



Novita Maizri/SMERU



CHILD MULTIDIMENSIONAL POVERTY IN INDONESIA¹

The last decade saw the emergence of a new view that measuring poverty requires comprehensive indicators beyond monetary indicators. Then it was argued that in order to look at poverty more comprehensively, a multidimensional analysis framework is needed. This framework is considered especially important when looking at children's situation, as they are the group most affected by poverty. Several studies show that many children in Indonesia are deprived of more than one life dimension². For example, a study conducted by The SMERU Research Institute (supported by Bappenas and UNICEF) in 2012 found that most children were deprived of both sanitation and access to clean water.

¹ This article is a summary of SMERU's research report titled "The 2013 Update of Multidimensional Child Poverty in Indonesia" (draft report 2017) by Luhur Bima and Cecilia Marlina.

² The life dimensions are health, education, housing, and legal status.

Child Multidimensional Poverty in Indonesia

1

Child Poverty in Urban Areas: Children's Condition and Perception

6

Preliminary Study of The e-Warong KUBE-PKH Program Implementation

9

Strengthening Indonesia's Health Services to Anticipate the ASEAN Economic Community

13

Community Empowerment: Past, Present, and Future

17

Continued on page 3

The SMERU Research Institute is an independent institution for research and policy studies which professionally and proactively provides accurate and timely information as well as objective analysis on various socioeconomic and poverty issues considered most urgent and relevant for the people of Indonesia.

With the challenges facing Indonesian society in poverty reduction, social protection, improvement in social sector, development in democratization processes, and the implementation of decentralization and regional autonomy, there continues to be a pressing need for independent studies of the kind that SMERU has been providing.

EDITORIAL BOARD

Asep Suryahadi, Widjajanti Isdijoso, Syaikhul Usman, Nuning Akhmadi, Nina Toyamah, Luhur Bima, Meuthia Rosfadhila, Ruhmaniyati

EDITORS

Hastuti, Liza Hadiz, Gunardi Handoko

TRANSLATORS

Fandi Muhammad Hizbullah, Liza Hadiz

GRAPHIC DESIGNER

Novita Maizir

DISTRIBUTION STAFF

Heru Sutapa

The SMERU newsletter is published to share ideas and to invite discussions on social, economic, and poverty issues in Indonesia from a wide range of viewpoints. The findings, views, and interpretations published in the articles are those of the authors and should not be attributed to SMERU or any of the agencies providing financial support to SMERU. Comments are welcome. If you would like to be included on our mailing list, please visit our website or send us an e-mail.



Jl. Cikini Raya No. 10A,
Jakarta 10330 Indonesia
Phone: +6221-3193 6336;
Fax: +6221-3193 0850
e-mail: smeru@smeru.or.id;
website: www.smeru.or.id

 The SMERU ResearchInstitute

 @SMERUInstitute

 The SMERU Research Institute

 The SMERU Research Institute

Dear readers,

In general poverty reduction uses two approaches: economic development to increase income, and community empowerment to improve the capacity of human resources. The success of poverty reduction schemes is determined, among others, by its policy and targeting accuracy. The policy can be targeted at the community, family, or individual which is disaggregated by age and gender.

In order to provide policymakers with research-based information on vulnerable groups, in the past several years The SMERU Research Institute has conducted various studies observing child poverty and poor families' access to public services.

In 2015, SMERU explored the multidimensional poverty of children aged 0–17 years. The study aimed to measure the deprivation level of individual children in order to assess their well-being across age groups.

SMERU conducted another study on children in Surakarta, North Jakarta, and Makassar in 2015 to obtain an understanding of the characteristics of child poverty, for both girls and boys aged 6–17 years old living in urban areas. This study reveals factors affecting a child's experience seen from her or his own perspective.

Subsequently in 2016, SMERU conducted a study on a poverty reduction program targeted at the family. The program is called e-Warong, an inclusive finance service that changed the disbursement of cash transfer assistance to a noncash method. The study observes stakeholders' perception on the concept of the program and their readiness to implement the program.

Still focusing on public services, SMERU then analyzed the ASEAN Economic Community Trade Agreement (MEA) in health sector. The study aims to identify MEA's implications on health services in regard to efforts to provide the basis for the formulation of quality and competitive health service policies.

At the end of this edition's newsletter, our guest writer reflects on Indonesia's various empowerment programs through the years. The author is in the view that there have to be a transformation in empowerment programs to one which will economically empower communities as well as develop their political sovereignty.

We hope you will enjoy this edition.

Syaikhul Usman

Editor

In 2015, SMERU conducted an exploratory study about child poverty using Multiple Overlapping Deprivation Analysis (MODA)³. This method allowed researchers to measure child deprivation on various basic needs across age groups. Therefore, this study categorized children into five age groups: (i) 0–23 months, (ii) 2–4 years, (iii) 5–11 years, (iv) 12–14 years, and (v) 15–17 years.

The implementation of MODA on the National Socioeconomic Survey (Susenas) data aims to measure child deprivation in Indonesia in relation to children's development, as well as to provide a profile of deprived children based on household composition and characteristic. Applying MODA on the Susenas dataset with overlapping analysis between several welfare dimensions and monetary poverty condition can present a useful and comprehensive information about the living situations of children.

This study used data from the first quarter of Susenas 2013 report to observe the profile of poor children and find the overlap between monetary poverty and nonmonetary poverty dimensions. At the household level, multidimensional deprivation was measured with several indicators such as water, housing, and sanitation. Other indicators were used at individual level that allowed researchers to identify the variation of child deprivation in a household. This study applied two thresholds of poverty, the provincial poverty line (PPL) and twice the poverty line (2PPL). The target is to obtain a more accurate overview of child poverty status in Indonesia. Children living under PPL are defined as poor, while children living above the PPL threshold and under 2PPL are defined as vulnerable. Therefore, children living under 2PPL are defined as poor and vulnerable.

The monetary poverty analysis result shows that child poverty rate is a little bit higher than the poverty rate of the overall population. In addition, children living in the rural areas are more likely to suffer from monetary poverty than children living in the urban areas. In terms of household composition, the existence of poor children in Indonesia is closely related to the age of the youngest child in the household and the number of household members. On the other hand, in terms of household characteristics, the existence of poor children is closely related to the level of education of adult female in the household and the job of the head of the household.

Analysis on nonmonetary deprivation finds that (i) 40% of children in Indonesia do not have access to proper sanitation, (ii) a quarter of children live in houses built of poor materials, and (iii) around one-fifth of children live in overcrowded houses. Besides that, in the health dimension, compared to other indicators, the medical treatment indicator has the lowest deprivation rate, with less than 10% across the age groups. Meanwhile, in the education sector, the deprivation rate of school enrollment of older children is higher than that of younger children. The school enrollment deprivation rate of children aged 12–14 years (junior high school) is around 5%, while children aged 15–17 years (senior high school) increases to 26%.

