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Early Childhood Development Strategy Study in Indonesia






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Results from the ECD strategy study are presented in two separate reports, each available as separate documents:

- ECD Strategy Study (this report)
- Study of Community-driven vs. Institutionally-Driven ECD Development Models

The Government of Indonesia (represented by the Ministry of Education and Culture, the Ministry of Religious Affairs, and the Ministry of National Development Planning/BAPPENAS), the Government of Australia, through Australian Aid, the European Union (EU) and the Asian Development Bank (ADB) have established the Education Sector Analytical and Capacity Development Partnership (ACDP). ACDP is a facility to promote policy dialogue and facilitate institutional and organizational reform to underpin policy implementation and to help reduce disparities in education performance. The facility is an integral part of the Education Sector Support Program (ESSP). EU's support to the ESSP also includes a sector budget support along with a Minimum Service Standards capacity development program. Australia's support is through Australia's Education Partnership with Indonesia. This report has been prepared with grant support provided by AusAID and the EU through ACDP.

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Foreword

The Millennium Development Goals (MDGs) have guided political energies and development resources over the last decade, with tangible progress across multiple areas including poverty reduction and human development. Early childhood development (ECD) remains one of the most powerful levers for accelerating Education For All (EFA) and meeting the MDGs for reducing poverty. Yet, ECD is the one key area that is not yet comprehensively represented in the MDGs. Indonesia's newly drafted Presidential Decree on Holistic Integrated ECD (HI-ECD) thus offers a prime opportunity to connect global and country-level priorities with practical implementation strategies in alignment with the goals of the MDGs. Progress toward the MDGs can be seen in the areas connected to young children, such as in breaking the cycle of poverty (MDG 1), achieving universal primary education (MDG 2), promoting gender equity and empowering women (MDG 3), reducing child mortality rates (MDG 4), and improving maternal health (MDG 5).

The ultimate goal of ECD programs is to improve young children's capacity to develop and learn. A child who is ready for school has a combination of positive characteristics: he or she is socially and emotionally healthy, confident, and friendly; has good peer relationships; tackles challenging tasks and persists with them; has good language skills and communicates well; and listens to instructions and is attentive. The positive effects ECD programs have can change the development trajectory of children by the time they enter school. A child who is ready for school has less chances of repeating a grade, being placed in special education, or being a school drop out.

ECD interventions include educating and supporting parents, delivering services to children, developing capacities of caregivers and teachers, and using mass communications to enhance parents and caregiver's knowledge and practices. Programs for children can be center or home-based, formal or non-formal, and can include parent education.

At a national conference on ECD held in Jakarta in October 2012, followed by an international conference where specialists from many countries deliberated on the importance of ECD in the post MDG agenda, Indonesia strongly recommended that the global forum give priority to the essential role of the early years in shaping individuals' and societies' well-being by creating a new development goal specifically for ECD. Indonesia supports the notion that all children have the right to develop to their full potential by growing up physically healthy, mentally alert, socially competent, emotionally sound, able to learn, and with the resources to live long and productive lives.

This study, undertaken in 2012, provides analysis and exploration of options and alternatives for meeting the Government of Indonesia's goal for expanding the availability of high quality HI-ECD as well as strengthening the planning and management of this important area of cross-sectoral support for young children. Using national level data sources such as the 2011 Census of Village Potential (*PODES*) as well as the 2010 National Socio-Economic Survey (*SUSENAS*), the research combined system-level macro analysis with quantitative and qualitative research and observations from six community case studies. Supplementary data on key aspects of community-driven versus institutionally driven ECD development models were collected during fieldwork.

Among the many valuable observations emerging from the study is that there is a strong institutional and programmatic foundation for HI ECD in Indonesia but there is a lack of a HI ECD development model for translating policies and objectives into sustainable levels support for children. Additionally, the report presents a number of strategic options for national, regional (provincial/district), and community levels that would involve the best mix of options depending on cost, political feasibility, and logistical feasibility while aligning choices with the Presidential Decree and the National Development Plan for HI ECD.

The insights and policy options will provide valuable input to extending and improving the quality of ECD provision throughout Indonesia. Building on the knowledge and recommendations provided in the study, other follow up work will be conducted to help identify how best to expand and improve good practices, to build government and stakeholder capacity for evidence-based advocacy, policy and operational reform of holistic and integrative early childhood development services in Indonesia.

Jakarta, August 2013
Deputy Minister for Human Resources and Culture
Ministry of National Development Planning (*BAPPENAS*)

Dra. Nina Sardjunani, MA

Table of Contents

List of Appendices

List of Figures

List of Tables

Acronyms

BAPPEDA	:	Provincial level development planning office
BAPPENAS	:	National Development Planning Agency
BKB	:	*Bina Keluarga Balita* (under-five child family development)
BOK	:	*Bantuan Operasional Kesehatan* (operational grant for Health sector)
BOP	:	*Bantuan Operasional PAUD* (operations grant for Early Childhood Education)
DAK	:	*Dana Alokasi Khusus* (Special Allocation Funds)
DAU	:	*Dana Alokasi Umum* (General Allocation Funds)
DBH	:	*Dana Bagi Hasil* (Shared Revenue Funds)
DGHE	:	Directorate General of Higher Education
DIDTK	:	*Deteksi Intervensi Dini Tumbuh Kembang* (early development detection and intervention)
FGD	:	Focus Group Discussion
GDP	:	Gross Domestic Product
GER	:	Gross Enrolment Ratio
GOI	:	Government of Indonesia
GSK	:	Glaxo Smith Kline
HIMPAUDI	:	The Association of Early Childhood Teachers and Personnel of Indonesia
HI ECD	:	Holistic Integrated Early Childhood Development
IPB	:	Bogor Agricultural University
ITB	:	Bandung Institute of Technology
JICA	:	Japan International Cooperation Agency
KB	:	*Kelompok Bermain* (Play Group (non formal ECD center) affiliated with MoEC)
MoEC	:	Ministryof Education and Culture
MoRT	:	Ministry of Research and Technology
MP3EI	:	Master Plan for Acceleration and Expansion of Indonesia Economic Development
NUS	:	National University of Singapore
OECD	:	Organisation for Economic Cooperation and Development
PAUD	:	*Pengembangan Anak Usia Dini* (Early Childhood Development)

PKK	:	*Program Kesejahterahan Keluarga* (family welfare movement)
PODES	:	Village Potential Survey
Polindes	:	Village Birthing Center (cottage)
Pos PAUD	:	Early Childhood Education Center where additional child development and early education activities have been added to a *Posyandu* program
Poskesdes	:	Village Health Post
Posyandu	:	Integrated Health Center (for mothers and young children)
Puskesmas	:	Community Health Center
RA	:	*Raudhatul* (Kindergarten under the auspices of the Ministry of Religious Affairs)
R & D	:	Research and Development
Rumah Bersalin	:	Birth hospital or delivery room
S-1	:	Strata 1, undergraduate program
SKPD	:	*Satuan Kerja Pemerintah Daerah* (local government work unit)
SUSENAS	:	National Socioeconomic Survey
Taman Paditungka	:	nurturing together (ECD program like *Taman Posyandu)*
Taman Posyandu	:	ECD program where child development and early education have been combined
TK	:	*Taman Kanak Kanak* (Kindergarten under auspices of the Ministry of Education and Culture)
TPQ	:	*Taman Pendidikan Al-Qur'an* (religious education program for children)
UI	:	University of Indonesia
UIG	:	University, Industry and Government (Partnership)
WB	:	The World Bank


MAN
OF STEEL

Executive Summary

1.1 Purpose and Focus of the Study

Quality early childhood development is now widely recognized as a key human development investment priority in Indonesia and this is reflected in national development planning. The purpose of the ECD (Early Childhood Development) Strategy Study is to provide analysis and exploration of options and alternatives for meeting Government of Indonesia (GoI) goals of expanding the availability of high quality holistic integrated early childhood development (HI ECD).

The *National Strategy for Holistic-Integrated Early Childhood Development* provides the primary point of reference for the study. The *National Strategy* - elaborated in a process of collaboration between government and national/international stakeholders – establishes a vision and direction for ECD in Indonesia in which the developmental needs of all children are met in an integrated and holistic fashion and all stakeholders are organized to play their complementary roles in ensuring the healthy growth and development of young children. The vision described for Indonesia in the National Strategy for HI ECD is consistent with many other efforts both in the region and globally to create a stronger web of integrated holistic support for children.

To identify options that are relevant and feasible for Indonesia the study addresses the issues of access, equity, quality and management taking into consideration 1) the characteristics of early childhood development that would be optimal for Indonesia and 2) the existing institutional/ administrative environment for the promotion, delivery and management of ECD. The research approach combines systems-level macro analysis with quantitative and qualitative research and observations from six community case studies.

1.2 Findings

Summary of Key Findings

The current provision and management of ECD is the point of departure for moving toward the national development goal of HI ECD

- Sectoral level capacity and institutions provide a strong technical foundation for the delivery of HI ECD but provision must be expanded – especially PAUD, which serves only about one half of the children who could participate.

- A legal/regulatory framework for HI ECD is emerging through the National Strategy for Holistic Integrated Early Childhood Development, some sectoral regulations that complement the National Strategy and the formation of government coordinating mechanisms for holistic integrated support for children at the national, regional and local level.
- Some examples of HI ECD implementation at the local level exist but they are very limited in the number of children served and not scaled up. These examples are generally the result of NGO investment and intervention.
- There is a growing trend of drafting local regulation to support services for young children, but the regulations often focus on single-sector interventions.
- Public resources are being spent on early childhood development activities, but prioritization and targeting are not clear.
- There is a growing awareness and demand on the part of parents of the value of early childhood development services.
- Institutionally-driven (usually by a government sector) approaches have demonstrated quick improvements in participation rates in PAUD. However some of these achievements may not be sustainable as they are dependent on short – term financing.
- Community-driven approaches require much more investment in time by skilled facilitators. While they do not produce quick results, the outcomes are generally more holistic and sustainable.

Access, Equity and Quality

Antenatal Care and Safe Delivery

The institutions, professionals and trained para-professionals that provide antenatal counselling, safe delivery and neonatal care, are widely available in Indonesia. Institutions include: Hospitals, District Health Centers, Satellite District Health Centers, Village Health Posts, Village Birthing Centers and community *Posyandu*. 95 percent of households have easy physical access to one or more of the institutions providing antenatal care and safe delivery. There are good quality tools developed for supporting practice (training materials, IEC materials, guidelines, etc.) that incorporate good practices. However utilization of a skilled provider is lower, with approximately 80 percent of the pregnancies in 2010 being supported by a skilled provider at some point in the pregnancy or delivery (these rates also vary by region and wealth of the household).

While quality and comprehensiveness of services vary, the system provides a good foundation for HI ECD. However, there has been little improvement in maternal mortality rates over the last 15 years. The reasons most often cited for this are challenges in the referral system for high risk pregnancies, and the challenge of outreach to vulnerable women with family planning to reduce high risk fertility behaviors. Management of the system as integrated and holistic with local planning could likely improve the effectiveness of outreach to households who have difficulties in accessing skilled providers and in raising the awareness of the importance of skilled antenatal support.

Growth and Development (birth to 2 years of age)

While a number of health sector institutions can be involved in providing support for growth and development of children from birth to 2 years of age, the primary point of contact – especially for households in rural areas is a *Posyandu*. *Posyandu* are present in about 95 percent of the villages in Indonesia and it is estimated that about 70 percent of children participate to some degree. While Posyandu are widely available there can be differences in participation, quality and the level of service provided. Immunization patterns and the persistent prevalence of severe chronic malnutrition suggest that coverage/participation and quality is not optimal.

Investments in strengthening Posyandu must be strategic and prioritize those areas/communities where Posyandu is the primary means of reaching mothers and children who otherwise would not receive this support. Posyandu must also have the capacity to undertake effective outreach to the most disadvantaged.

Early Childhood Development and Education (2 to 6 years of age)

The provision of opportunities for center-based child development and early education is well below the level required. Early Childhood Development (PAUD) is provided in formal and non-formal settings. In 2010 around 57% of children 5 years of age had attended a formal or non-formal PAUD center. Participation was much lower for children 4 years of age (35%), and 3 years of age (11%). Participation rates in formal or non-formal PAUD differ considerably by region and by wealth (70% for the richest 20% of households, and 45% for poorest 20% of households) and by mother's education (a child whose mother has at least completed primary education is 30 percent more likely to participate in PAUD or TK by age 5). In some areas there is competition and even conflict among the various types of PAUD provided, while other children remain without service in the same community. In many cases there are no links between center-based early education programs and other services for child development, nutrition, child health, etc. In some locations the perception that non-formal PAUD are of lower quality and for the "poor" is common.

The financing model for PAUD is complex. Public investment has clearly contributed to the expansion of PAUD but may not be well targeted to improve equity. The unintended consequence of current financing tends to favour centers with more capacity for self-financing and public support for training, materials, and operational support, over less well-developed centers that have lower capacity for revenue generation. Overall, public investment at the point of delivery is heavily dependent on transfers from the National budget and the functioning of many centers is only possible through the contribution of voluntary labour on the part of caregivers.

However, there has been an acceleration of growth in the provision of center-based programs and new guidelines and tools (training, curriculum, support materials) have expanded the focus from school readiness to a more comprehensive child development, active learning and learning through play approach. MoEC regulation 58 demonstrates a developmental approach consistent with the HI ECD vision. MoEC has also produced supporting materials for children and teachers and provided training consistent with this HI ECD framework. In addition to this, in 2011 and 2012 the national education budget provided operational subsidies for about 1.9 million children (per year) and invested in model programs throughout the country in terms of improvement of facilities and program development.

The field research samples for this study showed that, in general, the formal PAUD centers had teachers with generally higher academic qualifications, but these teachers had received training less recently than caregivers in the non-formal sector programs that were visited. The formal assessment of child interaction also highlighted differences between the programs, with the non-formal programs generally exhibiting interactions between children and teacher/caregivers that were more consistent with a child development approach. The research team's interpretations of these results were that the formal and non-formal centers are delivering different types of programs – even in the cases where the ages of the children were similar.

Planning and Management

Legal/Regulatory Framework

The National Strategy for HI ECD is the key conceptual framework that describes the Government of Indonesia's commitment to Holistic Integrated Early Childhood Development practice. The vision and

direction described in the National Strategy reflect global concepts of good practice and are consistent with regional and international initiatives in ECD development to bring support for young children into a holistic integrated system.

Ministry of Education Regulation 58 of 2009 provides norms for the development of center-based PAUD services. The regulation reflects an integrated holistic approach recognizing that PAUD must address the holistic needs of children rather than just academic school readiness. The *Ministry of Home Affairs regulation 54 of 2007* established a structure (*Pokjanal* or *Posyandu* working group) for the governance and management of *Posyandu*. This regulation describes the functions and lines of communication for *Posyandu* working groups from national to village levels. The *Ministry of Home Affairs regulation 19 of 2011* broadens the mandate of this governance structure from its initial focus on integrated health to include a much wider range of social service concerns like education and improving livelihoods through *Posyandu*.

Translating National Policy into Sustainable Local Level Delivery

Whilst there is a relatively strong institutional and programmatic foundation for HI ECD, there is no development model for translating policies and objectives into sustainable local level support for children. The delivery of holistic integrated support for all children in a community is likely to require:

- Initiating new services (new PAUD centers, revitalizing a Posayndu, relocating a midwife, etc.)
- Establishing formal and sustainable links between services (health facility, *Posyandu*, PAUD)
- Providing volunteers and professionals with new skills and capacity for new roles
- Developing strategies to provide sustainable operational resources
- Allocating the cost burden and directing public investment in a manner that promotes equity and sustainability

Without an HI ECD development model that enables and facilitates local level actions to undertake these activities; the policies, guidelines and coordinating bodies cannot effectively produce the delivery of holistic integrated support at the community level. This model must identify the roles of community level stakeholders, their responsibilities and provide them the capacity to undertake these important tasks.

Local Level Assets and Capabilities

Overall, there is a growing community level awareness of benefits HI ECD and rising demand for services as shown by increasing participation in programs for early childhood development and early education.

Models of integrated holistic services (HI ECD) are being implemented but these models generally are isolated, do not reach the majority of children in a district, and often have a history linked to a time-bound NGO or government project. While integrated services do deliver a mix of (primarily) health and education services they usually did not offer all inclusive services as described in the National Strategy. Regardless of the capacity and commitment of local officials (district and village), there are significant administrative and institutional challenges to working across sectors, especially across sectors directly with communities. While various forums, committees, and other mechanisms for coordination exist, the case studies suggest that community driven HI ECD does not develop without investments in mobilizing communities.

There is an emerging trend of local legislation and regulation to support HI ECD at the district and provincial levels. Administrative decentralization allows greater flexibility for local governments in determining the best strategies for meeting local and national development objectives. Developing appropriate local regulation is one indication that local decision making has been expanded in ECD. However, regulations tend to be sector focused and developed to formalize/enable a budgetary allocation for an existing program.

There is public investment in HI ECD delivery at the local level, but primarily for existing institutions and center-based programs rather than for developing new opportunities to provide holistic-integrated support to underserved children.

The field research samples suggest that capacity and knowledge about HI ECD are available at the local level in many places. Nearly 50% of caregivers reported that they had received ECD-specific training within the last two years and good practices were being applied by caregivers in many centers visited. Training resources (knowledgeable individuals and institutions) and some financial support is available at the district and even village level. However there does not seem to be a clear or well defined consensus on how to support HI ECD with these resources. Training tends to be sector specific with limited multi-sectoral focus.

HI ECD Resources and Cost

As is the case for most areas of public spending, districts and villages are highly dependent on national transfers for resourcing HI ECD. Approximately 90% of revenues accrue from national transfers and it is estimated that 60 percent of the activities implemented "on the ground" are executed by a national entity. Most of the expansion of opportunities in center – based PAUD has been financed through central transfers, typically through "once-off" injections of resources for a limited period.

Maternal and child health components of HI ECD are more favourably resourced than PAUD. Maternal and child health expertise and delivery of services are embedded in a network of existing institutions. While there is a need to support more effective outreach and collaboration this is as much a governance constraint as a financial constraint.

Non-sectoral financial resources like community development grants and poverty alleviation grants are available and have been utilized in some cases to support HI ECD although it appears that PAUD stakeholders at the local level are not fully utilizing these sources for PAUD development.

Using a simple model, IDR819,000 per child per annum is the estimated normative cost of basic PAUD provision at the community level. This is nearly 10 times the estimate of current spending per child, IDR77, 815, a figure based on *Dekonsentrasi* data and MoEC PAUD central level spending in 2011, but does not include any of the central level and sub national level administrative costs or any spending on delivery (incentives for teachers, materials, buildings, etc.) provided by provinces, districts and villages.

Community-driven versus institutionally-driven ECD Development Models

As part of the study, a four-site, qualitative research exercise was undertaken looking at the ways in which different types of ECD centers and ECD provision had evolved in communities[1]. The research was designed to explore the differences between PAUD Centers, which had developed as a result of community efforts with little or no external support, and PAUD Centers which had developed as the result of an institutional grant and support from the Government of Indonesia, Multilateral Donors or NGO funding.

Among the four districts visited, five types of ECD Center were found:

- ECD centers where the establishment was driven by a government institution, and which is not attached to a *Posyandu*;
- ECD centers where the establishment was driven by private institutions, and attached to a *Posyandu*;

1 This research is provided in a separate report - 'A study of Community-driven vs. Institutionally-driven ECD Development Models'.

- ECD centers where the establishment was driven by civil society institutions, and attached to a *Posyandu*;
- ECD centers where the establishment was driven by government institutions, and attached to a *Posyandu*;
- ECD centers where the establishment was driven by the community, and not attached to a *Posyandu* (PAUD Mandiri)

Center Establishment

A number of examples show that communities are capable of building PAUD initiatives on their accord, and raising awareness as to its importance. PAUD Mandiri provides clear evidence of this. However, these initiatives would frequently benefit from external input, be it funding support or capacity building. These initiatives would also benefit from support in optimizing their existing resources, and support for adapting their programs to best suit local needs. Institutionally-driven development tends to focus on creating new centers, rather than supporting already existing centers. Building awareness of the importance of the program and community institutional capacity to safeguard the program execution is key.

Center Operation

Anecdotally, the quality of provision and care does not correlate to the formal academic achievement of caregivers and tutors. Findings show that in most areas, tutors who were dedicated and performed well were not necessarily those who had an academic degree. Thus, personal skills and commitment were of more importance than a formal qualification. An affinity to children, acceptance by the society, patience, and willingness to dedicate a certain period of time seemed to be the basic requirements of most PAUD caregivers. While basic education is necessary, it is worth considering whether an S1 degree is more appropriate in comparison to other options, such as a diploma or a vocational school equivalent to the high school degree or a short course. There are also innovative ways to train caregivers who do not have a formal education. Using local trainers, peer review, and internship can provide basic and continued professional development.

In terms of co-ordination with the Office of Education, more effort should be made to integrate and support PAUD rather than just demanding that PAUD meet certain requirements. For example, in Kupang, the issue of PAUD operational permit licenses shows how the role of the Office of Education is still predominantly to supervise adherence to standards, rather than to advocate for the development and continual improvement of existing PAUD, which is the role that HIMPAUDI plays.

There is clear evidence that benefits arise from integrating early childhood health and education provision. The Taman *Posyandu* Model has shown that this holistic model can work effectively.

PAUD facilities that happen to be located at the same location as (or at least near) *Posyandu* are the ones that have integrated health into their service. Others that are in different locations sometimes benefit by having the *Posyandu* cadre as tutors, as the cadre co-ordinates with Puskesmas to some extent.

PAUD centers also have the opportunity to influence broader community issues. For example, in building awareness among parents and facilitating the process of obtaining birth certificates, which was discussed by tutors of some PAUD in this research. By making it a requirement to register a child at a PAUD HI institution, awareness of the importance of birth certificates would be built among the community.

Parents Involvement

Parents play a crucial role in determining child enrolment to PAUD. In general, most parents realize the

importance and benefit of PAUD for children. However, there is a strong perception which identifies PAUD as school-readiness preparation (reading, writing and counting skills) rather than holistic child development. Primary schools play a role in fostering inappropriate practices in PAUD centers, since they sometimes require that children graduating from PAUD centers already have formal education skills.. Advocacy is needed so that parents and PAUD can work together in improving children's developmental skills in the first place, rather than putting an emphasis on just reading, writing, and counting skills.

Parents' awareness of PAUD benefits does not always correlate with their willingness to pay for them. However, more and more parents are aware of the condition of PAUD and tutors, and are willing to get involved and contribute (financially/in-kind) in sustaining and improving PAUD operations.

Sustainability

A key finding is that over the longer term, community-driven ECD centers tend to be more sustainable than Institutionally-driven centers, which frequently become dormant once funding is stopped.

A community sense of ownership is key to sustaining the program. As demonstrated in the PAUD Mandiri and the *Taman Posyandu* models, the community has and is willing to contribute some resources, though this can be limited. Extra effort and communication should be made by PAUD, in collaboration with community figures and village officials, to demonstrate transparency in their use of resources. This will in turn build trust, which will be critical in developing community involvement in sustaining PAUD when external input alone cannot suffice.

The village leader has a potential role to play in ensuring sustainability and successful PAUD development, and this can be seen in several areas where the village leader is committed to PAUD development.

1.3 Strategic Options

The strategic options assume that, at least for the medium term future, PAUD remains non-compulsory and without a commitment for centrally funded PAUD provision with National, Provincial and District governments - who nonetheless play an important role of developing the sector, providing expertise and acting to ensure equity and quality. This is highlighted because much of the recent growth in PAUD provision has been the result of national level action; and financial support along with the current tools used for this expansion may not be sustainable or consistent with a community-led and community-resourced model.

An assessment of the financing, logistical and political feasibility, and potential impact, of each of the options are provided in Chapter 5.6.

Strategic Options at the National Level

1. Create a flexible 'Development Model', as a resource for districts and villages to draw upon

While the delivery of maternal and child health is supported by an existing network of health centers, meeting the needs for PAUD requires a significant expansion in the number of center-based programs. This need to expand the *institutions* of PAUD is taking place in an environment of administrative and fiscal decentralization.

HI ECD cannot be realized without addressing the governance/management constraints through an informed systematic process of decision making at the local level. But standardised resources must

be developed at the national level' that can inform and guide local level development. Creating a methodology and system for this process – referred to here as the HI ECD development model – is a key option.

The HI ECD development model includes techniques for:

- Socialization and mobilization of a community with respect to the benefits of HI ECD
- Identification of underserved children and services that are not accessible and developing a plan to address the problem
- Establishment of the appropriate linkages between the services (including how to manage and support the linkages both logistically and financially)
- Identification of caregiver requirements (capacity and support) and developing a strategy for meeting capacity development and financial/material support needs
- Identifying the available public resources and allocating them in a manner that promotes equity in access to HI ECD
- Developing an overall financing strategy that ensures sustainability taking into account available public funding
- Explicitly recognising the role that NGO's can play in supporting the development of ECD

This model should take into account the different development strategies available in different communities depending on their history and activism in ECD, their access to resources, and whether the development model is driven by a community or with external support. Locally-driven efforts generally require a longer and more intensive investment in facilitation, mobilization, planning, awareness-raising, advocacy and other activities before they produce improvements in participation rates.

2. Create a challenge or innovation grant fund for implementation of HI ECD in innovative, replicable ways

The creation of grant awards to local governments (Province, District, Village) that demonstrate promising and sustainable strategies for establishing one-roof or holistic- integrated early childhood development delivery will incentivise the use of innovative, replicable models.

A challenge grant program would provide funds for actions that can accelerate the HI ECD development process and encourage regional and local government to be more active in planning and development of HI ECD, even before formal resource allocations to support HI ECD are implemented. Funding for this challenge fund could be obtained from a combination of government (non-sectoral), corporate, and international development partner funding.

The fund could be managed by an ECD Task Force with a committee to evaluate proposals comprised of representatives of fund contributors, representative of key line ministries and BAPPENAS. Awards would not be used to meet regular operating costs of government entities or build infrastructure. Examples of the use of the grants could include: 1) local consultation and research activities leading to the elaboration of a local regulation that enables HI ECD, 2) capacity development for local NGOs in the concepts of HI ECD, 3) training of stakeholders in resource mobilization strategies, 4) non-infrastructure start-up costs for one – roof service delivery, 5) short-term training and capacity development for village heads and members of legislative bodies.

3. Identify and manage a specific research and policy analysis agenda for the promotion of HI ECD

In collaboration with the research and development unit of the MoEC, a specific research agenda can be developed to identify key issues arising in the sector. The research agenda would provide evidence for data-driven policy development and strategic planning.

4. Provide regular periodic capacity development for HI-ECD coordinating bodies

Local communities repeatedly state that one of the key problems with delivering integrated services is a lack of coordination amongst the line ministries at the district and local levels. Regular periodic capacity development and information sharing for relevant HI ECD stakeholders - particularly the established government coordination bodies (*Posyandu* working groups and the Coordinating Ministry for the People's Welfare) is essential.

5. Define a strategic investment policy and clarify the role of central level funding for PAUD delivery at local levels

Regional and local governments must be encouraged and provided incentives to take a more active role in allocating resources to HI ECD. It is only at the local level where decisions can be made as to how to most effectively link services in a given village, what kind of PAUD (KB, Pos PAUD, Taman *Posyandu*, TK) best capitalizes on existing investments and facilities, how to best support caregivers, and other issues that require local level deliberation.

Increasing local investment can also be promoted by using financial incentives to reduce the short-term risk of trying new solutions and to support new processes for incorporating local (village/community) planning for the delivery of HI ECD.In the case of PAUD, a strategic investment policy should be defined and the role of central level funding for PAUD delivery be clarified for local stakeholders.

6. Create a National Coordinating Body for HI ECD

A National Task Force to support the development and testing of mechanisms for promotion of HI ECD, which can inform and strengthen the existing formal coordination bodies, is a key option. The overall mission of the Task Force will be to develop, test and disseminate effective practices for the implementation of HI ECD and to provide capacity development for relevant government entities – especially formal coordinating bodies and regional/local government. Tasks would include research and analysis, publications and communications, policy advice to the national government, and the development of a limited number of indicators to monitor progress on HI ECD (in addition to the current sector specific indicators).

Strategic Options at the Provincial/District Level

1. Establish 3 to 5 regional resource centers with multi-year funding envelopes

One of the most important functions that a central government operating in a decentralised system has regarding quality and development, is that of knowledge broker. Developing a series of regional resource centers which combine demonstration models of effective HI ECD practice with an ambitious and adequately funded outreach and on-site training program could leverage a relatively limited amount of resources to provide support for local communities as they implement ECD. These centers could:

- Develop and document successful community-driven HI ECD models in their regions
- Provide short-term training courses using demonstration project sites for caregivers, local level officials, governors, village heads, and legislators
- Provide technical assistance regionally

2. Develop a resource bank within each district office to include materials that capture best practice in development, financing, and provision of HI ECD.

One of the key roles that a district should be playing in a decentralised system is as a knowledge broker, that is, an organisation that collects and shares best practice where it is needed. District offices should regularly document and disseminate examples of innovation in training for HI ECD to *Posyandu* working groups. District officers responsible for quality can champion the dissemination of the information available, and advocate for local communities to have access.

3. Identify and support a range of 'Model Centers' in districts, and provide resources for community level stakeholders

A key option for Districts would be to identify a range of high-performing integrated ECD centers and publicise their existence to local communities. With support from District offices, best practices can be shared at little or no extra cost to the state.

4. Develop and test community-led targeting strategies for local investment in PAUD and techniques for self-financing initiatives

The greatest challenge that local communities face in starting ECD centers is a lack of financial resources however many communities have overcome this barrier to start successful and sustainable provision for their children and mothers. In their visits to schools across districts, government officials have the opportunity to observe schools and collect and compile information about strategies that have resulted in successful investment in PAUD initiatives.

5. Create a capacity development and awareness-raising plan for local legislative bodies to promote greater investment of local government resources into ECD

The degree of local level (village) decision-making in the allocation of public resources for HI ECD is also quite low, reflecting the still evolving decentralization process, and the lack of capacity and systems for effective local planning. This has resulted in a continuing reliance on centrally funded initiatives and systems which is a significant constraint on the holistic integration of services for children at the point of delivery.

6. Develop an action plan for supporting local provision of ECD services in remote areas

Data shows that the most remote communities are the ones that have the most limited access to skilled early childhood development provision. This is not only because there are greater distances between centers in more remote areas, but also because poverty is more widespread in these areas. A comprehensive plan to provide ECD services to the most marginalised must be a key element of ECD development in Indonesia.

Strategic Options at the Community Level

1. Identify and allocate resources to a local ECD leadership/coordination function

Institutionally driven ECD centers that are successful at local levels have included resources for local level co-ordinators who receive a salary to make cross-sectoral linkages and bring health and education institutions together. With community-led initiatives, this role is seldom explicit, and there are rarely funds allocated for it even if it is recognised.

Posyandu working groups, with the support from the district, could identify a co-ordinated training plan for the local community, as well as develop local ECD strategies. The group can also maintain contact with the appropriate district officials to receive technical assistance and capacity development, and in turn strengthen and support other local coordinating structures that include non-government stakeholders (PAUD forums, etc.).

2. Strengthen the outreach of Posyandu, midwives or health facilities based on local assessments

The relatively large number of women who do not have professional birth support, and the lack of clear information on the status of a large number of *Posyandu*, are two key issues. The development of *Posyandu* is seen as a success story, and with funding, support from the district resources and a strong outreach program, they have the potential to significantly improve health outcomes for mothers and children. They also have the potential to reinforce integrated provision if they are part of a 'one-roof' ECD center. Strengthening the functioning of the *Posyandu* through a locally-led identification and assessment process, and developing the *Posyandu* through community and district support, are key issues.

3. Become familiar with development models, resources, regulations and tools available from District offices

Communities have the responsibility to become informed, seek help, and advocate for ECD support when it is needed. As a strategy, this is difficult to implement, and that the incentive for communities to become involved is not necessarily in place. However, districts must play a large role in advocating for community action, and communities must take their civic responsibilities seriously.

4. Develop strategies to identify women who are not likely to seek services, and children who are at risk of not attending ECD; and conduct local advocacy and rights awareness campaigns, including Parenting Education

Research findings show geography, education, and wealth to all play a factor in determining whether women seek ECD services for themselves or their children. It is only at the community level that the identification of hard-to-reach women can be done, and only at the community level that planning and measures can be taken. Districts need to make rural appraisal techniques available to communities, and sensitization must take place and be replicated so that communities are aware of the importance and existence of ECD Services. NGOs are usually skilled in this type of exercise and often can bring resources to bear. Parenting Education programmes can also greatly increase the likelihood of children attending and remaining in formal and non-formal settings, and remaining healthy.

5. Involve community members in the management of ECD centers to ensure sustainability

Community management of integrated ECD centers can ensure a sustainable future for schools and health centers in communities. The research shows that where institutions are managed by committees made up of community members there is more willingness to resource schools, engage with local issues that affect the center, and commit to ensuring the success of the center. Transparent management of schools and health centers allows communities to see how fees are spent, and provides opportunities to hold authorities accountable for poor performance.


Bks

Chapter 1
Introduction

1.1 Purpose and objectives of the ECD strategy study

Quality early childhood development is now widely recognized as a key human development investment priority in Indonesia, and this is reflected in national development planning. The purpose of the ECD (Early Childhood Development) Strategy Study is to provide analysis and exploration of options and alternatives for meeting GOI goals of expanding the availability of quality early childhood development. The Terms of Reference for the ECD Strategy Study (Appendix H) direct the research team to focus on:

- Expanding equitable access to Early Childhood Development,
- Improving the quality of Early Childhood Development, and
- Strengthening Planning and Management of Early Childhood Development

To identify options that are relevant and feasible for Indonesia, the study must address the issues of access, equity, quality and management taking into consideration 1) the characteristics of early childhood development that would be optimal for Indonesia and 2) the existing institutional/ administrative environment for the promotion, delivery and management of ECD.

1.2 Methodology

The research approach combines systems-level macro analysis with quantitative and qualitative research and observations in six community case studies. The study also examines planning, management and delivery of ECD with respect to the opportunities and constraints for realizing the vision of HI ECD as an integrated holistic system of support for children in Indonesia.

The key research questions were elaborated as follows:

- Is access and equity for each component consistent with the vision of a holistic system that meets the developmental needs of all young children?
- Are the current the characteristics (i.e. quality) of each component consistent with the vision for Holistic Integrated ECD?
- Does planning and management of HI ECD activities lead to the desired outcomes of the specific HI ECD component and the vision of a child focused integrated system of support for all children?

1.2.1 Measuring Access and Equity Panel Data from National Surveys

Access and equity were measured by using the appropriate national level data sources. The 2011 Census of Village Potential (*PODES*) was used to map the supply of HI ECD components in Indonesia. This data source was used because it provides information on a number of HI ECD components across multiple sectors and permits an examination of how the supply of the various services differs from village to village across Indonesia.

Because *PODES* data is provided at the village level, it may differ somewhat from the information maintained by national level line ministries. These differences can come from a number of sources since the data gathered and mechanisms for gathering and reporting the data are different. It may also be the case that some villages do a much better (or poorer) job of verifying the accuracy of their reporting and updating their reporting as the supply changes.

