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Research Paper

Utilization of Family Hope Program (PKH) Social Assistance by Beneficiary Families in Rimba Langgeh Village, Arongan Lambalek District, West Aceh Regency

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Abstract

The Family Hope Program (PKH) is Indonesia's conditional cash transfer for poor households, and local studies disagree on whether beneficiaries spend it on the purposes of its components. This study describes how beneficiary families in Rimba Langgeh Village, Arongan Lambalek District, West Aceh Regency, use PKH assistance in the education, health and social welfare components. A qualitative descriptive design was used. Ten beneficiary families were selected purposively and interviewed at home with a structured guide, and village documents were collected; the data were analysed by data condensation, data display and conclusion drawing. Respondents reported spending the education assistance on uniforms, shoes, bags, stationery, school fees, pocket money and transport; the health assistance on food, milk, vitamins, medicines and travel to health facilities; and the remainder on staple food, electricity and clothing. A few also reported house repairs, debt repayment, capital for a small shop and gold savings. The reported uses correspond to the three components and to the objective of reducing household expenditure, but they rest on self-reports from ten families and were not verified against school, health or spending records. Four of the ten families have received PKH for more than five years, the membership limit introduced in 2026.

Keywords: Family Hope Program; Conditional cash transfer; Social assistance utilization; Education; Health; Social welfare.

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1. Introduction

Conditional cash transfers pay poor households on condition that they use health and education services, and they are among the most widely adopted instruments of social protection in low- and middle-income countries [1], [2]. Indonesia's programme, the Family Hope Program (Program Keluarga Harapan, PKH), started in 2007 [3]. Until August 2026 it was regulated by Minister of Social Affairs Regulation No. 1 of 2018, which targets poor and vulnerable families that have a health component (pregnant or breastfeeding women and children aged 0–6 years),

an education component (children aged 6–21 years who have not completed 12 years of schooling) or a social welfare component (older persons and persons with disabilities) [4]. Beneficiary families are obliged to use health services and to keep school attendance at 85% or more of effective school days [4].

Quantitative evaluations show that PKH changes the use of services. Six years after its launch, childbirth assisted by trained professionals had increased, the share of children under 15 who were out of school had fallen by half and stunting had fallen by 23%, although the transfers had not transformed the economic position of recipient households [3]. PKH raised net enrolment by 7.1% and the gross participation rate of junior high school students by 7.6% [5] and increased per capita expenditure by 4.8% [6]. Reviews of cash transfers in other countries report higher use of health services, greater dietary diversity and longer schooling, with weaker evidence on learning [1], [2], and a meta-analysis found no increase in spending on alcohol or tobacco [7].

Qualitative studies of how beneficiaries spend the money give a mixed picture. In Tuban and Blora, beneficiaries used PKH for school needs, health care, food, business capital and savings in livestock [8], [9]. In other locations part of the money went to purposes outside education and health: farming inputs in Solok [10]; debt repayment, cigarettes, electronics and jewellery in Sidoarjo [11]; and kitchen supplies, debt repayment and business capital in Padang [12], [13]. Beneficiaries' understanding of the education component varied in Bekasi [14], and some recipients in Tana Toraja were no longer poor because the data had not been updated [15], [16]. These studies attribute non-aligned use to weak facilitation, limited understanding of the programme and household financial pressure [10], [11], [13].

Two gaps follow from this literature. First, the studies reviewed here come from Java, West Sumatra and Sulawesi, and none describes a village on the west coast of Aceh. Second, existing studies describe spending in general terms and seldom relate it to the three components and to the composition of each household. This study addresses both gaps by documenting, component by component, how ten beneficiary families in Rimba Langgeh Village use PKH assistance, and by relating the findings to the regulatory changes of 2025–2026. Its aim is to describe whether PKH social assistance in Rimba Langgeh Village, Arongan Lambalek District, West Aceh Regency, is used in accordance with the education, health and social welfare components.

2. Method

This study used a qualitative descriptive design, which is suited to describing a phenomenon in its own setting without manipulating variables [17]. It was conducted in Rimba Langgeh Village, which lies on the Meulaboh–Banda Aceh road in Arongan Lambalek District, West Aceh Regency. The study ran from September 2025 to August 2026, a period that covered the proposal, field data collection, analysis and reporting.

The subjects were ten PKH beneficiary families (Keluarga Penerima Manfaat, KPM). They were selected purposively, that is, for their fit with the aim of the study [18], so that the education, health and social welfare components were all represented. Respondents are identified by codes R1–R10.

Data were collected by two techniques. In-depth interviews were held face to face in the respondents' homes with a structured interview guide on the allocation and use of the assistance. Documentation comprised village demographic data, information on education and health facilities, a summary of assistance by component and photographs of the fieldwork. The data were analysed by data condensation, data display and conclusion drawing [19].