Nonmonetary deprivation variation analysis in all welfare groups finds that children living in better households are still suffering from deprivation in several dimensions. However, on the whole, the deprivation rate of children from better welfare group is still low if compared to children in the poor and vulnerable group.

Monetary poverty analysis result shows that child poverty rate is a little bit higher than the poverty rate of the overall population



Novita Maizir/SMERU

³ Moda is a method developed by UNICEF based on children's lifecycle. It captures deprivations that children suffer simultaneously to provide a better understanding of the complexity of deprivations faced by children.

Overall, around 16% of children suffer from multidimensional deprivation with different rates across age groups: 29% for age 0–23 months, 30% for age 2–4 years, 8% for age 5–11 years, 11% for age 12–14 years, and 17% for age 15–17 years. The two youngest age groups (0–23 months and 2–4 years) that are deprived in more than two dimensions are considered to be experiencing multidimensional deprivation. Children in the three older groups experiencing multidimensional deprivation are deprived in more than three dimensions.

The profile of deprived children provides information about their household background. Thus, it allows us to identify children with the most vulnerable condition. Child deprivation in households headed by females and households headed by males is not that different. Based on the marriage status of the head of household, children living with both parents have lower deprivation rate than children in other categories. Moreover, compared to all age groups, children aged 5–11 years have the lowest deprivation rate in all categories of the marriage status of the head of the household.

Children aged 15–17 years have the highest risk of suffering from deprivation if the youngest child in the household is less than one year. In general, this pattern is consistent in all age groups. In addition, children of all age groups tend to have a higher risk of suffering from deprivation if there are more than three children in the household. Around 25% of children in the age group of 0–23 months suffer from multidimensional deprivation if they live in the households with three children or less. The proportion of deprived children increases to 45% in the households that have more than three children.

Analysis on household characteristic shows that the risk of deprivation on all age groups is higher in rural areas than in urban areas. Moreover, there is a combination of pattern if seen from the number of working adults in the households. Children have a higher risk of suffering from multidimensional deprivation when there are no educated female adults in the households. Furthermore, heads of household working in the service sector reduce the risk of children suffering from deprivation. This pattern is consistent in all age groups.

Another aspect analyzed with MODA are the overlap between monetary and deprivation conditions based on the dimensions. In the age group of 0–23 months, 13.5% of poor and vulnerable children are deprived in both health and birth registration dimensions, and almost 30% of children are deprived in monetary poverty, birth registration, and housing all at the same time. Meanwhile, one-fifth of poor and vulnerable children aged 5–11 years suffer from deprivation in housing and birth registration dimensions. However, older age groups show different results. Only 5.5% of children aged 12–14 years suffer from deprivation in three dimensions, which are monetary, education, and birth registration. Around 6.8% of all poor and vulnerable children aged 15–17 years are child workers and deprived in the education dimension.

This study also highlights the overlap between the government programs in reducing poverty on one hand and monetary as well as multidimensional deprivation condition on the other hand. The program analyzed in this study is the subsidized rice (Raskin) program which was launched in 1998 to improve food security and social safety net for targeted households. In relation to



School enrollment deprivation rate of children aged 12–14 years is around 5%, while the rate of children aged 15–17 years is 26%.



Novita Maizir/SMERU

PKH's long-term aim is to break the chain of intergenerational poverty so that children in the very poor households can break away from the poverty trap.

the Raskin program, we found that the families of 21% of children who are monetarily poor and or suffer from multidimensional deprivation are not recipients of the Raskin program. In contrast, almost 11% of children whose families are recipients of the Raskin program are not poor nor vulnerable. This shows that there are inclusions errors in the program.

The government social safety net program that targets children is the Family of Hope Program (PKH). The long-term aim of this program is to break the chain of intergenerational poverty so that children in very poor households can break away from the poverty trap. Based on this analysis, around 62% of children are not the recipients of the PKH even though they suffer from multidimensional deprivation and or monetary poverty. There are even 12% of children in worse condition because they suffer from monetary poverty and multidimensional poverty simultaneously, yet they do not receive PKH assistance.

The findings of this study call for the government, researchers, and other stakeholders to be more careful when analyzing child deprivation based on life cycle. Comprehensive analysis on dimensions related with multidimensional deprivation will yield accurate information. This will allow policymakers and stakeholders to respond appropriately to multidimensional poverty issues in all age groups.

Finally, this study has its own limitation. The indicators used to measure the ability to access services and infrastructure are still lacking. Therefore, further studies need to consider indicators that can capture the quality of various basic social services for children. ■

“ Children have a higher risk of suffering from multidimensional deprivation when there are no educated female adults in the households. ”



Novita Maizir/SMERU

CHILD POVERTY IN URBAN AREAS: CHILDREN'S CONDITION AND PERCEPTION¹

Poor children in urban areas tend to experience deprivation in various important life aspects. They are usually deprived of proper sanitation and housing, and the right to a birth certificate. In addition, urban poor children aged 15–17 are vulnerable to deprivations in education and becoming child workers (Susenas, 2013).

Due to conditions above, in 2015, SMERU and UNICEF conducted a study in Surakarta, North Jakarta, and Makassar to gain an in-depth understanding about the characteristics of poverty and disparity experienced by children aged 6–17 living in urban poor households. This study also looks at how children perceive their living condition and the poverty they are facing. The findings of the study is disseminated to various stakeholders, among them policymakers, with the aim of developing policies and programs to improve the condition of urban poor children.

Children's Perceptions of Poverty

It is interesting that children in this study do not perceive themselves as poor children, but as children with an average welfare condition. Even though there are several children that consider themselves poor, they group themselves into the "humble group". In addition, children in this study, in general, subjectively rate their welfare level at 50% and above.

When describing their lives, children aged 6–14 tend to focus on material aspects. For example, they describe poor children as those who live in semi-permanent small houses located in poor areas.

Children and Family Environment

Both boys and girls believe that parents should allocate more time and attention to their children. They further say that family and friends are sources of happiness; and closeness to God is what makes them strong. Therefore, living in an incomplete family due to divorce or having to live apart from parents is what triggers their sadness and disappointment.

¹ This article is a summary from SMERU's research report titled "Urban Child Poverty and Disparity: The Unheard Voices of Children Living in Poverty in Indonesia" (2017) by Luhur Bima, Rachma Indah Nurbani, Rendy Adriyan Diningrat, Cecilia Marlina, Emmy Hermanus, and Sofni Lubis.

