The impact of the assistance of the Hope Family Program on the quality of life in coastal communities: a case study of *fishermen* of South Sulawesi Province

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Abstract: Several social assistance programs have been provided to coastal communities and fishermen such as those provided by the Hope Family Program (PKH). This study aims to discuss the effect of PKH assistance on the recipients in the fishing community of South Sulawesi. This involves using Takalar Regency which represents the Makassar ethnic group and Barru Regency which represents the Bugis ethnic group as the case study. Maslow's theory and Becker's were applied. The results showed that: 1) there are differences in the quality of life before and after receiving the PKH assistance based on age, tribe, education level, monthly income, as well as the number of dependents; 2) 17.3% of their livelihood is affected by the assistance provided while the rest is associated with other variables. Furthermore, health access was found to have a positive and significant effect on the improvement of the coastal community life quality.

Keywords: coastal communities; PKH recipients; South Sulawesi Province; quality of life.

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1 Introduction

The Indonesian Government continues to promote the improvement of the quality of life for communities by providing social assistance annually. This has led to the continuous increment of the country's budget as indicated by the increase from Rp.91.8 trillion which is equivalent to USD7.65 billion in 2014 to USD153 billion in 2020. The assistance is normally targeted toward poor people from different employment backgrounds such as farmers, fishermen, labourers, informal sector workers, and others. Meanwhile, those in the coastal areas are generally traditional fishermen (Yustika, 2003) and the data retrieved from the Ministry of Marine Affairs and Fisheries in 2011 showed that there are 7.8 million fishermen in the country which is 25% of the total poor population in Indonesia. This means there is a need for a serious effort to alleviate poverty and this can be achieved by providing Hope Family Program (PKH) assistance to coastal communities or poor fishermen.

Table 1 Budget of social assistances and the number of poor (2017–2020)

Years	*Budget of social assistances*	*The number of poor*
2017	Rp.53 billion	27.71 million people
2018	Rp.77 billion	25.94 million people
2019	Rp.97 billion	25.14 million people
2020	Rp.102 billion	26.42 million people
2021	Rp.110 billion	--

Source: Ministry of Finance (2020)

The population of the poor people in Indonesia in 2020 was more than 26.42 million and the majority, 15.26 million, are living in rural areas while 11.16 million are in urban areas (BPS, 2020). Meanwhile, the data from the Association of Indonesian Maritime and Capture Fisheries Companies (Aspitindo) showed that the country's fishery capture potential was 130 million tons which is equivalent to Rp.2,500 trillion to Rp.3,000 trillion a year (Ekofinance.com, 2019). This made the Indonesian Government form the National Poverty Eradication Acceleration Team (TNP2K) and the Central and Regional Regional Poverty Eradication Team (TKPD) through the Presidential Decree Number 15 of 2011

to improve the quality of life of the people. Therefore, the budget for social assistance programs is presented in Table 1.

The information shows that the budget increases every year but the poverty rate tends to fluctuate as indicated by a reduction from 27.71 million people in March 2017 to 25.94 million in March 2019 and a subsequent increase to 26.42 million in March 2020 (BPS, 2020). This means the poverty rate reduction is quite slow while the budget continues to increase significantly from 40 trillion in 2004 to 110 trillion in 2021 with the PKH specifically observed to have spent 28.7 trillion for 10 million beneficiary groups (KPM) in 2021. It is important to note that PKH was designed by the Indonesian Government to improve the quality of life of people in different communities of the country in line with the theoretical justification from the World Bank (2014) that social assistance programs through the provision of free funds to the poor without repaying can reduce poverty. This was further supported by several scholars such as Ravallion (2003), Sumarto et al. (2005), Grosh et al. (2008), Slater (2011), Pradhan et al. (2013), Nazara and Rahayu (2013), Marheni et al. (2014), Rozita and Ummu (2014), Jamaruddin and Arshad (2017), Domri et al. (2019) and Nikita et al. (2021). Meanwhile, the PKH assistance is unable to significantly reduce poverty levels in the country as indicated by an increase in the number of poor people in South Sulawesi Province from 767 thousand in March 2019 to 776 thousand in March 2020 (BPS, 2020) and the figure is expected to increase due to the disruption of economic activity by COVID-19 pandemic outbreak since March 2020. It is important to note that coastal communities and fishermen generally have a higher level of poverty compared to other professions due to the low level of income (Yustika, 2003). This province has 24 regions with 18 coastal areas engaged in the production of fish in public waters and fish farming and this means most of the residents are fishermen and farmers. The average income of Indonesian fishermen is 1–2 million/month which is 57% according to Chair et al. (2012) and also reported by Sonny (2014) to be an average of 1.1 million/month but the data from the Department of Maritime Affairs and Fisheries (DKP) of South Sulawesi estimated the income to be 1.6 million/month in 2015.