3. Results and Discussion

Location and Respondent Characteristics

Rimba Langgeh Village has 495 inhabitants (249 males and 246 females) in 172 households. Its education facilities are one elementary school, one dayah (Islamic boarding school) and three Qur'anic education centres; junior and senior high schools are outside the village. The only health facility in the village is one integrated health post/village maternity post (Posyandu/Polindes).

Table 1 presents the ten respondents. Nine are homemakers and one is a farmer; they are aged 28–64 years; four completed elementary school, two junior high school and four senior high school. Four families first received PKH in 2016–2018 and six in 2023–2025. According to household composition, seven families have children in elementary to senior high school (R1–R7), six have a pregnant woman or a child below elementary-school age (R1, R3, R4, R5, R9 and R10) and one respondent is an older person (R8).

Table 1. Characteristics of the PKH beneficiary respondents in Rimba Langgeh Village

No.	Code	Age	Education	Occupation	Household members	First received
1	R1	43	Elementary	Farmer	5: respondent, 1 adult, 1 senior high, 1 junior high, 1 toddler	2016
2	R2	38	Junior high	Homemaker	4: husband, wife, 2 junior high	2024
3	R3	38	Senior high	Homemaker	5: husband, wife, 1 junior high, 1 elementary, 1 toddler	2016
4	R4	34	Junior high	Homemaker	4: husband, wife, 1 senior high, 1 toddler	2025
5	R5	34	Elementary	Homemaker (pregnant)	5: husband, wife, 1 senior high, 1 elementary, 1 preschooler	2016
6	R6	43	Elementary	Homemaker	5: husband, wife, 1 junior high, 1 Islamic junior high, 1 elementary	2018
7	R7	42	Senior high	Homemaker	3: husband, wife, 1 junior high	2025
8	R8	64	Elementary	Homemaker (older person)	2: husband, wife	2023
9	R9	29	Senior high	Homemaker	3: husband, wife, 1 kindergarten	2025
10	R10	28	Senior high	Homemaker	4: husband, wife, 2 toddlers	2025

Source: Primary field data (2026).

Education Component

Respondents with school-age children reported using PKH assistance for school needs: uniforms, shoes, bags, notebooks and stationery; school and activity fees; daily pocket money; and transport (fuel), because the junior and senior high schools are outside the village. R1 stated: "I use the PKH funds primarily for my children's educational needs: buying uniforms, notebooks, bags, shoes and stationery, occasionally supplementary reading books and English dictionaries, paying school activity fees and transportation costs, and providing pocket money. This assistance has greatly helped my child become more diligent and enthusiastic about learning." R6 gave a similar account that also included tutoring and contributions for school events, and added that her child "frequently achieves high rankings" since the family began receiving PKH.

The respondents associated the assistance with regular attendance, motivation and achievement. These are the parents' perceptions; attendance was not checked against school records, so compliance with the 85% attendance requirement could not be confirmed. Some

families also set aside part of the education assistance to buy small amounts of gold as savings for future enrolment costs.

Health Component

In the health component, respondents reported buying food (eggs, fish, meat, vegetables and fruit), formula or supplementary milk, vitamins and medicines for sick children, and paying for transport to the village Posyandu or the sub-district community health centre (Puskesmas). R5, who was pregnant at the time of the study, stated: "During my pregnancy, I used the assistance for routine check-ups, minor medications and sometimes the cost of visiting the midwife, though not for every single check-up." R2 stated that the funds are used "to buy vitamins, nutritious food, supplementary milk and medicine during illness" and that the programme encourages visits to the health centre. R2's household has no pregnant woman or young child (Table 1), which shows that health-related spending is not limited to families with a health component. Nutritional status and immunisation were not measured in this study.

Social Welfare Component and Household Needs

The older respondent and several other families reported using the assistance for daily staples (rice, cooking oil, sugar, salt, chili, spices and vegetables), monthly electricity bills and basic clothing. R8 stated: "As an elderly person, I feel more secure, and this program helps prevent my family from falling into debt due to medical expenses or daily food costs." A few families used a small part of the assistance for minor house repairs and kitchenware, for repaying debts at local shops and as capital for a micro-enterprise. R9 reported using the funds for staples, children's clothing, electricity, transport and "capital for a small business (opening a shop)". Table 2 summarises the reported uses.

Table 2. Uses of PKH assistance reported by respondents, by component

Component	Reported uses	Respondents quoted
Education	Uniforms, shoes, bags, notebooks, stationery; school and activity fees; pocket money; transport; tutoring; supplementary books	R1, R6
Health	Eggs, fish, meat, vegetables, fruit; formula or supplementary milk; vitamins; medicines; pregnancy check-ups; transport to Posyandu/Puskesmas	R2, R5
Social welfare and household needs	Rice, cooking oil, sugar, salt, chili, spices, vegetables; electricity bills; basic clothing	R8, R9
Other uses	Minor house repairs and kitchenware; repayment of debts at local shops; capital for a small shop; gold bought as savings for school enrolment	R9

Source: Interviews with respondents (processed, 2026).

