	Mar	38/P	KPM	Daily activities as a KPM
10	Min	63/P	KPM	Daily activities as a KPM
11	Len	60/P	KPM	Daily activities as a KPM

Source: Processed by Researchers,2025

Result and Discussion

Implementation of National PKH

Launched in 2007 as a national priority program, the Family Hope Program (PKH), is a conditional social assistance scheme that provides incentives to low-income families to change their behavior toward improving their lives through access to healthcare, education, and social welfare facilities. This program is expected to reduce poverty and enable families to maintain their consumption patterns amidst negative incomes or crises. Specifically, PKH is expected to increase attendance of pregnant women and toddlers at primary healthcare facilities, support national immunization programs, reduce stunting rates, and increase school participation. It also provides protection for people with disabilities and the elderly within families of beneficiaries. PKH is also expected to contribute to realizing Indonesia's commitment to achieving various Sustainable Development Goals (SDGs),

including reducing extreme poverty and hunger, along with various other programs. To achieve PKH's mission, each beneficiary is required to meet various requirements, demonstrated through commitment verification. Commitment verification was implemented in 2010, so that aid payments are based on the previous month's compliance.

Aid is transferred directly to the beneficiary's account, with amounts varying depending on the number of beneficiaries in the family and the level of compliance with the requirements. The variation in the nominal value of monthly social assistance is influenced by (a) an increase or decrease in recipients (birth or death), (b) an unknown change of address, (c) ineligibility for assistance due to missing components, (d) sanctions for failure to comply with obligations. This last reason is what motivates all parties, including beneficiaries (KPM), companions, health facilities (Faskes), and education facilities (Fasdik), to work hard to avoid these sanctions. This is what is known as the PKH condition.

Through PKH, the government is optimistic about a domino effect in the form of an increase and improvement in the quantity and quality of the supply side of health and educational facilities, including an increase in human resources. PKH will, for example, improve the skills of traditional birth attendants in villages through health training, the proliferation of integrated health posts (Posyandu), and the availability of vaccines and basic medicines in villages/sub-districts. On the educational side, schools do not have to be formal but can be homeschooling, nature schools, ABC Package study groups, and so on. And all of this doesn't run on autopilot, but is controlled by companions through a strict verification system. The high expectations for PKH are partly due to the assistance provided. Companions are the

spearhead of the program's implementation in the field, facilitating PKH participants' access to health, education, and social welfare services.

Since its initial launch, there have been several changes to the beneficiary components. Initially, PKH assistance consisted of only four components: (1) assistance for children under 6 years of age, pregnant/nursing mothers, (2) assistance for children attending elementary school (SD/MI) or equivalent, (3) assistance for children attending junior high school (SMP/MTS) or equivalent, (4) assistance for children attending senior high school (SMA/MA) or equivalent. Later, these components were expanded to (5) assistance for persons with severe disabilities, and (6) assistance for the elderly. In 2025, these components were further expanded to (7) victims of gross human rights violations (Directorate General of Social Security and Protection Decree No. 59/3.4/Hk.01/1/2025).

This new policy also includes changes in the value of assistance for each beneficiary component, as shown in the following table:

Table 2
Types and Values of PKH Assistance

No	Category	Assistance Index/ Year (Rp)	Assistance Index /Three Months (Rp)
1	Pregnant Women	3.000.000	750.000
2	Early Childhood	3.000.000	750.000
3	Elementary School Children	900.000	225.000
4	Middle School Children	1.500.000	375.000
5	High School Students	2.000.000	500.000

6	People with Disabilities	2.400.000	600.000
7	Elderly People	2.400.000	600.000
8	Victims of Gross Human Rights Violations	10.800.000	2.700.000

Source: Decision of the Director of Social Security, Ministry of Social Affairs of the Republic of Indonesia No 59/3.4/HK.01/1/2025

About the PKH Social Assistance Index

In addition to policy changes regarding beneficiary components, the Family Hope Program (PKH) no longer requires beneficiaries to comply with all previously implemented requirements. It can be said that PKH no longer demonstrates its uniqueness as a conditional social assistance program. While in some countries CCT is treated very specifically, such as mentoring, real-time Information Technology Systems, selective beneficiaries, and strict compliance enforcement through various sanctions, some PKH protocols have abandoned these. The program, which was originally based on the latest information technology to calculate beneficiary compliance, has recently been discontinued. PKH Companions have been transformed into Social Companions, who also carry out multi-task mentoring for various social assistance programs at the grassroots level. The PKH Information System, previously specifically for PKH, is now integrated with the SIKS-NG of the Indonesian Ministry of Social Affairs..