The social assistances implemented in Bangladesh include cash transfer programs for the elderly, singles, widows, poor women, disabled, elementary, junior high, and high school students, and several others in addition to non-financial assistance such as food subsidies, electricity subsidies, health, free elementary to high school education, microloans including housing loans, recovery programs for beggars, and assistance for street swords (Pradhan et al., 2013). Several other countries proved the possibility of improving the level of people's quality of life using social assistance provided by the government or non-governmental organisations (Ashraf, 2014) and this is in line with previous findings that integrated and targeted social assistance can improve the quality of life of a community (Ravallion, 2003; Sumarto et al., 2005). The human development index (HDI) measures the level of people's quality of life based on the aspects of education, health, and income while the concept is evaluated by the United Nations through the Sustainable Development Goals (SDGs) which focus on poverty, health including child mortality, maternal health, HIV and AIDS, dengue fever, and other diseases, social as aspect including gender equality, women's empowerment, and global cooperation and environmental sustainability (World Bank, 2020). Meanwhile, the World

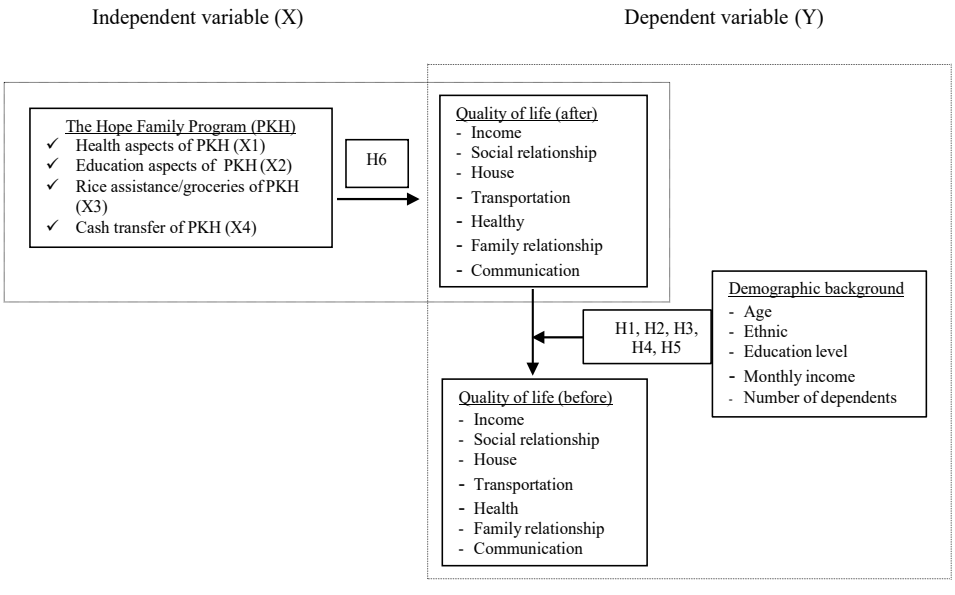
Health Organization (WHO) measures the quality of life from aspects of physical health, psychology, freedom, social, environmental, and spiritual relationships or religion (Marvin, 1997). This means there is no singular method to measure the quality of life because it is often influenced by different other factors such as local cultural values and the community's living environment (Ventegodt et al., 2003; Azahan et al., 2008).

This shows that quality of life cannot only be measured based on aspects of income, education, and health alone but with due consideration for others such as housing, environment, social, culture, politics, freedom, security, transportation, satisfaction, happiness, psychology, spirituality or religion, weather and others (Becker et al., 1997; Ventegodt et al., 2003; Dalia and Juozas, 2007; Azahan et al., 2008; Lavers, 2008; Dalia and Algirdas, 2009). It is also important to note that the perspective of quality of life in communities is also different from the perspective of the government in implementing PKH due to cultural, residential, social, political and other differences. Therefore, the ability of the PKH assistance to have an appropriate effect is highly dependent on the public's view of the objective and subjective elements of quality of life. Sirgy (1986), Michael (1999), Lavers (2008) and Lyndon et al. (2011) also showed that there are different views of the quality of life among developed, developing, and underdeveloped countries based on the hierarchy of human development (Maslow, 1954). This is due to the fact that the developed countries generally assess the quality of life based on Maslow's (1954) pyramid pattern. Maslow (1954), Sirgy (1986) and Michael (1999) while developing and underdeveloped countries do not evaluate the concept through these hierarchies (Lavers, 2008; Lyndon et al., 2011). Most of previous studies only focused on the level of quality of life after social assistance has been provided (Sumarto et al., 2005; Ansell, 2011). Therefore, this present study makes a difference by examining the aspects of quality of life among fishing communities before and after assistance is received from PKH. This is important because there are no appropriate studies within this scope and there is a need to identify the poor fishermen in order to improve the welfare of the community. The main study question is that "What is the difference in the level of quality of life before and after receiving PKH assistance and how much influence does PKH assistance have on the quality of life in coastal communities of South Sulawesi?"