Discussion

The uses reported in Rimba Langgeh correspond to the three components and resemble those reported in Tuban and Blora, where beneficiaries spent PKH on school needs, health care, food and small businesses [8], [9]. They differ from Sidoarjo and Solok, where part of the money went to cigarettes, electronics, jewellery or farming inputs [10], [11]; no respondent in this study reported spending of that kind, which agrees with the meta-analytic finding that cash transfers do not raise spending on temptation goods [7]. The education and health spending is also consistent with experimental evidence that PKH increases enrolment and the use of health services [3], [5]. The respondents' statements about achievement and nutrition should be read more cautiously, because reviews find weaker effects of cash transfers on learning than on schooling [1], [2].

Whether spending on staples, electricity, debts and shop capital is "in accordance with the components" depends on how the rule is read. The regulation attaches conditions to the use of health and education services and to school attendance, and its objectives include reducing the expenditure burden of poor families [4]. Studies in Padang nevertheless classified kitchen supplies, debt repayment and business capital as use outside the purposes of the programme [12], [13]. Under the first reading the pattern in Rimba Langgeh is aligned with the programme; under the second, part of it is not. The purchase of gold and the opening of a shop indicate attempts to build assets, as did livestock purchases in Blora [9], but they were reported by a few families only, and nationally PKH has not produced transformative economic change for recipients [3].

Monthly Family Capacity Building Meetings (Pertemuan Peningkatan Kemampuan Keluarga, P2K2) are held in the village, and elsewhere the quality of facilitation has been linked to how the assistance is used: facilitators who concentrated on attendance and disbursement were associated with non-aligned spending in Solok [10], and in Tana Toraja one facilitator covering seven villages met beneficiaries about once in two months [16]. The facilitator in Rimba Langgeh was not interviewed and the meetings were not observed, so their contribution to the reported pattern could not be assessed.

The findings also bear on two regulatory changes. Since February 2025 the National Socio-Economic Single Data (DTSEN) has replaced the Integrated Social Welfare Data as the basis for targeting [20]. In August 2026, Regulation No. 8 of 2026 revoked Regulation No. 1 of 2018; it defines health and education as the components of PKH and limits membership to five years, except for older persons and persons with disabilities [21]. Four of the ten respondents (R1, R3, R5 and R6) have received PKH for eight to ten years. Their accounts show continued reliance on the assistance for school and food costs, which makes the transition of long-standing beneficiaries a relevant topic for follow-up research.

This study has limitations. It relies on self-reports from ten purposively selected families, and respondents may describe their spending in the way the programme expects. No school attendance records, health records or spending records were examined, and the facilitator, school and health staff were not interviewed. The amounts of assistance received and spent per component were not recorded, so the share of each use is unknown. The findings describe the ten families and cannot be generalised to all beneficiaries in the village or the district.

4. Conclusion

Beneficiary families in Rimba Langgeh Village reported using PKH assistance for purposes that correspond to its three components. Education assistance was spent on uniforms, shoes, bags, stationery, school fees, pocket money and transport; health assistance on food, milk, vitamins, medicines and travel to health facilities; and the remainder on staple food, electricity and clothing. A few families also reported house repairs, repayment of shop debts, capital for a small shop and gold savings. These uses are consistent with the objective of reducing household expenditure, but they are based on self-reports and were not verified against records.

PKH facilitators and the village government are advised to use the P2K2 meetings to clarify which uses are expected and to help long-standing beneficiaries prepare for the five-year membership limit. Future studies should verify reported uses against school and health records, record the amounts spent by component, and include facilitators and service providers as informants.

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Authors' contributions and responsibilities

Umi Salamah: conceptualization, methodology, investigation, writing – original draft. Amrusi: supervision, writing – review & editing. Nana Suraiya: supervision, validation, writing – review & editing. Raihani: validation, formal analysis, writing – review & editing. Alfi Syahril Fuadi Jaya: validation, methodology, writing – review & editing. All authors have read and approved the final manuscript.

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Availability of data and materials

The interview data and village documents that support the findings are available from the corresponding author upon reasonable request, in a form that does not identify the respondents.

Competing interests

The authors declare no competing interests.

Ethical approval

This study did not require formal institutional ethical approval because it involved interviews with adult members of beneficiary families about their use of social assistance and did not collect sensitive personal or medical data. Before each interview, participants were informed of the purpose of the study and gave their consent to take part. Respondents are reported under codes, and no names or other identifying details are disclosed.

Declaration of generative AI use

Generative AI supported the revision of this manuscript in four tasks: restructuring the sections, editing the English, checking the consistency of the table with the text, and searching for and checking references and regulations. No respondents, interview data or findings were produced by AI. The authors compared the revised text with their field data and bear full responsibility for the content.

Additional information

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