Implementation of PKH in Cipayung District

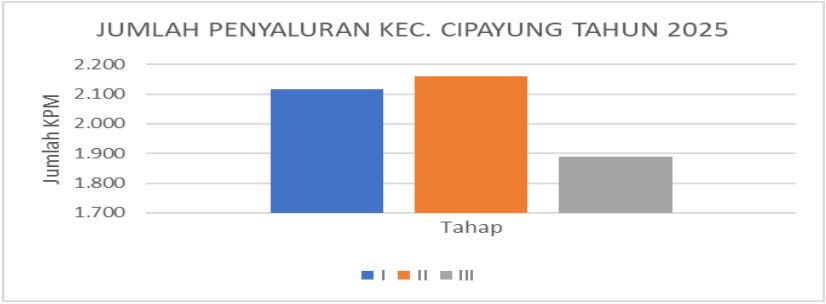
In the Cipayung District of East Jakarta, there are approximately 2,100 beneficiary families (KPM) spread across seven urban villages: Bambu Apus, Ceger, Cilangkap, Cipayung, Lubang Buaya, Munjul, Pondok Ranggon, and Setu. This sub-district has one main

community health center (Puskesmas) supported by auxiliary community health centers in each sub-district, and approximately 130 integrated health service posts (Posyandu) across various sub-districts. Basic and secondary education facilities include 59 elementary schools (28 public elementary schools and the remainder equivalent, including Islamic elementary schools), 16 junior high schools (SMP), and 45 secondary education units (SMA, SMK, MA). There are also approximately three special schools ready to foster children with disabilities.

According to the Work Instructions, a companion is a full-time employee who is not permitted to work multiple jobs in addition to his/her role as a companion. Since 2025, PKH Facilitators have been appointed as State Civil Apparatus (ASN) with the status of Government Employees with Work Agreements, with permanent duties to assist with PKH and other designated programs. Recently, they have been called Social Facilitators, with the additional task of providing assistance to various government social assistance programs. Facilitators no longer focus solely on assisting PKH beneficiaries.

When looking at the number of PKH recipients, there is variation in the number of recipients per payment phase. In 2025, for example, in Phase 1 there were 2,115 beneficiaries, in Phase 2 there were 2,160 beneficiaries, and in Phase 3 there were 1,890 beneficiaries (Source: Ministry of Social Affairs of the Republic of Indonesia, Cipayung Facilitators 2025). According to the Facilitators, this data fluctuation is part of the data updating mechanism and the results of the government's eligibility validation, not the result of compliance verification.

Image
Fluctuation in Social Assistance Recipient Data for Cipayung District, East Jakarta, 2025



Source: Ministry of Social Affairs of the Republic of Indonesia, Cipayung Companion 2025.

The numerous social assistance programs implemented by the government recently have impacted the work of PKH Facilitators in the field. Social assistance programs such as Non-Cash Food Assistance, E-Warong, PENA, and others (although not all are currently operational) have involved PKH Facilitators. Facilitators are tasked with assisting almost all social assistance programs, both PKH and non-PKH, at the grassroots level.

At the initial launch of PKH, Facilitators were required to fully control each beneficiary (KPM), from data validation, birth and death registration, residential transfers, school attendance records, attendance at Integrated Health Posts (Posyandu), and providing monthly education in the form of P2K2. Facilitators were required to ensure each beneficiary fulfilled their obligations as required. Recently, some of these facilitators' duties have been distributed among relevant stakeholders, ensuring greater alignment with their respective responsibilities and reducing overreliance on Facilitators. Data previously managed by the PKH Management Unit with its own management information system is now

integrated with the Ministry of Social Affairs' Data and Information Center (Pusdatin) through SIKS-NG. Similarly, school attendance data, previously entered directly by Facilitators into the PKH Student Assistance System (SIM PKH), is now processed through the Ministry of Education's Basic Education Data (Dapodik).

In the field, PKH Facilitators conduct ground checks (GC) to verify resident data. The GC conducted by Facilitators generates the percentage of residents in the integrated DTKS (Disaster Data Collection) or DTSEN (Standard Data Collection) data, allowing them to determine which decile a family falls into, for example, decile 1, 2, 3, and so on. The GC also serves as a tool to verify home ownership, land assets, and vehicles, as well as data on the ability to purchase and pay for electricity tokens according to their voltage. Assets and the number of watts of electricity determine whether a beneficiary is considered poor and eligible or ineligible for assistance.