Given these limitations, an analysis of the *PODES* may not provide an accurate and detailed picture of the distribution of HI ECD components for a particular village. However, looking at the entire database of village reporting provides an opportunity to examine how HI ECD components are distributed in Indonesia as well as the magnitude of the differences between the areas that are better served and those areas where the supply of HI ECD is much lower. While availability of HI ECD components is measured at the village level the results are presented at the district level since district decision making is key to the implementation of HI ECD in Indonesia's decentralized governance structure.

The 2010 National Socio Economic Survey (*SUSENAS*) is also used to assess access and equity for specific HI ECD components. As a data source based on households and individuals, the *SUSENAS* provides the opportunity to estimate actual participation rates in some of the HI ECD components as well as to explore the individual and household characteristics that affect participation and outcomes. While the *SUSENAS* data provides the opportunity to examine participation and outcomes, the sample is not large enough to provide statistically robust estimates for differences in access and equity across districts and villages.

1.2.2 Measuring Outcomes and Quality Fieldwork

An understanding of how local conditions and local decisions affect participation in HI ECD was realized through 6 community case studies. In each community case study the research team met with community and district government leaders, visited a range of ECD institutions and centers to observe conditions, and facilitated two workshops to first gather and then feed back data to stakeholders. A full report from each of the case studies can be found as Appendix G of this document.

The goal in selecting sites for case studies was to ensure a diversity of conditions with respect to: levels of economic development and household wealth, geographical constraints or challenges for providing HI ECD services and current levels of ECD participation (low and high). In addition, sites that had engaged in efforts to provide innovations in early childhood development were also prioritized. The selection of sites did not concentrate solely on locations where ECD participation is weak. Case study sites also included areas of relatively high levels of ECD participation in order to gain a more complete picture of necessary and sufficient conditions for equitable access to quality HI ECD.

The final selection of districts was: Banda Aceh, Bone, Garut, Probolingo, Kupang (District), and Sambas. Due to security concerns at the time of the scheduled study, Kupang district was substituted for Jayapura. Final determination of villages to include in the studies was made in collaboration with *HIMPAUDI* researchers based on logistical considerations as well as their knowledge of ECD delivery in the district.

A full description of the fieldwork methodology is included in Appendix B.

1.2.3 Measuring, Planning and Management

A review was undertaken of all key sectoral documents, and a series of interviews was undertaken with key personnel in national government, multilateral, bilateral, and other non-governmental institutions. The list of persons consulted can be found in the inception report and as Appendix A.

A financial analysis was undertaken on the basis of national public expenditure reporting, with budget data gathered from the Ministry of Finance, Ministry of Education, and Ministry of Health. This data was supplemented with other publicly available information such as synthesis reports from major institutions or articles published in peer-reviewed journals.

A significant amount of planning and management was also gathered during the fieldwork described above.

Supplementary data on key aspects of community driven versus institutionally driven ECD development models was collected during fieldwork undertaken by Frontiers For Health (F2H), and their methodology is described in detail in their final report.

Chapter 2

Access, Equity, Quality and Outcomes in HI ECD

2.1 Antenatal support and safe delivery: Maternal and Neo-Natal Child Health

Summary of Findings

Access and Equity

- Health institutions that provide antenatal support and safe delivery are widely available although isolated areas of inadequate provision still exist
- Roughly 80 percent of the pregnancies in 2010 were accompanied by a skilled provider of antenatal care
- Utilization of skilled providers is less prevalent among the poorest households and among women with lower levels of education

Quality Standards

- Public facilities must meet established official standards of care for antenatal care and safe delivery
- Medical professionals are licensed and trained midwives must complete a training program at a national accredited institution

Outcomes

- There has been little improvement in maternal mortality rates over the last 15 years. The reasons most often cited as explanations are challenges in the referral system for high risk pregnancies and difficulties of family planning outreach to reduce high risk fertility behaviors
- Neonatal mortality rates are improving but still do not compare favorably with other countries in the region
- Adverse outcomes (maternal and neonatal mortality) in Indonesia are more prevalent in particular regions, among poorer households and among less educated women

Access and Equity

HI ECD begins with support to a child before birth. A number of antenatal and delivery services intended to ensure that children are healthy and safe from birth are available in Indonesia. These include services ranging from care provided by a medical doctor in private settings (clinics and hospitals) to more widely available community based support relying on trained midwives and paraprofessionals supported by medical personnel. Table 1 presents an assessment or mapping of the coverage of these services.

In portraying the availability of support for maternal health, institutions rather than individual professionals were used. Professionals and paraprofessionals (Medical doctors, nurses, and trained birth

attendants/midwives) are usually linked to the formal and community health facilities. When a facility is accessible it is likely that a professional or paraprofessional is available and the facilities provide – at differing levels – many of the same services. Since the intention is to describe accessibility for the majority of Indonesians, the indicator was constructed using public facilities as this represents the source of support for those who cannot afford the more expensive private providers.

The presence or absence of accessible antenatal support was determined on the basis of whether individuals residing in a given village have access to any one of a group of institutions (see list below) that provide skilled providers of antenatal care and delivery services.

For each village a household was considered to have access to maternal health services if persons living in that village had access to:

Table 1. Access to Maternal Health

Hospital	Available in the village or with easy access
or	
Rumah Sakit Bersalin/Rumah Bersalin (Birth hospital or delivery room	Available in the village or with easy access
or	
Puskesmas (District level public health care center)	Available in the village or with easy access
or	
Puskesmas pembantu (Branch office of Puskesmas)	Available in the village or with easy access
or	
Poskesdes (Village Health Post)	Available in the village
or	
Polindes (Village birthing place)	Available in the village.

Maternal Health	
Percent of households with access to maternal health support	95%
Percent of villages access to maternal health support	93%
Number of Districts where 90% or more of households have access to maternal health support	89%
Number of Districts where 90% or more of villages have access to maternal health support	81%

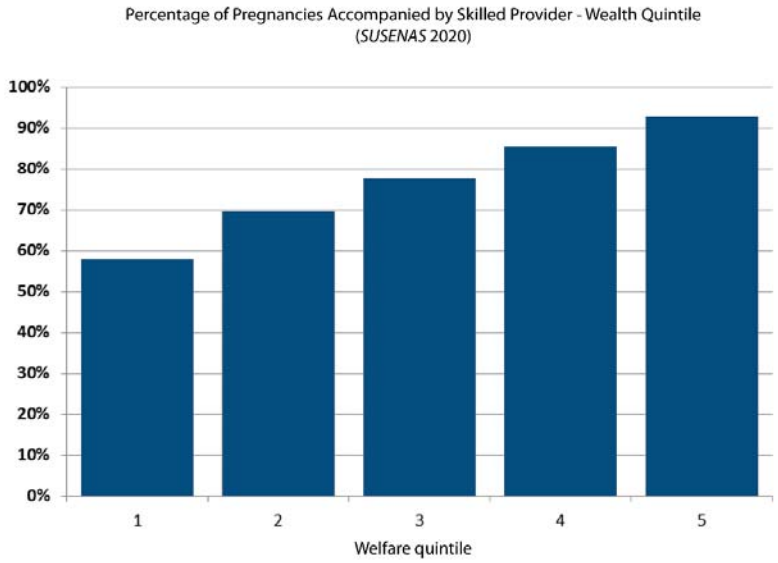
95 percent of households have access to at least one of the institutions that provides support for pregnancies and delivery either in the village or within easy access to the village of residence. 93 percent of villages have at least one of these institutions or are within easy access to one in a neighboring village. For nearly 90 percent of the districts analyzed,[2] 90 percent or more of the households have access to maternal health support and in more than 80 percent of the districts at least 90 percent of the villages have one of these institutions. Not surprisingly, the villages where there are much lower levels of availability of support for maternal health tend to be concentrated in particular provinces and districts. A presentation of the districts with the highest level of coverage and the lowest level of coverage is presented in Appendix C.

To supplement the analysis of the distribution of opportunities (supply) for antenatal attention and safe delivery, the actual utilization of antenatal and birthing services and outcomes were estimated using the 2010 *SUSENAS* survey. In the *SUSENAS* survey, households are asked to identify the source of antenatal support and birth attendance for each household member under the age of 5 years.

2 In the 2011 *PODES* some districts in South Sumatra reported data using a different system of geographical aggregation. Those districts were not included in the analysis. Even with those districts excluded the 487 districts that are included are sufficient to provide a good overall sense of the distribution of HI ECD components.

Overall, approximately 76 percent of pregancies for children under 5 years of age at the time of the 2010 survey had received support at some point by a skilled provider (either a medical doctor, a trained midwife or some other medical paraprofessional)[3]. While the *SUSENAS* based estimates are proxy measures of more formal measures derived from the Indonesia Health and Demographic Survey, they are more recent (2010 versus 2007) and provide important insights regarding how utilization of skilled support for pregancy and delivery differs for different sectors of the population. They also provide additional insights into required investments to ensure adequate provision of this aspect of the continuum of early childhood development support.

Figure 1. Percentage of Pregnancies Accompanied by Skilled Provider – Wealth Quintile



The data show that about 58 percent of the pregancies of mothers of children under 5 years of age at the time of the 2010 *SUSENAS* survey in households in the poorest wealth quintile had been accompanied by a skilled provider while the figure for wealthiest households was 93 percent (Figure 1).

There are also significant differences in the utilization of skilled providers of antenatal support between urban and rural households and between pregnancies of women with less than a complete primary education and women who have a completedcomlete primary education or higher (Figure 2). Nearly 90 percent of pregnancies in urban areas are accompanied by skilled providers. In rural areas only about 65 percent of pregnancies are accompanied by a skilled provider. A skilled provider accompanies about 73 percent of the pregnancies of women who have completed primary education or higher. For women with less than a complete primary edcuation, only about 53 percent of pregancies are accompanied by a skilled provider.

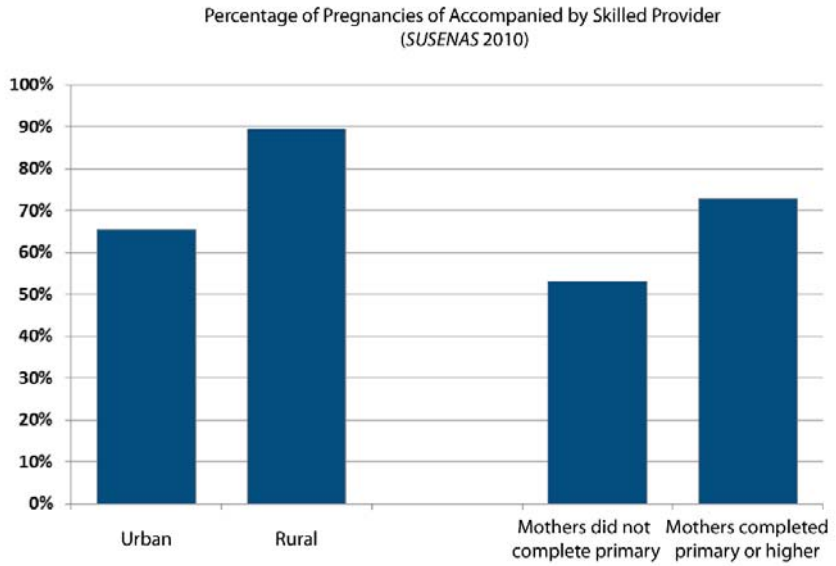
While the supply of institutions providing antenatal support and safe delivery are physically accessible to roughly 90 percent of women, the estimates of actual utilization are lower and are linked to household characteristics like wealth, urban/rural location and education of the mother. The differences in utilization of skilled antenatal care providers estimated in the 2010 *SUSENAS* are very similar to those estimated from the 2007 Indonesia Demographic and Health Survey. These estimates of utilization of skilled antenatal care indicate that there is still some gap between current access and the universal support envisioned as a complete continuum of services for HI ECD. This gap is a function of geographical areas where insituions and qualified professionals and paraprofessionals are not physically accessible, the inability

3 The other choices presented in the survey were traditional birth attendant (*dukun besalin*), family or other. The percentage of pregnancies monitored by a skilled provider for the last cohort (children aged one year of less) in the 2010 SUSENAS was 80 percent.

of poorer households to absorb the indirect costs of services (a basic number of visits/consultations are provided free of charge) and lack of awareness of the importance of adequate antenatal support.

The HI ECD vision provided by the National Strategy is one of universal support along the complete continuum of services for the development of young children. Ensuring universal access to this essential part of the continuum requires health sector planning and additional investment to address the remaining physcial accessibility contraints and multisectoral efforts to address less than optimal utlization due to household financial constraints and lack of awareness and knowledge.

Figure 2. Percentage of Pregnancies Accompanied by Skilled Provider – Urban/Rural, Mothers' Education



Quality

Support for antenatal care and safe delivery are provided through a number of insitutions: Hospitals, *Puskesmas* (community health center), Pustu –*Puskesmas pembantu* (community health post), *Poskesdes* (village health post), *Polindes* (village birth cottage), and *Posyandu* (Integrated Health Center). Health institutions are licenced by the Ministry of Health and medical personnel also are subject to national licensure.

In addition to trained medical doctors, the Ministry of Health also licenses trained midwives who have reached a minimum level of Diploma 3 and have successfully graduated from academic institutions that are nationally accredited to deliver training for midwives.

Outcomes

Table 2. Maternal Mortality Rate

	1990	2010	Change 1990 - 2010
Indonesia	**600**	**220**	**-63%**
Brazil	120	56	-53%
India	600	200	-67%
Malaysia	53	29	-45%
Thailand	54	48	-11%
Viet Nam	240	59	-75%

WHO, UNFPA, UNICEF, World Bank estimates maternal deaths per 100.000 live births

Another means of assessing the quality of antenatal support and support for safe delivery is maternal mortality and infant mortality and to a lesser degree under-five mortality.[4] Maternal mortality was estimated in 2007 as 228 maternal deaths per 100,000 live births.[5] While this figure is lower than previous estimates for three other surveys between 1994 and 2007, the sample sizes are too small to conclude with confidence that maternal mortality has decreased over this time period. The lack of clear evidence of a trend in reducing mortality has raised concerns in the GOI that it may be difficult to reach the MDG 2015 goal of 102 maternal deaths per 100,000 births.[6] Maternal mortality rates exhibit a great deal of regional variation.

Table 2 compares estimates of Indonesia's maternal mortality rate with neighboring countries and with two other rapidly developing countries with large populations – Brazil and India. The estimated rate for Indonesia in 2010 is significantly higher than neighboring countries and Brazil. Indonesia's rate is similar to the rate for India and the improvements in maternal mortality are also similar to India's.

Among frequently cited prioriities for improving maternal mortality rates include improving the system of referrals for high risk pregancies and reducing high risk fertility behavious through greater participation and effectiveness of familty planning programs..

Effective antenatal care and support for safe delivery also improve prospects for infants. Table 3 presents estimates of neonatal mortality rates for Indonesia over time and in comparison again with some selected counties in the region and with Brazil and India. As indicated neonatal mortality rates for Indonesia do not compare favorably with Malaysia, Thailand and Viet Nam but are significantly better than those for India. The trend in reducing neonatal mortality is slightly less pronounced for Indonesia – although the methods of measuring are subject to statistical imprecision because of the size of the sample.

Analysis of the *SUSENAS* 2010 and the Indonesia Health and Demographic Survey 2007 indicates that maternal mortality and neonatal mortality rates in Indonesia are more prevalent in particular geographic regions with low levels of development, among women and children from poorer households and for women with low levels of education.

Table 3. Neonatal Nortality Rates – Trend and International Comparison (Per 1000 Children)

Neonatal Mortality Rate (Per 1000 Children)					
	2007	2008	2009	2010	2011
Indonesia	**18**	**17**	**16**	**16**	**15**
Brazil	13	12	11	10	10
India	35	35	34	33	32
Malaysia	4	4	4	4	3
Thailand	9	8	8	8	8
Vietnam	14	13	13	12	12

Source: Level and Trends in Child Mortality. Report 2011. Estimates Developed by the UN Interagency Group for Child Mortality Estimation (UNICEF, WHO, World Bank, UN DESA, UNPD)

4 Maternal mortality is any death that occurs during pregnancy, childbirth or within two months of childbirth or the termination of the pregnancy. Neonatal mortality is the death of a child for any reason before one month. Under-five mortality is any death between birth and 5 years of age.

5 Indonesia Demographic and Health Survey

6 2012/03/15 Xinhua reporting

2.2 *Posyandu* (Integrated Health Center): Children Birth to 2 Years

Summary of Findings

Access and Equity

- About 99 percent of children live in a village where local officials report at least one active *Posyandu*
- Local officials report at least one active *Posyandu* in about 95 percent of all villages
- Villages without *Posyandu* tend to be concentrated in a relatively small number of historically underserved districts
- Recent estimates are that 60-70 percent of children participate in *Posyandu* programs – but typically for just the first 12 months of life

Quality

- *Posyandus* are classified into 5 categories on the basis of the programs offered and the number of regular volunteers.
- There is growing interest and activity in revitalizing *Posyandu* as a means to address early childhood growth and development challenges (nutrition, immunization, stimulation, etc.). This is evidenced by the national and international NGO activities that build on the *Posyandu* model, the establishment of official structures (working groups) for *Posyandu* through the Ministry of Home Affairs regulation 54 – 2007 and local initiatives like the East Java Provincial decree (and work plan) to increase and strengthen *Posyandu* in the province.
- As community based initiatives, the programs offered and the level of resources are variable and quality might be expected to vary considerably even within the official categories.
- Material inputs in the areas of health and nutrition can vary based on local government support through regular line ministry departments (dependent on local health authorities)
- Support for volunteers (*kaders*) varies with some locations providing incentives directly from regular local budget sources while other volunteers are provided support on an irregular basis or receive no support.

Outcomes

- Full immunization coverage in Indonesia is 59 percent. The rate of coverage declines over the period of administration of immunizations with initial neonatal participation nearly 86 percent and falling to just 59 percent for full immunization. A number of officials have stressed that having an attractive *Posyandu* program that encourages participation of children and households for a longer period of time could markedly improve immunization coverage rates.
- While indicators of malnutrition have improved over the last two decades, severe chronic malnutrition for children under 5 years of age (a stunting prevalence rate of 36 percent) is still higher than expected for a country of Indonesia's wealth and health sector spending. As with other indicators of child welfare there is considerable variation by region and by household wealth and education
- Under 5 child mortality has also improved consistently but is still at higher levels than many countries in the region

Access and Equity

Posyandu is a village based entity specifically mandated to attend to the needs pregnant women, mothers and newborns. The typical *Posyandu* program includes pregnancy monitoring, growth monitoring for newborns, immunization, and child health monitoring. Generally, *Posyandu* operates once or twice a month, but a growing trend is to expand *Posyandu* into child care and child development (PosPAUD). Assessing whether children have access to *Posyandu* was determined by examining whether the village had at least one *Posyandu* that was active (village officials report that the *Posyandu* has recently realized activities). The population with access to *Posyandu* is the estimated 0 to 3 years of age population in the villages that have at least one active *Posyandu*. The percentage of the population with access to *Posyandu* is the number of children 0 to 3 years of age that reside in villages with at least one active *Posyandu* relative to the total estimated 0 to 3 years of age population.

More than 99 percent of the 0 to 3 years of age population have an active *Posyandu* in their village and 95 percent of the villages report at least one active *Posyandu*. In 92 percent of districts 90 percent or more of the 0 to 3 population have access to an active *Posyandu* in their village. While *Posyandu* is very widely available, coverage is very low in a few districts. Districts with high levels of accessibility and low levels of accessibility are presented in Appendix C.

Table 4. Access to *Posyandu*

Posyandu	
Percentage of population aged 0 - 3 years with *Posyandu* in village	more than 90%
Percentage of villages with *Posyandu*	95%
Number of districts where 90% or more of population aged 0 - 3 years live in a village with active *Posyandu*	446 (92%)
Number of districts where 90% of villages have active *Posyandu*	426 (87%)

While *Posyandu* are numerous, they rely on community volunteers to function. It has been estimated that participation in *Posyandu* has fallen from nearly universal participation in the 1990s to recent estimates of 60 to 70 percent participation.[7]

Quality

From its inception, *Posyandu* has been conceived as a community led program. The functions of *Posyandu* are to promote safe delivery and child health through a menu of monthly activities including: grow monitoring, monitoring of child health, parental education and others. As a voluntary organization, the *Posyandu* quality is a function of local volunteers' the capacity and commitment, whichwhich can vary considerably from village to village. Support and investment from local government also varies from place to place as some *Posyandu* volunteers receive financial support ("incentive") while many do not.

Without a regular resource base for training and capacity development, the quality of *Posyandu*s is often linked to specific time bound government projects or international/national NGO initiatives. Some experts have cited the possible contribution of lower participation rates and irregular support for *Posyandu* with difficulties in improving immunization rates, nutritional status and other outcomes for young children.

Currently there is considerable interest and activity within government (including district governments) and international stakeholders in revitalizing *Posyandu* as evidenced by the promulgation of Ministry of Home Affairs regulation 54 of 2007, which establishes formal working groups on *Posyandu* at the national, provincial, district and village level. This same regulation describes a menu of activities for *Posyandu* and establishes the responsibility of districts (through district budgets) for financing operational costs of *Posyandu* and for training of volunteers (*kaders*). Each working group – national, provincial and district/ village is assigned the responsibility of capacity development and advocacy.

Outcomes

Using WHO guidelines, 59 percent of Indonesian children between the ages of 12 and 23 months were considered fully immunized.[8] Full immunization according to these guidelines includes:

- one dose of the vaccine against tuberculosis (BCG),
- three doses each of the DPT and polio vaccines and
- one dose of measles vaccine.

7 Discussions with Ministry of Health and recent publications of Demographic Institute at the University of Indonesia

8 Indonesia Health and Demographic Survey 2007

The WHO guidelines applied in Indonesia call for sequential doses of these immunizations to be provided at prescribed intervals over the period from birth (or first clinical contact) through soon after 9 months of age (measles).

Table 5. Immunization Coverage (IHDS 2007)

	Immunization Coverage (IHDS 2007) Percentage of Children									
	BCG	DPT			Polio			Measles	All	None
		1	2	3	1	2	3			
By time of survey (12-23 months)	85.4	84.4	75.7	66.7	89.2	82.6	73.5	76.4	58.6	8.6
By 12 months of age	84.4	82.9	73.7	64.3	87.2	81	71.1	67	50.7	10.7

While the focus of this section is the analysis of *Posyandu* as a component of HI ECD, all of the previously mentioned antenatal care and safe delivery support services may be involved in the provision of immunization coverage. Table 5 clearly indicates that participation in immunization decreases over time with a smaller percentage of children participating at each administration interval. For example, about 85 percent of children receive BCG provided at birth or the first clinical visit while the percentage of children receiving the third administration of DPT or Polio is 70 percent or less. This pattern is consistent with comments made by some Ministry of Health officials that a posayndu program that attracted regular participation over a longer period of time would be quite helpful in increasing full immunization coverage – especially in less developed areas.

The *Posyandu* program includes growth monitoring and surveillance of childhood illnesses. One outcome of these kinds of HI ECD support is a child's physical survival and development. Estimates of Under 5 child mortality rates are presented in Table 6. While Indonesia's under 5 child mortality rate is improving, the rate of improvement is less than the rate of improvement for countries of comparable income.[9] Again, it is important to keep in mind that while *Posyandu* is widely available, there are many health sector initiatives and insitutions that focus on child survival.

The prevalence rate of stunting – the failure to achieve a normal height for age – for children under 5- is 36 percent in Indonesia.[10] This level – while an improvement over rates in the 1980s – is considered below what would be expected for a country of similar income and similar health spending.[11] The prevalence rate for stunting varies significantly across regions with some provinces like Jakarta DKI having prevalence rates of about 27 percent while a number of provinces have rates in the low to mid 40s. Not surprisingly there is also a relationship between the prevalence of stunting for children under 5 years of age with indicators of wealth, employment and education as well as rural/urban residence.

Table 6. Under 5 Child Mortality Rate – Trend and International Comparison

Under 5 Child Mortality Rate (Per 1000 Children)					
	2007	2008	2009	2010	2011
Indonesia	**38**	**37**	**35**	**33**	**32**
Brazil	21	20	18	17	16
India	70	68	66	63	61
Malaysia	8	7	7	7	7
Thailand	14	14	13	13	12
Vietnam	26	25	24	23	22

Level & Trends in Child Mortality. Report 2011. Estimates developed by the UN Interagency Group for Child Mortality Estimation (UNICEF, WHO, World Bank, UN DESA, UNDP)

9 Indonesia Health Sector Review. World Bank. 2010

10 Indonesia Health and Demographic Survey, 2007

11 Indonesia Health Sector Review. World Bank. 2010

2.3 *PAUD* and *TK/RA:* Children 2 to 6 Years

Summary of Findings

Access and Equity

- Village officials report that non-formal *PAUD* (*Pos PAUD*, *TPA*, *KB*) is available in less than 50 percent of villages
- About 30 percent of the children aged 3 to 5 years live in a village without non-formal *PAUD* (*Pos PAUD*, *KB*, *TPA*)
- Only about 9 percent of children aged 4 and 5 years live in a village with public *TK*
- About 60 percent of the villages have *TK* and more than 80 percent of children aged 4 and 5 years live in a village that has *TK*
- In about 25% of the villages, the ratio of children 4 and 5 years of age to the reported number of *TKs* in the village is greater than 100 children per *TK*
- In 2010, slightly more than 57 percent of children 5 years of age had attended a non-formal *PAUD* program or *TK* at some point, but participation was much lower for children 4 years of age (35 percent) and 3 years of age (11 percent)
- About 50 percent of the 6 year olds enrolled in primary school in 2010 had attended some type of *PAUD* at some point previously
- Participation rates in non-formal *PAUD* and/or *TK* by age 5 years differ considerably by region (high of 70 percent, low of 20 percent) and by wealth (70 percent for richest 20 percent of households, 45 percent for poorest 20 percent of households) and by mothers' education (a child whose mother has at least a complete primary education is 30 percent more likely to participate in *PAUD* or *TK* by age 5 than a child whose mother has less than a primary education)
- Children who have multiple disadvantages tend to have very low participation rates in non-formal *PAUD* or *TK* (a child from a household in the poorest 20 percent of households and whose mother has less than a complete primary education only has about a 29 percent probability of having participated in non-formal *PAUD* or *TK* by age 5)

Quality

- All formal and non-formal *PAUD* is subject to quality norms defined by the Ministry of Education in Ministry Regulation 58 of 2009. Regulation 58 specifies standards for non-formal *PAUD* and for formal *TK*. The areas regulated included: Types of programs and expected outcomes, standards for teachers/caregivers and managers, program content, teaching/learning approach and assessment criteria for children and standard of facilities and infrastructure, management, and financing
- The National Ministry of Education and Culture has produced and distributed materials and curriculums over time, although centers are expected to elaborate their own program of study based on the national standards defined in Ministry Regulation 58
- The National Ministry provides financial and technical support for capacity development activities at all levels of the system. Districts and Provinces (usually through the District Education Office) also provide training and capacity development as do NGOs
- The Ministry of Religious Affairs has also recently produced a new curriculum that incorporates a child development orientation consistent with the National Strategy for HI ECD
- There appear to be two types of programs being delivered in *PAUD* centers. In centers (mostly non-formal) that were founded in the last 3- 6 years and where tutors and caregivers were more recently trained there is more focus on active learning and child development while some of the centers visited that had been providing services for 10, 15 or more years tended to have a much more pronounced focus on a school readiness and drill approach

Outcomes

- Consolidation and emphasis of the integrated child development approach in *PAUD* support for children 2 to 6 years of age in regulation, guidelines, materials and training
- New provision (new centers) are often the result of once-off government or non-government initiatives rather than local initiatives
- More than 40 percent of children never attend *PAUD*. Current provision is grossly inadequate for the relevant population
- According to Regulation 36, operational resources are to come from local sources. There is some scope for fee based cost recovery, but overreliance on fees can create a barrier for the children who can benefit the most from good quality *PAUD*. Even when households have the means to contribute to *PAUD*, it can be difficult to convince households to invest when the benefits – although large – are only perceptible after a long period of time. Strategies that encourage and incentivize local governments to make sufficient and strategic investments are required

Access and Equity

The 2011 *PODES* census asks village officials to identify whether non formal *PAUD* (*Pos PAUD*, *KB*, or *TPA*) are present in the village without asking for a count of the number of providers or sites. To simplify the presentation, we classify any village that reports any of these ECD services as having *PAUD* available in the village.

The population of children 3, 4 and 5 years of age with access to *PAUD* are those children residing in a village where the presence of some form of *PAUD* was indicated. The percentage of the population 3, 4 and 5 years of age with access to *PAUD* is the number of children in this age group that live in a village where *PAUD* is present relative to the entire population of children 3, 4 and 5 years of age. In addition, the number of districts where 50 percent or more of the children reside in a village that has some form of *PAUD* and the percentage of districts where 75 percent of more of the children 3, 4 and 5 years of age reside in a village with *PAUD* were also calculated from the *PODES* data (Table 7).

71 percent of children in the districts analyzed live in a village where non formal *PAUD* is available according to village officials. In 62 percent of the districts, 50 percent or more of the children 3 to 5 years of age live in a village with some form of *PAUD*. The percentage of districts where 75 percent of the children 3 to 5 years of age live in a village with some form of *PAUD* is 34 percent. The districts with the highest level of availability and the lowest availability of *PAUD* are presented in Appendix C.

Table 7. Access to *PAUD*

PAUD	
Percentage of population aged 3 to 5 with *PAUD* in village	71%
Percentage of villages with *PAUD*	47%
Number of districts where 50% or more of population aged 3-5 years in a village with *PAUD*	298 (61%)
Number of districts where 50% or more of villages have a *PAUD*	253 (52%)
Number of districts where 75% or more of population aged 3 to 5 live in a village with *PAUD*	159 (34%)
Number of districts where 75% or more of villages have a *PAUD*	135 (29%)

In the 2011 *PODES*, village officials are asked to provide the number of *TK*s in the village as well, regardless of whether they are private or public. To estimate the supply of *TK* relative to the potential participants, the age group of children 4 and 5 years of age was used. While these ages fall outside the official age for *TK*, about 70 percent of 6 year olds already attend primary school.[12] Mapping access for children 4 and

12 SUSENAS 2010

5 years of age indicates the accessibility of *TK* for children from an age cohort likely to be attending *TK* or to attend shortly (Table 8).

Public *TK*s are not common and only 9 percent of children age 4 and 5 live in a village that has a public *TK*. When all *TK*s are included, about 83 percent of the 4 and 5 year olds in the villages analyzed have a *TK* in their village. About 60 percent of the villages have at least one *TK*. (The difference in the percentage of children residing in a village with *TK* and the percent of villages with a *TK* reflects the pattern of larger more developed villages being more likely to have *TK*s). For about 80 percent of districts, more than 50 percent of the 4 and 5 year olds reside in a village with a *TK*. In 58 percent of the districts, 75 percent or more of the children reside in a village with at least one *TK*.

Since the *PODES* survey asks village officials to report the number of *TK*s, it is possible to examine the supply of *TK*s relative to the population rather than merely whether children have (or don't have) a *TK* in their village. Overall the ratio of the 4 and 5 year old population to the number of *TK*s reported by village officials is 91 children per *TK*. In the 60 percent of villages that report they have at least one *TK* available, almost 40 percent of the villages have an estimated ratio 50 children per *TK* or less. For 37 percent of the villages with *TK*, the ratio is between 50 and 100 4 and 5 year old children per *TK*. In 24 percent of the villages, the ratio of 4 and 5 year old children per *TK* is greater than 100 children per *TK*.

Table 8. Access to *TK*

***Taman Kanak-kanak** (TK)*	
Percentage of population aged 4 and 5 years with public *TK* in village	9%
Percentage of population aged 4 and 5 with *TK* in village	83%
Percentage of villages with *TK*	60%
Number of districts where 50% or more of population aged 4 and 5 in a village with *TK*	390 (80%)
Number of districts where 50% or more of villages have a *TK*	328 (67%
Number of districts where 75% or more of population aged 4 and 5 in a village with *TK*	282 (58%)
Number of districts where 75% or more of villages have a *TK*	215 (44%)
Ratio of 4 and 5 year old population to number of *TKs* reported by village officials	91
Percent of villages with ratio of population 4 and 5 years of age per *TK*	
Ratio of 4 and 5 years of age per *TK* less than 50	39%
Ratio of 4 and 5 years of age per *TK* less than 100	37%
Ratio of 4 and 5 years of age per *TK* greater than 100	24%

While the supply of the different components of HI ECD is important, the availability of a service does not necessarily mean that all young children benefit from those services. For the most part, the non-formal and formal *PAUD* components that were mapped from *PODES* charge fees and are also likely to have indirect costs like giving up time from working, finding someone to accompany the child and/oror other barriers to participation. In some cases, households do not have sufficient knowledge or understanding of the benefits of HI ECD and decide that participation has no benefits – only costs.

Another national level data source, the National Socio Economic Survey (*SUSENAS*), was utilized to provide information on actual participation for HI ECD components focused on social and cognitive development (*KB*, *Pos PAUD*, *TPA*, Taman Posayndu, *TK* and others).[13] The *SUSENAS* survey asks household respondents to identify whether a child under 6 years of age has participated in any one of a number of formal and non-formal ECD programs.

13 In *SUSENAS*: *TK*/BA/*RA*, Kelompok Bermain, Taman Penitipan Anak, *Pos PAUD*/*PAUD* terintegrasi *BKB*/*Posyandu*, Satuan *PAUD* Sejenis others

SUSENAS based estimates of participation in *PAUD* are based on household reporting rather than institution based reporting like that used by MoEC to estimate GER for *PAUD*. With household based reporting, it is possible to examine policy relevant questions about how individual and household characteristics affect participation in *PAUD*. Since the household data is a sample, an estimate of the participation rate will be subject to some sampling error. With a well-established survey like *SUSENAS*, it is possible to estimate a confidence interval (margin of error) around this participation rate. However, since the *SUSENAS* measure is based on a sample, small year-to-year changes in participation may be too small to be captured in the estimates for two consecutive years (changes might be within the margin of error).