2 Study methods

This study was conducted quantitatively using surveys and questionnaires. The samples were selected from 18 coastal areas in South Sulawesi through cluster sampling of the Bugis and Makassar ethnics by randomly selecting two regions considered to be homogeneous with the same characteristics and the ability to represent these ethnic groups effectively. This led to the selection of Takalar Regency to represent the Makassar and Barru Regency to represent the Bugis ethnic. The population of PKH recipients in these areas is 4,811 and 2,121, respectively, thereby leading to a total of 6,932. Therefore, a total of 378 people were used as samples at a significant level of 0.05 according to the formulation of Yamane (1967). The study framework is stated shown in Figure 1.

Figure 1 Framework of the study



Note: Quality of life (second order construct).

Table 2 References and statements of independent and dependent variables

Dimensions		*Statements*	*References*
1) Statements and references on PKH health (X1)			
Spending costs	1	Free health (assistance from PKH) can reduce household costs	Domri et al. (2019), Pradhan et al. (2013), Dwicaksono et al. (2012)
Access of services	2	My health condition and that of my family are better with free health services (PKH)	
	3	The service officer always provides fast and precise services	
Health Facilities	4	Health workers provide adequate facilities such as wheelchairs for patients	
2) Statements and references on PKH education (X1)			
Spending costs	1	Education (PKH funding) reduces my family's school fees	Nikita et al. (2021), Dewi and Edy (2014), Press (2009)
Education level	2	Education can improve my child's education level	
	3	Education (PKH funding assistance) can help students continue their education	

Table 2 References and statements of independent and dependent variables (continued)

Dimensions		*Statements*	*References*
3) Statements and references on PKH rice assistance/groceries (X3)			
Daily expenses	1	The assistance provided helps to reduce my family's expenses	Bungkaes et al. (2013)
Nutritional needs	2	Rice assistance for the poor helps meet the nutritional needs of families	
	3	Rice assistance for the poor supports families to eat 2–3 times a day	
Quality	4	The rice assistance received is in good condition (not worn/fleas)	
4) Statements and references on PKH cash transfer (X4)			
Basic needs	1	This cash assistance helps meet the family's living needs	Domri et al. (2019), Rozita and Ummu (2014)
Live load	2	This assistance helps reduce the burden of living from the financial aspect	
Income	3	This assistance helps increase family income	
Business capital	4	I also use the fund to start a small business	
5) Statements and references on quality of live (Y)			
Income	1	The assistance adds to my income	Shaladdin et al. (2009)
	2	Satisfied with the income	
Health	3	The assistance received has helped improve the health of my family and I	Shaladdin et al. (2009)
	4	There are sufficient number of health workers	
	5	Health service is within reach	
Education	6	Children can go to elementary school	Malaysia Well-Being Report (2013)
	7	Children can go to junior high school	
	8	Children can continue their education in high school	
	9	Education service is within reach	
Family relationship	10	The relationship with my mother, father, and mother-in-law is good	Lyndon et al. (2011)
	11	The relationship with my wife and children is fine	
Social relationship	12	Relations with neighbours are good	Lyndon et al. (2011)
House	13	I have my own house	Shaladdin et al. (2009)
	14	Tap and clean water is available	
	15	Electricity is available	
Transportation	16	I have a motorbike or bike	Shaladdin et al. (2009)
Communication	17	I own a telephone or mobile phone	Malaysia Well-Being Report (2013)

2.1 Measurement and preparation of questionnaires

The questionnaire was measured using an ordinal or a Likert scale (Sekaran, 2003) and formulated based on the independent and dependent variables. It is important to note that the independent variable is the cause of a problem while the dependent variable includes factors influencing the problem (Chua, 2012). Therefore, the independent variables in this study include:

1 PKH health

2 PKH education

3 PKH rice/groceries assistance

4 PKH cash assistance, while the dependent variable is the quality of life.

The statements used in the questionnaire and their references are presented in Table 2.

2.2 Results analysis

The responses to the questionnaire were analysed through the paired-samples t-test and multiple regression as shown in Table 3.

Table 3 Study objectives, hypotheses and subsequent analyses

Study objectives and hypotheses		*Analysis*
Assessing the differences in quality-of-life stages with the focus on ethnicity, education level, monthly income, and the number of dependents in coastal communities and fishermen of South Sulawesi Province before and after receiving PKH assistance.		Paired-samples t-test
Hypotheses:		
H1	There are differences in the quality of life of poor coastal and fishermen communities before and after receiving PKH assistance based on age category.	
H2	There are differences in the quality of life of poor coastal and fishermen communities before and after receiving PKH assistance based on ethnic categories.	
H3	There are differences in the quality of life of poor coastal and fishermen communities before and after receiving PKH assistance based on education level.	
H4	There are differences in the quality of life of poor coastal and fishermen communities before and after receiving PKH assistance based on monthly income.	
H5	There are differences in the quality of life of poor coastal and fishermen communities before and after receiving PKH assistance based on the number of dependents.	
Analysing the factors of PKH assistance affecting the level of quality of life among coastal and fishermen communities in South Sulawesi Province.		(Multiple regression)
H6	PKH assistance factors including PKH health access, PKH education access, rice/staple food assistance, and PKH cash assistance affect the quality of life among the coastal and fishermen communities in South Sulawesi.	