Data on PKH school children is managed in SIKS-NG and is no longer held by Facilitators. Each school enters the data directly into the Ministry of Education and Culture's Dapodik. Facilitators request child data from schools only when necessary. In other words, the school's attendance record is the responsibility of the school concerned and is entered into the Dapodik (District Data and Information System). Data from the Ministry of Education and Culture (Kemendikbud) is used by the Ministry of Social Affairs' Data and Information Center (Pusdatin) as a basis for payment of assistance per installment.

According to the Facilitator, compliance with the obligation to visit health and education facilities no longer affects the transfer of funds to their accounts. Beneficiary families (KPM) also understand that this obligation is no longer a mandatory requirement, which they must report monthly.

Recent changes to the Family Hope Program (PKH) assistance scheme have shifted PKH's character toward an unconditional cash transfer scheme. In practice, this has led to the perception that PKH is increasingly integrated or "blurred" with other poverty alleviation programs, such as food assistance, education, health, and even social empowerment programs that do not require specific obligations. The amount of assistance provided to recipients is based on components such as pregnant women, toddlers, school children (elementary, middle, and high school), the elderly, and people with disabilities, rather than on verification of compliance with requirements. The determination of participants still considers the household's welfare decile. PKH beneficiaries are primarily members of the poorest group in deciles 1–4, namely households with the lowest welfare levels in the National Socioeconomic Single Data (DTSEN). PKH recipients are drawn from Deciles 1 and 2.

Although there is no longer any oversight of fulfilling the obligations that underlie social assistance, a significant difference that has emerged is the absence of financial consequences for beneficiaries who fail to attend Posyandu (Integrated Health Post), pregnancy check-ups, or children who are absent from school. This seems to be tearing at the heart of the program, which relies on a reward-punishment strategy as leverage to encourage behavioral change in beneficiaries. Even PKH assistance, which continues to be distributed on a large scale, is no longer dependent on the program's performance in providing access to health, education, and social welfare. With the change in commitment verification policy, there is concern that there will be a gap in information regarding beneficiary compliance in utilizing these services.

This shift raises important questions about the program's effectiveness as a human resource development

tool. At first glance, without commitment verification, the mechanism for controlling participant behavioral change is weakened. There are concerns that PKH's initial goal as a long-term investment program to improve the quality of life for future generations could be compromised.

In Cipayung District, beneficiaries (KPM) acknowledged that they were no longer required to prove they regularly attended the Integrated Health Post (Posyandu), requiring 85% attendance at school. However, interestingly, for beneficiaries who had received the Family Hope Program (PKH) for more than six years, even though the requirement wasn't strictly enforced, they rarely missed gatherings at the Posyandu. Their children also continued to attend school diligently, even though they weren't forced to. The following statements from beneficiaries reflect this:

“"We're not asked every month whether we attend the Integrated Health Post (Posyandu), or whether our children should report to school. Even without being told, we pregnant women and mothers with babies always attend the Posyandu diligently. Our children always attend school diligently, never missing a beat." (Mar, 38, PKH Beneficiary, July 2025).

According to the Facilitators, they have not found any beneficiaries (KPM) who are reluctant to attend the Integrated Health Post (Posyandu). They have also not found any schoolchildren skipping or dropping out.

"We no longer strictly monitor the attendance of beneficiaries at the Posyandu or the children's attendance at school. Specifically, the school is responsible for collecting, summarizing, and reporting school attendance data through the Dapodik application. However, we have never heard or received complaints from families or schools about children skipping or dropping out. The Posyandu is always busy with mothers because it is held

once a month and is also run by the RT/RW PKK Team." (Cipayung Facilitators, July 2025)

The willingness of beneficiaries and their families to fulfill their obligations, even though it is no longer a requirement, is inseparable from the availability and convenience of facilities. According to the Facilitators, Jakarta is unlike any other region. Schools in Jakarta are relatively close and easily accessible. Learning at school is quite enjoyable, and the teachers are competent. It's no wonder that students attend school diligently. Parents, even from low-income families, remain very supportive of their children's schooling. The mentors also demonstrated that long-standing beneficiaries (KPM)—having been around for more than three years—know their health and education obligations. Therefore, even without supervision, they automatically understand and comply.

In the field, changes in PKH governance, which did not enforce these obligations, did not impact beneficiary compliance with access to health and education facilities. Health checks at integrated health posts (Posyandu), attendance at school every school day, and even health checks for the elderly at the Lansia Posyandu—continue as usual without the need for reminders from mentors. Although mentors are now more focused on administrative and coordinating roles for various social assistance programs and are no longer monitoring individual beneficiaries, this does not mean that beneficiaries are neglecting their obligations. Everything has become automatic.