An institution-based measure – like the GER measure calculated from actual reported enrollments – enables the reporting of differences in participation rates by age and geographical location but not a meaningful analysis of the individual and household factors that affect participation. Reporting actual enrollment by institution can capture small year to year changes in participation – but only if that reporting in generally without errors. In a subsector as diverse as *PAUD*, in a large system like Indonesia, institutional reporting will very likely have its own reporting errors. Choosing which measure to use is a function of the purpose of the analysis. It can also be assumed that unless there is some important difference between what each source considers "*PAUD*" and what is meant by "participation/enrollment" that the two sources should produce roughly the same results. In the case of the 2010 *SUSENAS*, an initial step was to compare the estimate of the total number of 4, 5 and 6 year olds participating in *PAUD* (any kind), estimated from the *SUSENAS* survey, to figures reported by MoEC for 2010. The difference between the total estimated number of participants and the MoEC enrollment figures for 4 5 and 6 year olds was only about 1 percent and the percentage of children who participate in *PAUD* for the 3 to 6 year age group was very close to the 35 percent reported by MoEC for 2011.[14]

Figure 3. Percentage of Children 3 to 6 Years Ever Attending *PAUD* in 2004 and 2010

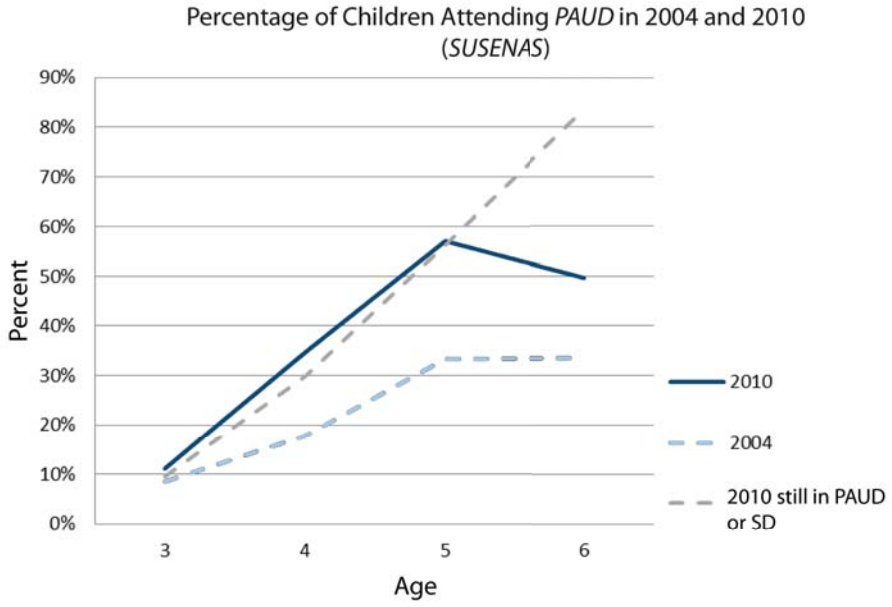
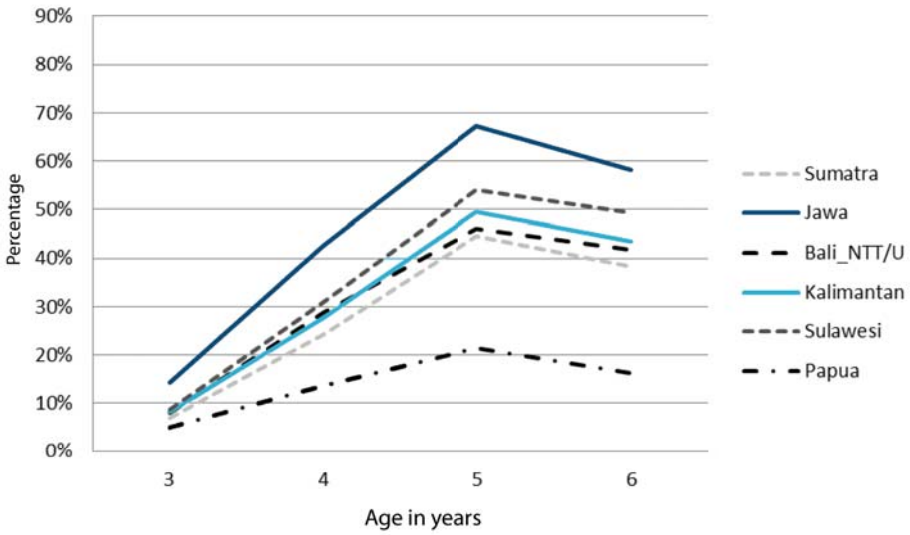


Figure 3 presents participation rates by age for any of the formal or non-formal *PAUD* programs in both 2004 and 2010. While participation rates for 3 year olds in these programs has changed little between 2004 and 2010, the number of 4 year olds who have attended some kind of program more than doubled in the six year period. Another important feature is the sharp decline in the percentage of children participating in *PAUD* programs between the ages of 5 and 6 in 2010. This decline results from an increase in the percentage of 6 year olds entering primary school (70 percent of 6 year olds in 2010

14 This 1 percent difference was excluding the incorporation of TPQ, a Ministry of Religious Affairs program that includes some children of PAUD age but also older children.

SUSENAS). The additional trend line in figure 1 indicates the 2010 rate of current participation in *PAUD* or primary school combined. Once current participation in either *PAUD* or primary school is included in the participation rates (as measuredmeasure by participation in either *PAUD* or primary school), rates continue to increase between 5 and 6 years of age as expected.

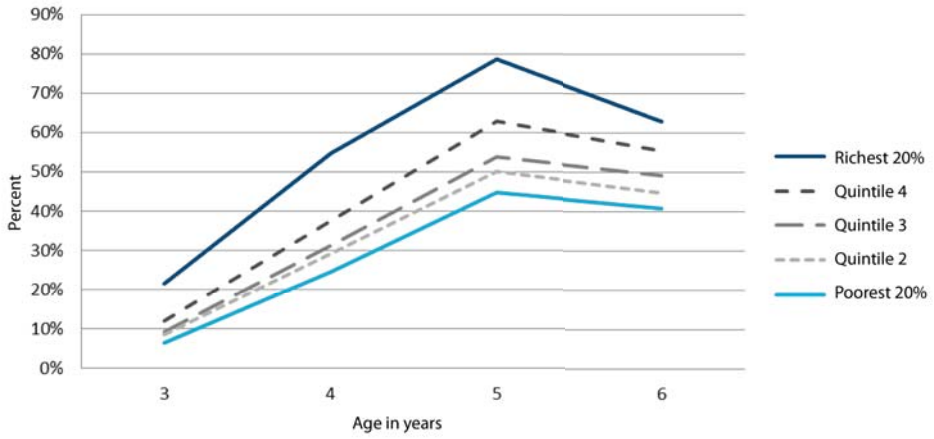
Figure 4. Percentage of Children 3 to 6 Years Ever Attending *PAUD* by Region



These national level participation rates vary quite considerably by geographical region. Figure 4 presents participation rates by age for six geographical regions. These rates tend to cluster for the regions at around 30 percent for children 4 years of age and nearly 50 percent for children 5 years of age. Two regions have participation rates that are quite different from the other regions. The participation of 3, 4 and 5 year olds on Java is much higher than the other regions with nearly 70 percent of children 5 years of age having participated in one of the formal or non-formal *PAUD* programs. The participation rates for Papua are much lower than the other regions with participation of children 5 years of age at only about 20 percent – less than half the rate for the other regions.

The different participation rates by region are roughly consistent with the analysis of the supply of *PAUD* opportunities (programs like PosPAUD,*TK*, *KB*, *TPA*, etc). The majority of the districts with low levels of availability of *PAUD* and *TK* are in the province of Papua, while many of the districts with the best provision of *PAUD* are on Java.

Figure 5. Percentage of Children 3 to 6 Years Ever Attending *PAUD* by Household Wealth



While participation by region differs, it is not just the residence of a child in a particular region or village that determines participation but rather the differences in supply and demand for *PAUD*. One obvious factor in the choices that households make isare the cost of participation relative to the households' wealth. Figure 5 illustrates how participation in *PAUD* varies by household wealth.[15] Participation rates are quite different for the poorest and the richest households. Children aged 4 and 5 years in the poorest 20 percent of households are only about one-half as likely to participate in *PAUD* programs than children of the same age from the richest 20 percent of households.

Of course wealth is not the only factor that would be expected to influence household decisions about participation in *PAUD* programs. Characteristics like the education of the parents, the size of the household, whether the household income comes from wages or from sales of agricultural products among other factors may influence decisions about participation. Effective strategies to promote participation – especially for poor and disadvantaged children must be developed taking these influences into consideration.

Household wealth, family size, family composition, educational levels of the parents, the household's primary economic activity and other individual and household characteristics all interact to influence decision making about participation in *PAUD* programs. The relative importance of these factors cannot be readily assessed by looking at each of them in isolation. For example, in a household where parents have low levels of education and have low income, it might be possible that parents' low education and low income have different effects on the likelihood of their children to participate in *PAUD*. In order to examine the separate impact of household and individual characteristics in determining whether or not a child participates in *PAUD*, a statistical method - logistical regression - was applied to the 2010 *SUSENAS* data.

The use of this method enables an analysis of the "net effect" of a particular characteristic on *PAUD* participation. For example, this method permits an estimate of the "net effect" of parents' education separated from the effects of wealth, location, etc. For policy and strategy development, what is of interest is the difference in estimated probability between characteristics like poor vs. non-poor, better educated parents vs. parents with low levels of education, etc.

To examine the impact of individual and household factors a model including:

- the gender of the child
- the wealth quintile of the household
- the composition of the household – single parent versus dual parent household
- education level of the parents
- economic activity of the household – does head and/or mother work outside the household for wages
- location of the household - region and whether the child lives in a rural or urban area was estimated using the individual level data in the 2010 *SUSENAS*. The model estimates the relationship between these characteristics and whether or not a child had participated in *PAUD* (including *TK*) in 2010. The formal and technical presentation of the estimating model is included in Appendix D.

Table 9. Likelihood of Participating in *PAUD* by Household Characteristics

The Estimated Probability that a Child 5 Years of Age will Participate in PAUD		
Probability that Any Child 5 Years of Age has Participated in PAUD = 58%		
Gender		
Girl	60%	**For households of similar composition, wealth, location, primary economic activity and parents' education:** Gender has a weak impact with girls being slightly more likely to participate in *PAUD* than boys
Boy	57%	

15 Household wealth quintiles were constructed on the basis of per adult equivalent monthly consumption.

The Estimated Probability that a Child 5 Years of Age will Participate in PAUD		
Probability that Any Child 5 Years of Age has Participated in PAUD = 58%		
Household Wealth		
Poorest 20%	45%	**Pada rumah tangga yang memiliki komposisi serupa, termasuk lokasi, mata pencaharian utama dan pendidikan parents:** kekayaan sangat berdampak pada anak yang masuk ke *PAUD* dengan kemungkinan 20% rumah tangga termiskin jauh lebih kecil masuk *PAUD* dibandingkan dengan 20% rumah tangga terkaya (perbedaannya sebesar 60%)
Richest 20%	72%	
Household Composition		
Male headed household	59%	**For households of similar location, primary economic activity and parents' education:** The household composition does not have a strong impact on the probability that a child will participate in *PAUD*. A child from a single parent/female-headed household is only slightly less likely to participate in *PAUD* than a child from a dual parent household
Single parent household with female head	56%	
Parents' Education		
Mother has less than complete primary education	46%	**For households of similar composition, wealth, location, and primary economic activity:** The education of the parents has a relatively important impact on the probability that a child will participate in *PAUD*. The impact of mother's education on the probability of attending *PAUD* is much larger than the household head (usually father) education.
Mother with complete primary education or higher	60%	
Household head has less than complete primary education	53%	
Household head with complete primary education or higher	59%	
Economic Activity		
Household head works for wages outside the household	58%	**For households of similar composition, wealth, location and parents' education:** a mother working outside the home increases moderately the probaiblity that a 5 year old has participated in *PAUD*
Household head does not work for wages outside the household	60%	
Mother works for wages outside the household	63%	
Mother does not work for wages outside the household	57%	
Location		
Rural	55.1%	**For houseolds of similar composition, wealth, primary economic activity and parents' education:** children in rural areas are somewhat less likely to participate in *PAUD*.
Urban	61.9%	

In order to better understand the effects in more concrete terms relevant to the elaboration of strategies and options for promoting HI ECD, the results from the estimating model were used to calculate the effect of some relevant characteristics on the probability that a child of 5 years of age would participate in a *PAUD* program.[16]

The calculated overall probability that a child 5 years of age has participated in some form of *PAUD* is 58%. The impact of gender on participation is quite small with little difference between girls and boys and a slight advantage to girls.

Reflecting that *PAUD* is for the most part financed through fees paid by households and can involve other opportunity costs; the impact of household wealth on participation in *PAUD* is quite strong. While

16 Calculating the probability for comparisons requires the choice of a specific age. The age of 5 years was chosen as this is the age that participation in PAUD (including *TK*) reaches its highest level.

the probability for participating in *PAUD* is 72% for children from the richest households, the probability that a child 5 years of age in a household in the poorest 20% will participate in *PAUD* is just 45%.

Children who live in single parent households headed by a woman are only slightly less likely to participate in *PAUD* than children in two parent households. Parents' education has an impact on the probability that a child participates in *PAUD* with children whose parents have less than a complete primary education having lower probabilities of participating in *PAUD* than children whose parents have at least a primary education. It is interesting to note that the impact of the mother's education is about twice as large as the impact of the father's education.

Working outside the home for wages has some impact on the probability of participation in *PAUD*. While the impact is not large, the effect of a mother working outside the home is much larger and positive (associated with an increased probability of participating in *PAUD*) than the impact of the father. This should not be too surprising as another function of this HI ECD component is to free up adults' time (especially women) for production.

As indicated previously, the method for calculating the probabilities described in Table 9 yielded the net impact of an individual or household characteristic on the probability of participating in *PAUD*. This method also permits the estimation of joint probabilities (combination of characteristics like being in a poor household and having parents with less than a primary education). While the overall probability of a child 5 years of age participating in *PAUD* is about 58 percent, a child from a household in the poorest 20 percent of households and with parents with less than a primary education is only about 29 percent.

The demand for HI ECD is linked to household wealth and the education of parents (especially mothers). Understanding how wealth affects participation is relatively straightforward. The direct costs (fees, uniforms, travel if necessary, materials, etc.) and indirect costs, like parents' time away from productive activities, will always disadvantage poorer children when there are charges for participation. The link between parents and education and participation is likely a function of parents with lower levels of education having less information about the potential benefits of *PAUD*.

Quality

As part of the community case study process, field research teams also made visits to ECD centers. While the focus of the community case studies was HI ECD and the opportunities and constraints for supporting children holistically, the analysis of services in chapter II of this report indicated that opportunities for structured programs for social and cognitive development (*TPA*, *KB*, *Pos PAUD*, *Taman Posyandu*, *TK*, *RA*, etc.) reach only about 35 percent of children under the age of 6.[17] The visits to ECD centers in each of the case study sites provided the opportunity to better understand the characteristics of the centers and the caregivers as well as how those characteristics varied by type of center and/or community.

For each visit to an ECD center, a short checklist (see Appendix F) was completed with the help of caregivers and managers. This short checklist survey captured information about the characteristics of the center such as the type of center, the history, the size and organization, the source of funding and the services provided. In addition, the survey also captured information about the caregivers present on the day of the visit. Information about the caregivers included information about their level of formal education, short term training they have received and how they are supported financially for their work at the centers.

At each visit, the research team also observed caregivers working with children. These observations ranged from about 25 to 50 minutes. In the observations, the researchers completed a Caregiver Interaction Scale form (see Appendix E). The results have been analyzed and are also presented in this chapter.

17 SUSENAS 2010

It is important to be clear about the limitations of the observations of the visited ECD centers. While very useful and interesting information was collected through the visits, the selection of sites to be visited was not systematic. The local research collaborators (HM*PAUD*I) identified – as per instructions from the CE/SMERU team – a list of centers representing various types (formal and non-formal) that could easily be visited within the timeline of the case studies. Without a more formal randomized selection process it is not possible to accept the 45 centers visited as representative of ECD centers in Indonesia or in the districts visited. What we can say about the centers is that the differences between them – formal versus non-formal, high fees versus low fees, large versus small, etc. does provide useful insights into constraints and challenges for providing equitable access to quality HI ECD.

Table 10. ECD Centers Observed (Center Observations)

ECD Center Fees and Finances								
	Number	Years in operation	Child-Caregiver ratio	Monthly fee	Other charges	Hours per	Ave. monthly fee	Ave. yearly charge
Non Formal	27	4.9	7.2	93%	81%	10	85,185	1,478,409
Formal	18	23.8	11.4	83%	89%	13.6	33,470	851,600
Total	45	12.5	8.8	89%	84%	11.4	65,204	1,224,297

Excluding Banda Aceh Centers		
	Ave. monthly fee	Ave. yearly charge
	10,227	220,000
	14,083	377,400
	11,588	278,296

The centers visited are classified as formal and non-formal. The formal category includes both *TK* (13) and *RA* (5) and the non-formal category includes a number of different types of programs (*KB*, *Taman Posyandu*, *Pos PAUD*, etc.). It is interesting to note that the formal centers have typically been operating for more than 20 years while the non-formal centers average less than 5 years in operation. Almost all centers charge monthly fees and more than 80 percent of all the centers also have other once-off or periodic charges. The average weekly hours for the non-formal centers is 10 while the average for the formal centers is nearly 14 and the child- caregiver ratios on the days observed was low for both formal and non-formal centers. About 37 percent of the non-formal centers reported that they received support of from public resources while 70 percent of the formal centers reported receiving public funds. About 80 percent of the centers occupy a site that is provided without charge, but less than 40 percent receive cash for operating expenses. More than 50 percent of the centers report that they receive some materials without charge.

Table 11. Caregiver Education and Training (Center Observations)

Caregiver Education and Training						
	Did not complete SD	Completed SD or SMP	Completed SMA/K	Diploma	S1 or S2	Have had training in last 2 years
Non formal	1%	9%	57%	12%	22%	56%
Formal	0%	1%	23%	37%	40%	31%
Total	1%	6%	45%	21%	28%	47%

Table 12. Caregiver Capacity Development Priorities (Center Observations)

	Caregiver Capacity Development Priorities	
Rank of Choices	**Non formal**	**Formal**
Continuing education to a higher level	**2**	**3**
Following the instructions of ECD managers	7	7
Continuing education majors/diploma ECD	5	6
Training on children with special needs	4	5
Training of health/nutrition	6	4
Improve teaching skills training	**1**	**2**
Training related to child development	**3**	**1**

When all the centers observed are included, the average monthly fees are unexpectedly higher for the non-formal than the formal *TK* programs. Examining the data in detail indicated that this result – as well as the rather large monthly fee averages – was due to the information gathered on centers in Banda Aceh. The centers observed in Banda Aceh (both formal and non-formal) were particularly well equipped and professional and served an urban wage-earning population. When the Aceh centers are removed from the analysis the pattern returns to the more expected pattern of non-formal programs having lower fees than formal programs and the overall average fees being much lower. While the small sample size and the lack of a random selection do not permit drawing inferences for the entire country, it is not unreasonable to believe that in communities where households with higher levels of earnings and education, fees are concentrated for ECD centers that could easily be comparable to those encountered in Banda Aceh.

In the 45 centers visited, the research team was able to interview 176 caregivers (112 non-formal, 64 formal). Very few of the caregivers found working on the day of the visit had less than an SMA/K education – just 10 percent of the caregivers working in the non-formal centers. About 77 percent of the caregivers in the formal ECD centers had reached a diploma level or higher, while the percentage of caregivers in non-formal centers with this level of education was 34 percent. With respect to training, a higher percentage of the non-formal caregivers reported that they had received specific ECD training within the last two years. Overall, in the centers visited, just under 50 percent of the caregivers reported that they had received ECD specific training within the last two years. These trainings have been provided by a wide variety of groups such as the district Education Office, *PUSKESMAS, HIMPAUDI, IGTK, LPPM*, NGOs and others.

Caregivers were asked to rank their personal priorities for training and development from a list provided by the researchers. Caregivers from both formal and non-formal centers identified the same three priorities in their top three choices: improving teaching skills (pedagogy and methods), improving knowledge of child development and reaching a higher educational qualification. Training from the ECD manager and training in health and nutrition were reported as the lowest priorities of the options presented.

Caregivers were also asked about financial support.[18] Nearly 60 percent of the caregivers working in the visited centers receive a salary (51 percent in the non-formal and 64 percent in the formal centers.). Overall, 95 percent of the formal ECD center caregivers received some type of financial support (either salary or incentive), while the figure for caregivers in the non-formal centers was 83 percent. About 17 percent of the caregivers in the non-formal centers were unpaid volunteers. The researchers also encountered a few centers that had participated in the MoEC/WB project but had recently reached the end of support for incentives from the project. At the time of the visit, the caregivers were continuing to work without support and caregivers were unsure of how that support would be provided in the future.

18 The number of caregivers here (260) is based on the number of staff the center reports as salaried, receiving incentives or working unpaid rather than the number of caregivers interviewed on the day of the visit (176).

Table 13. Caregiver Financial Support (Center Observations)

Caregiver Financial Support				
	Salaried caregivers	Caregivers supported with incentive	Unpaid caregivers	Total
Non formal	51%	32%	17%	152
Formal	64%	31%	5%	108
Total	57%	32%	12%	260

In order to assess child participation in ECD at the local level, caregivers were asked to identify the age group of the children present on the day of observation, the number of sub villages represented by the children and the caregivers' view regarding the number of children, of the appropriate age, residing in theth4 area near the center who did not participate in the center's activities. As expected, the non-formal centers provide services for younger children. It important to note, however, that a significant number of the non-formal centers visited serve the same age group (5 and 6 years) as the formal *TK* and *RA* centers. Since non-formal centers tend to serve younger children, it is not surprising to see that more of the centers draw participants from a smaller geographical area. More than 25 percent of the non-formal centers serve children from just one sub village, while nearly 80 percent of the formal centers visited report that participants come from more than 3 sub villages. Finally, caregivers at both formal and non-formal centers reported that the majority of children living in close proximity to the center do participate in the centers' program.

In each center visited, the researchers asked the caregivers to identify the accessibility of other HI ECD components for the children participating in the ECD center. Caregivers were asked about 14 types of HI ECD support and to identify whether the children attending the center received that support – "at the center", "in this village", "in another village" or "don't know". As noted previously, the formal ECD centers generally were initiated quite some time ago – prior to the emphasis on HI ECD. It is not surprising, then, that the more recently formed non-formal centers are more likely to provide more services on site.[19] The average number of services provided on site in the non-formal centers was nearly 7 of the 14 services assessed while for the formal centers the average was about 4.5 services provided on site. More than 50 percent of the centers reported that children received: religious guidance, school readiness (e.g. literacy and numeracy), character education, supplementary feeding, parent education and micronutrient supplementation through the ECD center. The services that were provided by less than 50 percent of the observed centers included: stimulation for growth and development, growth monitoring, immunization, maternal health and pregnancy counselling, integrated management of childhood illnesses, breastfeeding support and counselling, early detection and intervention for children with special needs and support to obtain birth certificate.

Table 14. Age, Access and Participation (Center Observations)

Age of the Majority of Children Present on the Day of Observation			
	Less than 3	Age 3 to 4	Age 5 and above
Non formal	15%	46%	38%
Formal	0%	0%	100%
Total	9%	27%	64%
Geographical Distribution of Participating Children			
	Only 1 sub village	Less than 3 sub villages	More than 3 sub villages
Non formal	27%	42%	58%
Formal	0%	22%	78%
Total	16%	43%	66%

19 As noted earlier some of the non-formal centers have been developed through adding child development and early education to an existing Posyandu resulting in a combination of those services with the Posyandu maternal health and child survival program.

Local Participation Rates Estimated by Caregivers			
	Most children participate	Some children do not participate	Many children do not participate
Non formal	76%	0%	24%
Formal	85%	0%	15%
Total	79%	0%	21%

The age of the children who attend the center is also linked to the kinds of services provided. However, even when only centers where the majority of the children were 5 and 6 years of age were analyzed, the non-formal centers averaged about 7 services provided on site while the formal centers averaged about 5 services provided on site.

In the observations of ECD centers, the research team also undertook formal observations, utilizing the Caregiver Interaction Scale (CIS). The CIS is a tool for comparing child – caregiver interactions in different settings. The scores provided by CIS are not referenced to norms indicating "good" or 'bad" child – caregiver interactions. CIS scores are only meaningful when they are used to measure how child-caregiver interactions change over time in a particular setting[20] or to compare child-caregiver interactions in different settings.[21] In the small sample from the case study sites, the total CIS score for non-formal centers was higher than that for the formal centers. Even with the small sample, the estimate of the differences in total scores between the formal and non-formal centers is statistically significant.[22]

This difference in mean total CIS scores between formal and non-formal centers indicates that the nature of child – caregiver interactions in the two types of centers is different. Using the CIS framework for measuring interactions, the higher scores for the non-formal centers indicates that caregivers in those centers as a group tended to demonstrate warmer, more developmentally appropriate and less punitive interactions with the children than the caregivers in the formal ECD centers observed. Understanding these differences clearly depends on whether the types of caregiver behaviours that receive higher scores in the CIS[23] are the types of caregiver practices that Indonesian ECD stakeholders see as relevant and appropriate. As indicated earlier, the CIS was chosen as a means to observe ECD center practices because the research team felt that the behaviours and practices that are considered higher value in the CIS are practices consistent with a consensus view on good caregiver practices and are also consistent with the type of ECD described in the National Strategy.

Table 15. Linkages between HI ECD Services (Center Observations)

	Linkages between HI ECD Services					
	At site			At site or in village		
	Non formal	Formal	Total	Non formal	Formal	Total
Religious guidance	96%	83%	91%	100%	100%	100%
School readiness (e.g. literacy and numerancy)	93%	89%	91%	100%	100%	100%
Character education	93%	72%	84%	96%	83%	91%
Supplementary feeding	78%	61%	71%	100%	89%	98%
Parent education	63%	44%	56%	96%	78%	89%
Provision of micronutrients	56%	44%	51%	100%	89%	96%

20 One example would be assessing how caregiver practices changed as the result of training.

21 For example comparing different kinds of centers or comparing caregivers who have received different types or levels of training.

22 A T test at the .05 level.

23 Those defined in the CIS observation form as being warmer, more appropriate, less punitive, etc.

	Linkages between HI ECD Services					
	At site			At site or in village		
	Non formal	Formal	Total	Non formal	Formal	Total
Stimulation for growth and development	59%	33%	49%	100%	72%	91%
Growth monitoring	56%	28%	44%	93%	50%	76%
Immunization	44%	17%	33%	100%	83%	96%
Maternal health and pregnancy counseling	33%	6%	22%	93%	78%	87%
Integrated management of childhood illnesses	30%	6%	20%	81%	56%	71%
Counseling for early initiation and exclusive breastfeeding	30%	0%	18%	89%	67%	80%
Early detection and intervention for children with special needs	15%	11%	13%	30%	22%	27%
Support to obtain birth certificate	7%	17%	11%	74%	67%	71%
Number of observations	27	18	45	27	18	45

In analyzing these differences between formal and non-formal centers, the research team has no basis for characterizing the caregiver-child interactions in the non-formal centers as being "superior" to those in the formal centers observed. What we can say is that when measured using this tool (CIS), there was a measureable difference in the nature of the interactions between the non-formal and formal centers. Rather than providing an evaluation of caregiver practices, this result should form the basis of a discussion about the type of child-caregiver interactions that are consistent with good ECD practice, as defined by Indonesian ECD stakeholders, and how best to promote them throughout the country.

Table 16. Child Interaction Scale Observations (Center observations)

Child Interaction Scale		
	CIS total score	N
Non formal	93.1	27
Formal	80.9	18
Total	88.4	45

One likely interpretation of the difference in CIS scores between the two types of centers is that the differences in child-caregiver interaction correspond to differences in the program being delivered in the observed centers rather than differences in caregiver background, education and training. Most of the formal centers (*TK*s and RAs) observed were founded nearly 20 years ago. At the time of their initiation, the prevailing vision of ECD in Indonesia was focused on practice and drill for academic readiness for schooling. So it is not surprising that the non-formal centers that are much more recently formed (generally the last 4-5 years) deliver programs and have practices more consistent with the more recent focus on child development rather than academic readiness.

Outcomes

The reorganization of MoEC to bring both formal and non-formal *PAUD* into the same structure has facilitated the consolidation of a unified holistic child development approach to *PAUD*. This approach (as described in Regulation 36, 2010) is consistent with the vision of the National Strategy on HI ECD. The national level *PAUD* budget clearly reflects this orientation as do the *PAUD* support materials developed by the ministry.

Field observations – admittedly from a small non-random sample of ECD centers – suggest that there are two *PAUD* approaches being implemented. More recently established center-based *PAUD* programs

tend to place greater emphasis on a child development approach while some older institutions tend to more exclusively emphasize school readiness. These newer institutions (generally non formal *PAUD*) tend to have caregivers with lower levels of academic qualification than their formal sector counterparts but also to have received *PAUD* training more recently. The fact that more recently trained caregivers tend to exhibit a holistic child development approach described in regulation 58 is consistent with the growing emphasis of this approach in training provided by government and non-government training providers. Our field study also suggested that more recently established centers exhibited more linkages to other HI ECD components.

The *PAUD HI* ECD component is clearly focused on an integrated holistic child development approach consistent with the National Strategy. This is reflected in standards, training and materials developed by the national ministry. However, approximately 40 percent of children do not participate in any *PAUD* before entering primary school and most of those that do participate receive just one year of support. There is tremendous need for the expansion of opportunities for this good quality and valuable support for children 2 to 6 years of age.

Even with a strong consensus on the holistic child development approach, excellent knowledge and capacity embodied both in government and non-government stakeholders, the expansion of opportunities to meet the needs of all children will be a significant challenge. Much of the new provision of child development focused *PAUD* has come about through once – off initiatives by government or NGOs, and there is concern in some cases about sustainability. Central government support for direct implementation is not sustainable as *PAUD* is not a mandated service, and the role of the central ministry is not implementation.

According to Regulation 36, operational resources are to come from local sources. There is some scope for fee based cost recovery, but overreliance on fees can create a barrier for the children who can benefit the most from good quality *PAUD*. Even when households have the means to contribute to *PAUD*, it can be difficult to convince households to invest when the benefits – although large – are only perceptible after a long period of time. Strategies that encourage and incentivize local governments to make sufficient and strategic investments are required.

2.4 Summary of Constraints and Opportunities of HI ECD Components

Support	0 years to birth Antenatal care and safe delivery	Birth to 2 years Immunization, growth monitoring, nutrition, management of childhood illnesses	2 - 6 years Child growth and development
Services	**Community health center** **Community health post** **Village health post** **Village birth cottage** ***Posyandu***	***Posyandu***	***PAUD*** **(non-formal and formal)**
Opportunities	Well established institutional infrastructure	Present in 95 percent of villages	National regulation consistent with holistic integrated approach for education sector established
	Standards, competencies, licensing for institutions, professionals and paraprofessionals	Located in the community and managed by the community	Training and support materials available consistent with holistic child development approach
	Resource base in government budget	Multisectoral *Posyandu* working groups established by home affairs regulation at all levels of government (2007)	Model programs established
	Accompanied by social insurance to subsidize costs for the poor		Operational support grants from national government
Constraints	Reaching remaining underserved areas with accessible services	Variable quality resulting from variations in support in terms of operational resources and capacity development (including variation in the type and amount of support for *kaders*)	As a service that is not mandated *PAUD* does not have regular guaranteed public financial support
	Lack of utilization of a skilled provider especially for poor rural women (especially if midwife not available in *Posyandu*)	Difficulty in coordinating inputs across all the sectors - few *Posyandu*s have complete program including parent education	Current model is dependent on once – off investment projects and/or on fees from participants. Once-off approach is not sustainable and fee based model will tend to exclude the children who can benefit most from participation.
			Much of recent growth in provision is nationally funded despite regulation specification that support is district responsibility

Support	0 years to birth Antenatal care and safe delivery	Birth to 2 years Immunization, growth monitoring, nutrition, management of childhood illnesses	2 - 6 years Child growth and development
Constraints	Capacity of midwives to assess and refer high risk pregnancies	Approximately 70 percent of children participate but the length of time of participation is typically less than one year (insufficient time for full immunization, adequate growth monitoring, etc.)	Lack of incentives and support for promoting public investment on the part of local governments
			Difference in approach between formal and non-formal *PAUD*
Improving outcomes for children	Reduction in maternal, perinatal and neonatal mortality	Healthy physical growth and development Improved social skills, instilling values	Better prepared for school and higher achievement: physical, social, moral and cognitive
Priorities for HI ECD	Improve competency of midwives and referral system for high risk pregnancies	Revitalize program so that participation is higher over a longer period of time to ensure better child outcomes	Ensure that all *PAUD* programs can apply the holistic child development approach described in Ministerial Regulation 58
	Outreach to women about value of skilled antenatal supervision	Develop skills of caregivers to meet HI ECD demands	Develop a strategy to shift operational support from national to local resources in a manner that ensures that poor children have equal access to quality *PAUD* support
		Expand the number of "full service" programs (all *Posyandu* services including parenting education)	Encourage and facilitate child participation in *PAUD* starting at earlier age (not just the one year prior to primary school)

Chapter 3

Planning, Management and Current Implementation of ECD in Indonesia

An analysis of planning and management is provided in three distinct parts. Firstly, we outline national strategy for HI ECD, and the regulatory framework in which ECD is currently implemented. Key findings from fieldwork undertaken in six districts are also presented.

Secondly, we provide financial analysis of national level expenditure on aspects of Early Childhood Development. We also provide analysis of the normative costs of some services.

Thirdly, we include for discussion key findings of the research undertaken to understand the implications of an institutionally-driven or community-driven development model for HI ECD.

3.1 The Regulatory Framework for HI ECD

The individual services that comprise a system of HI ECD are subject to sector specific quality norms. These quality norms take a number of forms: legislation/laws, ministerial regulations, standards, technical guidelines and training modules/curriculum. Currently most of the norms for specific HI ECD components are national. Generally these component-specific quality norms define "quality" by applying one of more of the following strategies:

- Defining an organizational structure for planning and management of a service,
- Specifying a body or knowledge or defining competencies that providers of HI ECD support must possess,
- Describing a package of services that each beneficiary should/must receive, or
- Identifying of a set of tasks, roles and responsibilities that different actors must execute.

In addition to component-specific quality norms, there is increasing activity to address quality in support for children 0 to 6 years of age across sectors.

As in many countries, the programs in Indonesia for supporting children under 6 have traditionally been planned and managed by the individual sectors (health, education, population and family planning, etc.). In 2006 the National Development Planning Agency (BAPPENAS) elaborated a policy study drawing highlighting the challenges in providing quality early childhood development in Indonesia and drawing attention to the growing national and global consensus on improving outcomes for young children through linking services into a single comprehensive integrated system. The term used to describe this concept in Indonesia was Holistic – Integrated Early Childhood Development (HI ECD).

Building upon this BAPPENAS study, a vision linking global knowledge and best practice with Indonesian culture and values was elaborated as a **National Strategy for Holistic Integrated Early Childhood Development.** The National Strategy describes this vision for early childhood development where support is available to ensure the physical, social, spiritual and cognitive development needs of each child at the appropriate stage of life.

An "ecology of child development"[24] framework was applied in developing the strategy. The framework explicitly recognizes the necessary and complementary roles of households, the immediate community and the larger community/nation in supporting the quality early childhood development required for Indonesia. From this ecological perspective planning and organization of support begins with the developmental needs of the child rather than the isolated planning of activities sector by sector. This approach represents a new way of thinking about support for early childhood development for Indonesia and is consistent with international and regional understandings of best practice for ECD.

Figure 6. National Strategy Goals and Strategies

Goal	To provide holistic-integrated early childhood development services that enable young Indonesian children to be healthy, intelligent, cheerful and to have good character
Specific Objectives	To meet the essential needs of early childhood in a holistic way including health and nutrition, education and care in accordance with age group
	To protect children from mistreatment at both family and community level
	To conduct early childhood services in an integrated and harmonized way between the implementing agencies, pursuant to the local conditions
	To mobilize the commitment of all stakeholders in the implementation of early childhood development

Three other documents provide the framework within which ECD is managed nationally.