Children, especially girls, describe their relationship with parents as discontenting due to lack of face to face interaction and quality time. Financial problems have quite an impact on the relationship between parents and children. Because parents in poor households must work outside the home for long hours to make ends meet, they do not have enough time to interact with their children. Meanwhile, children consider social relationships and environment as important for their well-being.

Children in this study also mostly live in violent family environment. These children experience physical and verbal abuses from older family members for behaving badly and not doing chores. Boys are more likely to experience physical and verbal abuses than girls, and domestic violence is generally committed by fathers.

Children and Social Environment

Boys and girls have different ways of describing their social lives. Boys are more likely to talk about things related to the social environment outside of their homes, while girls are more home-oriented. This reflects their different gender roles.

Boys tend to spend their time outside to play or work (for older boys), while girls tend to spend more of their time at home doing domestic chores.

Nevertheless, both boys and girls have the same perception regarding the impact of their social environment. Several children admitted that they have drinking and smoking habits due to the influence of their social environment.

In addition, both boys and girls experience violence in their peer environment that is triggered by misunderstanding or desire to show strength. Boys

usually experience abuse or are involved in a brawl, while girls usually experience verbal abuse in the form of harsh words and/or physical abuse such as beating.

Children and Work Environment

Children decide to work because they want to have more pocket money or help their parents meet daily needs. In North Jakarta coastal area and Makassar, children usually work in a fish market or peel shrimps or clams. Meanwhile, in the noncoastal area of Makassar, girls usually work peeling cashews and boys become parking attendants.

Working children are vulnerable to the danger in their working environment. Girls (teens) who work in North Jakarta as shrimp peelers in factories are exposed to dangerous chemicals such as chlorine. They also complain of having back pain and breathing problems.

Girls in all study locations tell of their female friends who are prone to prostitution because of their working environment or peer influence. According to them, teenage girls working as waitresses in restaurants often experience sexual exploitation.

Children and Fulfilment of Basic Needs

Gender roles influence boys' view towards education. Several boys believe their education must be prioritized because they are the ones who will work and become breadwinners. Influenced by gender stereotypes, several girls think that their education must be prioritized because they are more diligent than boys. The positive aspect from both perceptions is that boys and girls realize the importance of education despite the fact they face various problems such as transportation costs.

Because parents in poor households must work outside the home for long hours to make ends meet, they do not have enough time to interact with their children.



Novita Malzir/SMERU

Public schools infrastructure is sufficient and continues to improve, but access to quality education is still a problem faced by poor households. Children from poor households tend to attain low graduate score that hinders them from getting into public schools. Meanwhile, private schools are expensive because only a few of them receive assistance from the government.

Boys and girls are both critical towards the lack of access to various public services. They usually eat less than three times a day and suffer from lack of nutrition which causes various health problems. However, their access to health services is limited, causing them to only resort to traditional treatment. Despite this, children in Surakarta have better access to health services than children in Jakarta and Makassar. Children in Surakarta are only required to show their ID cards to access those services.

In addition, children also complain about the lack of proper public facilities in their environment, such as clean water, public toilets, and playground. Children from poor households are also excluded from enjoying playgrounds since many of the playgrounds have been converted into parking space or marketplace. This causes children to resort to other public areas that are unsafe or have negative influence, such as internet cafes or gaming centers. As a result, some of those children become addicted to computer games.

Policy Recommendations: Child-Friendly City

Illegal slums in urban areas expose children to various social risks and problems. In addition, children's access to proper basic services is also limited. Thus, policies on the development of the city must be sensitive to the fulfilment of children's basic needs based on age and gender.

Aside from infrastructure and access, family is also an important aspect that affects children's well-being. Therefore, policies that aim to reduce the vulnerability of urban poor children must consider family as a unit of intervention.

Furthermore, the usage of the term "poor" in social protection programs for poor households need to be reconsidered. If children tend to avoid the label "poor" as found in this study, then the usage of the term in social protection programs may bring bad influence for children's perception towards themselves. ■

In North Jakarta, particularly in coastal areas, many children work in the fish market or peel shrimps and clams with their parents.



Novita Mazzir/SMERU



Khairu Syukillah/SMERU

PRELIMINARY STUDY OF THE E-WARONG KUBE-PKH PROGRAM IMPLEMENTATION¹

In April 2016, President Joko Widodo instructed his ministers on (i) the importance of realizing an inclusive national financial system, and (ii) the distribution of all social assistance and subsidies in noncash by using banking services to facilitate control and monitoring, as well as to decrease possible misuse. The Minister of Social Affairs translated the instructions by launching the Electronic Joint Cooperative Business Group-Family of Hope Program (e-Warong Kube-PKH or e-Warong) to facilitate the distribution of noncash social assistance. The aims are, among others, to increase the effectiveness of social assistance and improve the access of poor families to inclusive financial services.

From 31 October to 6 November 2016, The SMERU Research Institute, as requested by the National Development Planning Agency (Bappenas), in collaboration with the Community and Service Collaboration for Welfare (KOMPAK), conducted a preliminary study on the implementation of the e-Warong program in four cities (Batam, Balikpapan, Malang, and Denpasar) and one *kabupaten*² (Kediri). The study aimed to (i) identify the perceptions of stakeholders towards the concept of the e-Warong program, (ii) to see whether