3 Results and discussion

The section discusses the profiles of the respondents and answers the study questions to determine the differences in the quality-of-life stages based on age, ethnicity, education level, and monthly income among coastal communities and fishermen before and after receiving PKH as well as the influence of its assistance on their quality of life using paired sample t-test and multiple regression analysis.

3.1 Respondent profile

A total of 322 people were used in this study and 43.5% were observed to age between 40–49 years, 28.6% were 30–39 years and the remaining 27.9% are 20–29 and 50 years and above. It was also discovered that 59.58% are from Makassarese while 40.42 are from Bugis, and for education, most of 49.7% finished elementary school (SD) and only 3.4% graduated from high school while the remaining 46.9% did not finish elementary or junior high school. The results showed that 29.2% have 3 children, 22% have 4, 20.2% have 2, and the remaining 28.6% have more than 5 or less than 2 children. It was also discovered that the majority of the respondents, 54.7%, have income between 1 to 2 million rupiahs, 12.7% have below 1 million rupiahs, and 32% have more than 2 million rupiahs. Most of the respondents spend 1–2 million per month on food and drink as indicated by 47.2% while 22.4% spend between 500 thousand to 1 million rupiahs and the remaining 30.4% spend less than 500 thousand or more than 2 million rupiahs. Furthermore, most of the respondents, 45.7% pay above 200 thousand for electricity while the remaining 44.3% pay between 100 to 200 thousand or below 100 thousand. Lastly, the PDAM/gallon water/clean water was observed by the majority, 78.9% to cost below 100 thousand while 21.1% paid above 100 thousand rupiahs.

It is important to note that a total of 343 were returned out of the 491 distributed and this indicates 69.9% which is more than the 65% required to be the desired target as indicated by Jobber (1989). However, only 322 or 65.6% were used in the analysis because 14 were incompletely answered and 7 were exempted due to outliers, and this is in line with the assertion of Sekaran (2003) that a rate of return of up to 30% is sufficient for a field study.

3.2 Descriptive analysis of independent variables (X1–X4)

The independent variables were analysed descriptively based on the frequency, min, and standard deviation, and these are explained as follows.

3.2.1 PKH health aspects (X1)

The results showed that 80% agreed this program reduced spending costs while 86% agreed the health conditions of the coastal families are better with a min. or average value close to 4 as indicated in Table 4.

Table 4 Descriptive statistics of PKH health aspects (X1)

Statements	Percentage					Min.	Std. deviation
	SD	D	DA	A	SA		
Reduce household costs	0	0	3	80	17	4.14	0.423
The health of me and my family is the better	0	0	10	86	4	3.94	0.373
Fast and accurate health services	0	0	15	82	3	3.88	0.411
Adequate health facilities	0	21	46	33	0	3.13	0.723

Note: SD: strongly disagree, D: disagree, DA: do not agree, A: agree and SA: strongly agree.

3.2.2 PKH education aspects (X2)

The results showed that 80% agreed free education can reduce the cost of education while 76% believed the children's education levels increased due to the implementation of the program as indicated in Table 5.

Table 5 Descriptive statistics of PKH education aspects (X2)

No.	Statements	Percentage					Min.	Std. deviation
		SD	D	DA	A	SA		
1	Reduce education costs	0	0	2	80	18	4.17	0.414
2	Increase education level	0	0	2	76	22	4.20	0.449
3	Continuing higher education	0	2	12	73	13	3.98	0.558

Note: SD: strongly disagree, D: disagree, DA: do not agree, A: agree and SA: strongly agree.

3.2.3 PKH rice assistance/groceries (X3)

The results showed that 64% agreed the program helps them to meet nutritional needs as presented in Table 6.

Table 6 Descriptive statistics of rice assistance (X3)

Statements	Percentage					Min.	Std. deviation
	SD	D	DA	A	SA		
Reduce shopping costs	0	18	4	53	25	3.85	0.994
Help with nutritional needs	0	18	6	64	12	3.70	0.902
Supports eating 2–3 times a day	0	18	6	59	17	3.76	0.944
Rice is in good condition (not worn out/lice)	0	22	16	59	3	3.44	0.867

Note: SD: strongly disagree, D: disagree, DA: do not agree, A: agree and SA: strongly agree.

3.2.4 PKH cash transfer (X4)

The findings showed that 76% agreed the cash transfers reduced the burden of living and 72% showed it assisted in meeting living needs as presented in Table 7.

Table 7 Descriptive statistics of cash transfer of PKH (X4)

Statements	*Percentage*					*Min.*	*Std. deviation*
	SD	*D*	*DA*	*A*	*SA*		
Helping the necessities of life	0	4	12	72	12	3.91	0.640
Reducing the burden of life	0	6	11	76	7	3.84	0.634
Increase income	0	13	16	64	7	3.64	0.798
Small business capital	0	29	34	27	10	3.18	0.962

Note: SD: strongly disagree, D: disagree, DA: do not agree, A: agree and SA: strongly agree.