PAUD as a component of HI ECD is governed by **Ministry of Education Regulation 58 of 2009.** This regulation describes standards for both non-formal and formal *PAUD*. Regulation 58 describes the standards for:

- Types of programs and expected outcomes,
- Standards for teachers/caregivers and managers,
- Program content,
- Teaching/learning approach and assessment criteria, and
- Standard of facilities and infrastructure, management, and financing.

The regulation outlines separate standards for formal and non-formal *PAUD*. The regulations describe age ranges and frequency/duration for the various types of programs as well as desired outcomes expressed as developmental milestones for children by age category.

Separate standards are described for teachers in the formal and non-formal sectors as well as for caregivers in *TPA* (day care). Teachers in the formal *PAUD* sector are expected to meet the requirements set out in the teacher's law (university graduates), while those working with children in the non-formal sector are expected to have at least a Diploma and to have completed training in *PAUD*.

The regulation also describes a standard teaching process that integrates health, education, nutrition, child protection and parenting education. The regulation also describes the teaching-learning process as active, creative, interactive, effective, and child centered and that learning should occur through play.

24 See for example: Bronfenbrenner, U. (1979). The ecology of human development. Cambridge, MA: Harvard University Press.

Facility standards for formal *PAUD* are similar to standards for schools, while standards for non-formal *PAUD* are basic and include stipulations pertaining to the minimum space per child and basic water and sanitation requirements. Administrative guidelines are focused on principles of transparency and finance guidelines merely describe the types of possible funding (government and private from various sources).

Ministry Regulation 58 for the most part complements the vision described in the National Strategy for HI ECD. The strategy incorporates an integrated child development perspective and sets standards for service delivery that promote HI ECD rather than a more narrow Early Childhood Education perspective.

MoEC is supporting the strategic direction outlined in regulation 58 with investments from the *PAUD* budget. Using central funds and deconcentration funds, per capita operational grants for nearly 1.9 million children were budgeted for 2011 and 2012. In addition, investments were made in supporting the establishment of model programs, the development and dissemination of materials and training for managers and practitioners as well as funding national level workshops and meetings.

Ministry of Home Affairs regulation 54 of 2007 establishes formal working groups on *Posyandu* at the national, provincial, district and village level. This same regulation describes a menu of activities for *Posyandu* and establishes the responsibility of districts (through district budgets) for financing operational costs of *Posyandu* and for training of volunteers (*kaders*). Each working group – national, provincial and district/village is assigned the responsibility of capacity development and advocacy.

The **Draft Minimum Service Standards** (MSS/SPM) for *PAUD* are an extension of the requirement to establish, plan for, and meet a minimum service level across to all public sectors. They establish benchmarks for assessing district, province and national progress against a set of basic indicators regarding access to *PAUD* and quality. The proposed strategies also specify the roles of the various ministry and other government stakeholders in managing the collection and reporting of data on the indicators as well as providing descriptions and examples of calculating the standards. All of the proposed standards have a target date of 2019.

The draft document describes minimum standards for coverage of *PAUD* based on the percentage of villages that have at least one *PAUD* of any of the generally recognized types (*TK*, *KB*, *TPA* and SPS). By 2019, 90 percent of the villages in a district are expected to have met the 'one *PAUD*' criteria. The basic coverage indicator is refined in two additional indicators reporting the percentage of *PAUD* centers that have at least 20 participants (90%) and the percentage of *PAUD* centers that have both indoor and outdoor activity areas (95%).

An additional set of standards focus on *PAUD* teachers. One standard is that 50 percent of the *PAUD* teachers in district must have obtained an officially recognized certificate for training in *PAUD*. A second indicator sets a minimum of 25 percent of all *PAUD* teachers having an academic qualification of D4 or S1. The final indicator establishes a standard of 100 percent of all *PAUD* centers providing the official character education curriculum.

Implementation arrangements for Early Childhood Development

Most of the key components of a system of HI ECD have a long history of delivering services in Indonesia and were initiated in an environment of strong central planning, financing and implementation. This legacy of central planning has left behind structures and institutions that are very similar from district to district and village to village. However, evolving decentralization of decision making based on local priority setting may result in dfferences in the level of support to HI ECD. In addition, support by non-government actors (national and international NGOs) and special government programs have played an important role in the historical development of the sector and have resulted in a number of innovations in diverse parts of the country.[25]

25 Increasingly subnational governments are taking the initiative in HI ECD. These would include the cases of Surakarta

The *PAUD* component of HI ECD differs from the other components in the nature of its governance and management. Health sector support for antenatal care and safe delivery relies for the most part on programs and institutions (Puseksmas, Pustu, *Polindes*, etc.) developed during an era of more centralized planning and implementation. These programs are now implemented in a decentralized system where central government assumes the role of policy leadership and quality assurance and implementation decision making is increasingly undertaken at the provincial/district and even village levels.

The context for *PAUD* is very different. The role of the central government in implementing early education has historically been quite small with respect to the number of institutions considered state run or state supported. The challenge of the central level education authorities is that their mandate for developing policy and setting quality standards may not have an immediate impact on the amount of service delivery that local authorities prioritise. In the case of basic education it is possible for the central level MoEC to channel resources to implementation because provision of basic education for all children is mandated by law. As briefly described earlier, central level resources for non-formal and formal *PAUD* are channeled to districts for implementation but the level of support is not linked to the mandate of providing universal access as is the case for basic education resources.

The central level Ministry of Education reorganized the *PAUD* structure in 2010. Both formal (*TK*) and non-formal *PAUD* (*KB*, *Pos PAUD*, *TPA*, etc.) were combined into one directorate. This effort was intended to consolidate the approach to *PAUD* within the education sector. With this new structure, policy, guidelines, and support/training can reflect a consolidated child development approach to education sector support to HI ECD.

The support services for children under 6 are managed primarily through:

Stakeholder	Roles
Ministry of Home Affairs	Formulation, adoption and implementation of policies in the field of domestic governance. Technical oversight on national implementation of governance program in the regions.
Ministry of Health	Maternal and child health (antenatal care, safe delivery, immunization, nutrition). Community health promotion (health volunteer outreach including volunteers).
Ministry of Education	PAUD formal and non-formal. Program development, model programs, curriculum, guidelines, teacher training, quality assurance, monitoring and evaluation.
Ministry of Religious Affairs	Manages directly more than 25,000 *RA* (Islamic preschools). Program and curriculum development, teacher training, quality assurance and reporting.
Coordinating Ministry for People's Welfare	Facilitates coordination of national government action on government priorities in social welfare.
Ministry of Women's Empowerment and Child Protection	Develops policy and synchronizes government efforts in the area of women's empowerment and child protection.
Ministry of Social Affairs	Policy formulation, program development and capacity development in the areas of social assistance and protection for special populations like orphans and disabled.

municipality with its innovative use of private sector resources through a system of discount cards provided by businesses to support elements of HI ECD and East Java province where a provincial level multi sectoral plan has been elaborated to expand the types of services available in Posyandu.

Stakeholder	Roles
PNPM Mandiri (National Poverty Reduction Program)	National poverty reduction program with community development focus. Several programs could provide potential support to HI ECD.
Multilateral and bilateral development partners, national and international NGOs, foundations, and religious organizations	Technical assistance, resource mobilization, and capacity development in HI ECD.
Private sector Corporate and small business collaboration, community volunteers, private households	Resource mobilization, volunteering.

3.1.1. The Presidential Regulation on HI ECD

A Presidential Regulation governing HI ECD is currently being finalised and signed off by the Ministry of Education and Culture (Kemdikbud), the Ministry of Health (Kemenkes), the National Board for Population and Family Planning (*BKKBN*), the Ministry of Home Affairs (Kemendagri), the National Development Planning Board (Bappenas), and the Coordinating Ministry of People Welfare (Kemenkokesra).

It is worth noting that the regulation has incorrectly been referred to as a 'decree', which it is not. As a 'regulation', it provides a broad framework for continued action, for example through a *national task force* which it establishes.

Kemenkokesra will play the lead role in the HI ECD national task force, with Bappenas and the Ministry of Home Affairs as vice leads. The following ministries and institution will be represented:

- Ministry of Education and Culture
- Ministry of Health
- Ministry of Social Welfare
- Ministry of Religious Affairs
- National Board for Population and Family Planning
- Ministry of Woman Empowerment and Child Protection
- National Statistics Center
- Presidential Secretariat

The National Task Force will report to the President, the Provincial Task Force will report to the governor, and the District Task Force will report to Bupati (regent).

The role of the task force at each level of government will be to provide norms, standards, procedures, and criterion for HI ECD implementation. Each task force will have a coordination meeting once every three months. It is important to note that financing of HI ECD implementation will still be through each sector. Following the presidential signature of the HI ECD regulation, the next step will be to update the HI ECD general guidelines to harmonize them with the current context of HI ECD implementation and the MDG targets, as well as longer term development goals and focus. A task force secretariat will also be established by ministerial decree.

3.2 Implementation of Early Childhood Development: Results from Fieldwork

The fieldwork undertaken by the research team focused on understanding issues in implementing the regulatory framework described above. Using the Appreciative Inquiry framework, the research team gathered data to

- **discover** the HI ECD successes (assets) already in place in these communities,
- describe a **dream** about how these successes could lead to quality HI ECD for all children in their communities,
- elaborate a **design** that can make that dream a reality and
- describe the necessary preconditions to enable that dream to become a sustainable **destiny**.

The full data sets can be found in Appendix G. In the following text, key themes emerging from a cross-district comparison of data are presented.

Theme 1: Models of Integrated Holistic Services (HI ECD) are Being Implemented but These Models Generally are Isolated, Do Not Reach the Majority of Children in a District and Often Have a History Linked to a Time Bound NGO or Government Project.

In all six of the case study sites the research team found existing models of one roof/one stop or formally integrated HI ECD services. While these examples of integrated services did deliver a mixture of (primarily) health and education services they usually did not offer all inclusive services as described in the National Strategy. These examples were also generally isolated models implemented in particular communities rather than district-wide or village-wide models of service for all children.

In one village in Probolinggo a mixture of HI ECD services were delivered at a single site. In this community a building located within the village government complex was provided for *KB* for children aged 2 to 4 and a *TK* was located just outside the village office. Once a month a building in the same village office complex is used for *Posyandu* with children from the *KB* participating in the *Posyandu* program located in the compound. Growth monitoring, health and child development assessment (*DIDTK*), immunization follow up, micronutrients and other services are provided at both the *KB* and the *Posyandu*.

In another village visited in Probolinggo a number of additional services have been incorporated into an existing *Posyandu* site. The *Posyandu* had already achieved *Mandiri* status, meaning that it realizes activities at least once a month, has at least 5 *kaders* and offers all five maternal and child survival services in the *Posyandu* program (maternal and child health, family planning, immunization, nutrition, treatment and prevention of diarrhoea). With support from UNICEF for basic inputs and training, child development and early education activities were added to the program. The expanded service (combining *Posyandu* with regular ongoing center based child development and early education) goes by the name of "*Taman Posyandu*" in this village and in many other locations in Indonesia where this strategy has been implemented. Since 2008 operational support for this *Taman Posyandu* site has been provided through village level resources. With the national program to revitalize parenting education a parenting program was added to the existing services in 2011.

Another example of one stop/one roof services was identified in Bone district, where 4 villages implement the *Taman Paditungka* (nurturing together) program. *Taman Paditungka* provides maternal health, education, health, nutrition, and parenting education (with collaboration of personal from *Puskesmas*) at one site. *Posyandu* is provided on-site once a month in the *Taman Paditungka* and a child development and early education program serves children 3 to 6 years of age. *Taman Paditungka* is managed by a local management team of 8 to 10 persons. Infrastructure and inputs are financed through a system of household contributions combined with contributions from local businesses where possible. UNICEF played an important role in initiating the development of *Taman Paditungka* through socialization, advocacy and capacity development for communities and local governments.

In Garut district there were also examples of one roof/one stop services delivered at or near the village government office. In this example *Posyandu* was integrated into the existing community health post (*Poskesdes*). The management of both services is provided by the same midwife and *kaders*. A play group (*KB*) is operated in the next building for children age 3 to 6 years. The addition of the play group in close proximity has expanded the reach of the *Posyandu* and children who come to the play group also

receive *Posyandu* services on those days of the month when the *Posyandu* is active. As was the case in the other examples where *Posyandu* and *KB* are jointly managed, participating children receive a range of supporting services including immunization, growth monitoring, micronutrients, *DIDTK* and early education. Capturing children from 0 to 6 in one place also facilitates access to mothers on the part of the midwife and the integration of PHBS (health promotion) into the available services. The development of this one stop service linked to the village government offices was an initiative of the community and financial support was provided in the village budget. Subsequently the *KB* was strengthened through financial and technical support provided by the MoEC/World Bank ECD development project.

In two of the villages visited in Sambas district *Posyandu* and *KB* were combined at the same site, with some *kaders* participating in both programs. This continuity of service provides an integration of maternal health and child survival support with activities for child development and early education. In both villages the addition of *KB* to the *Posyandu* provides opportunities to more easily reach children for immunization and other public health campaigns. In one of the villages the initiative to add *KB* to the existing *Posyandu* was developed through mobilization and socialization activities supported by Wahana Visi (NGO).

Examples of providing services in a one stop/one roof manner in two villages were also identified by stakeholders in Kupang. As was the case in several other case study sites child development and early education activities through *KB* were added to an existing *Posyandu* program. Stakeholders informed the research team that the initiative to provide child development and early education activities in the village came from visits made by a religious leader who advocated for the importance or providing early childhood development. The program is managed by PKBM (Center for Community Learning) and was originally financed by village resources. Subsequently funding was also provided through public funds (deconcentration funds).

Stakeholders in case study sites also identified examples of services that were not delivered in a one stop/one roof setting but were formally integrated through close formal cooperation. In two villages in Probolinggo district *TK* and *KB* are provided in a single location. While *Posyandu* is provided in a separate nearby location the *TK* and *KB*, teachers and caregivers meet with the *KB* and *TK* children at the *Posyandu* site when *Posyandu* activities are being held to ensure that there is continuity for all mothers and children for growth monitoring, health checks, *DIDTK* and other *Posyandu* programs. The integration also facilitates the provision of parenting education sessions. Support from UNICEF played a role in the design of this integrated approach and in mobilizing the communities for implementation.

Discussion and Findings

In each case, study stakeholders identified examples of HI ECD services that were integrated – either as one stop/one roof service or through formal integration of services across various sites. In a number of cases, the integration of services was the result of physical proximity and sharing buildings belonging to the local government office. Clearly, all village level governments should be encouraged and provided support and appropriate financial incentives to use their facilities for HI ECD in an integrated fashion. This would require continuous on-going advocacy, capacity development and financial incentives/ support[26] for local governments. Given the number of villages, this represents a significant financial investment – even if all operational expenses were met by communities. The size of many villages means that providing HI ECD for all children cannot be accomplished exclusively through sites located at the village government offices.[27]

26 In this case, financial support does not necessarily equate with large scale national transfers for infrastructure, training and materials, as villages should be encouraged to develop locally supported HI ECD. However, well-structured financial support that serves as an incentive to villages to undertake such actions should accompany the advocacy with local governments. Many potential models and mechanism for villages to access additional financial resources exist in Indonesia and the focus of a strategy to promote HI ECD should focus on encouraging and facilitating village governments and communities to access these existing sources rather than creating entirely new systems of financing.

27 As indicated previously less than 50 percent of the villages reported that they currently had any PAUD -*KB*, *TPA*, *Pos PAUD*

Another critical aspect that emerges from analyzing the case studies is the importance of community mobilization. A number of examples where HI ECD services have been integrated either in a one roof/ one stop manner or through formal integration across separate sites have resulted from NGO activity working directly with communities. Regardless of the capacity and commitment of local officials (district and village), there are significant administrative and institutional challenges to working across sectors and especially across sectors directly with communities. These challenges include each official only having a partial mandate linked to a line ministry (parenting education, or *PAUD*, or maternal health, etc.) and budgetary resources that are allocated to delivering a set of sectoral outputs. "*Koordinasi*" was often mentioned in the focus groups and interviews. While various forums, committees, appointment letters and other mechanisms for coordination exist, the case studies suggest that community driven HI ECD does not develop without investments in mobilizing communities.

NGOs have frequently played the community mobilizing role in the case study sites (and also in many of the instances of HI ECD across Indonesia identified through interviews with stakeholders). This sustainability is quite likely the result of the initial investment of socializing communities to the importance of HI ECD and, perhaps, more importantly, the development of community leadership that can sustain and expand the processes.[28]

Community mobilization is indispensable in realizing effective and sustainable HI ECD. Communities know best their unique challenges (geography, economic conditions, available technical capacity, community attitudes about the value of ECD, etc.). In a decentralized environment communities will also be asked to bear a substantial share of the costs of HI ECD. Purely private provision of HI ECD will exclude the neediest children who can most benefit from HI ECD, while community provision that is uncoordinated, poorly planned and depends on NGO investments for community mobilization will result in an uneven ad hoc provision of services for children. How to best develop and support sustainable community level leadership in HI ECD to play this mobilization role is an essential element in the design of a strategy to expand equitable access to HI ECD.

In the communities visited, the examples of integrated services were frequently developed by adding services to an existing *Posyandu* site. This has been a frequent strategy employed in other areas outside the community case study sites and has featured in government and NGO projects over the last decade. As discussed in Chapter II, *Posyandu* is widely available and provides a logical point of entry for developing a community driven system for HI ECD.

Theme 2: A Local Regulatory Framework or Legal Basis for HI ECD

Administrative decentralization allows greater flexibility for local governments in determining the best strategies for meeting local and national development objectives. Developing appropriate local regulation is one aspect of local decision making. In the Discovery phase of the Appreciative Inquiry process stakeholders identified existing (mostly recent) local regulations that support aspects of HI ECD. Often the regulations mentioned by the stakeholders were linked to sector-specific elements of HI ECD.

In the discovery process in Garut district stakeholders identified the *Program Keluarga Harapan*[29] (*PKH*) as a regulation that supported HI ECD. The *PKH* provides a cash grant to households below the poverty line to improve health status and participation in education. The program targets the improvement of

- provision (PODES 2011). In the 45 centers observed, the nearly two – thirds of the centers had participating children that came from 3 or more sub villages, suggesting problems with the distribution of HI ECD opportunities.

28 Frontiers for Health (F2H) reports that in one district where they had worked mobilizing communities to deliver the combined Posyandu and child development/early learning program (taman Posyandu) a number of taman Posyandu centers ceased to operate upon the termination of the external assistance provided. Recently F2H were informed that a number of those same communities had reinitiated the taman Posyandu service with their own resources and were interested in reestablishing their affiliation with F2H without the provision of external resources.

29 Family Hope Program

health status for pregnant woman, infants and children under 6 years of age. Among the conditionality for receiving the grant is compliance of children under 6 with MOH protocols for the frequency health checks for children as well as participation of pregnant women in programs for maternal health and safe delivery. This program requires collaboration at the district level among *Bappeda, Dinas Sosial, Dinas Kesehatan, Dinas Pendidikan, Departemen Agama, Dinas Komunikasi, Informatika* and the statistics office. The coordination mechanism is an appointment letter for a task force involving representation from each of these government entities. Stakeholders reported during the field visit that the program had yet to be expanded to all of the sub districts.

Bone, like many other districts in Indonesia, has regulations promoting exclusive breast feeding. Bone also has a regulation regarding iodized salt. Banda Aceh has municipal level regulations specifying support and committing health sector public resources for services to pregnant women and newborns. Banda Aceh also has a child protection regulation that describes the duties of the community in protecting children. The provisions of the child protection regulation incorporate many elements from the UN Convention on the Rights of the Child.

Sambas district has a local regulation that formalizes financial support (incentives) for some ECD *kaders* and managers as the district begins to assume the operational costs of the ECD centers developed and supported through the MoEC/WB project. This regulation is accompanied by an appointment letter that creates an ECD activity team (reported to be 132 persons) in the district.

In Kupang district one important element of the legal and regulatory environment is the provincial level Gerakan Revolusi KIA (Revolutionary movement for mother and child health). This provincial wide regulation developed in response to poor provincial-wide indicators for maternal health/mortality and neonatal mortality. The regulation describes a number of actions and responsibilities for accompanying pregnancies, promoting safe births and monitoring newborn health status.

Probolinggo is affected by a provincial level (governor's) regulation explicitly focused on improving equitable access to HI ECD. The regulation describes a process for establishing 10 thousand *Taman Posyandu* (combination of *Posyandu* and *KB* program for child development and early education) in East Java province. The regulation specifies the objectives of HI ECD and formalizes systems for management, supervision and capacity development.

Discussion and Findings

The emphasis of the Appreciative Inquiry 4D process in the case studies was to elicit and explore those things viewed by stakeholders as their current successes in HI ECD. The research team did not undertake a systematic census of existing regulation since our objective was to understand what stakeholders saw as 'success" in HI ECD.

While we did not gather an exhaustive description of all relevant local regulation, it is important to note that stakeholders at all case study sites identified local regulations as successes in delivering HI ECD. Much of the regulation identified is linked to a single sector. In some of those cases the regulation also describes formal mechanisms for coordination with other government sectors. The East Java regulation is one example of a recent local regulation that is explicitly focused on supporting HI ECD in a holistic cross-sectoral manner consistent with the vision of the National Strategy.

ECD advocates have had increasing success in promoting regulation for supporting HI ECD at the district and provincial level and establishing local regulations was identified as a success by stakeholders in all of the case study sites. Much of the time the regulations identified by stakeholders are focused on issues traditionally seen as priorities of particular sectors and often was elaborated so that a formal budgetary commitment from either provincial or district budgets could be provided (for example, safe births, pregnancy counseling, neonatal survival, etc.). The regulations typically recognize that effective implementation requires actions across sectors and frequently incorporate mechanisms for

formal coordination across government sectors. The question that remains difficult to assess relates to the impact of regulation on outcomes for young children. For the most part the coordinating mechanisms described in existing regulations are for the coordination among government entities. Fewer mechanisms exists that relate to coordination with households and communities. If local regulation is to have an impact on services that are community driven, more consideration must be given to understanding how regulation can be structured to promote government collaboration with community ECD leadership.

Theme 3: Public Financial Support

As was the case with local regulation, the focus of the Appreciative Inquiry Discovery phase was to identify what stakeholders viewed as successes in HI ECD, rather than undertake the task of identifying all the types and quantifying the amounts of financial resources for HI ECD in a district or village. There are a number of existing mechanisms and sources for supporting the costs of delivering HI ECD. There are budgetary resources from the national level,some of which are channelled through the province and some that are transferred to districts and villages. There are also provincial and district budgets elaborated by provincial and district representative assemblies. In addition, there are special project funds for poverty alleviation for districts formally designated as poor districts.

Both the MOH and MoEC provide operational funds to services for children under 6 years of age. The funds, *BOP* (Early Childhood Development Operational Funds) and *BOK* (Health Sector Operational Funds) are mechanisms to transfer funds from the national budget to the point of delivery of health and ECD services. These two mechanisms are components of national to local transfers that are referred to as deconcentration funds. In stakeholder interviews and focus groups the *BOP* was frequently mentioned as a key local asset. According to stakeholders, the *BOP* was used for both operational support to ECD centers and for incentives for caregivers. While *BOK* was mentioned less frequently, it plays a critical role in financing delivery of health services (*Puskesmas*, *Poskesdes*) at the local level but perhaps is less visibly associated with HI ECD since it serves the entire population.

The allocation of village level funds (village budget – ADD) was reported in some, but not all of the case study sites. The village level resources were utilized mostly for ECD operational costs for center based programs and for providing financial incentives to *kaders* working in some aspect of HI ECD. Some of these allocations of ADD are responses of village governments now trying to absorb the operational costs of ECD centers developed through the MoEC/WB project.

Discussion and Findings

Public investment in HI ECD is critical. Over-reliance on private investment in the form of fees results in inefficient outcomes. Poor children – the ones who can most benefit from HI ECD – are less likely to participate when financial support is primarily private. Public financial resources for HI ECD come from national, provincial, district and village sources and all of these sources were mentioned in interviews and focus group discussions. The public resources mentioned by stakeholders tended to be associated with support for ECD centers as public financial support to other HI ECD components is less visible - but not less important. (For example the sectoral support for the administrative systems of health, education and community development as well as operational support for service delivery in the health sector). Most of the public financial support identified by case study stakeholders was focused on support of existing entities rather than developing additional access points for service delivery (with the exception of the ECD pilot grant mentioned in the Kupang case study).

There was a good deal of diversity in the stakeholder's descriptions of how public financial resources are utilized for HI ECD. This diversity in stakeholder descriptions may reflect actual differences in how public resources are utilized for HI ECD in districts and villages or differences in the knowledge different stakeholder groups possess about how public resources for HI ECD are utilized. These differences in knowledge about the potential sources for public investment in HI ECD – or perhaps the lack of general

public awareness of the potential sources of public support for HI ECD – is quite likely a constraint to efficient investment in HI ECD. It seems reasonable to assume that government officials would have better knowledge about the potential resources in the sector in which they work than in other sectors. Community members who are interested in improving opportunities for children to grow and develop may know very little about potential sources of public support. A fundamental challenge for maximizing efficient investment in HI ECD is linking knowledge about potential sources of funding to community level mobilization and planning for HI ECD so that investment is maximized and it is allocated efficiently to improve access, equity and quality in holistic integrated support for young children.

Theme 4: Capacity and Knowledge Available at the Local Level

93 percent of all caregivers[30] in the centers visited (90 percent of caregivers in non-formal centers) had a complete secondary education or possessed a higher education qualification (see Table 11). Of the caregivers interviewed, 77 percent of the caregivers in the formal centers had an education level of D1 or higher, while 34 percent of the caregivers in the non-formal centers had completed at least the D1 level of education. Nearly 50 percent of the caregivers reported that they had received ECD specific training within the last two years. The study team noted that good practices were being applied by caregivers in many centers visited. Most of the training has been provided by local entities (government and NGOs) – frequently training in the methodology BCCT.[31] In addition to resources for providing capacity development in ECD, stakeholders mentioned that Indonesia has a number of systems in place that provide non-formal opportunities for caregivers to improve their educational qualifications up to a complete secondary qualification (packet A, B, C).

Garut stakeholders identified a West Java provincial initiative that provided *kaders* training through one of the local universities – UNINUS. The university not only provided an initial 5 day ECD training but also subsequently adapted the original training course to better align it with the concepts of HI ECD and the educational backgrounds of the caregivers. The result was a 5 month course provided on weekends. Participants in this program were also awarded secondary level credit hours toward completion of formal secondary education. Some scholarships were provided using Ministry of Education funding to subsidize caregivers who wanted to continue on from this program to secondary level completion.

Discussion and Findings

Accessibility to quality HI ECD is dependent on the availability of adequate numbers of skilled caregivers to support all of the elements of HI ECD. These caregivers include: midwives, *Posyandu* caregivers (*kaders*), and caregivers and teachers in center-based programs like *KB*, *TPA*, *Pos PAUD*, *Taman Posyandu*, *TK* and *RA*. Current caregivers require ongoing capacity development to maintain and improve skills and opportunities for new caregivers must also be available so access can be expanded and quality maintained.

Training is a significant component in various health sector programs. Whether the budgetary allocation is adequate for the capacity development needs was not something that could be assessed in the case studies.[32] The Education sector also provides some training for caregivers in center based programs – either with district level resources or with national resources transferred to ECD development in the districts. The national level training resources included until recently[33] an ECD development initiative

30 The total number of caregivers in the 45 centers was 260. ECD centers did provide information concerning the educational level of all of the caregivers (present and not present on the day of the visit). Other information was gathered through group interviews with caregivers present on the day of the site visit. The number of caregivers interviews was 176.

31 Beyond Centers and Circle Time© Preschool curriculum

32 Subsequent comments by national level Ministry of Health officials indicated that meeting minimum training needs with current allocations is a significant challenge.

33 The MoEC World Bank ECD development project (5 years) ended in 2011.

(project) managed with the World Bank. As provision of education for children prior to primary school is not a mandated government service, education sector financial resources for training of caregivers in ECD can vary from district to district. About half of the caregivers in the ECD center based programs visited had received ECD specific training within the last two years. The trend of increasing educational attainment in Indonesia also provides an opportunity for improving access and quality of HI ECD. The number of caregivers (*kaders*) with less than a complete secondary education will decline and the increasingly well-educated caregivers will have more capacity to absorb more complex and comprehensive training.

In addition to the government-led training initiatives, in nearly all of the case study sites the research team encountered individuals and institutions with experience and expertise in HI ECD – including in the challenges of linking services for children together in a systematic holistic manner. There is also evidence – at least from interviews- that capacity development initiatives within the sectors are trying to incorporate a more holistic perspective consistent with the vision of the National Strategy. In the case of the East Java initiative of creating 10 thousand *Taman Posyandu*, the capacity development plan for caregivers includes training by a combination of various government sectors in an effort to provide the *Taman Posyandu* caregivers with skills that permit them to work with children and households across traditional sectoral boundaries and in a holistic manner.

Training resources (knowledgeable individuals and institutions) and some financial support is available at the district and even village level. However there does not seem to be a clear or well defined consensus on how to support HI ECD with these resources. Sector specific skills are still relevant and still provided but an emphasis on ensuring holistic and integrated support has implications for training curriculums and programs across the relevant sectors. For example, integrated and holistic services may require caregivers in *Posyandu* to have new skills and better knowledge about child social and cognitive development as well as basic methods for effective early education. Caregivers and teachers in center-based programs for child development and early education like *KB* and *TK* would need enhanced capacity to enable them to identify health concerns and a better understanding of how to refer parents to needed services or support. Effective delivery of HI ECD also requires capacity development and training and new skills for stakeholders in how to develop and implement strategies to link and deliver holistic services in an integrated and cost effective manner.

Theme 5: Growing Community Level Awareness of Benefits HI ECD

As mentioned in Chapter II (see Table 4), participation in programs for early childhood development and early education[34] improved considerably between 2004 and 2010 - especially for children 4 years of age. MoEC also reports that the enrolment data collected by the Ministry indicates that participation has continued to increase rapidly between 2010 and 2012.

Government investment in early childhood development and early education has increased, but these programs are not a mandated service and household spending still plays a very important role in their provision. Since participation in a program is funded to a large degree through fees, improvements in participation rates are the result of a combination of the expanded opportunities created by greater public investment and a growing awareness on the part of households of the benefits of participation in these programs. While the research team did not have a means to systematically measure this growth in awareness directly it was noted that this increased demand for early childhood development and early education programs was mentioned by stakeholders in all of the research sites. A sample of the comments from stakeholders includes:

> *Children's school readiness increases not only in cognitive aspect, but also in social and emotional. There is a lower level of repetition in primary school for children who had attended early childhood program*

34 Typically center based programs (*TPA*, *KB*, *Pos PAUD*, *Taman Posyandu*, *TK*, *RA*, etc.)

Primary teacher – Probolinggo district
Before we educated children with violence, but now this is much less and we are more patient than before
Parents - Garut district

Children become more independent, sociable, and are able to interact with others with courtesy. Health and hygiene behaviour improves and they can recognize letters, numbers, shapes, colours, and say prayers.
Community view – Sambas district

Easier access to give booster immunization to children above 1 year old, easier to detect problems in children's' growth and development, sanitation and health behaviours improve, fewer malnutrition and diarrhoea cases
Midwife - Probolinggo district

It is better to leave your child at an ECD center where they engage with trained caregivers *than to leave the child at home with a housekeeper who has many other things to do and doesn't have any training.*
Parent – Banda Aceh

Discussion and Findings

Participation rates in center-based programs for early childhood development and early education have increased significantly since 2004, however rates are still below GOI targets of participation rates of 75 percent. As private spending plays an important role in funding these programs, children from poorer households are less likely to participate (see Table 9). In Banda Aceh the case study observations were realized in the city. Fees were much higher than those found in the other case study sites that were predominately rural. While systematic data on fees paid is not widely available the high participation rates in the more developed urban areas in Indonesia suggest that the fees encountered in Banda Aceh are likely in line with fees paid in areas of Jakarta, Yogyakarta, Bandung, Semarang and other major urban areas where household wealth is higher. Evidence presented in Chapter II indicates that this higher participation is the result of both more wealth *and* better awareness of the benefits of these programs. It follows that significant improvement in the participation rates of poorer children will require both public investment in lowering the cost of participation as well as effective outreach to households about the benefits of participation in center based programs. Relying on only reducing the cost or only raising awareness will not be as effective as a strategy that addresses both cost and awareness.

3.3 HI ECD Resources and Costs

Summary of Findings

- For HI ECD - as is the case for most areas of public spending - districts and villages are highly dependent on national transfers (about 90 percent of revenues). It is estimated that 60 percent of the activities implemented "on the ground" are executed by a national entity.
- While public finance reporting meets Indonesia public finance reporting standards, the nature of routine public finance reporting is not conducive to analyzing the resources committed to HI ECD. To understand actual spending on activities across the spectrum of components requires detailed information only available at the activity level in local administrations.
- Most of the expansion of opportunities in center–based *PAUD* has been financed with central level spending transfers to provinces and districts. The support to *PAUD* is typically through "once-off" injections of resources for a limited period. This strategy is a response to uncertainty about the continuity of support as *PAUD* is not a mandated service. Since local spending across most sectors is dependent on national level support, district level and local level investment in *PAUD* is then also low.

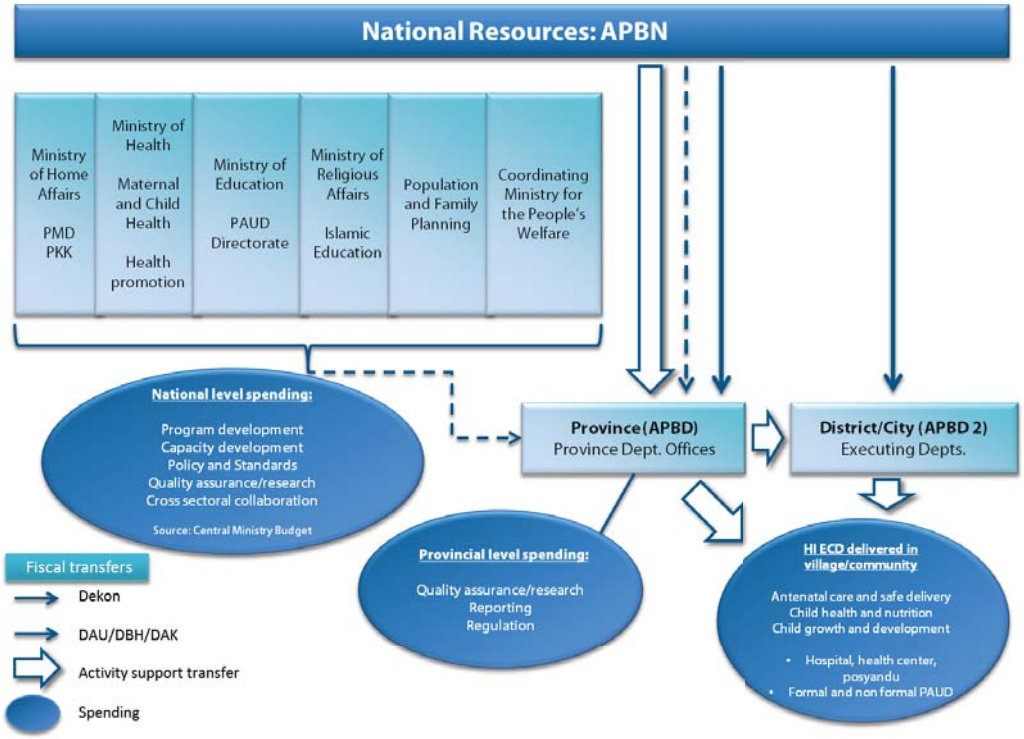
- Maternal and child health components of HI ECD are in a more favorable resource position when compared to *PAUD*. Maternal and child health expertise and delivery of services is embedded in a network of existing institutions. While there is a need to support more effective outreach and collaboration this is as much a governance constaint as a financial constraint.
- Non-sectoral financial resources like community development grants and poverty alleviation grants are available and have been utilized in some cases to support HI ECD. While grants are comprehensively reported, the level of detail in the reporting can makes it difficult in some cases to link grant spending to HI ECD. With the otherwise once-off approach to *PAUD* development it is likely that *PAUD* stakeholders at the local level are not fully utilizing these sources for *PAUD* development.
- Promising examples of HI ECD encountered in the field studies incorporated important development and mobilization activities that do not appear to have a readily apparent funding source within current financing arrangements

3.4 Sources of support

3.4.1 Primary sources of investment in HI ECD

HI ECD is provided through support from public and private resources. Public resources are provided at the national, provincial and district/community level from the national budget, and, because of a the holistic nature of HI ECD, these resources are allocated and managed across several government sectors. Private resources, in the form of fees, collaboration and in-kind contributions, play an important role, as does support from private foundations and collaboration of the private sector. Figure 7 shows the flow of the major sources of funding to ECD.