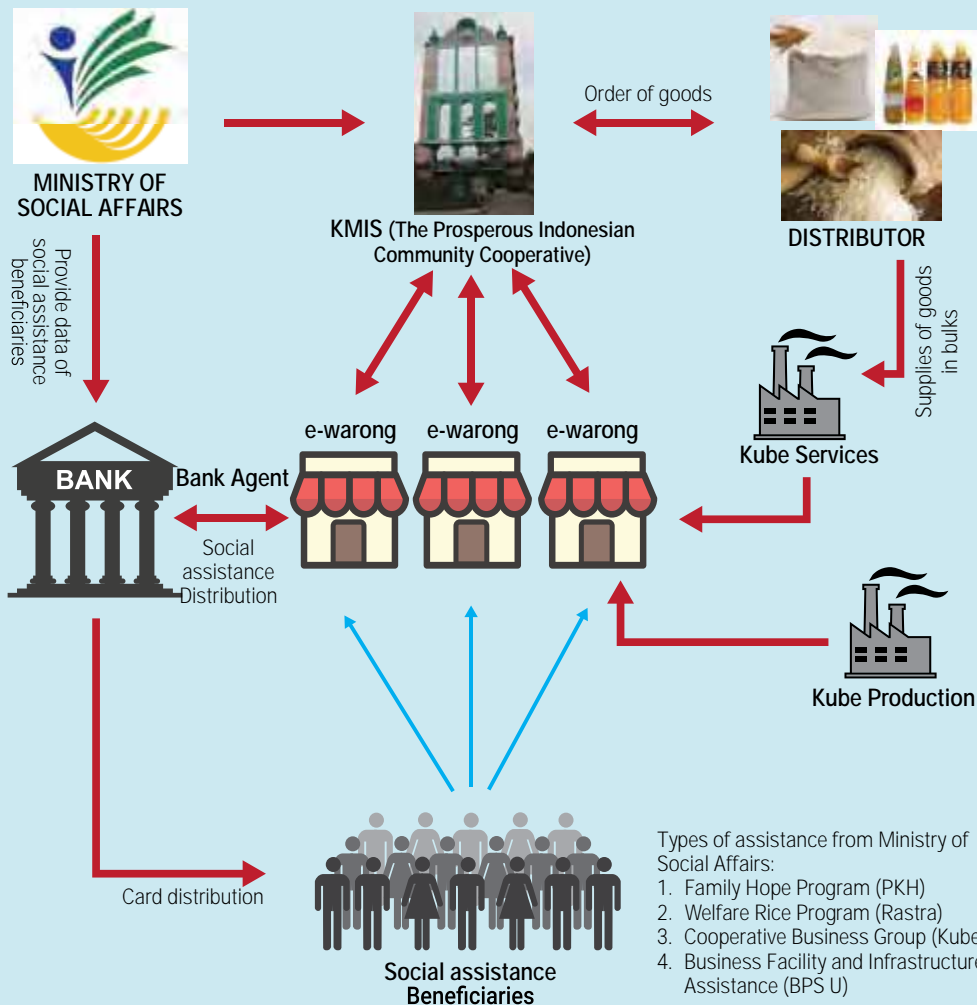
stakeholders are ready to implement the e-Warong program, and (iii) provide feedback and lessons learned to improve the implementation of the e-Warong program. This study used a qualitative approach. Data collection was conducted using in-depth interview and observation. The resource persons of this study consisted of various stakeholders at the central and regional government level as well as the community level.

The e-Warong implementation program is a cooperation between the Ministry of Social Affairs (Kemensos) and the implementing banks (BNI and BRI when the study was conducted), the National Logistics Agency (Bulog), and the Prosperous Indonesian Community Cooperative (KMIS). In general, the roles of those parties are: (i) Ministry of Social Affairs is responsible for the overall implementation of the program; (ii) implementing banks are to provide digital transaction facilities and issue the Prosperous Family Card (KKS) to conduct noncash transaction at e-Warong; (iii) Bulog becomes a distributor that supplies basic necessities to e-Warong; and (iv) KMIS, which consists of family beneficiaries of the Family of Hope Program (PKH), acts as the representative of e-Warong in conducting collaborations with the implementing banks and Bulog.

¹ This article is a summary of the report titled "Preliminary Study of the E-Warong Kube-PKH Program Implementation" by M. Sulton Mawardi, Ruhmaniyati, Ana Rosidha Tamyis, Syaikhul Usman, Asep Kurniawan, and Budiani (SMERU and KOMPAK, 2017).

² *Kabupaten* is the Indonesian equivalent to district.

PATTERN OF RELATION BETWEEN THE MINISTRY OF SOCIAL AFFAIRS, E-WARONG, BANKS, AND DISTRIBUTORS



1. Ministry of Social Affairs gives data of PKH beneficiaries to implementing banks and KMIS.
2. Implementing banks open new accounts, issue KKS, and distribute it to PKH beneficiaries.
3. Ministry of Social Affairs transfers PKH funds to implementing banks and they disburse the funds to the accounts of each PKH beneficiary.
4. KMIS orders goods from Bulog or other distributors, and then makes payments to them.
5. Bulog distributes the goods ordered by KMIS to each e-Warong which is managed by Kube Services.
6. PKH beneficiaries withdraw noncash social assistance at e-Warong.
7. E-Warong can also market products of Kube Production.

Source: Direktorat Jenderal Penanganan Fakir Miskin Kementerian Sosial, 2016.

Minister of Social Affairs Regulation No. 25/2016 about Business Facility Development Assistance through e-Warong stipulates that e-Warong has several functions, namely as a (i) place to sell cheap and quality food and basic household needs; (ii) noncash social assistance distribution agent; (iii) marketplace of products by Kelompok Usaha Bersama (Kube); and (iv) place for savings and loan cooperative.

As a kiosk, e-Warong is a facility established and jointly managed by social assistance beneficiaries from the e-Warong Services Group at the *kelurahan*³ level with

a noncash transaction system utilizing internet-based information and communication technology. Every e-Warong serves 500–1,000 family beneficiaries. Through the e-Warong program, family beneficiaries will have bank accounts at the implementing banks that handle the distribution of cash and noncash social assistance. Family beneficiaries can withdraw the social assistance through an ATM or e-Warong kiosk (for cash social assistance like PKH) or by purchasing basic commodities at an e-Warong kiosk (for cash and noncash/e-voucher social assistance).

³ A *kelurahan* is a village-level administrative area located in an urban center.

In 2016, the Ministry of Social Affairs planned to open 302 units of e-Warong. By 29 November 2016, 108 units had been established in 35 *kota/kabupaten*. In 2017, the Ministry of Social Affairs planned to open 3,500 units across Indonesia. In order to establish e-Warong, the Ministry of Social Affairs provides Kube Services with 10 million rupiah for business facility development and 20 million rupiah for purchasing tools, equipment, and working capital.

In general, the results of the study are as follows:

1. Stakeholders state that the e-Warong program is strategically and technically worth to implement. The program allows the possibilities to improve the effectiveness of social assistance, such as (i) facilitating family beneficiaries in accessing social assistance and conducting transactions; (ii) giving opportunities to family beneficiaries to conduct business activities, (iii) encouraging a more effective use of social assistance; and (iv) introducing the banking system to poor people.
2. At the implementation level, stakeholders are actually not ready to implement the e-Warong program in accordance with its concept and goal. The indications are, among others, that the program has not been equipped with general guidelines, technical instructions, modules, and monitoring and evaluation system which provide reference. This leads to variations in the understanding and technical implementation of e-Warong program. However, this is understandable because all stakeholders at the central or regional level realize that the e-Warong implementation in 2016 was still at its early stage. Regarding this, the following conditions were generally found in all study locations.
 - a) E-Warong dissemination had not engaged all stakeholders, and the information regarding e-Warong was not comprehensive, hence resulting in limited understanding of the program among the stakeholders.
 - b) In every location, the preparation for the e-Warong program implementation (including opening up the kiosk was short—around one to two weeks—because the Ministry of Social Affairs would like to achieve its target before the inauguration of the program.
 - c) The Kube Services was established so instantly that the family beneficiaries who were appointed as Kube Services members did not know each other (in Denpasar) or did not even know that they were members (in Kediri). In Malang, Kube Services has not been officially established even though e-Warong has been inaugurated and begun operating.
 - d) Training for operators of e-Warong was still limited to operating digital devices for noncash transaction. There was no facilitation and education for community members related to e-Warong's function as a bank agent and livelihood component for the poor.
 - e) The number of PKH recipients throughout the locations of the study was around 33,000 family beneficiaries, but only 264 family beneficiaries have received KKS. Around Rp110,000–Rp420,000 of the fund which has been disbursed to the account of every KKS recipient did not come from the PKH fund. The fund came from the corporate social responsibility (CSR) funds of the implementing banks for simulation on how to obtain noncash social assistance. The simulation took place during the inauguration of e-Warong by the Minister of Social Affairs.
 - f) After the inauguration of e-Warong, some e-Warong kiosks in the locations of study (Kediri, Batam, and Denpasar) immediately closed down



There was no facilitation and education for community members related to e-Warong's function as a bank agent and livelihood component for the poor.