3.3 Descriptive analysis of the dependent variable (Y)

The dependent variable covers eight dimensions analysed based on frequency, min, and standard deviation, and these include:

1 income

2 health

3 education

4 social relations

5 family relationships

6 housing

7 transportation

8 communications.

The min. or average value after PKH has been received is close to four and the answers provided to the questionnaire by the respondents are quite good because the standard deviation value is less than one. These are further explained as follows.

3.3.1 Income

The results showed that 62% of respondents agreed they are satisfied with their income after receiving PKH and 55% showed their income has increased as indicated in Table 8.

Table 8 Quality of life (before and after) based on dimension of income

Statements before (B) and after (A) receiving PKH	*Percentage*								*Min.*	*Min.*	*Std. deviation*	*Std. deviation*
	B	*A*	*B*	*A*	*B*	*A*	*B*	*A*				
	D	*D*	*DA*	*DA*	*A*	*A*	*SA*	*SA*	*Before*	*After*	*Before*	*After*
Increase income	41	15	56	30	3	55	0	0	2.62	3.41	0.546	0.748
Satisfied with income	22	9	51	29	27	62	0	0	3.06	3.53	0.701	0.661

Note: B (before), A (after), SD: strongly disagree, D: disagree, DA: do not agree, A: agree and SA: strongly agree.

3.3.2 Health

The findings showed that 78% of respondents agreed they were able to improve their health with the help of PKH as observed in Table 9.

Table 9 Quality of life (before and after) based on dimension of health

Statements before (B) and after (A) receiving PKH	*Percentage*								*Min.*	*Min.*	*Std. deviation*	*Std. deviation*
	B	*A*	*B*	*A*	*B*	*A*	*B*	*A*				
	D	*D*	*DA*	*DA*	*A*	*A*	*SA*	*SA*	*Before*	*After*	*Before*	*After*
Improving family health	28	3	57	14	15	78	0	5	2.88	3.84	0.649	0.546
Sufficient number of health officers	21	1	58	19	21	79	0	1	3.00	3.80	0.651	0.458
Health facilities can be easily reached	17	0	44	15	39	82	0	3	3.22	3.88	0.716	0.411

Note: B (before), A (after), SD: strongly disagree, D: disagree, DA: do not agree, A: agree and SA: strongly agree.

3.3.3 Education

The results showed that 89% agreed their children are able to go to junior high school and 86% to elementary school due to the assistance provided as indicated in Table 10.

Table 10 Quality of life (before and after) based on dimension of education

Statements before (B) and after (A) receiving PKH	*Percentage*								*Min.*	*Min.*	*Std. deviation*	*Std. deviation*
	B	*A*	*B*	*A*	*B*	*A*	*B*	*A*				
	D	*D*	*DA*	*DA*	*A*	*A*	*SA*	*SA*	*Before*	*After*	*Before*	*After*
Continue primary school	23	0	46	1	31	86	0	13	3.07	4.13	0.732	0.350
Continue junior high school	26	0	56	3	18	89	0	8	2.93	4.04	0.661	0.323
Continue senior high school	30	3	59	17	11	76	0	4	2.81	3.82	0.615	0.534
The school distance is easy to reach	20	1	43	15	37	82	0	2	3.17	3.85	0.737	0.416

Note: B (before), A (after), SD: strongly disagree, D: disagree, DA: do not agree, A: agree and SA: strongly agree.

Table 11 Quality of life (before and after) based on dimension of family relationship

Statements before (B) and after (A) receiving PKH	*Percentage*								*Min.*	*Min.*	*Std. deviation*	*Std. deviation*
	B	*A*	*B*	*A*	*B*	*A*	*B*	*A*				
	D	*D*	*DA*	*DA*	*A*	*A*	*SA*	*SA*	*Before*	*After*	*Before*	*After*
The relationship between parents and in-laws is good	2	0	11	0	75	77	12	23	3.98	4.22	0.541	0.425
The relationship between wife and children is good	1	0	6	0	69	74	19	31	4.10	4.31	0.463	0.534

Note: B (before), A (after), SD: strongly disagree, D: disagree, DA: do not agree, A: agree and SA: strongly agree.

3.3.4 Family relationship

The results showed that 77% agreed that they have a good relationship with their parents and in-laws while 74% with their wives and children after receiving PKH as indicated in Table 11.

3.3.5 Social relationship

The results showed that 85% agreed and 13% strongly agreed they have a good relationship with their neighbours are good as shown in Table 12.