Figure 7. Financial Resources for HI ECD



3.4.2 Primary Sources of Investment in Public Investment in HI ECD

While HI ECD actives are executed at the local (district/village) level, public investment in HI ECD primarily comes from resources in the National Budget (*APBN*). Regions do raise their own revenues through local taxation and fees for the provincial (*APBD*) and district budget (*APBD*2) but the share of own revenues as a percentage of the *APBD* is estimated at less than 10 percent nationally.

The *APBN* allocates resources to sectoral national level line ministries and national institutions. The *APBN* also allocates resources directly to regions (provinces and districts). These funds allocated from the *APBN* to the regions become revenues for district development managed through the provincial (*APBD*) and district (*APBD*2) budget.

The revenues are transferred from the *APBN* to the regions (districts and provinces) through four mechanisms:

DAU: The *DAU* (General Allocation Fund) is an open allocation of resources from the national to regional administrations. In practice, as much as 80 percent of this transfer is consumed by routine expenditures, primarily public sector wages.

DBH: *DBH* (Shared Revenue Funds) transfers are made from the *APBN* to districts on the basis of a combination of formulas involving land, buildings, personal income and natural resources.

DAK: The *DAK* (Special Allocation Fund) is not an open transfer like *DAU* and *DBH*. There are specific requirements and technical criteria including a requirement for matching contribution from district level own revenues. The objective of the *DAK* process is to close interregional gaps in public services provision, with priority given to education, health, infrastructure, maritime affairs and fisheries, agriculture, regional

Dekon: The other primary source of revenues for the regional budges are deconcentration funds (Dekon). Dekon resources are transferred from the *APBN* to provinces for executing tasks for the national government. In addition, Dekon funds are allocated by line ministries to their regional offices in the provinces. As most activities are realized at the village level, some portion of these resources are transferred to district offices of line ministries for the purpose of realizing specific activities (an activity support transfer – contract, MOU, etc.). The allocation of Dekon to priorities and tasks differs by ministry but generally involves a process of consultation among officials at the district, provincial and national level.

The primary public sector financial resources for HI ECD development and delivery at the community level are:

Public resources for HI ECD		
Source	**Utilized at National and/or Province for**	**Utilized at District/Community level for**
The Ministry of Health: The most directly relevant resources are managed by the General Directorate of Nutrition and Maternal and Child Health. As is the case with most ministries, the ability of a General Directorate or Directorate to deliver services is dependent on many other functions in a ministry that provide a structure, facilities, management and other functions that support the delivery of services. However, when considering policies and strategies for developing or expanding a system of HI ECD the most immediate impact would be felt in this General Directorate – and particularly in the Directorate of Maternal Health and Directorate of Child Health.	Policy development National Regulatory environment Program development Research Monitoring and Evaluation Quality Assurance and reporting Capacity development	At the community level: Financial resources for support of HI ECD are embodied in the costs of the health centers (all) and the costs of District Health Office. The resources for HI ECD can be thought of as that portion of the operational and development costs for programs supported by those institutions that address the needs of pregnant women and young children – primarily those linked to maternal and child health. In addition, district office spending on capacity development and monitoring and evaluation linked to initiatives in maternal and child health. ***Through: PAD, DBH, DAU, Dekon, DAK***
The Ministry of Education: Since 2010 PAUD development and management have been brought together in a single Directorate of PAUD. This Directorate brings together the formal and non-formal PAUD initiatives that were previously managed by separate Directorates. While other functions in the Ministry of Education and Culture have roles in PAUD (Research and Development, EMIS and others), the majority of the public resources for HI ECD provided by the ministry are managed by the PAUD Directorate.	Policy development National Regulatory environment Program development Research Monitoring and Evaluation Quality Assurance and reporting Capacity development	At the community level: MoEC financial resources for HI ECD are those resources expended on the development and provision of PAUD in the district and for the professionals that provide technical support and management/ oversight for PAUD.[37] Depending on the district, a different percentage of the resources for PAUD flow through the District Education Office or are implemented through activities managed by the province or national ministry. ***Through: PAD, DBH, DAU, Dekon, DAK***

37 Some districts have undertaken a reorganization that is similar to the national level reorganization and have formed a PAUD unit while others have not yet adopted this structure.

Public resources for HI ECD		
Source	**Utilized at National and/or Province for**	**Utilized at District/Community level for**
The Ministry of Religious Affairs: The Ministry of Religious Affairs manages a system of schools, including PAUD, through the Directorate of Islamic Education. Spending by this directorate is a component of the current investment in HI ECD.	Policy development National Regulatory environment Program development Research Monitoring and Evaluation Quality Assurance and reporting Capacity development	At the community level: Unlike the support from the Ministries of Education and Health, MORA support to PAUD is granted directly to the individual institutions rather than through provincial and district offices. In addition, the central ministry manages the resources for program and capacity development **Central ministry pays salaries and purchases goods and services directly for approximately 25,000 *RA* (Islamic kindergartens).**
The Ministry of Home Affairs: The Ministry of Home Affairs has a wide range of functions, including a governance function. Of particular importance to the development of HI ECD is the ministry's role in governance, decentralization and community empowerment (PMD). All levels of local government have a link to the Ministry of Home Affairs. Also, the Family Empowerment Welfare program as a formal government sponsored structure at all levels of administrative governance in Indonesia is located within the Ministry of Home Affairs.The PKK plays an important role in Posyandu in many locations.	Policy development National Regulatory environment Program development Research Monitoring and Evaluation Quality Assurance and reporting Capacity development	At the community level: Support for PKK (Family Empowerment Welfare Program) and grant funds distributed through Community Empowerment Program (PMD) ***Through: PAD, DBH, DAU, Dekon, DAK and direct provision by central. In addition there are several grant processes depending on the sector for utilization of PMD funds.***
Ministry of Social Affairs: The Ministry of Social Affairs is concerned with policy and program development and capacity development in the areas of social assistance and protection. The most direct link to HI ECD is the protection of women and social protection as it relates to children.	Policy development National Regulatory environment Program development Research Monitoring and Evaluation Quality Assurance and reporting Capacity development	At the community level: Support for social workers and capacity development and activities in social protection for women and children. ***Through: PAD,DBH, DAU, Dekon, DAK and direct provision by central***
Ministry of Women's Empowerment and Child Protection: The Ministry of Women's Empowerment and Child Protection is mandated to develop policy and direction and to synchronize government efforts in the area of women's empowerment and child protection. The ministry does not have a presence at the district level.	Policy development National Regulatory environment Program development Research Monitoring and Evaluation Quality Assurance and reporting Capacity development	Spending at national level only

Public resources for HI ECD		
Source	**Utilized at National and/or Province for**	**Utilized at District/Community level for**
Coordinating Ministry for the People's Welfare: This Ministry performs the role of facilitating coordination for national priorities in social welfare that involve multi sectoral initiatives like HI ECD. While the Coordinating Ministry has an important role in promoting and facilitating the delivery of HI ECD, resources managed by the ministry do not play a direct role in the delivery of HI ECD at the community level.	Policy development National Regulatory environment Program development Research Monitoring and Evaluation Quality Assurance and reporting Capacity development	Spending at national level only
Community Development Poverty Alleviation Program (PNPM Madiri): PNPM Mandiri is a poverty alleviation facility managed by a secretariat comprised of a steering committee and technical committee. Most of the funding comes from the *APBN* (state budget) of the ministries/agencies. The ministries/agencies allocate the budget for the technical assistance component and BLM (Community Block Grant). In addition, local funding is also required to support joint activities of PNPM Mandiri, including the implementation of coordination, BLM component of matching funds, and technical assistance to assist the implementation of BLM.	Grant programs for communities qualifying on the basis of poverty indicators. 11 grant programs – several with potential links to HI ECD – for example Education and Health, "CARE" (support for relief managed by local entities/NGOs)	In 2013 allocation to be made available is: 9,703,067 million IDR across all the grant programs. Not all areas qualify for all the grant programs. Specific pilot demonstration program is being developed in 2013 that focuses on HI ECD.

In the case of Health and Education, one component of the Dekon transfer is an operational grant.[36] These transfers are intended to provide operational support for delivery in health and education and are determined ,in some part, on the basis of the relative needs (population) for delivery of services but not linked to an estimate of the unit cost of a service.[37] For the education sector *PAUD* support the context is more problematic. While operational grants for basic education (BOS) for schools can be programmed on the basis of estimated enrollments (demand for services), the allocation of resources for *PAUD* operational grants (*BOP*) is more ad hoc since government-provided *PAUD* is not a nationally mandated service. While the Ministry of Education estimated that an operational subsidy of about Rp 600,000 annually per *PAUD* participant is required, budget constraints resulted in scaling back the actual *BOP* to a figure of Rp 240,000 in 2011. The grants also only reach about 12 percent of the population between 3 and 6 years of age.

This fiscal regime is especially challenging for HI ECD. Delivering services comprehensively – across sectors - based on the developmental needs of children in a community requires more rather than less local level autonomy in allocating resources. As previously noted, the more promising examples

36 BOK for the Ministry of Health and BOP for PAUD specifically from the Ministry of Education and Culture

37 While amounts allocated to districts are generally linked to differences in potential demand for services, the grants are not based on estimates of the actual financial requirement for meeting the minimum services standards.

of HI ECD delivery encountered in the field research were usually made possible through investment outside the sectoral boundaries that supported critical processes and activities that typically do not have government sectoral financial support.

3.4.3 Typical Funding Practices

Maternal and Child Health
Minimum service standards in the health sector specify a basic level of antenatal care and support for child health. For qualifying poor households there is also support provided through the social insurance program, Jameskesmas.

Posyandu
Posyandu is generally provided free of charge (just one or two meetings a month) but collaboration from mothers for activities is not uncommon. Health inputs (vaccinations, vitamin A, etc.) are provided through health sector funding. The support for the volunteers (*kaders*) varies from location to location. Some are purely volunteers, while others receive varying amounts of support from either district or village budgets. Some *kaders* have been included in sponsored income generating schemes and micro finance initiatives. In some cases, facilities have been established or improved using community empowerment or poverty alleviation grant programs.

PAUD
Although there are some state supported *TK*s, the provision of *PAUD* is predominately private. As private institutions, they generally rely on user fees from households. In the 45 ECD centers visited as part of the initial field studies nearly all charged fees. The level of fees varied considerably and with such a small and non-random sample it is not possible to make a meaningful estimate of fee levels in HI ECD. Some operational support and support for caregivers was also provided from government sources – either district or village – but this practice varied considerably and in many places was absent.

Very few of the more than 170 caregivers interviewed in these 45 centers served entirely as a volunteer. The various centers visited that were initiated as part of a time-bound government project (MoEC/World Bank) were provided with startup costs and operational support, including incentives for two caregivers for two years. This project initiated in 2006 and ended in 2011. Many of those centers no longer receive operational support and must now look for support from other sources.

Facilities have been developed through various sources including the time bound government project, education sector *DAK* utilization, community empowerment grant funds, lease or loan of government property, and private provision. Training and capacity development has been provided by local training providers with funding from various sources. Some caregivers report that on an ad hoc basis they are included when local education authorities are providing training. In some locations *HIMPAUDI* provides training. This training is often partly funded by fees from participants, which makes it difficult for some centers and caregivers to participate. Health sector training – especially for those caregivers working in *PAUD* that combines *Posyandu* and *PAUD* – is provided for the regular realization of the *Posyandu* program.

3.5 Current Spending

As illustrated in Table 17 and described in that section, public spending on HI ECD crosses a number of sectoral boundaries. In addition, these expenditures occur at the national, provincial and district/community level. While the expenditures at the national level are important for the development and management of quality HI ECD, expenditures at the national level would likely not be very sensitive to the implementation of strategies that improved access and quality. The nature of the national activities might change, but the amount of activity and the costs would not be expected to change significantly.

Improving access and quality would be expected to have more serious implications for spending at the point of delivery. Reaching more children with more services will require more resources. Most of this additional activity would involve the health sector (primarily nutrition and maternal and child health) and the provision of *PAUD*.

Table 17. Current Spending on HI ECD Delivery

	2011
Ministry of Education - PAUD Directorate (million IDR)	1,727,496
Ministry of Health: DG Nutrition and MCH and proportion of General Directorate of Health (million IDR)	12,467,907
Children aged birth to 6 years	30,000,000
Children aged 2 to 6 years	22,200,000
Nutrition and Maternal and Child Health per child birth to 6 (IDR)	415,597
PAUD per child 2 to 6 years of age (IDR)	77,815
Annual Exenditure per child HI ECD	493,412

This perspective of the "cost" of current provision of HI ECD is presented in Table 17. What we observe is that approximately Rp 493,412 is spent on HI ECD per child per year. The difference between health and education spending is significant, obviously due to the nature of the services required at different ages, but as will be shown shortly, this difference reflects the lack of a national mandate (and therefore budget) for early childhood services.

The per-child estimate is based on the assumption that maternal and child health spending applies to all children across the age range from birth to 6 years of age. Spending per child for *PAUD* was based on the assumption that *PAUD* spending is relevant for the population of children 2 to 6 years of age.

Note that the table includes just the two sectors that would be expected to experience the most significant changes in resource requirements in response to efforts to improve access, equity and quality of HI ECD as delivered. In order to further narrow the estimate, only those resources most closely linked to direct service provision are included in the estimate. For the maternal and child health spending, the estimate includes decentralized dekon and "assistance tasks" (tugas pembantuan) from the General Directorate of Nutrition and Maternal and Child Health. This does not include any central level costs or spending linked to regional offices. Child and maternal health interventions draw more widely on health sector interventions outside the Nutrition and MCH General Directorate. To account for this spending that is a part of attention to HI ECD, a percentage of the dekon, assistance tasks and decentralized presence of Ditjen Bina Upaya Kesehatan was also used in the calculation. In this case, regional staff was included along with the decentralized dekon and task assistance spending, as some Ministry of Health staff are qualified medical caregivers and provide service in health institutions. From this directorate spending, 12.5 percent of the total is considered HI ECD spending corresponding to the percentage of the population under 6 years of age.

In the case of *PAUD*, the *PAUD* directorate provided the research team with a detailed activity budget for years 2011 to 2013. This activity budget does not include central level costs and is financed though dekon funds allocated to provincial offices and then executed through a combination of province and district led activities and some limited central level spending on service delivery.

A Note on Methodology

Conceptually it is relatively straightforward to estimate the current resource envelope (all public and private spending) for HI ECD. However, in practice, the multi sectoral nature of HI ECD support, fiscal decentralization and routine public finance reporting practices in Indonesia mean that attributing public spending to HI ECD requires a number of simplifying assumptions. Even as a concept, it is important to

highlight cautions concerning the interpretation of this kind of estimate and the implication of the simplifying assumptions necessary to elaborate it.

Total spending on the components of HI ECD cannot be interpreted as the cost of HI ECD. Even if current spending can be perfectly captured, without a sufficiently detailed definition or model of HI ECD delivery there is no way to understand the relationship between what is spent and the delivery of HI ECD. Current spending may also fail to reflect hidden costs and subsidies. In the field research, the few examples of promising HI ECD delivery usually involved extensive consultation and mobilization activities with the community. These types of activities do not appear to have a regular source of financial support in the current financial support system.

In addition, the delivery of some HI ECD components rely on subsidies that result in underestimates of their true economic or opportunity cost. Just one example is that of *kaders*, who provide service in *Posyandu* or some of the informal *PAUD* of various types. In many instances there is an assumption that the cost of *kaders* is 0 Rp or an administratively determined "incentive". But support provided by *kaders* comes at the cost of what they can produce for their own households and by dedicating themselves to other activities they are providing an unmeasured subsidy to HI ECD.[38] While the contributions of *kaders* to HI ECD is admirable, having a system of HI ECD that can only survive on the basis of contributions from relatively poor households may not be of good quality or sustainable.

A final caveat on elaborating this resource envelope is that costs for a given level of service are quite likely to differ significantly across districts and even villages. In an analysis of spending required to meet Health sector SPMs (minimal service standards) Ensor et el (2010) estimated that per capita costs for meeting the minimal service standards differed by a factor of 3 or 4 between provinces with the lowest costs and provinces with the highest costs.[39]

3.6 Estimating the Financial Requirements of HI ECD Using Normative Methods

Normative costing methodologies can be applied to address some of the limitations of using current spending as a measure of the "cost" of HI ECD. These normative methods explicitly incorporate all costs (including hidden costs and subsidies). The normative methods begin with a complete description of a service or activity and include costs for all the necessary elements of that activity without regard to their source – even if they are activities that currently are not funded from any source.

For example, *Posyandu* is a widely available service that currently provides support to pregnant women and young children. While there is a description of support to be provided through *Posyandu* as well as a ministerial regulation that mandates the delivery of integrated social services through Posyandu[40] the link between these demands and financial resources available to execute them is very unclear.

Another characteristic of normative methods is that they estimate the cost of providing a particular service or undertaking a given activity on an ongoing basis. For example, current *PAUD* development strategies from government budgets tend to provide once-off grants for large and small capital items and even for operational support. While this strategy assumes that other sources will provide replacement costs for critical items like toys and materials and even repair and replacement of facilities, the ongoing cost of these items must be included or the estimate has to be built in the idea that the cost of buildings, materials, or even training occur just once.

38 Using the Indonesia Labor Force Survey (SAKERNAS) the estimated the mean monthly earnings for females between 20 and 40 years of age with a complete SMA/K and living in a rural area is about 29,000 IDR per day or about 580,000 IDR per month.

39 Ensor et al: Budgeting based on need: a model to determine subnational allocation of resources for health services in Indonesia. Cost Effectiveness and Resource Allocation 2010: 10:11

40 Ministry of Home Affairs regulation 19 2011

Finally, the most important and useful aspect of normative methods is that they directly link policy/strategy choices and resource requirements. In some cases these normative estimates can be compared to current spending to elaborate a rough estimate of the breach between service requirements and available resources. The normative estimates can also be used to project financial requirements on the basis of assumptions and scenarios.

Using a normative costing methodology, Ensor et al have estimated the cost of meeting health sector minimum service standards (SPM). Included in these estimates are component services for:

> Maternal health: Basic Antenatal Care, Abortion, Antepartum Haemorrhage, Hypertension PET, Severe Anaemia, Premature Labour, Abnormal foetal presentation, Prolonged Labour, Caesarean Section, Uterine Rupture & Hysterectomy, Intrapartum & post partum infection, Post Partum Haemorrhage, Normal Delivery, Routine Post Partum Care
>
> Child health. Neonatal Complications, Routine Infant Health, Routine Child health, Child Immunisation, Nutrition for the poor, Severe Malnutrition, School Health

These estimates were elaborated using information gathered in 5 districts concerning clinical best practice in Indonesia, direct costs and overheads for each SPM. The estimates also incorporate epidemiological estimates for service requirements[41] based on the analysis of Riskesdas and IDHS data. The results are presented as an estimate of the cost per capita for each SPM. These per capita estimates have been converted to estimates per child birth to 6 years of age so as to provide a comparison with earlier estimates and to facilitate projection on the basis of HI ECD strategies.

These normative estimates represent what resources would be required if, given the usage rates expected for the population in Indonesia, every child and pregnant woman were provided care that met the SPM for any maternal health or child health need (see standards list above). The cost of meeting both maternal health and child health minimum service standards is nearly 550 thousand Rp per child 0 to 6 years of age per year.

Table 18. Estimated Cost to Meet Maternal Health and Chlld Health Minimum Service Standards

	IDR per Child
Maternal health	192,000
Child health	357,600
Total	549,600

A similar method can be applied to the *PAUD* component of HI ECD. This is particularly relevant since participation in *PAUD* for children 2 to 6 years of age has relatively low coverage and will need to grow in order to deliver on the vision of comprehensive system HI ECD

An "ingredients method"[42] was used to estimate an annual recurrent cost per child for *PAUD*. This estimate of an annual recurrent cost was based on a center-based program for children 2 to 6 years of age. The program description upon which the cost estimate is based captures cost elements that would likely be important across a number of different types of programs (*Pos PAUD*, *KB*, *TK*, etc,). It is important to emphasize that this estimate is an annual recurrent cost per child over the medium term rather than the cost of a particular program in a particular year. Multiplying this estimated annual recurrent cost by the number of children to be served yields a benchmark annual resource requirement for providing this service. A final caution is that this annual resource requirement should be thought of as what would need to be spent on average over some period of time – for example 8 to 10 years. If policy priority is

41 For example – given the population structure of Indonesia what is the likelihood that a woman of a particular age would need antenatal support.

42 Levin & McEwan (2001) *Cost-effectiveness analysis: methods and applications* Sage: California

to expand access more quickly, spending in initial years would be higher than the annual benchmark requirement, with spending later in the cycle being lower, to arrive at something approaching the benchmark as the average annual spending required.

Table 19. Estimate of *PAUD* Medium Term Annual Unit Cost

Center based PAUD Program Unit Cost Estimate (for 50 children)		
Facility	**IDR**	**IDR per child**
Value (replacement cost)	70,000,000	
Annual equivalent cost (3%, 18 years)	**5,089,609**	**101,792**
Services (electricity, water and sanitation)		
Tot**al annual at 525,000 per month**	**6,300,000**	**126,000**
Materials and equipment (for 50 children)		
Equipment value	3,500,000	
Annual value of equipment	689,561	
Consumable 15,000 per child per month)	7,500,000	
Total annual for equipment and materials	**8,189,561**	**163,791**
Caregivers		
Total annual (3 caregivers 500,000 per month)	**18,000,000**	**360,000**
Capacity development caregivers		
Daily cost of training	475,000	
Total annual (5 days every 3 years per caregiver)	**2,375,000**	**47,500**
Community mobilization		
Total annual (meeting and transport cost per year)	**1,000,000**	**20,000**
Annual Unit Cost		**819,083**

The calculation of a medium term annual unit cost for *PAUD* is presented in Table 19. Facilities were valued using an assumed cost of 70 million Rp . This value was converted to an annual equivalent using an assumption of a functional life span of 18 years and a social discount rate of 3 percent. Again, note that this conversion to an annual equivalent for a facility is not the cost of a specific building. The annual equivalent is used to determine what annual spending would be required to ensure that the number of facilities necessary to meet the demand for the population of children 0 to 6 was available. In this particular case the estimate suggests that having sufficient facilities (like the one described) on an ongoing basis would require spending approximately Rp 100,000 annually per child age 2 to 6 years.

Items that are consumed in a single year are simply summed and divided by 50 children and items like the facility that have a life span of longer than one year -like equipment- are first converted to an annual equivalent and then divided by 50 children. It is important to note that the model of *PAUD* service used to estimate this unit cost includes resources for regular ongoing community mobilization and ECD development as well as ongoing training costs for caregivers. Using this description of a generic *PAUD* service, the total annual cost per child is approximately Rp 819,000 per year.

Table 20 presents a comparison of the estimate of current spending per child for HI ECD delivery at the community level and normative estimates of the resources required for the delivery of HI ECD at the community level.

Table 20. Expenditure per Child HI ECD Service Delivery

PAUD (2 to 6 years)	
Current spending	**Rupiah**
Per child 2 to 6 years of age	78,000
Per child with 50% private contribution	156,000
Per child 50% private contribution and for 3 to 6 years	200,000
Normative Estimate	
Per child 2 to 6 years of age	819,000
Per child with 50% private contribution	410,000
Per child without training and mobilization costs	752,000
Per child with unpaid caregivers	459,000
Mother Child Health (birth to 6 years)	
Current spending for child birth to 6 years of age	416,000
Per child estimate to meet SPMs in MCH	550,000

- Using the model for estimating the ongoing cost of a fairly simple *PAUD* provision, the estimated annual cost – Rp 819,000 – was nearly 10 times the estimate of current spending per child based on the dekon and central level spending on direct implementation in 2011.
- Rp 819,000 is the normative estimate of total cost of delivery per child of *PAUD* at the community level. If the assumption is made that households can, or should, contribute 50 percent of the cost of *PAUD*, the public resource requirement is cut in half to Rp 410,000 per child per year, but still this is more than 5 times the estimate of current spending per child.
- If we incorporate the assumption that current *PAUD* spending is effectively oriented toward children 3 to 6 years of age rather than 2 to 6 years of age and include the assumption that private spending is equal to public spending, the estimate of current spending increases to about Rp 200,000 Rp per child, about one-half the estimated need of Rp 410,000.
- While the results must be interpreted with caution, the gap between an estimate of what is currently spent on HI ECD from the health sector and the Minimum Service Standard based estimates of spending requirements are much closer than those for *PAUD*.

The per child spending in *PAUD* (see table 17) is based on Dekon and central ministry spending for 2011. This spending was for activities linked to the delivery of *PAUD* at the community level – across the various types (*TK*, *Pos PAUD*, *TPA*, etc.). One of the largest budget items in the activity budget for 2011 was support for the re-initiation of *PAUD* centers that were previously initiated through InPres (Presidential instruction). The need to revisit and revitalize centers that were once central government priorities indicates the challenges to expanding this component of HI ECD. Clearly an "InPres", like solution is not possible or desirable in the current context in Indonesia. *PAUD* in the districts is being supported by knowledgeable and dedicated persons both in and out of government, however there is no framework for moving forward. The situation of caregivers illustrates this challenge. A key element in any expansion of service or improving the quality of service is certainly dependent on the support – both material and technical – provided to caregivers. Having continuity of caregivers who continue to build their skills is clearly important to the delivery of HI ECD. However, support to caregivers is ad hoc, once- off and sporadic. One of the constraints is the understandable concern of public officials of not violating public finance norms and also not creating expectations for material and financial support that may not be sustainable. Despite the innovations in Ministry Regulation 58, the regulatory framework applied is still focused on standards and procedures more appropriate for a formalized state run system. Liberating financial and material resources for HI ECD will require establishing a framework that facilitates the provision of public financial support in an appropriate and sustainable manner for community-led HI ECD.

The situation for the maternal and child health component of HI ECD differs considerably from *PAUD*. As a formal system that has already established a wide network of service providers, the challenge for reaching more children is more of an administrative and collaboration challenge than a lack of resources. Again, the overlap of financial and governance issues is considerable when considering the provision of HI ECD health components at the local level. The challenge is to have a framework that formalizes and financially and materially supports processes that facilitate collaboration so that current health resources can be maximized with respect to addressing the needs of children 0 to 6 years of age.

Chapter 4
A Study of Community Driven Vs Institutionally Driven ECD Development Models

Even though National Education System Law No. 20/2003 recognises early childhood education as a stage preceding basic education, it is not part of the compulsory education system. The national Education for All (EFA) target is 75% coverage of early childhood education services for 0-6 year olds by 2015, with an interim target of 60% coverage by 2009. However, the majority of pre-primary school-age children still do not have access to developmental and early learning opportunities. Currently only about 37% of 3-6 year old children participate in structured developmental and early learning activities, with huge disparities between rural and urban areas. 70% of children who are not attending ECD are from rural areas. Poverty and isolation, as well as insufficient services, put pressures on the family and limit the capacity of parents to provide good early child-care for their children.[43]

Evidence from around the world clearly shows how ECD programs that integrate health, nutrition, and early education interventions have more impact than those aimed at one aspect of child development alone. This is because disadvantages in one aspect reinforce disadvantages in another .For example: (1) severe problems in food intake lead to weight loss; (2) vitamin deficiency in children's weakened immune systems, and in areas lacking health infrastructure, mean they are more likely to be ill and die; (3) children with iodine deficiency have lower IQ; (4) children who are malnourished and frequently ill play less, have a shorter attention span, have less learning capacity in class, and are more likely to drop out.[44]

The concept of Holistic and Integrative Early Childhood Care (HI ECD) recommended by BAPPENAS, is challenging to implement due to the fact that it requires an inter-sector, integrated and comprehensive approach focused on the "holistic" needs of the young child, with the child as the center of all activities. Currently these concepts are not fully understood or well implemented in Indonesia.

ECD programs in Indonesia have a long history. F2H involvement in this area started in 1998-2000, with the development of the Early Child Care and Development (ECCD) model in the framework of a demonstration project funded by UNICEF.[45] The ECCD model has been developed and integrated with *Posyandu* (Pos Pelayanan Terpadu – Integrated Health Service Post), and is referred to as "*Taman*

43 UNICEF Indonesia, Early Childhood Development Program In Rural and Poor Areas in Indonesia, 2006-2010

44 R. Heaver and J. Hunt, Improving Early Childhood Development, An integrated Program for the Philippines. World Bank and ADB, 1995

45 F2H foundation was formerly known as WHO Collaborative Center for Perinatal Care (1993-2003). It became an independent Research Foundation under the name Frontiers for Health Foundation (F2H) in 2003 with the main interest in community empowerment.

Posyandu".[46] *Taman Posyandu* expands the traditional health post's (*Posyandu*) activities by providing learning through play experiences for children and introducing as well as monitoring child development for parents. In this model, health, nutrition, psycho-social, education, and cognitive development aspects are integrated into one service. In addition to improving the health and nutritional status of pregnant mothers, infants and young children and decreasing the incidence of malnutrition, the *Taman Posyandu*'s objectives include the provision of support to improve children's psychosocial development and their readiness for school.

Taman Posyandu is a community-based program which starts from existing programs using a "bottom-up" planning approach to create ownership of the community as well as to build community confidence to support community unity and strength. This approach is totally different from the institutionally driven Pendidikan Anak Usia Dini (*PAUD*) model which was later established and supported by the government.

In 2006, UNICEF Indonesia began to support the Ministry of National Education (MoNE) as well as provincial and district governments aiming to develop a holistic ECD model suitable in the context of rural and poor communities in Indonesia. The ECD model has been developed and integrated with the *Posyandu*, which was initially established to provide health, nutritional care, and immunisation for pregnant women, babies, and children under five years of age. This ECD center is following the *Taman Posyandu* model, which integrates children's psycho-social cognitive development and pre-school education with traditional *Posyandu* service. By December 2008, 341 ECD centers had been established and were in operation across 22 districts in 12 provinces.

At the central level, support has been provided for the Ministry of Education to contribute to the creation of a Policy Guideline for comprehensive ECD approaches. As part of the result, the Ministry of Education later developed the *PAUD* (Pendidikan Anak Usia Dini – Early Childhood Education, with emphasize on "education") concept, which by now has been widely implemented all over Indonesia. However, unlike *Taman Posyandu*, the *PAUD* concept doesn't readily integrate health and nutrition, although it is recommended that each participating child visit the *Posyandu* for growth monitoring and immunisation.

In a key 2009 report, BAPPENAS recommended the concept of Holistic Integrative Early Childhood Development or *PAUD HI* (in which P=*Pengembangan* or Development and HI=Holistic Integrative) as a national strategy. This had the important step of including health & nutrition as important components of ECD. BAPPENAS' end goal for *PAUD HI* is to contribute to the achievement of EFA and related Millennium Development Goals, and to promote school readiness of young children. The objectives of the program are as follows:

- Develop and consolidate a holistic ECD model in close coordination with core relevant government institutions and non-government organisations.
- Support the government to establish an integrated and comprehensive ECD policy framework.
- Support the government to institutionalise and expand a holistic and integrated ECD model by providing appropriate capacity development at central, provincial, and district levels.
- Support the government in advocacy and social mobilisation to enhance awareness of the ECD program for the general public, mainly at the community level.

Since the concept of HI ECD is relatively new, a research study ("Early Childhood Development Strategy Study") was conducted by Cambridge Education with the following objective: "to contribute towards achieving medium- to long-term social and economic national development goals through the

46 *Taman Posyandu*, "*taman*" means garden, similar to "*Garten*" in "Kindergarten" which literally translates into *Taman Kanak-kanak*.

development of effective policies, strategies and programs for the provision of ECD in Indonesia."[47] The Terms of Reference for the study identify the areas of focus as follows:

- Expanding Equitable Access to Early Childhood Development.
- Improving the Quality of Early Childhood Development.
- Strengthening Planning and Management of Early Childhood Development.

While development goals and policies are established centrally, it is community (district and village) level organisation and practices that determine the availability of quality ECD services and the efficiency of integration of services into a comprehensive system of HI ECD. A critical issue emerging from the initial ACDP 001 research was that the essential question of how best to bring about a sustainable and locally relevant HI ECD in communities where it does not currently exist remains unanswered.

As the government plan is to expand HI ECD, the consideration of which model/approach to use for developing ECD services will have important implications for public policy. Focusing on either an institutionally driven model, or a community driven model– or mixing elements of the two – may require quite distinct types of policies, financing mechanisms and systems for quality assurance. For this reason it is important to more explicitly address this issue of approaches to developing HI ECD in communities and provide stakeholders with a relevant explanation of the strengths and weaknesses.

For this reason, F2H (as the initiator of the *Taman Posyandu* concept & program) and its research partners were invited to conduct a field survey that could provide an analysis on the institutional and child-community-focused ECD development approaches implemented in some areas in Indonesia. The proposed research collaborators bring significant expertise and experience with HI ECD development through the application of the *Taman Posyandu* model in Tanjungsari, Sumedang District.[48]

4.1 Methodology

4.1.1 Research Objective

To identify the process of alternative strategies of HI ECD development (institutional- versus child-community-focused) at the community level and its impact on tutor, parent, and community knowledge, perception, and capacity in the delivery of sustainable holistic integrated early childhood development.

4.1.2 Methodology

The research explored tutor, parent, and community knowledge, perceptions and capacity in the delivery of sustainable holistic integrated early childhood development.