The e-Warong program has not been equipped with general guidelines, technical instructions, modules, and monitoring and evaluation system which provide reference.



because the digital devices (tablets) for transaction recording were withdrawn by the Ministry of Social Affairs, electronic data capture (EDC) machines were broken, and applications were unavailable on the tablets. In addition, stakeholders thought that e-Warong would start operating in 2017. As a result, until early November 2016, the goods to be sold at e-Warong, such as rice, sugar, flour, and cooking oil remained unsold. In Malang, e-Warong operated for three weeks before closing down because the EDC machines were broken and the funds in KKS had run out, making the e-Warong managers unable to conduct transactions. In Balikpapan, after all KKS recipients had conducted transactions, e-Warong no longer operated because supplies of new goods from Bulog and funds in KKS had run out.

In full operational scale and in order to support widespread distribution of noncash social assistance, the e-Warong program will need to be equipped with (i) program regulations; (ii) organizational development; (iii) e-Warong management capacity building in accordance with its functions (as distribution channel of noncash social assistance, bank agent, and livelihood component for the poor); and (iv) provider of effective monitoring and evaluation mechanism. Particularly, several aspects below need more attention so that the implementation of e-Warong can proceed in accordance with its concept.

1. E-Warong Organization

- a) The Ministry of Social Affairs needs to finalize the program regulations, such as operational technical guidelines, and encourage various related parties to finalize the cooperation among them formally in writing. Afterwards, the regulations and the details related to the cooperation must be disseminated to all stakeholders so that all stakeholders have the same understanding of and united support for e-Warong and the functions of e-Warong can proceed well.
- b) E-Warong is established by taking into account the area coverage and access, family beneficiaries access to e-Warong, and the number of family beneficiaries served. Besides that, the e-Warong

kiosk does not have to be located at family beneficiaries' house. It can also be located at a facilitator's house or other locations that meet several prerequisites, such as security, accessibility, and adequate storage space. Kube Services that was suddenly formed and was not able to carry out its role as e-Warong manager must be given special attention through, for example, the re-establishment or intensive guidance.

- c) The Ministry of Social Affairs/KMIS must provide facilitation/training/education to build the capacity of e-Warong and family beneficiary managers so that e-Warong can encourage family beneficiaries to be able to help themselves in improving their welfare. The Ministry of Social Affairs also needs to provide incentives for PKH facilitators if they are involved in the e-Warong program implementation.

2. Regulating supply of goods to e-Warong

- a) The government needs to create a legal basis that allows Bulog to conduct transactions with e-Warong apart from Bulog's standard of procedure, such as in ordering, payment, risk accountability for damaged goods, etc.
- b) KMIS needs to create an easy and fast mechanism for good procurement from suppliers (non-Bulog) to e-Warong.
- c) The central and regional governments or KMIS need to build several distribution posts that connect suppliers (non-Bulog) to e-Warong and prepare resources for Kube Services to manage e-Warong in accordance with its functions.

3. Monitoring and Evaluation

E-Warong implementation must be overseen by an internal and external monitoring and evaluation system regularly with strong transparency and accountability. The result of the monitoring and evaluation must also be used as a reference for program improvement. In addition, this program needs to create an accessible and responsive mechanism for complaint handling and reporting. ■



Toni Parawanto/ SMERU

STRENGTHENING INDONESIA'S HEALTH SERVICES TO ANTICIPATE THE ASEAN ECONOMIC COMMUNITY¹

Multilateral trade cooperation between Southeast Asian countries through the ASEAN Economic Community (MEA) agreement was launched on 31 December 2015. MEA's objective is to increase the integration of the ASEAN economy as the center for production and single market. With the establishment of MEA, barriers to the trade of goods, services, and intercountry investment is eliminated. Professional or skilled workers will have more freedom to find work across ASEAN countries. However, despite offering economic opportunity and well-being, MEA will also raise challenges for Indonesia.

At present, MEA has 12 sectors of priority, including health. The health sector has acquired the mutual recognition arrangement (MRA) for health workers, nurses, doctors, and dentists. The health sector is currently developing an MRA for pharmacists, health equipment, and supplements. As health is a sensitive issue, Indonesia needs to formulate its policies with caution.

In preparation of health policies in regard to MEA, in 2016 The National Planning and Development Board (Bappenas) in cooperation with The SMERU Research Institute conducted a study with the objective of (i) identifying MEA's implications to Indonesia's health care system, especially health services; (ii) analyzing MEA's strengths, weaknesses, opportunities, and threats to Indonesia's health system; and (iii) providing feedback

to policies that may increase access to and quality of health services in order to achieve quality and competitive services. Data collection and analysis for this study used a qualitative approach. Information was gathered through interviews and focus group discussions with stakeholders at the national and regional levels. In addition, a literature study and secondary data analysis of the Indonesian as well as ASEAN health sector were conducted. The study area was selected based on specific issues. In Central Java Province the focus was on Kota Semarang and Kabupaten Semarang as herbal medicine producing areas. In West Java Province the focus was on Kota Bandung and Kabupaten Bandung Barat as homes to the pharmaceutical and health equipment industry. Finally, in Bali Province, Kota Denpasar and Kabupaten Karang Asem were selected because they are global tourist destinations that attract health tourism.

MEA's implications on Health Services: Transmission Channels

Health sector agreements which support MEA include MRA for health workers, ASEAN Trade in Goods Agreement (ATIGA), ASEAN Framework Agreement on Services (AFAS), and ASEAN Comprehensive Investment Agreement (ACIA). These agreements affect various elements of health services directly and indirectly through different modes of trade and services which can bear positive as well as negative impacts.