Table 12 Quality of life (before and after) based on dimension of social relationship

Statement before (B) and after (A) receiving PKH	*Percentage*								*Min.*	*Min.*	*Std. deviation*	*Std. deviation*
	B	*A*	*B*	*A*	*B*	*A*	*B*	*A*				
	D	*D*	*DA*	*DA*	*A*	*A*	*SA*	*SA*	*Before*	*After*	*Before*	*After*
The relationship with neighbours is good	1	0	9	2	85	85	5	13	3.94	4.12	0.406	0.368

Note: B (before), A (after), SD: strongly disagree, D: disagree, DA: do not agree, A: agree and SA: strongly agree.

3.3.6 Housing

The findings showed 89% agreed that piped or clean water is available, 88% on electricity, and 72% have their own house as presented in Table 13.

Table 13 Quality of life (before and after) based on dimension of housing

Statements before (B) and after (A) receiving PKH	*Percentage*								*Min.*	*Min.*	*Std. deviation*	*Std. deviation*
	B	*A*	*B*	*A*	*B*	*A*	*B*	*A*				
	D	*D*	*DA*	*DA*	*A*	*A*	*SA*	*SA*	*Before*	*After*	*Before*	*After*
Have your own house	30	9	51	16	19	72	0	3	2.89	3.69	0.694	0.667
There is tap water or clean water available	19	3	41	8	40	89	0	0	3.21	3.87	0.737	0.412
There is electricity available	20	2	42	9	38	88	0	1	3.17	3.88	0.745	0.396

Note: B (before), A (after), SD: strongly disagree, D: disagree, DA: do not agree, A: agree and SA: strongly agree.

Table 14 Quality of life (before and after) based on dimension of transportation

Statement before (B) and after (A) receiving PKH	*Percentage*								*Min.*	*Min.*	*Std. deviation*	*Std. deviation*
	B	*A*	*B*	*A*	*B*	*A*	*B*	*A*				
	D	*D*	*DA*	*DA*	*A*	*A*	*SA*	*SA*	*Before*	*After*	*Before*	*After*
Have a motorbike or bike	34	16	50	19	16	65	0	0	2.81	3.49	0.682	0.758

Note: B (before), A (after), SD: strongly disagree, D: disagree, DA: do not agree, A: agree and SA: strongly agree.

3.3.7 Transportation

The results showed that 65% agreed to have a motorbike or bike after receiving PKH as shown in Table 14.

3.3.8 Communication

The results showed that 71% agreed they have a telephone or handphone after receiving PKH as presented in Table 15.

Table 15 Quality of life (before and after) based on dimension of communication

Statements before (B) and after (A) receiving PKH	*Percentage*								*Min.*	*Min.*	*Std. deviation*	*Std. deviation*
	B	*A*	*B*	*A*	*B*	*A*	*B*	*A*				
	D	*D*	*DA*	*DA*	*A*	*A*	*SA*	*SA*	*Before*	*After*	*Before*	*After*
Have a phone or handphone	46	11	47	16	7	71	0	2	2.61	3.64	0.613	0.702

Note: B (before), A (after), SD: strongly disagree, D: disagree, DA: do not agree, A: agree and SA: strongly agree.

3.4 Analysis of study result

A paired sample t-test was conducted to satisfy the first objective of this study which is to assess the differences in the quality-of-life stages based on age, ethnicity, education level, monthly income, and the number of dependents among coastal and fishermen communities in South Sulawesi before and after receiving the PKH assistance.

3.4.1 Analysis of differences in quality of life based on age

The paired sample t-test analysis was conducted on Hypothesis 1 (H1) which states that 'there are differences in the quality of life of poor coastal and fishermen communities before and after receiving PKH by age category' and the results are presented in Table 16.

The results showed that the quality of life before and after receiving PKH assistance is significant based on the age category. This is observed from the min. group value with a minus (–) which means there is an improvement in quality of life due to the rejection of the min. after by the min. before. It was also discovered that the 40 to 49 years (–0.613) age category has the highest difference followed by 30 to 39 years (–0.594), 50 to 59 years (–0.578), 20 to 29 years (–0.576), and the lowest was recorded with 60 years and over (–0.525). This means the PKH assistance is able to improve the quality of life of the poor coastal and fishermen communities in all age categories.

This finding is supported by Muchlisin et al. (2013) that 31 to 45 years and over age group experienced more improved quality of life after receiving assistance in Aceh. A similar result was reported by Loyland et al. (2011) in Norway that there is a significant difference after receiving social assistance based on age. This means age affects individual behaviour, even in the process of responding to the given stimuli, with the younger ones tending to have unstable emotional characteristics compared to older age groups (Ida, 2009).

Table 16 Paired samples t-test based on age category

Age groups	*Min.*	*Deviation*	*T*	*Df*	*Sig. (2-tailed)*
20 to 29 years					
Quality of life before	3.129	7.660	–8.398	16	.000*
Quality of life after	3.705	9.969			
(Before – after)	–0.576	13.024			
30 to 39 years					
Quality of life before	3.141	9.407	–25.425	19	.000*
Quality of life after	3.735	7.687			
(Before – after)	–0.594	10.312			
40 to 49 years					
Quality of life before	3.179	9.795	–35.063	139	000*
Quality of life after	3.793	8.714			
(Before – after)	–0.613	9.530			
50 to 59 years					
Quality of life before	3.255	10.000	–23.603	60	.000*
Quality of life after	3.834	9.415			
(Before – after)	–0.578	8.809			
60 and above					
Quality of life before	3.206	11.041	–10.021	11	.000*
Quality of life after	3.731	6.414			
(Before – after)	–0.525	8.353			

Note: *Significance $p < 0.05$.