A participatory rural appraisal was conducted through brainstorming sessions and focus group discussions, followed by in-depth interviews and observations to assess tutors' capacity, parents' perception, and the role of the community, including local government. At the end of the sessions, a confirmation workshop was held, involving approximately 40-45 participants comprising representatives of tutors, parents of each ECD model, as well as formal and informal leaders from sub-district and village levels.

Four districts were taken as sample areas, namely Garut (West Java), Kupang (East Nusa Tenggara), Sumedang (West Java), and Bengkulu (South Sumtera). The assessment was conducted in one village in each of the four sample districts. Two districts, namely Garut and Kupang, are taken from the

47 ACDP 001, Terms of Reference, 2012

samples previously used in ACDP 001 community case studies of holistic integrated early childhood development. This enabled the integration of information from both this new assessment and the information previously gathered. Two other districts, namely Sumedang and Bengkulu, are the sites where *Taman Posyandu* (i.e. community driven, child-centerd ECD services) and CSR *PAUD* (i.e. private-institution-driven ECD service) have been developed. Both models currently exist side-by-side with other *PAUD* established by government (i.e. government-institution driven ECD service), particularly those established under the current World Bank ECD expansion program.

A number of criteria are defined for FGD/interview respondents and observation samples:

- *PAUD* has been in operation for at least 1 year, and accommodated at least 20 children of 3-6 year-old age. In each sample district, 1 representative of each ECD model will be selected for observation.
- The tutor has served at *PAUD* for at least 1 year. In each sample district, 2 representatives of each *PAUD*, and 10 representatives of each ECD model will be selected for tutor FGD.
- Parents of children who have attended *PAUD* regularly for at least 1 year. In each sample district, 2 representatives of each *PAUD*, and 10 representatives of each ECD model will be selected for parent FGD. 1 representative of each ECD model will be selected for parent observation.
- Community figures who are actively engaged in developing *PAUD*. In each sample district, 10 representatives will be selected for community figure FGD.
- Village leader and officials of related institutions (i.e. *Puskesmas*, UPTD). In each sample district, 10 representatives of each village will be selected for officials FGD
- Head of sub-districts. In each sample district, 3 representatives will be selected for in-depth interview.
- Parents whose children are not enrolled at *PAUD*. In each sample district, 1 representative will be selected for in-depth interview.

4.1.3 Limitations

This study was undertaken in a very short time frame, limiting the time available at each of the sites. Only 4 locations/districts were taken as samples, using a purposive (not random) design. The findings therefore do not represent the general condition of *PAUD* in Indonesia, although inferences can be drawn. We also note that the typology we offer is a subjective interpretation of the types of institutions that exist.

4.2 Findings

The Findings section of this report uses data from focus group discussions (FGDs), in-depth interviews, and observations conducted in 4 districts. Separate FGDs were conducted with parents, tutors, community figures, and local officials. The report describes the findings from each district. The following points served as guidelines in obtaining information:

1. Knowledge of *PAUD HI*
2. Process of developing/initiatives.
3. ECD tutor (cadres, teacher) a description of selection criteria, education, incentives (honorarium) provided.
4. Requirements to participate in *PAUD* activities.
5. Community participation: enrolment, parents' involvement, contribution (financial/others).
6. Village Coordination: with whom, decision making process.
7. Expectation (the Dream) of Parents, Tutors, Community Figures, Local Government Official.

4.2.1 Sumedang District

In Sumedang, the following activities were conducted:

- 3 FGDs with parents group (parents from *Taman Posyandu* Perintis – i.e. the pilot project, *Taman Posyandu Mandiri* – i.e. self-replication of the pilot project, and World Bank *PAUD*)
- 3 FGDs with tutor group (tutors from *Taman Posyandu* Perintis – i.e. the pilot project, *Taman Posyandu Mandiri* – i.e. self-replication of the pilot project, and World Bank *PAUD*)
- 1 FGD with community figures and 1 FGD with local officials
- In-depth interviews with sub-district officials and parents of those not enrolling in *PAUD*.
- Observations on tutor-child interaction at school and parent-child interaction at home.

Knowledge of *PAUD HI*

Though all parents, tutors, community figures, and local officials were familiar with the term *PAUD*, none had heard of *PAUD HI*, except for an official from the local Office of Education. As the moderator explained 'Holistic and Integrated', a tutor referred to *Taman Posyandu* as *PAUD HI* model.

There is an impression growing in some parents that *PAUD* is an education service for the poor (as the facility is far below that of kindergarten), though in fact *PAUD* serves as a good day care alternative for parents from every economic class. An official clarified the terms in use: *PAUD* is the education service for 0-6 years, comprised of both formal/school-based education (kindergarten and Islamic kindergarten) and non-formal/community based education (playgroup, day care, and similar education unit), although the program and target of both formal and non-formal service are the same.

All parents agreed that location and affordability are the main reasons for choosing where to enrol their children. They also agreed on a number of benefits of *PAUD* for the children: independency, fun-learning (introduction to reading and writing), socialisation/communication skills, and better self-regulation. Tutors and a number of community figures mentioned that children who had gone to *PAUD* institutions tended to rank very well in primary schools. Most parents agreed that independence and social skills are the main positive points for children who enter *PAUD* (in comparison with those who don't).

A number of barriers prevent children from entering *PAUD*, among which are cost and parents' anxiety that children would get 'tired of learning'. In some cases it is the children who are unwilling to join *PAUD*, as the facility is not appealing (in comparison to that of a kindergarten). However, tutors also mentioned that sometimes parents' prestige hinders them from enrolling in *PAUD*. Another case is that, although the tuition fee is not applied, children are not willing to go to *PAUD* as the parents cannot provide 'pocket money' (so that unlike other children they cannot buy snacks at school). A local official also mentioned that although a clear instruction has been already given to *PAUD* management about tuition fee dispensation, it is the awareness-raising (about the importance of early childhood education) that is difficult.

Process of Developing *PAUD* Initiative

The *Taman Posyandu* pilot was started by health cadres. In the scope of WHO research, it was started from *Posyandu* with an active '5 tables system' (i.e. comprehensive service and active reporting). F2H provided training and seed capital of 1 million Rp . Later on, the *PAUD* center conducted fundraising through various proposals (such as PNPM, district head, *PIK*, Office of Education), but funding for some of the approved proposals was not received in full. The fund was used mostly for building renovation and education/play equipment.

Most *Taman* Posyandus have been running for more than 10 years.

From the *Taman Posyandu* pilot, a number of cadres were asked by the community to replicate *PAUD* in areas where there was no provision. This is partly a result of active communication (door-to-door) regarding the importance of early childhood education. Thus, *Taman Posyandu Mandiri* emerged. *Taman Posyandu Mandiri* started to appear as early as 5 years ago. A *Taman Posyandu* forum was established in 2010 for sharing purpose.

Aside from cadres, some community members also started *PAUD* initiatives, such as Islamic early education, day care, and play groups. They formulated their own curriculum and maintain the operation independently, with no relation to the Office of Education.

WB *PAUD* started from a community facilitator who was appointed to introduce *PAUD* in areas not yet covered. Through 'musyawarah *dusun*' (musdus – hamlet discussion) and 'musyawarah desa' (musdes – village discussion) the facilitator helped villages to establish *PAUD*s. The first of the World Bank's *PAUD*s was started about 3 years ago. None of the parents, tutors, community figures, or local officials could explain.clearly about the amount of funding and its allocation. Funding support was channelled directly to the *PAUD* initiator/manager. Some community figures argued that World Bank support created envy among existing *PAUD* centers, and that there were cases that new *PAUD* centers were established with the sole purpose of taking advantage of the funding opportunity.

Note: The World Bank's funding support was also later accessed by a number of existing *PAUD*/*Taman Posyandu*, which received education/play equipment (in-kind) and tutor's transportation support. These *PAUD* were then also referred to as WB *PAUD*. A local official mentioned that during a 3-year support period for World Bank *PAUD* no operational support was given from the Office of Education.

ECD Tutor (Cadres, Teacher) a Description of Selection Criteria, Education, Incentives (Honorarium) Provided, Training

Taman Posyandu tutors were health cadres in existing active *Posyandu*. Their education background is mostly primary or junior-high graduates. Despite their education level, they received training from F2H covering child growth, early childhood care and development, "9 messages on child care", and basic administration skills. The training was held over 15 days, using both theoretical and practical approaches. Participants received modules in simplified language.

Since tutors are volunteers, selection was based on candidate's willingness to contribute/commit time. Most *PAUD* have difficulties in finding tutors, as there's no "regular" incentive provided. Usually managers recruit from their own family/relatives. There is also a case where a cadre who had already received training ended up leaving *PAUD* to open a new kindergarten instead.

Incentives from the Office of Education are available, but only for those with a high school certificate, and those registered as tutors (given a unique identification number). An official mentioned the availability of incentives for regular *PAUD* as being the sum of Rp 100,000/month. However, up to now most tutors of *Taman Posyandu* only received incentives from the co-op. Local officials also mentioned that the regulation stated tutor qualification as S1. The D3 degree is valid only for the tutor assistant qualification, while high school education only for care-giver. This has motivated cadres to join equivalence degree through education packages (kejar paket B/C). Those with high school education are then pursuing S1 degree majoring in *PAUD* education. The education cost is provided by individuals.

In WB *PAUD*, tutors are selected by village officials from the community. The selection criteria include high school education and maximum age of 30 years for tutors. Tutors are categorised into 2 types: education worker (with an emphasis on education) and child development worker (with an emphasis on health). Tutors are given incentives in the form of 'transportation funding support'. In areas with large coverage, one tutor is sometimes assigned to 2 *PAUD*s, namely a 'central *PAUD*' and a 'remote *PAUD*' – spending 3 days per week in each *PAUD*. An official mentioned World Bank incentive support to be a sum of Rp 250,000/month for 2 tutors, per *PAUD*.

The tutors received training to become a CDW (child development worker) from the World Bank via a 200 hour training course delivered over 12 days. The participants were 2 representatives of each *PAUD*. The material covered included environment, ECCD program, how to create daily learning planning documents, children's health, children with special needs, CDW tasks, and how to create educational tools/equipment. The training was conducted using theory, discussion, and micro teaching approaches. Participants also received training modules. However, most of the tutors who have been trained are no longer involved in *PAUD*, and no training has been provided for new tutors.

Requirements to Participate in *PAUD* Activities

To enroll their children in *PAUD*, parents have to provide a birth certificate, the registration fee, uniform cost, and tuition fee.

Birth certificates: some of the children have no birth certificate as the parents were not aware of its importance. However, the process of applying for a birth certificate is not difficult. Now every baby born assisted by midwives will receive a birth certificate for free (fee included in birthing cost), as long as the parents apply within 1 month of the baby was born. However, for children over 1 year of age, parents have to undergo a court trial and provide a birth witness, and pay a penalty fee (around Rp 1 million – based on local regulations). In some cases, the difficulty of obtaining a birth certificate is due to the unavailability of a marriage certificate, family ID card, or individual ID card.

The registration fee and uniform cost: payment can be made in installments. For those who cannot afford this, *PAUD* makes exemptions. In one *PAUD*, the manager collects the uniform of its alumnae to be passed to pupils from poor families.

The tuition fee: In non-WB *PAUD*, those who cannot afford are exempted from paying the fee. There is coordination with village leaders to determine poverty status. The basis of ee collection varies from daily, weekly, monthly, or a combination, starting from a cost of Rp 1000/day for attendance. In WB *PAUD*, the tuition fee is not applied during the funding support period. However, for those no longer receiving support, the tuition fee is applied.

Community Participation

In *Taman Posyandu*, the enrolment of children is advocated by cadres. The first target is children who were weighed in *Posyandu*. The cadre also promotes *PAUD* activity to parents of children suspected of having special needs (e.g. those with speech problems). Children who cannot fulfil the requirements, such as birth certificate, registration fee, or even tuition fee are still invited and not differentiated from others.

Parents' involvement in the learning process is through formal discussion with tutors (particularly at the beginning of every school term) and informal (for example specific consultation about their own children). Some parents who wait during school hours are given regular early childhood care tips by the *PAUD* manager. Tutors also conduct regular home visits to promote early childhood health and education, and sometimes to check on children who have missed school. From such sessions, some parents also received new knowledge about the relationship between children's health, development, and school readiness. At home, most parents assisted children with homework or repeat lessons in school (memorising songs, introducing numbers and the alphabet). However, some parents have problems handling their children in terms of attitude and behavioural change. In this case, tutors help mediate between parents and children during home visits.

Most parents are aware of and grateful for tutors' contributions, and are overall satisfied with the service (mostly have no complaints, and no suggestions to put to *PAUD*, except those regarding facilities). Most parents have no objection to the tuition fee, though there were also cases where parents eventually ignored paying the tuition fee payment for unknown reasons. Some parents realise that tutors'

incentives are far below their contribution, thus they also regularly send gifts to the tutors, individually or collectively. In one case a group of parents initiated a collective fund.

To sustain *PAUD*'s operation, a community contribution can be found in various forms, among which are free rent of an unoccupied house, endowment of land for *PAUD* building, building materials for renovation, and financial contributions.

For WB *PAUD*, enrolment of children is advocated mainly by the village leader, who also co-ordinates with the *PAUD* manager to enable children from poor families to attend.

Parents' involvement in the learning process is through formal discussion with tutors (particularly at the beginning of every school term), and informal (for example during school field trips, when parents are asked to accompany their children). At home, most parents also assisted children with homework or repeat lessons in school (memorising songs, introducing numbers and the alphabet).

In one case, parents collectively raised funds to improve *PAUD* facilities with proper toilet construction. There is also one case in which the *PAUD* established a forum for parents and tutors, managed by parents.

Coordination and Integration

a. Coordination at Village Level

Coordination of rural development is officially conducted through musyawarah perencanaan pembangunan (*musrenbang* – development planning fora), discussing various issues, starting from hamlet level to village, sub-district, and district level. At village monthly meetings, health and education issues are also discussed.

In some cases, meetings of community figures are held involving the *Taman Posyandu*'s tutor to discuss and decide the amount of *PAUD* tuition, how to handle children from poor families, and how to obtain funding for *PAUD*. However, some neighbourhoods (RT/*RW*) have little involvement with *PAUD* issues.

Some tutors participate in *Musrenbang*, however most did not, as they were not invited. One interesting case is a health cadre who actively participates in Musrenbang to voice *PAUD* aspirations. The cadre managed to get approval for a proposed village budget allocation for *PAUD* funding, though only a small amount of Rp 250,000/year. Sometimes *PAUD* tutors and/or managers also co-ordinate with village officials in applying for funding opportunities, such as PNPM.

However, most tutors of WB *PAUD* admitted to being seldom invited, except at the beginning of World Bank funding dissemination. Village leaders are involved in the beginning of *PAUD* establishment, together with community facilitators from World Bank. Coordination was also conducted with *PKK* (family welfare) groups, through which *PAUD* is promoted for those who cannot afford kindergarten.

b. Health Integration

In the Office of Health, *PAUD* were not included as school-related health program, thus only formal and registered education units are served. From a range of services within the *PAUD* definition, only kindergarten is covered by a health program. An official recommendation from the Office of Education is required to include *PAUD*. Ideally an operational task force is formed across sectors to manage integrated health and education services.

For *Taman Posyandu*, a health service is provided through *Posyandu*, where the *PAUD* facility is located. Each month *Puskesmas* provides regular check-ups, for early detection of problems, body weight and height, provision of vitamin A, and dental checks. One *PAUD* also serves as a monthly meeting venue for health cadres. For health cadres, a quarterly mini-workshop is held by the Office of Health. The information is then passed to parents via the health-cadre cum tutor.

For WB *PAUD*, during the funding support period, *PAUD* is obliged to conduct regular health check-ups. *PAUD* usually asks *PUSKESMAS* and midwives to carry out check-ups once per semester. Check-ups involve checking body weight and height, head circumference, eyes, ears, teeth, and checking glands for Tuberculosis diagnosis. The cost for such a health services is included in the funding support. However, at the end of funding support period, a health service is not compulsory, not funded, and thus no longer provided.

In terms of children with special needs, all types of *PAUD* accommodate children with special needs. Although most tutors admitted to having no particular knowledge of how to handle such children, they intuitively serve these special needs, sometimes also involving parents as helpers. Cases found included speech delay, indications similar to Down Syndrome, autism, hyperactivity, and communication disability. Particularly in *Taman Posyandu*, one parent mentioned a tutor's knowledge of child development from 0-6 years old as a plus point in comparison with that of kindergarten teacher, who, according to her, merely emphasised education aspects. An example here was when the tutor cum cadre explained how a toddler's crawling is related to writing skills in the pre-school year. Another parent mentioned that one cannot expect to have such information from an average kindergarten teacher.

c. Coordination with the Office of Education

In general the Office of Education organises regular internal meetings for Sumedang District, regardless of the type of *PAUD*. There is a regular monthly meeting among *PAUD* headmaster, *HIMPAUDI*, inspector, UPTD, and head of the *PAUD* section from district government. Gugus *PAUD* also organises regular meetings, particularly to discuss a tutor's competence. One *PAUD* manager mentioned that *PAUD* tutors/managers are underrated in comparison with those from kindergarten.

HIMPAUDI also organises monthly meetings in the form of various training sessions, and workshops. In relation to this, each *PAUD* is allocated a sum of money based on the number of tutors and pupils. A community figure argued that *HIMPAUDI*'s role is more a social gathering rather than professional forum. Some tutors also argued that training is relatively costly, with too many participants and too much material delivered in a very short time. Thus knowledge retention is limited. No module is provided, and participants have to pay extra to copy the materials.

Expectation (the Dream) of Parents, Tutors, Village Leaders, Local Government Official

Most parents have a dream that *PAUD* will improve, particularly in terms of physical facilities, tutors' incentives, and, if possible, provision of free tuition. Parents also expect that tutors will stay to improve the *PAUD* and that as *PAUD* quality increases so will the quality of the children. There is a hope that *PAUD* will no longer be undervalued, and that its human resources can be optimised.

Most tutors dream of improving *PAUD* facilities and teaching quality through appropriate training. Tutors also expect *PAUD* to last as an alternative for children to play and learn. Tutors are committed to the vision of assisting children to obtain quality character and life. However, they also expect some attention from the government. Many of them never received any kind of support (government support has not been evenly distributed).

Community figures dream of improving *PAUD* awareness, so that knowledge about the importance of *PAUD* grows among the community. They would like to see better incentives for tutors as well as managers, for tutors to be appointed as civil servants, and for *PAUD* to be equal to the formal education unit. On the one hand, they perceived standardisation of *PAUD* as important (in terms of syllabus, material, and tutor training), but, on the other hand, they would like to maintain the status of *PAUD* as non-formal, so that an academic degree is not required from the tutors. They also expect continual assistance for *PAUD* improvement, better integration with other services (particularly health), and better facility/infrastructure (particularly in terms of physical building).

An official from the Office of Education dreams of increased quality of human resource in *PAUD* (tutor qualification). It is mentioned that within the Minister of Education's regulation the minimum requirement for a tutor to be eligible for an incentive is a high school degree. Moreover, *HIMPAUDI* policy on *PAUD* tutor certification requires an S1 degree. Village officials however emphasised the existing reality, how most of the cadres are housewives and senior citizens, and how they should be supported and motivated, and not discouraged in any way, to sustain the *PAUD* service. An official from the Office of Education also expects more opportunities to sit together and improve coordination across sectors, such as in stakeholder meetings/discussions.

Village officials dream of improved communication with *PAUD*, so that every village is aware of the condition and benefit of *PAUD*. Such communication has been developed in only one village, where tutors' aspiration were heard, and where incentives for the *PAUD* cadre were then allocated within the village budget, despite its small size. In the future, this model of coordination is expected to spread to other villages. However, village officials also expect better communication with parents, as they are the ones who are relied on in the effort to improve their environment/neighbourhood. On this Officials from the Office of Education agree, believing that, despite the availability of external funding support, constant effort should be made to increase a community's trust in *PAUD* and the awareness of the importance of education. To deal with the lack of funding, tutors must be creative, e.g. utilising used materials for educational toys. External funding should be perceived as a stimulant.

Officials from the Office of Health dream of better quality of tutors developed through appropriate training, so that despite their academic degree the community will put more trust in them and thus be willing to pay more for the good service.

4.2.2 Garut

In Garut, the following activities were conducted:

- 2 FGDs with parents group (parents from WB *PAUD* and non-WB *PAUD*),
- 2 FGDs with tutor group (tutors from WB *PAUD* and non-WB *PAUD*),
- 1 FGD with community figures,
- 1 FGD with local officials.
- In-depth interviews with sub-district officials and parents of those not enrolling to *PAUD*.
- Observations on tutor-child interaction at school and parent-child interaction at home.

Knowledge of *PAUD HI*

All parents understand the concept of *PAUD* as early childhood education, learning while playing. However, none have heard of *PAUD HI*. Only a few tutors recalled *PAUD HI* as holistic and integrated, covering health, nutrition, and education. Such information was obtained from socialization events held by World Bank.

Parents, tutors, community figures, and local officials all agree on and are aware of the importance of *PAUD*. Among the main reasons for enrolling children in *PAUD* are to introduce them to reading and counting, along with basic skills, and to foster independence and confidence. Most agree that children who attended *PAUD* are more advanced (they are already familiar with letters, numbers, time), and more confident, disciplined, independent, and responsible in terms of character. Other skills gained form *PAUD* that pleased parents included the ability to recite prayers, take showers and brush teeth, and better communication.

As for the reasons preventing children from attending *PAUD*, most agree that awareness about the importance of *PAUD*, location, and economic problems are the main factors. However, interestingly,

economic reasons sometimes mean that parents cannot pay for snacks. Since the schools are usually crowded by hawkers selling snacks, sometimes parents decide not to send children to school despite having money to pay for transportation.

Process of Developing *PAUD* Initiatives

Many non-WB *PAUD* started from tempat penitipan anak (*TPA* – day care) or a similar unit. Some were established by foundations and others by family/citizen groups. Around 2006-2007, along with a massive campaign from the government, such *TPA*/similar units were legalized into '*PAUD Mandiri*', which provide pupils with additional nutrition. By 2008 most of the managers of these *PAUD* had received legal certification of establishment. In some cases, there are also *PAUD* established by a foundation as an extension of existing kindergarten.

In 2009, World Bank funding support was announced for establishing new *PAUD*. This caused resentment in the community, in which existing *PAUD* institutions felt that the support was supposed to be given to those already established as proof of their dedication rather than to establish new ones.

To establish new *PAUD*, location is determined based on Musdes (village meeting), facilitated by consultants from provincial government. There is a one month process of research, mapping, and field visits for location survey. A community facilitator from World Bank organises a meeting for each hamlet. The process was conducted in coordination with the village, and Musdus (hamlet meeting) was held prior to funding disbursement. Funding support from the World Bank was given only for building construction, educational toys/equipment, and tutors' incentives, while the land was provided by the community.

The funding support from the World Bank, a sum of Rp 90 million for three years, disbursed in three phases, was wired directly to the *PAUD* manager's account. As a requirement, the account must have stand-by capital of Rp 1,800,000, which was expected to be obtained from community savings. However, in most cases it was taken from the manager's personal funds.

Following the requirement of the World Bank, in one village 2 *PAUD* were to be established, namely 'central *PAUD*' and 'visiting *PAUD*'. Visiting *PAUD*' were establish by request for those located far from 'central *PAUD*'. The tutor (tendik) is chosen by the community through Musdus and Musdes.

ECD Staffing

For non-WB *PAUD*, tutors are recruited mostly from the surrounding area, or from relatives of *PAUD* managers. The educational background of tutors varies. Some are graduates of junior high school or senior high school, while others are in the process of obtaining an S1 degree. Tutors formulate the curriculum and distribute the tasks among themselves. Managers in general supervise implementation of the curriculum and daily learning activity. Efforts to improve the curriculum are taken through visits to other *PAUD* institutions for comparative study, as well as *HIMPAUDI* tutor meetings.

The tutor's incentive (a range of Rp 20,000 to Rp 70,000 monthly) is obtained from monthly tuition fees. In some cases, tutors receive no incentive (they perfom the role "lillahita'ala" – 'only for the glory of God', i.e. they are purely voluntary). A number of tutors have received 'monthly incentives' from the sub-district, allocated for one tutor in each *PAUD*. Thus usually not every tutor receives a regular incentive. Tutors within a *PAUD* have to take turns as the Education Department has insufficient funding for each district and, especially, each sub-district.

Most tutors have participated in mini training sessions, but only a few have received formal training. Mini training consists of regular workshops (usually monthly) organised by district level *HIMPAUDI*, while formal training is usually organised by the university, which charges a relatively high fee. Training is given for one representative of each *PAUD*, who will later share their learning with their colleagues. Tutors agree that the training helped them to give a better direction in teaching.

In WB *PAUD*, every neighbourhood unit (*RW*) proposes candidates as a tutor and CDW (child development worker), who then undergo a selection process in the hamlet, and a further process in village meetings. The CDW was selected by the community during socialization by the facilitator. There is confusion among the community about the CDW and tutor's qualifications, particularly whether a high school degree is required or not. In some cases, to fill the position in WB *PAUD*, the tutor was 'taken' from existing *PAUD* in operation. Managers are selected from community figures and, to avoid nepotism, civil servants and local officials are not allowed to become *PAUD* managers.

Tutors' incentives are provided for 2 people (1 tutor and 1 CDW), but usually distributed evenly within a *PAUD*, considering the similar workload. The amount is Rp 200,000/person, or Rp 400,000/*PAUD*.

Training was provided for the head tutor, not for the assistant tutor. Topics covered include: teaching methods, children stimulation methods, children songs, BCCT (Beyond Center and Circle Time), learning strategy, child development psychology, children with special needs, children PHBS health, fun learning, management, evaluation, how to make educational tools, how to document RKH, RPM, and curriculum. For the chair and treasurer, there was one day of training about bookkeeping. However, the training was so intensive that not all of the materials were able to be applied eventually. As quoted by one tutor "digerebeg belajarna, padat pisan, janten aya nu tos lebet, kaluar deui, 'barho' – bubar poho" ["learning was conducted in such a rush, very intensive, thus the bulk of information that have entered my head went out almost instantly, most had already forgotten what they learned by the end of the training"]. Tutors expect such training to be given gradually.

Note: at the end of financial support period from the World Bank, some tutors ceased to teach, and some *PAUD* even ceased activity. From the recorded 48 *PAUD*, currently only 33 are active. In such cases, pupils were usually transferred to independent *PAUD*s in the area.

Requirements to Participate in *PAUD* Activities

To enroll their children in *PAUD*, parents have to provide: a birth certificate, the registration fee, uniform cost, and tuition fee.

Birth certificate: some of the children have no birth certificate as the parents were not aware of the importance of it. Parents recalled one occasion of mass application for birth certificates, the cost of which is around Rp 50, 000 for two children. However, the program has now been stopped.

Those giving birth in a midwife facility usually obtain a birth certificate. A local health officer also mentioned that the birth certificate fee is included in the birthing fee for those giving birth with the help of midwife. The only requirement to obtaining the certificate is presenting an ID card, family card, and marriage certificate. However, many are still assisted by traditional birth attendants at home, thus they have to directly apply for the child's birth certificate in the village. Previously, even cadres can facilitate the birth certificate process, provided a family card and marriage certificate of the parents can be produced.

A village usually provides "Komsen" – a memo from village head announcing the birth of a villager. The content of the letter is similar to a birth certificate, the main differences being the paper colour and size. In every village in Garut District "komsen" is compulsory as a memo to obtain birth certificate. Although it should be only a temporary birth certificate, most people use it to replace a birth certificate when registering in *PAUD*. For primary school registration sometimes it is also accepted. There's no cost for obtaining "komsen" – sometimes just Rp 5,000 as a tip for the typist.

Starting from 2012, there is a new regulation for obtaining a birth certificate. For children under 1 year of age the cost is between 40-70,000 rupiah, but for children above 1 year old a court trial is required, and this costs 400-500,000 rupiah. Others mentioned that the cost can reach 1.5 million.

Community Participation

Information about *PAUD* is spread through word of mouth among parents in a village. Children from poor families are also motivated to join. At home, most parents assisted children with homework or repeat lessons in school (memorising songs or prayers). Parents also contribute in-kind, e.g. donating timber to make educational tools, lending house/land for *PAUD* activity, presenting gifts to tutosr at the end of the academic year, and helping during events at school.

For non-WB *PAUD*, parents contribute financially through payment of various fees. Registration fees range from Rp 7,000 to Rp 170,000, for which parents get a set of uniforms, books, and colouring crayons. Monthly tuition ranges from Rp 1,000 to Rp 6,000. However, for some, this fee was not applied. Sometimes people also contributed agricultural products or wood.

For WB *PAUD*, during the support period no fees were charged. At the end of support period, fees were charged, the amount of which was determined based on a consensus between parents and *PAUD* managers and normally ranged from Rp 5,000 to Rp 12,000. Although it was not clearly mentioned that WB *PAUD* should exempt all children from tuition fees, the community refused to pay upon knowing that there was funding support. Quoting their perception "*Kenapa kalau ada bantuan dari pemerintah masih diminta bantuan? Emang uangnya dikemanakan?*" ["Why are we asked to pay, while there's support from government? What have you done with the money from the government?"]

However, a local community figure mentioned that actually parents don't mind contributing tuition fees, so long as it is still affordable. On the other hand, some parents did object to paying tuition, saying "SD aja gratis, kenapa *PAUD* harus bayar?" [We know that primary school is free (of tuition fees), so why should we pay for *PAUD*?]

Coordination and Integration

a. Coordination at Village Level

In non-WB *PAUD*, tutors are often invited to village meetings as representative of *PAUD*. Although complaints and requests for support (both financial and in-kind) are often mentioned, so far none of these complaints or requests have been officially addressed. However, in one case the village head often personally contributes some donations for incidental needs, such as replacing roof tiles or painting the wall.

PAUD also invites village heads and district heads to events like religious celebrations (Maulud or Rajab events) and graduation day. However, there were also cases when *PAUD* managers/tutors were asked by some officers to provide stamped signatures for unclear purpose (i.e. suspected of being used for personal interest).

In WB *PAUD*, from the very beginning, the village heads took part in selecting the tutors through Musdus. *PAUD* managers are invited for annual *Musrenbang/Musdes* (development planning meeting/village meeting), along with *PKK* (Family Welfare) cadre, community figures, and head of RT/*RW* (smaller/larger neighbourhood unit). Also, there is a monthly coordination meeting with *PKK*, for tutors who are also *PKK* cadre (most of the tutors are also *PKK* cadre).

As mentioned by a community figure, coordination between village members (formal leader, community figures, and neighbourhood leader) and *PAUD* managers needs improving. In one case, a community fund (tabungan amal ibadah – charity saving) already exists, and should be accessible by *PAUD* (e.g. have some percentage of the saving allocated for *PAUD*). The problem is that there is little opportunity to meet and discuss *PAUD*-specific issues.

In most villages, funding for *PAUD* had not been specifically allocated in village budgets, except for some allocation from the 'social fund', a small amount used mainly for maintenance or purchase of stationery. Currently, particularly for building maintenance, fund allocation has been proposed in RPJMDes budget. PNPM program is also planned. All of these are discussed in Musrenbang Desa.

b. Health Integration

In non-WB *PAUD*, while some happen to be located near a *Posyandu*, collaboration occurred mainly through the PNPM program, in which a *PAUD* building is established on the same site as the *Posyandu*. In other *PAUD*, there was also collaboration with *Puskesmas*, but this did not last long and was discontinued by 2008. *Posyandu* exist in every village, but there is no direct relation with *PAUD*.

In WB *PAUD*, during the support period, a health check-up (including dental check-up) and light medication is provided, funded by World Bank. Measurement of head circumference is conducted by CDW. Additional nutrition was also given with support of the World Bank. *Posyandu* provides additional nutrition, supported by sub-district funds. However, after the financial support period ended, regular health check-ups are no longer available. As one tutor explained, "*Sedikitnya harus ada ongkos, malu dulu biasa mengongkosi sekarang no lagi. Dulu kan ada jatah dari WB.*" ["At least we should give some amount of (transportation) fee, we used to give them some money so what would they say (we would be ashamed) when we no longer provide them anything now. Previously we had a budget from the World Bank."]

Officials from the Office of Health also stated that the school health service was only available from primary school to high school level. For *PAUD* and kindergarten, it is only available by request. For tutors who also are *Posyandu* cadre, regular mini-workshops are given.

In terms of dealing with children with special needs, tutors have no specific knowledge/training and rely mostly on their intuition. In practice, special needs children are usually helped by one tutor, who observes, approaches, and persuades more frequently. Most instances found are of children with speech delay and emotional imbalance (aggressive or crying all the time).

c. Coordination with the Office of Education

The Office of Education, in this case "Penilik Non Formal" (Non Formal Observer), sometimes visits *PAUD* to disseminate information, including information on seminar events and the possibility of support.

The Office of Education provides *BOP* (education operational support) and incentives for tutors. *BOP*, which has reached Rp 6-9 million per *PAUD*, is mostly used for *PAUD* infrastructure and education tools/equipment. To access the funding, *PAUD* have to write a proposal. Tutors received incentives based on experience (minimum of 5-years teaching) and whether they are still actively teaching. Tutors' incentives reach Rp 1,750,000 per year, for one tutor per *PAUD*, and revolving (only a small number of *PAUD* tutors have received such support).

Specifically for WB *PAUD*, *PAUD* sends monthly reports to the sub-district Office of Education, covering the number of pupils and existing facilities (including broken ones). *PAUD* also purchase report books. *PAUD* also attend assistance meetings, receive observer visits, and co-ordinate for socialization of the program, but no training was given.

HIMPAUDI facilitates regular monthly tutor meetings to discuss the problems in *PAUD* and to share teaching experience among tutors. Relations with *IGTKI* are limited to assistance, observation, and directive through the sub-district Office of Education. *HIMPAUDI* organizes monthly meetings or training sessions of 1-2 hours. Since a fee is charged (Rp 40,000/tutor), only one tutor per *PAUD* per event usually attends.

Expectation (the Dream) of Parents, Tutors, Community Figures, Local Government Official

Parents dream of receiving donor support for building construction, education tools/equipment (adding quantity and variety and allowing *PAUD* to serve the large number of children) and chairs (currently some *PAUD* are still only use carpets). Parents also expect that tutors' welfare will increase, as they believe job satisfaction will increase motivation. Some parents also expect additional classroom and toilet facilities.

Tutors dream of increased quality of teaching (not dominating and more caring toward children), and reduced conflict with kindergartens over child enrolment. Tutors also expect support to be given to existing rather than new *PAUD*, as many are still in need of support, mainly to improve buildings. Tutors also expect an improved relationship with the sub-district Office of Education, *HIMPAUDI*, as well as with other *PAUD*.

Community figures dream of regular support from government for tutors' incentives and building maintenance, and increased community involvement (e.g. allocation from community fund/tabungan amal ibadah for *PAUD*). They agree on the *PAUD* benefit among the community. They also expect to have more opportunity to sit together and discuss *PAUD* issues regularly, particularly *PAUD* managers and community figures.

Authorities and officials dream of a better legal basis/policy for *PAUD*, allowing better authority for *PAUD* managers to co-ordinate with relevant institutions, such as asking for support to *Puskesmas*, the sub-district Office of Education, the Office of Religious Affairs, etc. UPTD Dinas Pendidikan, KUA, etc. They also expect that *PAUD* will be supported by all stakeholders: community, parents, as well as government.