¹ This article is a summary of the research report "Penguatan Pelayanan Kesehatan dalam Menghadapi Masyarakat ASEAN: Implikasi dari Masyarakat Ekonomi ASEAN (MEA)" [Strengthening Health Services to Anticipate the ASEAN Economic Community] (draft report June 2017; authors: Meuthia Rosfadhila, Rika Kumala Dewi, Nurmala Selly Saputri, Michelle Andrina, dan Widjajanti Isdijoso).

In terms of the health sector's human resources, MEA has direct implications on the mobility of professional or skilled workers. In the field of pharmacy, MEA may increase export and import as well as foreign investments which will build the raw pharmaceutical material industry in Indonesia. The same implication goes for health equipment; MEA may increase trade of health equipment and foreign investment in Indonesia. In terms of health service facilities, MEA will increase the consumption level of people outside their country of origin and increase foreign investment through the establishment of hospitals and clinics. In the field of traditional medicine and health services, aside from increasing the export and import of traditional medicine and investment, MEA may also increase consumption of people outside their country of origin. Aside from bearing direct implications, MEA also has indirect implications resulting from the consequent impact of the free movement of trade and services.

Health Sector Human Resources

Even though MRA for health workers had already been signed, nurses, doctors, and dentists have not experienced mobility. ASEAN member countries continue to uphold a protectionist stance against foreign labor. Singapore, Brunei Darussalam, and Malaysia have already sent health workers overseas but have not used the MRA scheme. Health workers are expected to use the MRA scheme in 2020. Considering the size of Indonesia's population, in addition to the lack of the number and low quality of health workers, as well as its uneven distribution, Indonesia is a good market for MEA. In the MEA era, there is more opportunity to improve access to and quality of health services because the mobility of skilled workers can even out the distribution of health workers and increase their quality through transfer of knowledge and higher competition. On the other hand, foreign labor can pose as a threat to the local health workers' market. Moreover, quality health workers may leave and go overseas because of low income at home. As a consequence, Indonesia may face a drop in the quality of its health services.

Pharmaceuticals

Among the ASEAN countries, Indonesia's pharmaceutical industry is considered advanced. Indonesia's vaccination products have been endorsed by WHO. In addition, Indonesia is the only ASEAN country whose domestic market is dominated by the domestic industry. MEA may have an impact on Indonesia's pharmaceutical products through the requirement to comply with the ASEAN medicinal product standard of medicine production (known as CPOB) and the establishment of its oversight institutions in each country. The requirement of an international standard can increase the quality of pharmaceutical products. However, not all pharmaceutical industries are ready to adopt the CPOB standards due to high investment. Without any facilitation for the adoption

of CPOB standard, the local pharmaceutical industry can go out of business. This problem is further severed by the fact that MEA can increase the export and import of pharmaceutical products as well as foreign investment.

Indonesia's population size and the presence of a national health security program (JKN) which increases the access of the people to health services have increased demand of domestic medicinal products. However, the supply and distribution of medicines in a number of regions is weak, while dependence of the pharmaceutical industry on imported raw materials is high. As a consequence, if the domestic pharmaceutical industry is unable to fulfill domestic demand, MEA will increase import. Nevertheless, this will not occur in the near future due to the limit on imported pharmaceutical products which applies to medicines that are (i) listed in community health programs, (ii) newly produced products, and (iii) not domestically produced. Importing may secure the need for pharmaceutical products with an international standard, but the government need to take caution of poor quality products coming in due to weak oversight.

Through Presidential Instruction No. 44/2016, the government opened opportunities for foreign investment in the pharmaceutical industry and raw materials. The goal is to reduce the dependency on imported raw materials, reduce price, and meet the need for medicine supplies. However, in reality, the medicine raw material industry are drawn back by problems of policy inconsistency across ministries.

Health Equipment

Among ASEAN countries, the market value of Indonesia's health equipment is still low but demand for it continues to increase. This is driven by the presence of: (i) JKN; (ii) the 2015–2019 health development policy that aims to increase the supply, affordability, even distribution, and quality of pharmaceutical products and health equipment; and (iii) the Sustainable Development Goals (SDGs) health development targets. MEA can attract foreign investment to Indonesia to develop the raw material industry and health equipment for the purpose of export. The fact that there is a quality standard to comply to, forces the domestic industry to improve the quality of its products so that it will have a higher chance at export. However, this opportunity may threaten to increase import if Indonesia does not have a policy that supports the development of the health equipment industry. This includes second hand, illegal, and low quality imported products. This situation will ultimately increase people's tendency of seeking medical treatment abroad.

Among the problems faced by the health equipment industry is weak research and development. This is due to low budget and the gap between what is conducted in research and development and what is needed in health facilities. Furthermore, domestic management of the

Indonesia is still facing issues concerning the quantity and quality of health facilities.



Sri Budiyati/ SMERU

quality of health equipment is weak due to limited ISO 17025 accredited clinical labs and limited calibration institutions, which impede export. This limitation also encourages the production of counterfeit imported goods and local hospitals to use foreign services for calibration and maintenance of equipment.

Other issues include weak industrial and business development, competitiveness, and logistics management as well as lack of raw material supplies. For easier management of health equipment logistics in health facilities and control of market price, health equipment procurement has been conducted through e-catalog. However, since there are no standards for the quality of human resources in the health agency, health facilities, and the Policy Institute for Procurement of Government Goods/Services (LKPP), there are discrepancies between what was planned and what is needed on the ground. Low quantity and quality of human resources are the challenges faced in ensuring oversight of the health equipment industry, whilst at the moment the industry is still dependent on imported goods.

Health Services Facilities

The implication of MEA on health facilities is reflected by people's tendency to obtain medical treatment abroad and by foreign investment. The ASEAN medical tourism market is currently dominated by Malaysia, Singapore, and Thailand, which is secured by competitive pricing and a reputation of quality service. Today, there is still a tendency for Indonesians to seek treatment abroad, particularly in Malaysia and Singapore.

In general, Indonesia is still facing issues concerning the quantity and quality of health facilities. There is still a lack of hospital references from JKN, and not all health facilities are accredited. Actually, a number of hospitals in Indonesia are already equipped with modern facilities (with competitive price) similar to those provided in medical tourist destination countries. However, there is very little information about this because Indonesia does little to promote it.

To accelerate the establishment of hospitals, the government has issued President Regulation No. 44/2016 which states that the government is open to foreign investment for establishing hospitals, particularly in some provincial capitals in Eastern Indonesia, except Makassar and Manado. However, oversight is still limited due to the lack of human resources in the health agency. The government plans to establish ten medical tourism hospitals in tourist destination areas to attract overseas patients.

Medicines and Traditional Health Services

In the ASEAN region, the Indonesian traditional medicine market is one of the biggest alongside Malaysia, Singapore, and Vietnam. More than half the population of these four countries uses traditional medicine. Meanwhile, the largest market for traditional health services in the form of spas is dominated by Thailand and Indonesia. Users of traditional medicine in a number of ASEAN countries have support from their government through the inclusion of these medicines in health insurance systems as well as their promotion.