3.4.2 Analysis of differences in quality of life based on ethnicity

Hypothesis 2 (H2) which states that 'there are differences in the quality of life of poor coastal and fishermen communities before and after receiving PKH based on ethnic categories; was also analysed and the results are indicated in Table 17.

Table 17 Paired sample t-test based on ethnicity

Ethnic groups	*Min.*	*Deviation*	*T*	*Df*	*Sig. (2-tailed)*
Bugis					
Quality of life before	3.095	7.996	–35.315	157	.000*
Quality of life after	3.731	7.701			
(Before – after)	–0.636	10.419			
Makassar					
Quality of life before	3.263	9.891	–37.343	163	.000*
Quality of life after	3.821	9.161			
(Before – after)	–0.557	8.801			

Note: *Significance $p < 0.05$.

The results showed PKH was more significant in the Bugis ethnic group as indicated by –0.636 than Makassar ethnic group with –0.557 and this means there are differences based on ethnic categories before and after receiving PKH. The findings indicated that the Bugis people can feel the benefits of the assistance more than the Makassar and this can be associated with the fact that they have better income per capita or community economic level on the average compared to the Makassar ethnic group (BPS, 2020).

3.4.3 Analysis of the differences in quality of life based on education level

Hypothesis 3 (H3) which states that 'there are differences in the quality of life of poor coastal and fishermen communities before and after receiving PKH based on education level' was also analysed and the results are indicated in Table 18.

Table 18 Paired Sample t-test Based on Education Level

Groups of education level	*Min.*	*Deviation*	*T*	*df*	*Sig. (2-tailed)*
Did not finish primary school					
Quality of life before	3.175	10.411	–24.482	82	.000*
Quality of life after	3.772	8.794			
(Before – after)	–0.597	10.222			
Primary school					
Quality of life before	3.195	9.296	–35.372	159	.000*
Quality of life after	3.777	8.815			
(Before – after)	–0.582	9.570			
Junior high school					
Quality of life before	3.145	9.238	–24.585	67	.000*
Quality of life after	3.770	8.594			
(Before – after)	–0.625	9.633			
Senior high school					
Quality of life before	3.231	14.678	–8.946	10	.000*
Quality of life after	3.861	7.419			
(Before – after)	–0.630	10.751			

Note: *Significance $p < 0.05$.

The paired sample t-test results showed that the PKH assistance was able to improve the level of quality of life of coastal and fishermen communities significantly based on educational level. This was observed from the fact those with high school education (–0.630) had the highest difference followed by junior high school graduates (–0.625). This is in line with the findings of the previous study conducted in Norway by Loyland et al. (2011) that there is a significant difference in the impact of social assistance received based on the level of education while Nikita et al. (2021), Domri et al. (2019) and Astina (2014) showed that a higher level of education usually leads to a higher quality of life on the average.

3.4.4 Analysis of differences in quality of life based on monthly income

The results of paired sample t-tests Hypothesis 4 (H4) which states 'there are differences in the quality of life of poor coastal and fishermen communities before and after receiving PKH based on monthly income categories', as shown in Table 19.

Table 19 Paired sample t-test based on monthly income

Groups of monthly income	*Min.*	*Deviation*	*T*	*Df*	*Sig. (2-tailed)*
Rp.351,000–Rp.1,000,000 ($15–$71)					
Quality of life before	3.199	9.663	–26.069	106	.000*
Quality of life after	3.747	8.917			
(Before – after)	–0.548	10.008			
Rp.1,001,000–Rp.2,000,000 ($71–$143)					
Quality of life before	3.173	9.564	–43.239	201	.000*
Quality of life after	3.790	8.561			
(Before – after)	–0.617	9.320			
Rp.2,001,000–Rp.5,000,000 ($143–$357)					
Quality of life before	3.148	14.153	–9.356	12	.000*
Quality of life after	3.829	8.513			
(Before – after)	–0.681	12.064			

Note: *Significance $p < 0.05$.

The paired sample t-test showed the impact of PKH on the quality of life of the residents is significantly affected by the level of income. This was discovered in the fact that the group with a monthly income level between $143–$357 (–0.681) showed the highest difference in the quality of life before and after receiving PKH followed by $71–$143 (–0.617). This agrees with the findings of Patmawati and Rahisam (2010) in Negeri Sembilan, Malaysia, and Astina (2014) in Malang, Indonesia, that a higher income usually leads to a better quality of life due to the ability of the income or finances to meet daily needs (Dalia and Algirdas, 2009) and improve the quality of life of fishermen (Nikita et al., 2021; Domri et al., 2019; Mazuki et al., 2013).