4.2.3 Kupang

In Kupang, the following activities were conducted:

- 2 FGDs with parent group (parents from Child Fund *PAUD* and non-Child Fund *PAUD*)
- 2 FGDs with tutor group (tutors from Child Fund *PAUD* and non-Child Fund *PAUD*)
- 1 FGD with community figures
- 1 FGD with local officials
- In-depth interviews with sub-district officials, the manager of Child Fund *PAUD*, and parents of those not enrolling to *PAUD*
- Observations on tutor-child interaction at school and parent-child interaction at home.

Knowledge of *PAUD HI*

No parents or tutors have heard about *PAUD HI* Parents' knowledge about *PAUD* is more directed to the preschool program (emphasis on school readiness instead of child development). All parents saw the introduction to letters and numbers as the main reason to enroll their children in *PAUD*. In addition, some mothers also see *PAUD* as an alternative day care. The biggest motivation comes from the children, who want to enrol as they see their peers enrolling in 'school'.

All parents agree on the benefit of attending *PAUD*: children can play and learn the alphabet, colour, write, and sing. Notably when attending primary school, *PAUD* alumni are, despite their younger age, more advance in comparison with children who do not attend *PAUD* (who, in one case. didn't pass to the next grade).

Several reasons prevent children from attending *PAUD*. A common one is the that parents are busy with other activities, e.g. caring for a new born baby at home, so that no one is available to send the child to

PAUD. Another reason for not enrolling is that some parents also take children to work in the fields, or, in other cases, children are left at home to help their grandparents while both parents work in the fields. Unlike in 3 other districts, most parents in Kupang stated that it is the children who request/push their parents to enrol to *PAUD*.

However, for *PAUD* without an operational permit, there is also an image that *PAUD* is illegal, as the pupils wear no uniform and parents talk of the *PAUD* as not 'official'. Some parents are of the opinion that the *PAUD* building is not in a good condition, thus parents prefer to enrol their children in the Catholic kindergarten (which, although it is more expensive, has a better building). Another constraining factor is the perception that parents know best about children's health and education. Grandparents also seem to play a role in deciding about enrolment.

Local government officials estimated that there are fewer than 50% of children attending *PAUD*, as there are not many 'official' (i.e. have building, furniture, and permit) *PAUD*s in operation.

Process of Developing Initiatives

Child Fund (CF) through partner NGO, LPM2 (Lembaga Pemberdayaan Masyarakat Madani) first asks the district government to recommend the location/village. After compiling a village profile, social preparation is conducted through a multi-stakeholder meeting (village government, officers from education and health, community and religious figures) on village/sub-district level. LPM2 then assess the response; should it be negative, the assistance will be transferred to another village.

There are 10 villages in Kupang District which received CF/LPM2 support, namely: East Penfui, Oelnasi, Oebelo, Kuakelalo, Oletsara, Oeltua, Oben, Oenone 1, Oenone 2, and Apren. Some have received assistance since 2000 and the last one started in Oebelo in 2005. These 10 villages are still supported.

The community is responsible for the initiative (location, construction, provision of facilities, and building maintenance), while the responsibility of CF is merely to support funding for building construction. For the *PAUD* program, the community expresses a willingness to pay monthly fees, the sum of which varies between Rp 1,000 to Rp 20,000. The fund is managed in the village under supervision of LPM2; the fund is inclusive of children graduation ceremony.

Note: a number of existing *PAUD* also accessed funding support from CF in 2009.

For non-CF *PAUD*, the initiative came from community members who are concerned about children who cannot afford to enter kindergarten in their neighbourhood. They began by organising education activities voluntarily. Some of them used their own house, or a PLS/PKBM (Pusat Kegiatan Belajar Masyarakat – community learning center) building. Among them are *Posyandu* cadres who were concerned upon seeing that so many children failed the primary school entry test because they had not been able to attend kindergarten due to the distance. *Posyandu* cadre, *PKK*, and community figures work together during the initiation of the *PAUD*. Some of the initiative also started from charity foundations or church figures.

ECD Tutor (Cadres, Teacher) a Description of Selection Criteria, Education, Incentives (Honorarium) Provided

The tutor of CF *PAUD* is selected by the community based on whether they satisfy a number of criteria: originating from local area, familiar with children, responsible, and literate. Almost all tutors have no background in children's education, only experience as a mother. The tutor receives an incentive from CF, a sum of at least Rp 250,000/month, which is given to 1-2 tutors in each *PAUD*. However, *PAUD* managers are working voluntarily.

Note: A volunteer supervisor is also selected by the community to supervise, monitor, and ensure implementation of all activities within CF program (including *PAUD*, *Posyandu*, and child-friendly neighbourhood), determining who and what to train, etc. This volunteer is paid by CF a sum of Rp 250,000/ month. The volunteer also takes on a facilitation role in each village, assisted by a committee for each program (*PAUD*, *Posyandu*, economic development, youth reproductive health). This committee is working voluntarily.

Training is provided by CF on how to create a curriculum and educational tools from used materials. Training was organised over 3 days, using an in-class method, with 30 participants in each class. Prior to CF training, tutors merely taught singing, the alphabet, and numbers (without curriculum). The tutors expect more material on the basic technique of early childhood teaching, how to do reporting, and more on curriculum. They also expect to receive training modules and have internship opportunities in local kindergarten

Most tutors of non-CF *PAUD* receive no incentive, or, if they do, it is not regular. Incentives are taken from the tuition fee, but some parents do not pay. Some said that the Office of Education provides incentives for tutors who have an NUPTK (unique registration number). However, as one tutor mentioned, "*Tetapi kami no tahu bagaimana dapat NUPTK, dinas no pernah sosialisasi, no pernah datang satu kali. UPTD Kecamatan no pernah datang ke sini melihat kegiatan*." ["We never know how to obtain NUPTK. no socialization was made by the Dept. Office of Education, they have never visited us, not even once. Sub-district Office of Dept. of Education has never visited us either."]

Tutors from some *PAUD* have received training from the NTT Province Office of PPO, covering child development, curriculum, and practice. Training was held over 3-4 days. However, not all *PAUD* were invited by the District Office of PPO to join the training. They also expect more material on playing in centers, bookkeeping and reporting, and how to create daily activity planning (as there are differences between the previous and the subsequent training).

Requirements to Participate in *PAUD* Activities

To participate in *PAUD* CF, parents only have to register their name. No fees are charged for registration, uniform, or tuition. A birth certificate is not compulsory, as many children still have no birth certificate. The uniform is given by CD, however only in the first year. Parents have to pay for the graduation certificate, a sum of Rp 12,500, because it has to be bought from the District Office of Education.

To participate in non-CF *PAUD*, parents have to provide a birth certificate, a baptism certificate, and registration. There is also a minimum age of 2 years for children. Tuition fees are applied based on a consensus between tutor and parents. However, not all are paying. For those who cannot afford the fee, tutor/managers usually provide the books and stationery.

On birth certificates, there's no clear information about the cost of obtaining one. Some said it is Rp 20,000 for the 1st and 2nd child and Rp 10,000 for 3rd and 4th child. An announcement is usually made in church. The time limit to obtain a birth certificate is 60 days after birth, after which a charge of Rp 1 million is applied.

Many children have no birth certificate due to the marriage status or their parents, most of whom were considered not yet officially married, as the dowry hasn't been paid in full.

Community Participation: Enrolment, Parents Involvement, Contribution (Financial/Others)

At home, most parents help their children with homework. They also provide the facilities needed (books, paper, and stationery). *PAUD* pupils are sometimes also helped by older siblings.

In non-CF *PAUD*, a parent's contribution to *PAUD* is through the registration fee (around Rp 25,000) and tuition fee (varies from Rp 10,000 to 20,000/month). Some also donate in-kind (e.g. providing chairs) at the beginning of *PAUD* operation.

There's no regular meeting with *PAUD* tutors/managers; interaction happened only with those who walk their children to school.

For CF *PAUD*, no registration and tuition fees apply. However, parents are encouraged to do voluntary saving at school, the collected amount of which would be returned upon graduation and used to help with primary school registration. Some parents donate in-kind (land, material, and manpower) during the construction of the *PAUD* building.

Meetings with parents are conducted at the beginning and end of the academic year. Interaction also happened as tutors fetch the children and take them home (one by one), to ensure good attendance rate.

Village Coordination: Coordination, With Whom, Integration, Who Decides

a. Coordination on Village Level

Child Fund organises regular village level meetings, chaired by *BMM* (badan masyarakat madani – civil society agency). During the meetings, tutors, parents, and volunteer supervisors from each village attend and give suggestions about what is needed. Usually *PAUD* received funding support of Rp 150,000 for stationery, but the support has been cut recently. In general, tutors felt that Child Fund pays them more attention than the government, who hardly responds. As one tutor mentioned, "Kami sering diperhatikan oleh Child Fund, tapi pemerintah no ada respon apa-apa" (Child Fund takes care of us almost all the time, but the government gives no response at all"). However, *PAUD* admitted to never having submitted any proposal and they have no idea about how to write one.

PAUD has also been invited to village meetings, organized by local village officials, to discuss the village budget. On one occasion, tutors proposed an allocation for *PAUD*, but it was not granted.

Coordination with village government is not going well, which makes it difficult to access funding from other sources like PNPM. On one occasion, a tutor asked about village allocation for education, but the response was negative (and unpleasant).

b. Health Integration

In CF *PAUD*, the integration of a health services is provided through *Posyandu*, in the form of measurement of weight and height, and additional nutrition. Some of the tutors are *Posyandu* cadres and participate in regular discussions (usually about nutrition) with *Puskesmas* every six months. *Posyandu* cadre is given knowledge about early childhood education and prenatal care.

In collaboration with the *Puskesmas* team, Child Fund provided training on child health, and also ran training sessions with a psychologist from Nusa Cendana University on child development. However the training is not yet integrated.

In terms of children with special needs, CF *PAUD* had received one case, i which the tutor handled based on intuition.

A number of parents understand the basic health services needed by mothers and children. Some mentioned that *Posyandu* suggested pregnant mothers give birth in health facility, *puskesmas*, or hospital, and not at home. Cadres help to take the birthing mother to the nearest facility. Nobody give birth at home with traditional birth assistant. The cost is Rp 10,000, but the service is free for jamkesmas holder.

In non-CF *PAUD*, some parents know about basic health services needed by mothers and children. Some mentioned de-worming, medicine, weight and height measurement for children, and pregnancy checks, vitamins to combat anaemia, and T1 T2 injections for pregnant mothers. However, in one case observed, parents had never taken their child to doctor/hospital/*puskesmas*. In case of illness, no specific care is given, as it is believed that it will be cured by itself. When the illness gets worse, parents buy medication (Amoxilin or panadol) in the warung. The practice of giving birth at home with the help of traditional birth assistant still exists.

In terms of children with special needs, one non-CF *PAUD* decided not to accept such children, as the tutor felt incapable of handling them (no training has been provided), and the parents were also reluctant. Better-off parents of children with special needs send them to special schools.

c. Coordination with Office of Education

Some non-CF *PAUD* received start-up funding and *BOP* support from the Office of Education, however they did not receive this support regularly. One *PAUD* also received books from the Office of Education, however the books received didn't match the *PAUD*'s needs. There is an impression that the sub-district Office of Education is not supporting tutors' efforts to pursue higher education majoring in *PAUD*. One tutor mentioned "*Sampai saat ini sudah bertahun-tahun status kita no jelas. Jadi tutor sampai mati juga begini saja*." ["It's been years, even until right now, we don't have any clear status. Thus for tutor perhaps this is the way it will always be (condition won't change) until we die."]

Some *PAUD* still haven't obtained any operational permit. Most tutors have no idea about how to obtain an operational permit license, as it was not disclosed by the manager.

For CF *PAUD*, there's hardly any coordination with the sub-district Office of Education. Most CF *PAUD* still have no operational permit license. The cost of copying the bulky documents needed to apply is a major barrier to obtaining such a license. Other requirements are the availability of a management structure (some *PAUD* are now self-managed by the tutor), signatures of parents, and a pupil attendance. Both *PAUD* with and without a permit license have to buy graduation certificates from the Office of Education. For *PAUD* without permits, graduation must be merged with those that already have a license.
Almost no tutors had heard of *HIMPAUDI*, in either CF or non-CF *PAUD*.

Expectation (the Dream) of Parents, Tutors, Community Figures, Local Government Official

Parents dream that each *PAUD* can have an operational permit in order to access funding support from the government, particularly when support from CF will have ended. Parents also expect that tutors to be given some reference letter for their dedication in *PAUD*, so that in the future it could add some credit to their CV when they want to apply for a civil servant position. Parents also expect that the number of tutors and educational toys to be increased, and those classrooms be improved (so that they are larger and not so crowded).

Tutors dream of more support from the community and village officials, not merely material support from the village budget, but moral support, such as more opportunities to discuss together on an equal footing. As mentioned above, "Walaupun no memberi bantuan, kita hanya butuh perhatian, seperti pertemuan hari ini." ["Although we're not given any support, at least give us some attention, like in the meeting (with the FGD) that we had today"]. Tutors expect more coordination with the Office of Education and primary schools, training for all *PAUD*s, and incentives for those who haven't received any. Tutors also expect that after CF support ends the government will take over the support of the *PAUD* operation.

Community figures dream of a better understanding from government of local needs and conditions. Most communities felt that CF and other NGOs have contributed much more than the government.

Apart from financial support, community figures mostly appreciated the responsiveness of CF and the attention paid to their complaints or suggestions. Community figures also expect that community participation will increase.

Local officials dream of more support at the village level, e.g. in form of village budget allocation. Officials also dream of more health integration within current *PAUD*s, e.g. regular health check-ups and blood type tests, in collaboration with *Puskesmas*. Along with tutors, officials also expect that after CF support ends the government will take over to continue the *PAUD* operation.

4.2.4 Bengkulu

In Bengkulu the following activities were conducted:

- 2 FGDs with parent groups (parents from World Bank *PAUD* and CSR *PAUD*)
- 2 FGDs with tutor groups (tutors from World Bank *PAUD* and CSR *PAUD*)
- 1 FGD with community figures
- 1 FGD with local officials
- In-depth interviews with sub-district officials and parents of those not enrolled in *PAUD*.
- Observations on tutor-child interaction at school and parent-child interaction at home.

Knowledge of *PAUD HI*

All parents of WB *PAUD* know *PAUD* as early childhood education for 0-5 year olds, however neither parents nor tutors had heard of *PAUD HI*.

By enrolling their children in *PAUD*, parents expect the children to become more confident, obtain social skills, and acquire writing and counting skills. They agree that most children have been able to recognize and write letters and numbers, name the colours, and write their own name. Most children are also able to easily socialize with other children, are more confident to join *PAUD* activities without being accompanied by parents, and are able to listen when being spoken to. Parents of picky eaters also noted an increase in appetite as the children learned to eat together with their peers.

The decision to enter *PAUD* comes mainly from mothers. Both parents co-ordinate to determine the task sharing on accompanying the child to and from the *PAUD*. However, some parents whose child is not entering *PAUD* mentioned having no time to accompany the child to the center as the main reason for not enrolling their child in *PAUD*. Tutors argued that, possibly, they have just not realized the positive side of *PAUD*.

In CSR *PAUD*, parents identify *PAUD* as education for 3-6 year old children to help children gain independence prior to entering primary school. Most know *PAUD HI* as holistic-integrative service, i.e service for pregnant mothers is included. Tutors and parents admitted to having obtained this knowledge from F2H.

Among the reasons for enrolling are parents' expectation for their children to improve social skills (so that children have many friends of their own age), to be introduced colours, letters, and numbers, to improve confidence and independence (so that children can do things by themselves – e.g. eating – and not become cry-babies or overly shy), to learn to pray, and to be more prepared upon entering primary school. They agree that most children have been able to recognize letters, colours, and recite some prayers before eating and sleeping. Children also do their routines without having to be told, e.g. taking a bath right after waking up. The decision to enter *PAUD* comes from parents.

A local official explained *PAUD* as early childhood education for 0-6 year olds, including all types of schooling prior to primary school, including play group, kindergarten, day care, and similar education units. In the beginning, the Ministry of Health launched a similar program focused on child development (not education); in the year 2000 the program was called PADU, but was then renamed *PAUD*. *PAUD* is a facility to develop children's potential, which covers nutrition, intelligence, care, and health. It targets the child, the parents and other adults, as many are unaware of early childhood care and development. *PAUD HI* integrates two aspects: education and development.

Most agree that *PAUD* benefits children, improving their socialisation skills, manners, confidence, controlling their tempers, and helping them to memorise prayers and passages from the Quran. There is also less evidence of children crying at health check-ups. More and more children are able to join in activities without having their mothers nearby.

Community figures also note how *PAUD* brings about a change to the parents as well as the children. For example, parents are no longer authoritarian and copy the style of the *PAUD* teacher in educating their children.

Process of Developing/Initiatives

WB *PAUD* started in 2009 with socialization, followed by a proposal to the Office of Education. Two *PAUD*s were then established. In order to obtain funding, the *PAUD* manager provided the land required by *PAUD* managers, as required by World Bank.

Based on information from the Office of Education, World Bank funding support totals Rp 90 million, divided into 3 years/phases. To access the fund, a funding management team was established through Musdes, which was then legalised through a Regent's Decree. The facilitator and this team formulated a community work plan, which is a requirement for receiving the funds, and this was proposed to the local Office of Education to be verified. The funding allocation for each semester is determined in RAD (village budget plan).

Note: In another case, the initiative came from local community members upon seeing the large number of children in the neighbourhood. *PAUD* managers and/or tutors then proposed to village officials to utilize a building constructed through PNPM funds as the *PAUD* institution. Later the *PAUD* accessed World Bank funding support.

CSR *PAUD* began in the year 2006. By then, four *PAUD*s were established: Mawar, Seruni, Dahlia, and Al Ikhlas, with support from CSR of PT Bionusa. The initiative is meant to help the children of their employees, as transportation to the nearest facility is difficult to access. However, due to lack of pupils, two *PAUD* were merged into *PAUD* Mawar and Al Iklas. Both *PAUD*s offer a lower tuition fee in comparison with others.

ECD Tutor (Cadres, Teacher) a Description of Selection Criteria, Education, Incentives (Honorarium) Provided

In *PAUD* WB, tutors are required to have a junior high/high school degree with some experience in dealing with children. Some tutors in the FGD were from the *Posyandu* cadre and some were from madrasah.

Tutors received a 21-day-training course, which covered how to make RKH (rencana kegiatan harian – daily activity plan), child teaching-learning menus and how to make educational tools from used materials. Participants were divided into groups. Two sessions were delivered 3-4 hours per day. Sessions consisted of theory, practice and simulation.

WB tutors agree that the training is very useful for improving their knowledge about children, how to communicate with parents, and how to manage children with special needs. Tutors expect more materials on how to identify children's talent and how to make RKH.

Tutors currently use a curriculum based on Permen 58. However, some *PAUD*s also use curricula developed by F2H. Some tutors are confused by the large number of existing models (Permen 58, F2H, and Office of Education), and are not sure which curriculum to use.

In CSR *PAUD*, the tutor requirement is a high school degree, a caring attitude toward children, and good social skills. The selection process is conducted by F2H. They received training from F2H (five days in 2004 and 2008), as well as from the Office of Education (three days). Training from the Office of Education covered proposal writing, RKH, how to establish play groups/day care and what to prepare. No training module was given.

In terms of curriculum, all tutors from both *PAUD*s usually plan together, using F2H material with some development. Weekly activity plans will then be placed on the wall.

Tutors are given monthly incentives (a sum of around Rp 700,000) per month. Sometimes the incentive is cut to pay in advance for the cost of uniforms, which parents pay in installments.

Requirements to Participate in *PAUD* Activities

In WB *PAUD*, some requirements to enrol are a copy of the birth certificate, a photograph, a bio data form, the registration fee and uniform cost (not charged previously during the funding support period) – which can be paid for in installments throughout one academic year. Those who cannot afford are not charged. So far, there has been no objection from parents as all decisions were made through consensus.

WB *PAUD* activity is held from Monday to Friday from 08.00-10.00 or 11.00. The center's main activities are conducted between Monday and Thursday, while Friday is for sport and religious activity. Educational tools/equipment were not differentiated based on age, and obtained through World Bank funding support. The procurement is determined in RAD. However, most are already broken or are missing some parts (e.g. puzzles). Those made from used materials sometimes only last a few days.

In CSR *PAUD*, some requirements to enrol are a birth certificate, the registration fee (includes uniform) – which can be paid for in installments until graduation, and a photograph. No objection has been raised from parents; in addition, the *PAUD* is considered the most affordable in comparison with others.

Note: not all children have a birth certificate, particularly those previously living in remote villages, who only realize the importance of a birth certificate when they come to register for school. For current new born babies, the midwife service is inclusive of a birth certificate.

PAUD activity is held from Monday to Friday, 08.00-10.00, or sometimes 10.30 due to additional reading skills tutorials. Educational tools/equipments were obtained from F2H, with specific instruction for teachers on how to organise children in using toys (e.g. children should take turns so that all children get the chance to play). 3-5 year old children use these toys the most, while for 5-6 year olds more emphasis is put on writing skills. The Office of Education also provided outdoor play equipment (swings and slides).

Community Participation: Enrolment, Parents Involvement, Contribution (Financial/Others)

During the support period, no registration fee was charged in WB *PAUD*. Following the end of the support, *PAUD* charge a registration fee of Rp 15,000 plus uniform cost of between Rp 120,000 to 235,000 (which can be paid in installments over one academic year). A tuition fee is also applied, and this varies between Rp 10,000 to 15,000/month. Other costs, like building maintenance, are discussed with parents, and determined through consensus.

At home parents don't always ask children to repeat lessons. Most of the time children learn at home in the afternoon and shortly after dawn.

Regular meeting practices vary among *PAUD*. In one case, a meeting only occurred incidentally. In another, it is held monthly in and each semester in other. For parents who wait at school, communication between parents and tutor occurred frequently, discussing the progress of the pupil, teaching methods, and the making of suggestions for *PAUD*. Parents are mostly satisfied with the benefit of joining *PAUD*, and thus rarely give suggestions (as they considered the service to have been good enough).

In CSR *PAUD*, a registration fee is applied, of between Rp 250,000-350,000 (inclusive of uniform cost),. The fee can be paid in installments throughout one academic year. A tuition fee of Rp 10.000 is also applied. Children from poor families and the tutor's children are exempt from paying a tuition fee. In addition, there is a 2-in-1 policy whereby parents of two children only pay for one. There is also voluntary collective saving which comes from parents and tutors (the amount of which is not determined). This saving is used for charity (e.g. when somebody is ill, or dies). Building maintenance is covered by PT Bionus.

At home, parents mentioned continuation of lessons from school, e.g. teaching the child not to litter everywhere. One parent also complained that sometimes it is still difficult to change the child's eating habits; although there has been improvement after entering *PAUD* – the child shows a good appetite at school, but not at home.

Regular meetings are held at the beginning, middle, and end of academic year. Attendees usually discuss the various costs that need to be negotiated with parents, and suggestions are given to the tutor for *PAUD* development. In the case of a specific problem with an individual child, the tutor will discuss this with the parents in private. Parents are mostly satisfied with the *PAUD* service, and willingly contribute to daily activities, such as helping to tidy up the class.

Village Coordination

a. Coordination at Village Level

Tutors of WB *PAUD* are often invited to village meetings, such as when the village budget is being determined. Coordination with the village has started, through inclusion in PNPM allocation. However, the reality depends on village priorities (e.g. when road construction is cancelled the funds might be reallocated to *PAUD* building). There is no regular meeting with *PKK*, although *PKK* has been very involved in *PAUD*. In the future, there is a plan from village officials to allocate village budget funds for *PAUD*.

For CSR *PAUD*, there is a feeling that *PAUD* are already well-off, so they are not supported significantly by village officials. Government's involvement is limited to participation in monthly meetings organized by *PAUD*. There is a plan from PT. Bionus to facilitate regular stakeholder meetings, as well as community based economic development projects.

b. Health Integration

For WB *PAUD*, coordination is between the village midwife and pustu (*Puskesmas* pembantu/Assistant *Puskesmas*) for dental check-ups, nutrition, and regular *Posyandu* activity.

In terms of children with special needs, there are some pupils with physical limitations. The pupil was introverted, had difficulty in socializing with peers, and needed the tutor's assistance to help in focusing attention. However, not all parents are aware of children with special needs.

For CSR *PAUD*, there is coordination with *Puskesmas* for regular weighing.

In terms of children with special needs, *PAUD* had received one. The child was not differentiated from other children, but treated more intensively (the tutor talked with the child more often).

Officials from the Office of Health mentioned that *Puskesmas* can only assist *PAUD* based on official request from the *PAUD* manager, thus it is not under sub-district coordination. Note: as *PAUD* is still under the education authority, health officials have no authority to intervene, unless being officially invited (by the *PAUD* manager) or there is a justified legal basis.

c. Coordination with the Office of Education

FOR WB *PAUD*, the Office of Education provided a 'parenting fund' and the tutor's incentive. There is also *BOP*, the amount of which is limited by the number of pupils (Rp 280,000 per pupil). Together with *HIMPAUDI*, a proposal for the tutor's incentive in the local budget allocation is submitted by *PAUD* to District government. Together with *IGTKI*, *PAUD* is involved in events, such as the inauguration of the District first lady as '*PAUD* Matron'.

As for CSR *PAUD*, there is very little coordination with the Office of Education. However, there are regular monthly meetings with a staff member from the Office of Education and *HIMPAUDI*. This meeting involves all 84 *PAUD*s. Each *PAUD* takes it in turn to host the meeting, thus tutors can see the conditions of other *PAUD*s.

The sub-district Office of Education once paid a visit to CSR *PAUD*, and instructed the tutor to change the currently-used daily activity planning (RKH) into the official 'generic menu.' In response, tutors tried to copy the material but failed to understand how to use it. Finally, tutors returned to initial RKH (provided by F2H).

HIMPAUDI facilitate regular monthly meetings for tutors, however CSR *PAUD* tutors hardly participate, as most find it difficult to follow the direction and training outcomes of the Office of Education.

Expectation (the Dream) of Parents, Tutors, Community Figures, Local Government Official

Parents dream of improvement in *PAUD* buildings (more space and furniture) and general operation (categorisation of service based on age group).

Tutors dream of increasing *PAUD* quality, as in the near future primary schools will include participation in *PAUD* as one of the requirements for enrolment. Tutors also expect improved coordination and support from relevant institutions, not just in the form of financial support, but also in the form in program support e.g. vitamin supplements. Some tutors also would like to establish co-operatives. Specifically for parents, tutors expect a better understanding that *PAUD* is not to teach writing and reading.

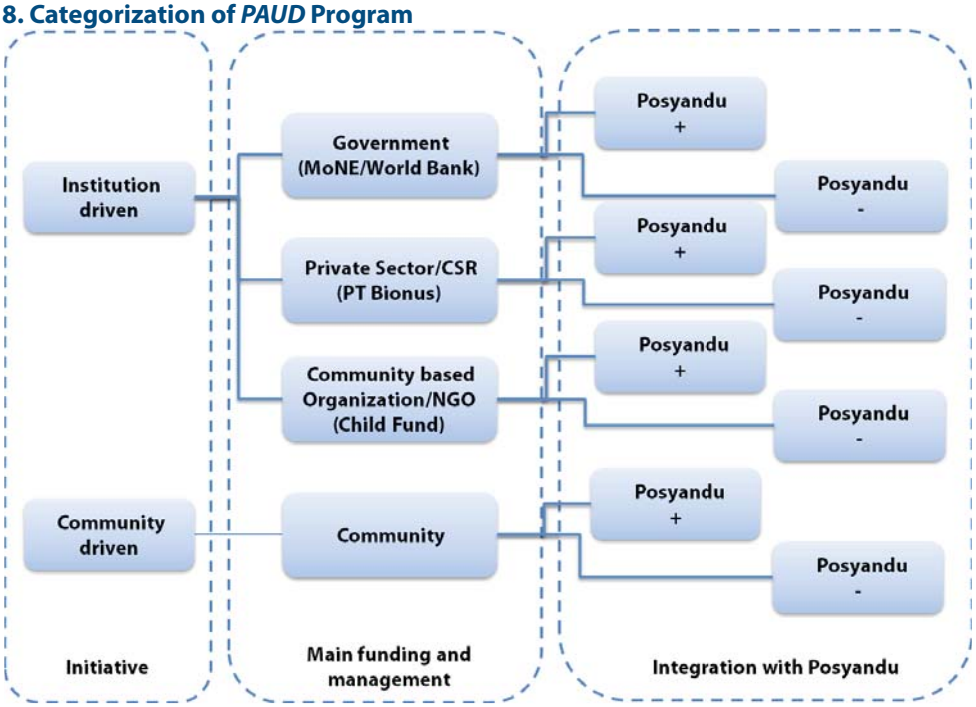
Community figures dream of a better generation who can match their peers in urban areas. Thus they expect support for building construction (as poor building condition is a major constraint factor for enrolling children on *PAUD*). Community figures also expect more meetings with parents to socialize *PAUD*.

Local officials dream of *PAUD*s with good, comfortable, and decent facilities. In order to achieve this, they also expect an empowerment program instead of relying on donations. For example, farming projects or canteen ventures so that children can have healthy snacks at school, while the profit can go to subsidising operational costs.

4.3 Discussion of Findings

From the findings in the field, ECD can be categorised into 4 main models based on how the institution was established and developed. In relation to the concept of ECD-HI, where health, nutrition and psychosocial development should be integrated in the program, the 4 models can be further divided into two more categories based on ECD integration with *Posyandu*, namely those integrated and those not integrated to *Posyandu*. The categorization of ECD centers is shown in the following diagram.

Figure 8. Categorization of *PAUD* Program



Among the 4 districts visited for this research, 5 types of ECD Center were found, namely:

- Type 1, also called World Bank *PAUD*: ECD where the establishment is driven by a government institution, and not integrated to *Posyandu*. This type was found in Sumedang, Garut, and Bengkulu districts.
- Type 2, also called CSR *PAUD*: ECD where the establishment is driven by private institutions, and integrated with *Posyandu*. This type was found only in Bengkulu district.
- Type 3, also called Child Fund *PAUD*: ECD where the establishment is driven by citizen sector institutions, and integrated to *Posyandu*. This type was found only in Kupang district.
- Type 4, also called *Taman Posyandu*: ECD where the establishment is driven by the community, and integrated with *Posyandu*. This type was found only in Sumedang district.
- Type 5, also called *PAUD Mandiri*: ECD where the establishment is driven by the community, and could either be integrated or not with *Posyandu*. This type was found in Sumedang, Kupang, and Garut districts.

Advantages and disadvantages of each type are discussed based on the following aspects:

1. Process of establishment
2. Operation
3. Coordination and integration with other institutions
4. Community/parent's role
5. Sustainability

4.3.1 Process of Establishment

One of the main objectives of any *PAUD* program is to reduce the gap in early childhood education service availability between urban and rural areas by increasing access. Depending on the model, we found that frequently, rather than focusing on increasing the number of services available, previously existing institutions should be taken into account, in the effort to expand the coverage.

In World Bank *PAUD* however, there is a strong perception in the field (particularly in Garut) that support is given only to establish new *PAUD*s, which to some extent caused negative responses in the community and even creates disadvantages against existing *PAUD*s. For example, qualified tutors from existing *PAUD* are 'taken' in order to fulfil the requirement to build new *PAUD*s. Conflict also arose when the location of this new *PAUD* was within the coverage of existing *PAUD*s, despite being in a different administrative area. The resentment arose among the existing *PAUD*s, as they felt that their efforts – starting a *PAUD* from zero, and struggling to sustain it – was not taken into account at all by the government. There were also occasions on which *PAUD* was established with the sole purpose of optimising the funding opportunity. However, it interesting to note how some communities found ways around the requirement by renaming an existing *PAUD* and reporting it as newly established. Thus, it can be said that the increased number of new *PAUD* is not always equivalent to increased quality and coverage.

To ensure community participation in a program, a thorough public sensitisation exercise should be carried out right from the very beginning of the implementation. Building awareness of the importance of the program and community institutional capacity to safeguard the program execution are key. This is apparent in the case of Child Fund *PAUD*, where, separate from the *PAUD* institution itself, another institution (committee) is also established in the community to maintain a monitoring function. This committee is involved in, for example, recommending capacity building for the *PAUD* tutor, and supervising the proper management of funding. Thus, the community gained a sense of ownership (i.e. control and responsibility) over the *PAUD* operation.

A number of examples show that the community is capable of building *PAUD* initiatives, provided it has an awareness of its importance. *PAUD Mandiri* are clear evidence that, despite the lack of basic know-how, once the community perceived the need for early childhood education, such a service emerged naturally with minimal external input. However, such a service could be optimised with proper knowledge, and would benefit greatly from proper external input. This is what *Taman Posyandu* and CSR *PAUD* in this research are trying to do: providing capacity building and stimulation to build a replicable *PAUD* model that maximises the use of local resources. Thus, the existing model is expected to become "viral" – i.e. self-replicating among the community. In this case, *PAUD* establishment is truly based on local need instead of the motivation to receive funding. However, there are constraints, particularly among communities with a low income economy, for *PAUD* to spread widely by itself. One cannot expect resources from the local community itself to be adequate for such an effort. Thus, external input is still necessary, but the important thing is how the community can seek and access the resources they need and prepare to manage the resources properly once they have it in hands.

Another note on external input: consideration should be given to optimizing existing resources rather than starting from scratch and how to best to suit local needs.

4.3.2 Operation

Because the day to day operation of the institution is generally reliant on the tutor, this section will discuss certain aspects of center operation in relation to the tutor. In one regulation, the Ministry of Education has put the S1 academic degree as a requirement for the *PAUD* tutor. However, findings show that in most areas, tutors who are dedicated and performed well often turned out to have only low academic degrees (as low as primary school graduate). Thus, personal skills and commitment are here

of more importance than formal qualifications. Affinity to children, acceptance by the society, patience, and willingness to dedicate themselves for a certain period of time are the basic requirements of most *PAUD* institutions.

Lessons learned from the village midwife program might be worth considering. As human resources with high academic degrees are rarely found in rural areas, a program to place 55,000 village midwives from urban areas was implemented. However, most of these midwives left the village at the end of their contract period, leaving the village with their traditional birth attendant as the main maternal health service provider. This case might be repeated in cases of rural *PAUD*.

On the positive side, some local tutors were motivated to obtain further education under their own steam. Among them are many older ladies who willingly join equivalent degree courses using their own personal finance, in order to increase the credibility of their *PAUD*. While basic education is necessary, it should be reconsidered whether an S1 degree is more appropriate in comparison with other options, such as a diploma or a vocational school equivalent to a high school degree or a short course.

Related to tutors' qualification, training is necessary to improve their knowledge of child development, particularly in the effort to integrate health in *PAUD HI*. In terms of training, communication techniques and level of participants' capacity to absorb the materials have to be considered. For example, intensive training might not be appropriate, or if it is conducted in a one-way classical method. Training should be conducted step-by-step, one subject at the time. A new subject is introduced only if the previous one has been fully accomplished. Thus, it takes time to ensure full comprehension of materials. Some principles from adult education (appreciative, participative, and interactive approach using multi-media) should be implemented. Role play and micro teaching are among the methods that can help tutors in putting their knowledge into practice.