MEA may have some implications on the traditional medicine industry through efforts to ensure that all ASEAN traditional medicines comply with the international standard (CPTOB²). The requirement to fulfill this international standard increases the quality of traditional medicine as well as its import and export. Issues concerning traditional medicine include the inability to fulfill market demand due to low production. Although public consumption is high, health facilities receives low rate of traditional medicine because doctors seldom use traditional medicine, except phytopharmaca.³ Traditional medicines are not listed in the national formulary⁴ so they are not covered by JKN. At present, Indonesia's traditional medicine industry still relies on exported raw materials and uses a number of imported raw materials.

The impact of MEA on traditional health services can occur through the wellness tourism and foreign investment. Indonesia has yet to issue a regulation on wellness tourism. Bali is still the center of traditional wellness health services. However, the services are still in the form of traditional spas and not medical spas. The absence of a regulation that sets the location of foreign investment causes the spa industry to be centered in one area.

Policy Recommendations

- ◆ Increase the supply and quality of health workers. Efforts to increase the supply and quality of health workers require the support of the government. This particularly include efforts to develop the transfer of knowledge from foreign workers to Indonesian workers and the monitoring of the process in order to ensure the safety of patients and prevent illegal practice. In addition, government support is also needed for policy improvement in regard to health worker's wages as well as the development of an incentive system to prevent brain drain.

- ◆ Develop the quality standard and the business scale of the health industry. This will require intensive guidance and increase of product supervision through the increased supply of human resources, cooperation between relevant institutions, and community involvement.
- ◆ Reduce dependence on pharmaceutical raw materials and imported health equipment, Incentives are required in the form of ease in tax payment, purchase guarantee, facilitation of research and development, and the establishment of accredited facilities for clinical tests to expand the health equipment industry.
- ◆ Improve the quality and distribution of health facilities offered through JKN. This requires the increase of network of health service references which can be achieved through cooperation with private hospitals and involvement of regional governments as well as the efforts to develop a comprehensive monitoring system.
- ◆ Develop Indonesia's medical tourism. This can be initiated by the establishment of a tourism health agency which will involve health facility workers and tourism industry actors. In addition, there is the need to promote the superiority and uniqueness of these health facilities and their medical services which is in harmony with the superior quality of traditional medicines and services. ■

” Improving the quality and distribution of health facilities offered through JKN requires the increase of network of health service references which can be achieved through cooperation with private hospitals and involvement of regional governments. ”

² CPTOB stands for “Cara Pembuatan Obat Tradisional yang Baik” (literally, good method of producing traditional medicine).

³ Phytopharmaca is a form of standardized clinical-based herbal medicine which its safety and potency has been proven through pre-clinical and clinical tests.

⁴ The national formulary is a list of drugs compiled by a national committee based on scientific evidence with the criteria that the drugs are potent, safe, and affordable. This list is used as reference for drug prescription in the JKN health system.



Dok: SMERU

COMMUNITY EMPOWERMENT: PAST, PRESENT, AND FUTURE

Muhammad Syukri¹

Empowerment is understood differently by different stakeholders. One definition of empowerment frequently referred to is the definition used by the World Bank because the Bank is one of the world's leading supporters of empowerment. According to the Bank, empowerment is the "expansion of assets and capabilities of poor people to participate in, negotiate with, influence, control, and hold accountable institutions that affect their lives" (World Bank, 2002). Based on this definition, there are two major components of empowerment, i.e., increasing economic capacity and strengthening social and political capacity.

The implementation of the definition of empowerment can be seen in various empowerment activities in Indonesia, such as in programs under the Mandiri National Program for Community Empowerment (PNMP Mandiri). Long before this program, Indonesia already had several empowerment programs, such as Mass Guidance (BIMAS), Mass Intensification (INMAS), and Farmers' Business Credit (KUT). However, when an idealistic effort aiming to empower the community becomes a "program", the effort tends to turn into a routine activity and implemented in a uniform fashion. This happens when activities become part of government bureaucracy. In a situation as such, empowerment frequently loses its ultimate spirit. Activities in empowerment programs that generally bring about real benefit are labor intensive ones. However, at the same time, efforts aiming to

strengthen the household economy—not to mention political capacity—tend to fail. Therefore, there needs to be program innovations in order to escape the bureaucracy trap and avoid the uniformity of community empowerment activities.

This article aims to reflect upon the various empowerment efforts in Indonesia, including those conducted in the past. It discusses a number of aspects that need to be considered in order to transform empowerment activities so that it can achieve its objective: to establish an economically empowered and politically independent community.

Empowerment Programs of the Past

In the beginning, empowerment programs in Indonesia were generally output oriented. They aimed at increasing productivity, mainly in the agricultural sector, while the process itself was not the focus. This is due to the fact that various programs during that period were bound to development targets set by the authoritarian government. Out of those various programs, one worth mentioning is the BIMAS Program which was launched in 1963 and eventually was converted to the INMAS Program. The program promoted new knowledge and technology on agriculture, in addition to providing business credits for farmers to increase agricultural output with the view of achieving food self-sufficiency. In this program, farmers

¹ The author is a sociology/anthropology Ph.D candidate of the University of Western Australia.

were required to use seeds, fertilizers, and pesticides determined by the government. This program was a success and led Indonesia to food self-sufficiency for the first time in 1983.

Another program, known as the P4K program, which was designed to increase the income of small farmers and fishers, was launched in 1973. This program was one of the most important empowerment programs in Indonesia. P4K was the first program to use an empowerment approach aimed especially at poverty reduction. The program had already included components usually found in modern empowerment programs, such as facilitation, credit for capital assistance, group formation, and support for economic activities outside the agricultural sector. Several studies show that this program was relatively successful in improving the livelihood of farmers and fishers.

Another program which also had a significant impact was the Disadvantaged Village Presidential Instruction (IDT) program which was established based on President Instruction No. 5/1993 on Accelerating Poverty Reduction. This program was similar to P4K in terms of providing capital assistance and facilitation for the poor in disadvantaged villages. With assistance and facilitation, poor villagers were encouraged to operate their business in accordance to their proposed plan. The difference between the two programs was that P4K was for the agricultural sector whereas IDT was a cross-sectoral program. Besides that, IDT was synchronized with other national and regional programs targeting the disadvantaged areas.

Present Empowerment Programs

Present programs are characterized by the centrality of the role of process rather than output. Although previous programs had facilitation components, its implementation was not intensive or not specifically designed to empower beneficiaries. Among programs especially focused on beneficiaries are the Kecamatan Development Program (PPK) and the Urban Poverty Reduction Program (P2KP). Both were expanded into national programs and in 2007 were renamed PNPM-Mandiri.