3.4.5 Analysis of differences in quality of life based on the number of dependents

Hypothesis 5 (H5) which states that 'there are differences in the quality of life of poor coastal and fishermen communities before and after receiving PKH based on the number of dependents' was also tested using paired sample t-test and the results are presented in Table 20.

The min. value showed a significant effect of the number of dependents on the differences in the effect of PKH before and after implementation on the quality of life and this means the hypothesis was accepted. It was discovered that the family with 7 to 9 dependents (–0.695) has the highest difference and this is in line with the findings of Astina (2014) that a family with a high number of dependents usually has a better quality of life stage due to the physical and emotional support the children can provide despite the fact that they are considered an economic burden. Moreover, children in

coastal and fishermen communities usually assist with daily chores or earn an income. Muh. Koesnoe in Siregar (2003) also showed that children can give happiness to their parents and help the family economy based on the perception that having many children is getting many fortunes.

Table 20 Paired sample t-test based on number of dependents

Groups	*Min.*	*Deviation*	*T*	*df*	*Sig. (2-tailed)*
One to three people					
Quality of life before	3.150	9.846	–31.216	149	.000*
Quality of life after	3.763	8.773			
(Before – after)	–0.613	11.058			
Four to six people					
Quality of life before	3.212	9.599	–40.524	163	.000*
Quality of life after	3.786	8.459			
(Before – after)	–0.574	8.343			
Seven to nine people					
Quality of life before	3.164	10.817	–8.866	8	.000*
Quality of life after	3.869	11.303			
(Before – after)	–0.695	10.828			

Note: *Significance $p < 0.05$.

3.5 Classical assumption test

This test was conducted before the data were processed using the multiple regression method to determine the changes in two or more independent variable factors contributing to the dependent variable (Chua, 2012). The classical assumption was in the form of a normality test with the data found to be normal because the skewness and kurtosis values were within the range of ±1.96 (Chua, 2012), indicating there is no multicollinearity and heteroscedasticity. This shows it was possible to use the data for multiple regression analysis.

3.6 Multiple regression analysis

This analysis was used to test the 6th hypothesis (H6) which states that 'the PKH aspects including health, education, rice assistance, and cash transfer affect the quality of life of coastal and fishermen communities in South Sulawesi Province'. The results showed that only one independent variable, namely PKH health, has a positive and significant influence on the quality of life of the fishing community as shown in Table 21.

The multiple regression model showed a coefficient of determination (R^2) of 0.173 as indicated in Table 22 and this means all the independent variables used were able to explain 17.3% of the influence on the quality of life while the remaining 82.7% is due to other variables outside the scope of this study.

The regression model was later tested simultaneously using the F (F-test) and ANOVA test as shown in Table 23.

Table 21 Results of multiple regression analysis on the effect of the PKH assistance on the quality of life

	Unstandardised coefficients	*Standardised coefficients (R)*	*T*	*Sig.*
Constant (α)	118.125		15.756	0.000
Health aspects of PKH	0.616	0.199	3.543	0.000
Education aspects of PKH	0.060	0.016	0.292	0.771
Rice assistance/groceries of PKH	0.087	0.061	1.174	0.241
Cash transfer of PKH	0.107	0.046	0.817	0.415

Note: R = 0.416, R^2 = 0.173, F = 13.218 and Sig. F = 0.000.

Table 22 Coefficient of determination of multiple regression analysis results PKH assistance on the quality of life

R	*R square*	*Adjusted R square*
0.416	0.173	0.160

Table 23 Multiple regression model simultaneous test results

	Sum of squares	*Df*	*Mean square*	*F*	*Sig.*
Regression	2,957.298	5	591.460	13.218	0.000
Residual	14,140.267	316	44.748		
Total	17,097.565	321			

The independent variable, namely PKH health, was also found to have a positive and significant effect with 0.616 while PKH education, rice assistance, and cash transfer have a positive but not significant effect on the quality of life in coastal and fishermen communities as indicated by 0.060, 0.087 and 0.107, respectively.

4 Conclusions

The conclusions of this study are as follows:

1 Hypotheses H1–H5 tested through paired sample t-test analysis showed there are differences in the quality of life of coastal and fishermen communities before and after receiving the PKH assistance based on age, ethnicity, education level, monthly income, and the number of dependents with a significant value (two-tailed) of 0.000 < 0.05. This means the PKH assistance is able to improve the quality of life of the community in all the stated categories.

2 The multiple regression analysis (H6) showed that all the independent variables had a positive relationship with the quality of life but only PKH health had a significant effect ($r = 0.000$, $p < 0.05$). Moreover, the coefficient of determination was found to be 17.3% and this means the variables of the PKH assistance provided can only explain 17.3% of the quality of life of the poor coastal and fishermen communities in South Sulawesi Province while the remaining is determined by other variables.

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