Referring to Amitai Etzioni's Compliance Theory, individual or group compliance within an organization is not solely determined by the presence of sanctions or material incentives, but rather by the appropriateness of the type of power exercised and the form of involvement of its members. In the PKH context, the initial compliance

mechanism for beneficiaries tended to be utilitarian, where compliance was fostered through material incentives in the form of social assistance linked to the fulfillment of health and education obligations. However, when financial sanctions for non-compliance were no longer imposed, beneficiary compliance remained strong. This indicates a shift in compliance from a calculative approach to normative compliance.

Etzioni explains that normative compliance emerges when individuals exhibit moral involvement, a condition in which individuals comply with regulations because they internalize the organization's values, norms, and goals. In this case, PKH beneficiaries continue to receive medical check-ups at health facilities and send their children to educational facilities, not out of fear of losing their assistance, but out of an awareness of the importance of health and education for the well-being of their families and their children's futures.

Thus, the absence of financial sanctions does not necessarily eliminate PKH beneficiary compliance. Instead, such compliance reflects the program's success in instilling normative values in beneficiaries. This aligns with Etzioni's view that the most stable and sustainable compliance is based on normative power and moral involvement, rather than solely on coercive or utilitarian power. The willingness of KPM to continue to utilize health, education, and social welfare facilities that are no longer calculative, but rather become normative compliance, is a behavioral transformation towards moral responsibility for the welfare of the family and the future of children.

Conclusion

In summary, the important findings of this study are as follows:

- A fundamental change has occurred in the governance of the PKH program. Since 2021, PKH management has undergone a fundamental shift from a system based on field verification by facilitators to a centralized data-based recipient determination system. SP2D data is no longer provided to local coordinators and PKH facilitators, while facilitators' access to SIKS-NG is limited (viewable only, not copied or downloaded). As a result, transparency and field control over beneficiary data have been further reduced.
- The role of PKH companions has experienced substantive weakening. PKH facilitators no longer play a primary role in verifying beneficiary family member compliance or overseeing education and health aspects. Facilitators' current duties are more administrative, specifically monitoring aid distribution through Receipt Letters (STM). Facilitators also no longer have adequate information regarding the number and identities of beneficiaries in their assisted areas.
- Data integration and matching is a determining factor in PKH acceptance. The determination of PKH recipients is currently based on cross-sectoral data matching, including data from the Civil Registration Agency (Dukcapil), the Jakarta Disaster Management Agency (Dapodik), the Jakarta Samsat (Sat), the NJOP (Value Taxable Income Tax), electricity capacity, and employment and income data for household members. In Jakarta, beneficiaries identified as having high-value assets, motorized vehicles, electricity consumption of ≥2,200 watts, or family members earning above the minimum wage (UMP) are automatically declared ineligible for assistance without field verification by a companion.
- Data update asynchronization causes inaccuracy of targets. Research has found a discrepancy in the frequency of

data updates between the Ministry of Social Affairs' Data Center (Pusdatin) and the Jakarta Social Services Center (Pusdatin). This lack of synchronization has resulted in the PKH recipient list remaining unchanged, resulting in some graduated beneficiaries still receiving assistance, while new potential recipients are struggling to be accommodated.

- *PKH's* function *as a human resource development instrument is weakening.* PKH funds are no longer effectively directed to ensuring the fulfillment of KPM's education and health obligations. Facilitators no longer monitor children's attendance at school or the health of pregnant, postpartum, breastfeeding, and elderly women. Education control has now been transferred to the Dapodik system through the KJP sanction mechanism, while the sustainability of PKH assistance remains unclear.
- The PKH program tends to shift to general social assistancePKH functions more as social assistance to meet the basic needs of poor households, rather than as a conditional cash transfer. This is evident in the use of assistance by beneficiary families (KPM), which largely allocates it to daily consumption needs, such as food, electricity, and other household obligations.
- There are still long-term KPM PKH without an effective graduation mechanism. The research found that there were KPM who were still receiving PKH assistance since the program was launched in 2007. This condition indicates a weak evaluation mechanism, the absence of an exit strategy and weak preparation for graduation.
- The Social Assistance Check Application is considered vulnerable to subjectivity. Informants perceived the Social Assistance Check Application as a system potentially influenced by the subjectivity of officers (likes and dislikes), particularly in the process of proposing and validating potential aid recipients.

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