The process-oriented approach of PPK, and later, PNPM is considered an empowerment strategy. The program operates on the assumption that if the people of the community follow each designed process and stage, they will be empowered. To ensure that the process runs smoothly, PNPM recruited and trained thousands of university graduates for the position of program facilitators. Recruitments continued to be expanded to different areas. PNPM was deemed the first program that made facilitating a prestigious profession with a decent income.

PNPM has contributed significantly to development, especially in the provision of small-scale infrastructure, community participation in development, and the strengthening of community livelihood. However, several studies show that PNPM did not have a significant impact on community empowerment. This is because people's participation in the program was mobilized and forced rather than arising from their own awareness about the importance of being involved in the program. Moreover, poor households did not experience significant livelihood improvement compared to nonpoor households.

After being implemented for almost two decades, in 2015 PNPM was terminated because Indonesia launched a new policy on village development with Law No. 6/2014 on Villages. In short, this law took over all the empowerment activities conducted through the central government's programs. The new law is an effort to institutionalize empowerment programs into the governance of the village government. Looking at the various regulations on the program's implementation, it appears that this policy is progressive because it transfers more authority and resources to each village to design and implement its own development policies. However, the impact of this law on the lives of people in the villages still needs to be further examined.

Empowerment Challenges in Indonesia

There are several issues in regard to empowerment programs of the early period. First, these programs hardly touched the community empowerment aspect. The design was, in nature, instrumental. It predominantly aimed at achieving government development programs rather than community empowerment. Second, its authoritarian nuance was quite strong as it did not provide the community with choices. Moreover, the military was often sent to the villages to ensure the implementation of the program. Third, corruption also took place, something unanticipated by the programs. Finally, although a number of programs began to focus on poverty reduction, most programs were still generally targeted. This was due to the fact that during that time, the number of poor people was still very large.

Although there have been efforts to overcome the weaknesses of past empowerment programs, present programs still have their issues. The major problem with present programs is their mechanistic approach. Empowerment is assumed as a series of mechanistic stages, which, if passed consecutively, will empower a community. Facilitation by community workers is understood as necessary to ensure that the community implements the mechanism set by the program. This assumption may not always be correct. Community members followed the mechanism only because they were mobilized and because there was an incentive. If

Facilitators are sent to communities only to ensure that the people will implement the already set program mechanisms.



Dok. SMERU

there were no incentives, the mechanisms would have not been implemented. In this context, what has been established is mobilization and not participation. What has been established was pragmatic thinking, not critical and political awareness.

Unfortunately, the problem of this half-hearted empowerment program continues to the present age of the Village Law (UU Desa) policy. Many of its subordinate policies are inconsistent with the spirit of empowerment. For example, the government issued a rigid technical guide and detailed development priority list. Instead of making matters easier, increasing trust, and encouraging villagers to be creative and innovative in regard to development, the policy on accountability and supervision tends to cause villagers to play it safe. One of the clauses that needs to be amended is the one concerning the involvement of the police force in the supervision of the implementation of the Village Law. The law appears to have no trust in the village governance and communities. It is assumed that they will take advantage of the village funds, therefore they should be closely supervised. As a consequence, the authority and freedom transmitted to the people through the Village Law cannot be fully exercised.

Conclusion: Future Empowerment Programs

Reflecting on past empowerment programs in Indonesia, the following should be noted:

1. Empowerment does not happen instantly with immediate results. The urge to gain quick results tend to cause program designers to create short cuts by creating mechanisms that will quickly deliver output. This is in contradiction with the objective of empowerment.
2. The dominant presence of the state has obscured the essence of empowerment. On the one hand, the Village Law as a platform for the empowerment of the village communities is quite an achievement in itself because it ensures the constitutional rights and authority of the village. On the other hand, with the Village Law, the number of regulations concerning the village is multiplied. Meaning, one cannot avoid the fact that along with the power of the state there will always be a power that will stand in the way and suppress innovation and transformation.
3. One of the general issues surrounding empowerment programs is the neglect of political perspectives. Most empowerment programs are designed within technical and mechanistic perspectives aiming to increase people's income and well-being through economic empowerment. However, a problem arising from this is the lack of concern of the marginalization of the poor in decision-making processes. Even when they are invited to participate—a case which is rare in itself—they are merely being present at official decision-making forums. Without involving the poor in the dynamics of political processes, i.e., involving them in negotiations related to their interest and in the distribution of resources, it will be difficult to ensure the state's support of the poor.

The three issues above are fundamental issues found in almost every empowerment program in Indonesia. They emerge because of the existing policy and institutional paradigm. Therefore to make changes, paradigm transformation and institutional reform is needed. In the case of the Village Law, there is a need to revisit a number of policies that are counterproductive to the spirit of empowerment. ■

REFERENCE

World Bank (2002) *Empowerment and Poverty Reduction: A Sourcebook*. Draft. PREM, World Bank [online] <<http://siteresources.worldbank.org/INTEMPowerment/Resources/486312-1095094954594/draft.pdf>> [20 Maret 2018].



SMERU's Publication



Studi Implementasi Undang-Undang No. 6 Tahun 2014 tentang Desa: Laporan Baseline

Research Report

Muhammad Syukri, Palmira Permata Bachtiar, Asep Kurniawan, Gema Satria Mayang Sedyadi, Kartawijaya, Rendy Adriyan Diningrat, Ulfah Alifia

Editor: Mukti Mulyana



Mengefektifkan Pengawasan Desa oleh Masyarakat

Policy Brief

Rendy Adriyan Diningrat

Editor: Alia An Nadhiva



Dari MDGs ke SDGs: Memetik Pelajaran dan Menyiapkan Langkah Konkret

Buletin SMERU



Menilai Dampak Politik Bantuan Tunai Bersyarat: Bukti dari Eksperimen Kebijakan Acak

Working Paper

Julia E. Tobias, Sudarno Sumarto & Habib Moody

Editor: Liza Hadiz



Mengestimasi Dampak Ketimpangan terhadap Pertumbuhan dan Pengangguran di Indonesia

Working Paper

Athia Yumna, M. Fajar Rakhmadi, M. Firman Hidayat, Sarah E. Gultom, Asep Suryahadi

Editors: Gunardi Handoko & Liza Hadiz



Ketimpangan dan Stabilitas di Indonesia yang Demokratis dan Terdesentralisasi

Working Paper

Mohammad Zulfan Tadjoeddin, Athia Yumna, Sarah E. Gultom, M. Fajar Rakhmadi, M. Firman Hidayat, Asep Suryahadi

Editor: Liza Hadiz

These publications are also available in English on SMERU's website.