To ensure retention of knowledge, refreshing (re-training) is also needed after a certain period of time, and also if there are distortions in the practice in the field. To optimise local resources, training of trainers can be conducted for potential tutors, thus they can assist other tutors or even conduct basic capacity building for other community members interested in starting a *PAUD*. Peer review and internship can be included as mechanisms to provide continual capacity building and improvement.

Findings in the field also show how an incentive for the tutor is only effective if it is given as an appreciation to those who have already proved their dedication, and not as a means to "buy" tutors with high academic qualification. The resentment that grows among the community is caused by their sense of justice – how unfair it is to give a high incentive to new tutor only based on their academic degree, rather than to those who have already dedicated their lives for such a long period of time. Negative perception grows further as the new tutor stops work when they no longer receive an incentive at the end of the funding support. On the contrary, no incentive is given to tutors from *PAUD Mandiri* and *Taman Posyandu* already contributing their time and energy, just because they are not qualified in terms of academic degree.

Moreover, even for those already qualified, the government's budget (through the Office of Education or local government) is not yet sufficient to cover tutors' incentives for all *PAUD* in most areas. Thus the incentive is received irregularly and is unreliable. This is ironic, considering that there is a high expectation among *PAUD* tutors (particularly in Kupang) to be assigned as a civil servant at some point of their "career". It is worth noting, however, how in some areas parents and village officials have begun to show more appreciation toward tutors, in the form of paying more regularly tuition fees and an allocation of the village budget, no matter how small. Some thankful parents of *PAUD* alumni even maintain silaturahmi (building good relationship) with the tutors, by sending Lebaran (led el Fitri) gifts for example.

4.3.3 Coordination

A number of issues appeared in terms of coordination with related sectors, such as the Office of Health, the Office of Education, *BKKBN*, and village officials. The highlights are as follows:

a. Operational permit license: particularly in Kupang. An operational permit license is issued by the Office of Education for *PAUD*. To apply for this license, a number of requirements are: a "proper" organisational structure (i.e. include management structure), the list of pupils' attendance, a list of parents' signatures, *NPWP* (tax payer number), and certificate of establishment. Due to the extensive paper requirement, many *PAUD* in Kupang had not obtained this operational permit license. This has caused them to be labelled as "illegal *PAUD*" and reduces their credibility among the community. Moreover, Kupang District Office of Education *PAUD* also publishes the certificates of graduation, in response to an unwritten policy that *PAUD* completion is required to enter primary school. A "legal" *PAUD* is entitled to graduation, while "illegal" ones have to merge their graduation with "legal" *PAUD*s. For both, a *PAUD* graduation certificate costs Rp 10,000 – 15,000 each. Further clarification is needed as to whether this policy comes from central or district government, and what the impact of this is. This case shows how in the Office of Education monitoring function (demanding adherence of standard) is still predominant rather than supporting function (encouraging continual development and improvement of *PAUD* to reach the standard). Moreover, in relation to the standards of *PAUD*, a thorough evaluation is needed to determine whether it has included all aspects required for the holistic needs of the child, and whether it is acceptable, applicable, and its implementation is affordable.

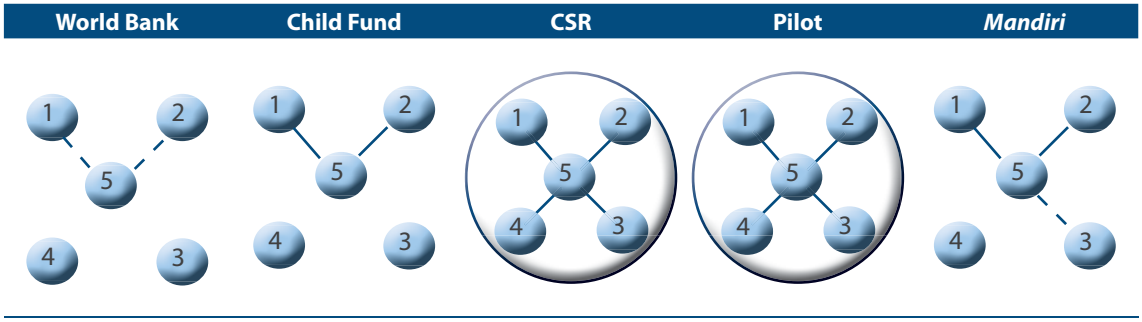
b. Health integration: In terms of *PAUD HI* (Bappenas HI ECD Program), to ensure integration of health, nutrition, care, and psychosocial development, it is necessary for the government to have accurate mapping on existing health-related facilities such as *Puskesmas*, Pustu, midwives, schools, *Posyandu*. The effort to couple this facility with *PAUD* in turn will help building a holistic service for early childhood development.

   So far, *PAUD* facilities that happen to be located near or at the same location as *Posyandu* are the ones that have integrated health into their service. Others that are in different locations sometimes benefit by having *Posyandu* cadre as part of the teaching staff, as cadres receive regular mini-workshop from *Puskesmas*. Cadre-cum-tutors also co-ordinate with *Puskesmas*, reporting health problems and the nutrition status of the children. World Bank *PAUD* have put some effort into integrating health into the service, in collaboration with *Puskesmas*. However, in most cases such collaboration finishes at the end of funding support, as *PAUD* can no longer provide transportation costs for *Puskesmas* staff.

   The Office of Health also emphasises how integration of health services in school is still limited to formal entities (kindergarten and primary school), such as in form of school health unit/dental health unit. This is due to the lack of a legal umbrella to provide such authority (and consequently budget) to conduct such interventions. However, the Office of Health through *Puskesmas* is ready to deliver such services in school, provided that *PAUD* officially send a request/invitation.

   Referring to Technical Guidelines of *PAUD HI* (Bappenas year...) and categorization of *PAUD* model as previously discussed, the type and accessibility of service found on the field can illustrated as shown on Figure 9.

Figure 9. Illustration of Character of Services Available in Each *PAUD* Model Based on Bappenas Guidelines for *PAUD HI*



Types of activities in Holistic and Integrative *PAUD*

1. Health care
2. Nutrition care
3. Parenting
4. Protection
5. Education excluding special needs

c. Birth certificates: The inclusion of the birth certificate as one of the requirements for enrollment in *PAUD HI* is an effort to build awareness among the community of the importance of the birth certificate. A birth certificate is one of the basic rights of a child, namely legal acknowledgement. Findings show that people still have a poor understanding of the importance of a birth certificate.

   Many parents complain about the high cost needed and the unclear/complicated procedure to obtain the certificate. Currently for a new born baby, a birth certificate is included in the midwife service. However, in some areas, birthing is still assisted by a traditional birth attendant instead of a midwife. In Garut and Sumedang particularly, the local regulation stated a penalty of up to 1.5 million rupiah for those who apply for birth certificate for children over 1 year old.

   Another constraint is the marriage certificate, as some parents still have no certificate due to the traditional custom of dowry (particularly in Kupang) or the cost of acquiring the certificate from KUA. This case needs immediate follow up from civil registration, in coordination with *PAUD* within the framework of *PAUD HI*.

d. *HIMPAUDI*: Coordination between the *PAUD* tutor and *HIMPAUDI* was quite intensive in the beginning of WB *PAUD* establishment. However *HIMPAUDI* policy of charging *PAUD* a membership fee is considered a burden by some *PAUD*s. Some tutors felt that *HIMPAUDI* training and regular meetings had helped them in their daily activity, although some complained about how the training was conducted (too many participants in a session, no module/hand-out, and the additional training fee that is charged). Overall, *HIMPAUDI* is still considered as a social gathering rather than a professional association. Particularly in Kupang, *HIMPAUDI* is almost unknown among the *PAUD* and the community.

e. Government and village leader: In some areas, a specific section for *PAUD* has been established within the district government administration, with the district first lady as "*PAUD* matron". This section has the potential to become the district-level co-ordinating body for *PAUD*. However, this role has yet to be optimised. The village leader has the potential to play a key role in co-ordinating the utilization of village potential across the sector. It is interesting to note how some village leaders gave full support to the *PAUD* operation, while some others took no interest at all. Village leaders' awareness and commitment to *PAUD* is essential to facilitate better cross-sector coordination in the *PAUD HI* program. Most village leaders are elected by the community, unlike lurah (sub-sub-district leader) who is appointed by the government. Thus, they have more flexibility in terms of authority within the bureaucratic structure.

4.3.4 Parents Involvement

In general, most parents recognise the importance and benefit of *PAUD* for children. However, there is a strong perception which identifies *PAUD* as school readiness preparation rather than holistic child development. Many tutors complain of parents who request tutors to put more weight on reading and writing, despite the fact that the *PAUD* focus is more on improving the underlying skills in order to succeed at school. However, this request is related to the current practice of most primary schools that demands reading-writing-counting skills as a prerequisite to enter.

Also interesting to note is that parents' awareness of *PAUD* benefits doesn't always correlate with their willingness to pay. However, some parents are aware of the condition of *PAUD* and tutors, and as mentioned previously, they are willing to get involved and contribute (financially/in-kind) in sustaining and improving *PAUD* operation.

4.3.5 Sustainability

As mentioned previously, a sense of community ownership is key to sustain the program. Such a sense of ownership can be built by involving the community throughout the life of the program: starting from socialization, planning, implementation, and evaluation of the program. As proven from the *PAUD Mandiri* and *Taman Posyandu* models, the community is willing to contribute some resources, though these are often limited. Thus, one should take into consideration existing local resources and initiatives.

The findings also show some interesting efforts to increase the sustainability of *PAUD*, both already implemented or still in the planning stage. For example, Child Fund conducted a separate microfinance program as an economic development activity in an effort to increase welfare and thus sustain *PAUD*. *Taman Posyandu* tutors have set up a co-op to provide their own incentive. A number of WB *PAUD* have started to plan ways of sustaining funding, such as writing proposals to access funding from other programs.

An interesting case is a plan from one *PAUD* to collaborate with local small business to generate income for parents. One *PAUD* mentioned approaching a craft business to provide part-time work for the mothers, e.g. making brooches while they are waiting for their children at school. For CSR *PAUD*, the company also realised the importance of further community development efforts to sustain *PAUD*. Some venture plans were discussed, e.g. canteens and small agriculture businesses as income generating units for the *PAUD* and community.

4.4 Conclusions & Recommendations

The following conclusions can be drawn from this research:

- In general, institutionally-driven *PAUD* (be it World Bank, CSR, or Child Fund in this research) are bound by targets, and have limited, specific coverage as well as time limits. This in turn means a shorter, more focused establishment process for the *PAUD* institution. While trying to reach the maximum number target in the minimum time, consideration must be given to the quality of the process in the preparation of a *PAUD* establishment.

- On the contrary, community-driven *PAUD* (be it *Taman Posyandu* or *PAUD Mandiri*) are not bound by any targets, and therefore development can occur more slowly. However, this model can be sustained with minimal external input, and is self-replicating. As the *PAUD* institution grows and the local community sees the benefit, more people are interested in establishing new ones. Some external support could benefit this model in terms of increasing quality and coverage, as well as accelerating the replication process in other communities. Unfortunately, the findings from the field

showed that these *PAUD* are not taken into account, particularly by the government. As shown in World Bank *PAUD*, financing is only given for the purpose of establishing new *PAUD*, while existing *PAUD*, despite needing support for improvement, do not qualify for support. This in turn caused a "negative perception" among the tutors and managers of an existing *PAUD*, which was established based on concrete local needs, and to some extent conflicts also occurred.

- While ensuring the coverage target and quality, the sustainability issue should be also taken into account. This is lacking in the World Bank *PAUD* model, in which most *PAUD* are highly dependent on the continuation of external support/funding. When the government's budget alone cannot ensure such support, a proper exit strategy or an integration of economic development model might be needed to address this issue. During consultation on a draft version of this report, useful discussions with the World Bank team revealed their approach to this issue, and several contextual factors which affected outcomes- including specifically providing three year support for a six year program in order that communities become more involved, and difficulties ensuring commitments made by outgoing local political figures were maintained by incoming individuals.

- Incentives for tutors can threaten the sustainability of the program if it is implemented as a means of "buying" tutors' qualification rather than "rewarding" a tutor's dedication. Lessons learned from the village midwife program showed how most academically qualified village midwives tend to leave the job at the end of their contract period to seek new opportunities with better wages in the city. Such is also the case with academically qualified tutors in the *PAUD* program.

- It is nevertheless important to support building the capacity of existing tutors in order to increase the credibility of *PAUD* among the community. While basic education is necessary (high school degree) for these tutors to pursue, there should be a reconsideration of the effectiveness of further schooling – particularly whether an S1 degree is more appropriate in comparison with other options, such as diploma or vocational school equivalent to a high school degree or short course.

- In terms of tutor's training, communication techniques, training method, and duration have to be formulated based on participants' background and capacity to absorb the materials. Intensive training with a one way classical method only resulted in low levels of participants' perception and comprehension. To ensure retention of tutors' knowledge, principles of adult learning methods: appreciative, participative, interactive using a range of media are necessary. Role play and micro teaching are among the methods that can help tutors put their knowledge into practice.

- The role of *HIMPAUDI*, as an extension of the Ministry of Education in relation to tutors' capacity building, has yet to be improved to bring more benefit for the tutors. *HIMPAUDI* is a long way from meeting tutors' expectations of a professional association, despite the fees being charged for membership and training.

- In terms of integration of health in *PAUD HI*, attachment to an existing health service (particularly *Posyandu*) is most beneficial to ensure minimum cost of the integration of health service into *PAUD*. This is apparent in the *Taman Posyandu* model. Nevertheless, the model needs improvement by including services for children with special needs, and other vulnerable groups.

- In terms of integration of the basic legal rights of children in *PAUD HI*, *PAUD* has the potential role to build awareness among parents and facilitate the process of obtaining a birth certificate, as shown by tutors of some *PAUD* in this research. However, advocacy should be directed to civil registration, in order to provide clear information about the process. Also awareness on this issue should be raised among community figures in order to address constraints related to marriage certificates and local customs.

- In terms of coordination, so far there is no clear mechanism for inter-sector coordination at village levels in the case of reporting, monitoring and evaluation. Thus, the village leader has a potential

role to play, as has been shown in some areas where the village leader is committed to *PAUD* development.

- The regulation on operational permits and graduation certificates for *PAUD* pupils is considered a burden by most tutors, particularly tutors at *Taman Posyandu* and *PAUD Mandiri*, as one of the requirement is a legal certificate (notary act) of foundation establishment. This is made worse by the practice of some personnel of authority who took advantage of the opportunity for personal interest.

- Parents play a crucial role in determining children's enrolment in *PAUD*. In general, most parents are aware of the importance and satisfied with *PAUD* services. However, there's a strong perception which identifies *PAUD* as school readiness preparation (i.e. reading-writing-counting skills) rather than holistic child development. Parents' awareness of the benefits of *PAUD* doesn't always correlate with their willingness to pay, particularly when they know that *PAUD* has received some sort of external support. Extra effort in communication should be made in such *PAUD*s, in collaboration with community figures and village officials, to demonstrate transparency in their use of resources. This will in turn build trust, which will be critical in developing community involvement in sustaining *PAUD*, when external input alone cannot suffice or when funding period has come to an end.

In conclusion, some strategic recommendations that can be proposed for the development of HI ECD:

- *PAUD* Integration with *Posyandu*: To optimise the integration of health service into *PAUD*, *Posyandu* has a number of advantages over other health facilities. Its service (health and nutrition) and target beneficiaries (mothers in general, pregnant mothers, breastfeeding mothers, infants, and young children) will ensure a continuum of care of children from -1 (pregnancy period) to 6 years old. *Posyandu* is also widely distributed across Indonesia, and already well known, particularly in rural areas. Furthermore, introducing *PAUD* to *Posyandu* will bring the advantage of an improved health infrastructure and beneficiary target. *PAUD* can be used to revitalise the currently inactive *Posyandu*, as parents and children visit *PAUD* at regular intervals.

- Local mothers and women as teachers/tutors: As shown in the findings, tutors' academic levels do not always correlate with the quality of their teaching. High academic qualification standards correlate positively with high turnover of tutors, due to the tendency of tutors with advanced academic qualifications to search for better job opportunities. "Ordinary" mothers, or women in general are proven to be capable of delivering quality *PAUD* service, provided they have experience in handling children and are enhanced by proper training. Women are indispensable and can be considered as an untapped human resource available in all areas. Giving housewives the chance to become tutors and providing them with scholarships as an acknowledgement as well as academic capacity building exercise might be a more feasible option for *PAUD HI* development. Such an approach has been implemented in Rajasthan (India) through Aga Khan Foundation, and it was demonstrated that housewives as teachers are powerful agents of change for early childhood development and education (Arnec newsletter, Early Childhood in Asia and The Pacific No.1. 2008).

- ECD Resource Centers: Considering the large number of children under five years of age in Indonesia (approximately 24 million), it is impossible for the government alone to provide ECD services covering all these children. ECD resource centers would serve the roles of capacity building, supervision, monitoring, and evaluation for *PAUD HI* development. ECD resource centers could also function as co-ordinating bodies which promote partnership, transparency, and openness in facilitating ideas, implementation, research, and dissemination of best practices among government, private sector, academics, and citizen sectors at all levels (local, national, and international), including communities at local, district, provincial, or national level. This model has been demonstrated by the Institute of Educational Development (IED), BRAC University Dhaka, Bangladesh (Arnec newsletter, Early Childhood in Asia and The Pacific No.1. 2008)

Chapter 5
Strategic Options

5.1 Introduction

Two Key Considerations must inform any proposals for a development model for ECD in Indonesia.

Consideration 1: There is a Strong Institutional and Programmatic Foundation for HI ECD in Indonesia

Antenatal Care and Safe Delivery

The institutions, professionals and trained paraprofessionals that provide antenatal counselling, safe delivery and neo natal care are widely available in Indonesia. This system provides a strong foundation for HI ECD. While these institutions are widely available there are some remaining underserved areas. Additionally, utilization of available of antenatal support and attended birth is not universal. Poor women and women with lower levels of education are less likely to utilize the available services. The link between poverty and lower rates of utilization of skilled providers for antenatal counseling and attended births is likely linked to the costs.

Strategic Implications for HI ECD Delivery

While various health sector institutions provide antenatal support and support for safe delivery, the most accessible – especially for poorer women in rural areas – is *Posyandu*. Ensuring that all Posyandus are equipped to meet the demand in their community for antenatal and safe delivery support can close this gap in the HI ECD system for the most disadvantaged mothers and newborns.

Support for Mothers and Newborns (0 to 2)

The vast majority of children in Indonesia live in a village that has active *Posyandu* and active *Posyandu* is found in more than 95 percent of villages. It is estimated that about 70 percent of children participate in *Posyandu*. As *Posyandu* is a community initiative, the implementation of the *Posyandu* program of services varies depending on local conditions and support.

Strategic Implications for HI ECD Delivery

While *Posyandu* sites are available for most children, the quality of services and the capacity and skills of the *Posyandu* caregivers is more difficult to assess. Since *Posyandu* relies on volunteers from the community, it is likely the case that poor areas of Indonesia with lower levels of education may have *Posyandu* caregivers with less capacity and that they receive less training and material support. In a number of communities in Indonesia a system of integrated services has been constructed by expanding

services and days/hours of operation of *Posyandu*. Adding new tasks and new roles for *Posyandu* caregivers requires more careful recruiting, much higher investments in training across a larger number of topics and monitoring of performance and quality assurance across a number of different sector reporting systems. The expansion of *Posyandu* also places much higher demands on caregivers with respect to their time commitment. These higher demands must be addressed with a model for financial support for these caregivers that promotes continuity. (International evidence suggests that continuity of support from a single caregiver is more effective than support from caregivers who frequently change.)

While various health sector institutions that can provide support for 0 to 2 year olds, the *Posyandu* is the most accessible. Immunization coverage suggests that children tend to become "invisible" to this supporting network sometime after few a months of age and only reappear to attend *TK* or primary school. A revitalized and attractive *Posyandu* program that secured the participation of children for longer than just the first few months after birth could improve immunization coverage, encourage more proactive management of childhood illnesses, identify and remediate nutritional deficiencies and assess developmental problems.

Support for Child Development and Education (2 to 6 years)

There has been a rapid increase in the opportunities for participation in center-based early childhood development programs. Many of these new opportunities reflect global best practice with respect to integrating support for physical, social and moral development based on an active learning model. A sector regulation – Ministry of Education Regulation 58 – has been developed that is consistent with this child development orientation, materials have been produced and disseminated and training by government and NGO partners has been provided. There is a wide network of knowledgeable advocates and practitioners to support expansion of this approach.

Strategic Implications for HI ECD Delivery

While there has been an expansion of center-based programs that focus on integrated child development (physical, psychosocial, cognitive and moral), existing opportunities are clearly inadequate to meet government participation goals. The recent growth in provision is, for the most part, the result of central level government investment. This may not be sustainable and would seem to be inconsistent with the government's own guidelines that emphasize that *PAUD* provision is a local (district) level responsibility.

In case studies the research team utilized the Child Interaction Scale to examine the process of engagement between caregivers and children. The results suggested that there are two different kinds of existing center-based programs. The tendency was for older, formal programs to focus more on school readiness and newer, non-formal programs to focus more on child development – even when the age of the children was similar. In the view of the researchers, this child development focus is more consistent with the HI ECD vision described in the National Strategy. However, the issue of expectations and goals for these center-based programs is something that must be decided by the Indonesian HI ECD stakeholders

Consideration 2: Realizing the Vision of the National Strategy Requires Investment in a Sustainable HI ECD Development Model

Administrative decentralization means that a single model of HI ECD cannot be implemented from Jakarta. While this presents challenges, it also enables the local communities to mobilize human, material and financial assets and utilize the strong institutional and programmatic foundations of HI ECD to address challenges in a manner that best suits local conditions.

The outline of a sustainable community development model of HI ECD can be drawn from F2H research, as well as the fieldwork conducted for this study. In those case studies stakeholders identified the

necessary components of a development model: knowledge and capacity; a locally relevant regulatory framework; good models of effective HI ECD organization and practice; and public resources. The F2H research has shown that:

- Institutionally-driven models of ECD tend to be target driven in terms of scope. This means they can be scaled quickly, and will reach a specific target within a given amount of time. The quality of the intervention will depend on how well the project is implemented (quality of model, quality of implementation).
- Institutionally-driven models tend not to be as sustainable however. There is clear evidence from multiple contexts of major government-led *PAUD* interventions stopping shortly after resources stop being provided. In these cases, a comprehensive exit strategy can mitigate this issue but frequently there will still be problems.
- Community-driven models tend to expand organically. This means a slower expansion, but will involve organic expansion which could result in exponential growth if enough interest is gathered, and stakeholders are convinced of value.
- Introducing incentives into any model can have negative consequences and must be considered carefully. Lessons learned from a village midwife program have showed unintended negative consequences. Nevertheless, a community-driven model can be given much needed credibility if it is officially recognized.
- Once recognition is given, innovative models for regulation need to be considered. For example, requiring caregivers who have successfully qualifications of caregivers
- The physical proximity of Health and Education institutions to each other appears to be correlated to how successfully an integrated childhood development service can be provided to a community. The *Taman Posyandu* model is a good example of how this can work in practice, but other models exist.
- Results from the F2H fieldwork show that there is no clear coordinating mechanism at the village level for HI ECD.
- Advocacy and communication should play a strong role in any national development model that is proposed. Parents play a crucial role in deciding whether children will be enrolled in schools, and therefore need a strong understanding of the benefits of educating their children. A second key message to communicate is the importance of parent's and the communities' involvement in supporting Education and Health initiatives in the village.

Expanding on existing innovative practices, developing effective local regulation that enables and encourages HI ECD rather than single sector approaches, and efficiently allocating public resources and developing strategies to increase public financial support for HI ECD all require quality local ECD leadership. Unfortunately, it is these critical local processes and this leadership that is without an institutional home and technical and financial support. Without an investment in a development model and HI ECD leadership, HI ECD expansion will continue to be dependent on national level sector by sector programs and projects and isolated NGO initiatives.

5.2 A National ECD Model

A model can be elaborated to show how high quality Holistic-Integrated ECD services can be provided to all Indonesian mothers and children using the current institutional framework.

The model is also based on the current regulatory framework - in particular, the policies stated in the National Strategy for HI ECD .

Cross-sectoral collaboration at national, provincial, district and village levels are essential for integrated provision to occur, but the sheer number of institutions and stakeholders make this a complex and difficult outcome to achieve.

The National Strategy for HI ECD describes policies, strategies, and activities which should result in the provision of high quality early childhood development services. But this is currently not the case. As our consultations and fieldwork show, although there is a significant regulatory and legislative framework which is based on current best international practice, as well as some capacity at all levels of the system to implement ECD services, the end result is still low levels of quality provision, with limited collaboration and resourcing at local levels.

In order to identify the implementation gaps, we elaborate a working model for ECD in Indonesia by asking the question, 'If the National Strategy was implemented correctly under the current institutional arrangements, what would high quality, equitable ECD provision look like?' Using this model, we can then compare the 'working model' to the current picture of implementation, as presented in the research report. Strategic options for progressing can then be based on that comparison.

The model is developed by looking at the policies, strategies, and activities described in the National Strategy for HI ECD, which fall into four categories: access, quality, planning and management.

Figure 10. Government of Indonesia National Strategy for HI ECD: Policies and Strategies

Policies		Strategies	
1.	Improving access, distribution and completeness of the types of early childhood development services	1. 2.	Improving the skills of prospective brides, parents, families and replacement caregivers in optimally taking care of child Conducting equitable and reachable early childhood development services
2.	Improving the quality of the implementation early childhood development services	3. 4. 5.	Improving the quality of early childhood development services Internalizing religious and cultural values; Empowering communities and business world;
3.	Improving cross-sectoral coordination and cooperation and partnership among government agencies, implementing agencies and related local, national and international organizations	6.	Enhancing commitment, coordination and cooperation among government agencies, implementing agencies and related organizations.
4.	Strengthening institutions and legal basis and involving community including business world and mass media in implementing early childhood development services	7.	Strengthening and harmonizing the legal basis of providing holistic-integrated early childhood development services

Because of the nature of the decentralised system, a first step is to describe the outcomes we would expect if the policies were fully implemented at a community, regional, and national level. This is important because while actors at different levels greatly influence each of the other levels, communities, districts, and national government can all take action to a greater or lesser extent to improve provision. The following list of outcomes is not exhaustive, but provides a basis for the analysis of the data gathered during this research.

Figure 11. Outcomes of a working HI ECD model

Community Outcomes

Skilled antenatal care and safe delivery is provided for all children.

There is growth monitoring, early detection of physical and developmental problems, full immunization, management of childhood illnesses, early stimulation for development from birth to two years of age.

All new mothers are provided support for care and stimulation of infants and children to 2 years of age.

All children 3 to 6 years of age participate in a program for early childhood development and early education that is holistic and integrates support for physical, social and cognitive development.

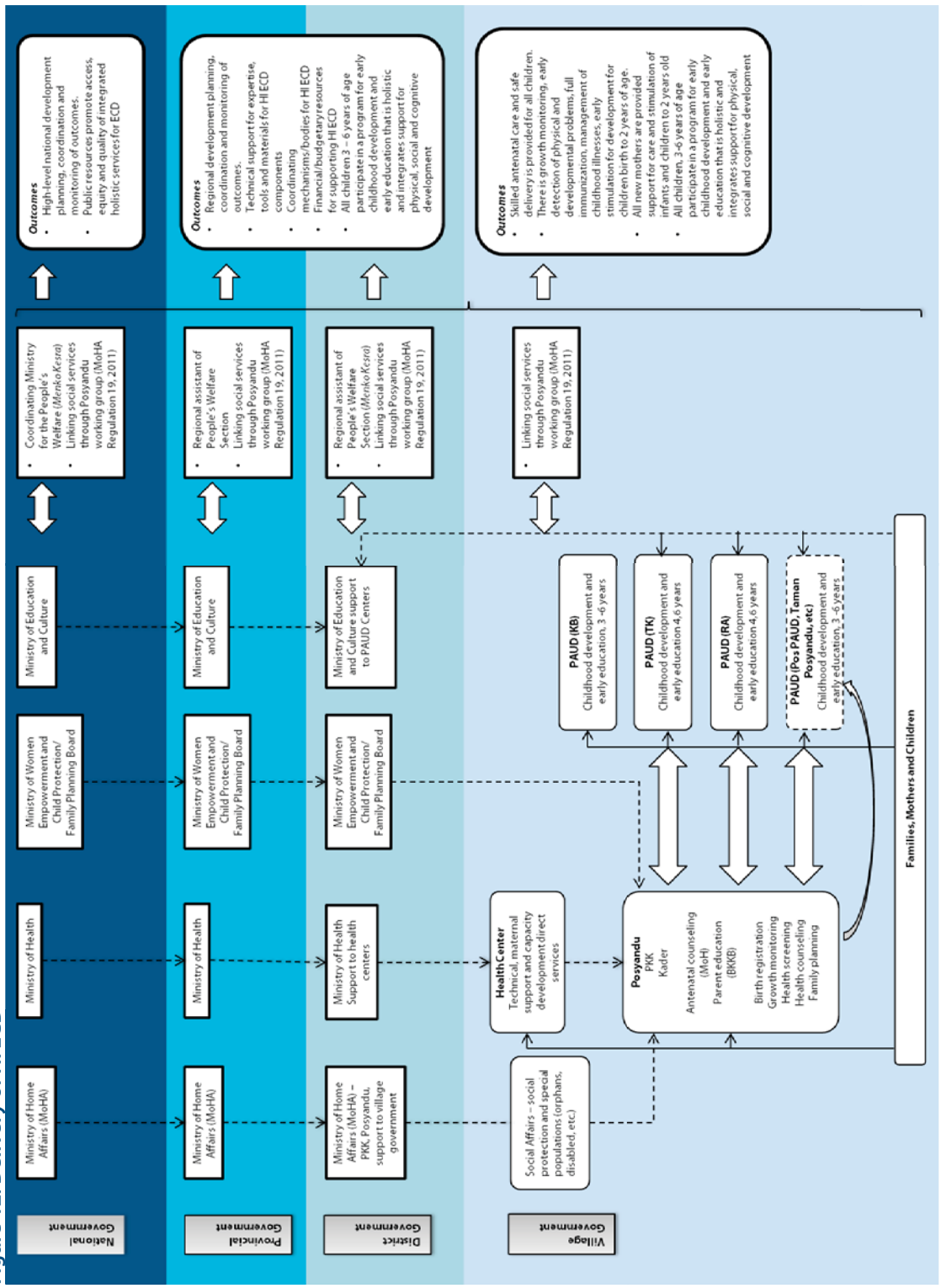
Regional (District/Province) Outcomes
There is regional development planning, coordination and monitoring of outcomes.
There is technical support for expertise, tools and materials for HI ECD components.
There exist coordinating mechanisms/bodies for HI ECD.
There are Financial/Budgetary Resources for supporting HI ECD.

National Government Outcomes
There is high- level national development planning, coordination and monitoring of outcomes.
There is strategic investment of public resources to promote access, equity and quality of integrated holistic services for ECD.

We can develop the model further by showing how these outcomes relate to the current institutional framework for provision of ECD.

Figure 12 represents the existing institutional structure for delivery of HI ECD in Indonesia, with the outcomes mentioned above mapped onto the corresponding administrative level. At the national and regional levels most of the relationships of authority and/or funding (identified by the dashed line arrows) are vertical between the national, provincial and district level dependencies of the line ministries.

Figure 12. Delivery of HI ECD



At the National Government level, development priorities are established through processes managed by the National Development Planning Agency (BAPPENAS) and correspond to targets emerging from the National Development Plan. Line ministries develop strategic plans also based on those targets and elaborate budget requests. Finance flows through the several existing national and district budgets (*APBD*), Special Allocation Funds (*DAK*) (which are usually sector focused), and Community Development Poverty Alleviation funds (PNPM). ECD implementation finances are supplemented through Village budgets and community collaboration (fees, community donations, volunteers, Corporate Social Responsibility programs).

The two formalized structures for coordination, the *Posyandu* working groups and the Coordinating Ministry for the People's Welfare, are present at each level (regional assistant at province and district level) and coordinate cross-sectoral dialogue and implementation issues. In a fully functioning model, they play a lead role in driving collaboration and cross-sectoral planning.

In our model, the District Government plays an important role in supporting the delivery of high quality HI ECD. In the decentralised system, one of the functions that it carries is quality assurance. This requires it to have the capacity to monitor and support health and education outcomes through quality assurance mechanisms, which include support to schools to achieve minimum standards. Districts also play a role in planning and coordinating the equitable provision of HI ECD through consulting with local communities, and acting as a technical resource that shares best practice. They act as coordinating bodies that ensure communication between the planning and implementation of different sector institutions and departments. They also play a key role in financing HI ECD, both through their onward allocation of national resources, and as a technical resource for community fundraising and auto financing techniques.

The Village Government level in Figure 3 presents possible institutional arrangements that a typical community may have in order to provide HI ECD. The formal service linkages between institutions are identified with solid arrows, while authority and/or financing flows are identified by the arrows composed of a dashed line. The block arrows indicate potential HI ECD linkages rather than actual linkages; currently, formal linkages across the services are not typical. There are also variations in potential linkages to deliver HI ECD. For example, an Early Childhood Development (*PAUD*) center could have a formal linkage with a health facility rather than an Integrated Health Center (*Posyandu*) if local conditions made this linkage more efficient. In some communities, services typically provided through *Posyandu* – like family planning – may be more effectively provided by a health facility.

The actual institutional arrangements for providing HI ECD in a community will depend on the assets and resources a community has available. Many key HI ECD decisions can only be made at the local (village/community) level. Local conditions, local geography, the nature of the population, the types of livelihood activities that predominate, and the local history of institutional development, among other factors, determine how HI ECD is most effectively provided.

Local level information is necessary for understanding which children are being excluded and how best to reach them and the most efficient linkages between services to ensure that all children reach primary school in optimal condition to learn. While national and regional technical capacity and resources are necessary, it is only through systemic processes to mobilize and link these resources at the local level – an important component of an HI ECD Development Model - that holistic integrated services can be delivered.

Nevertheless, some features of a strong community level provision are:

- A *Posyandu* with strong links to health facilities and midwifes and to the Population and Family Planning Board for parent education;
- In some cases, health facilities may undertake outreach to households directly through various forms of *PAUD* (such as *TK*, *RA*, *KB*, *Pos PAUD*, *Taman Posyandu*, etc.).
- All *PAUD* have formal and strong links to *Posyandu* for integration of health and growth monitoring.

In some villages, the link might be provided directly through a health facility via the midwife. In other cases, a *PAUD* program has been added to an existing *Posyandu* site/program creating a "one – roof" delivery mechanism;

- There is a great variety in the provision of the *PAUD* component and the mix of the particular types of *PAUD*. Some center-based programs are well funded and self-sustaining on the basis of fees, while others are dependent on subsidies provided by public funds, NGO funds or through the provision of free labour on the part of caregivers.

5.3 Strategic challenges for HI ECD development in Indonesia

Strategic Challenges to realizing HI ECD in Indonesia

- Despite the institutional and programmatic foundation for the delivery of HI ECD, equitable access to an integrated system of quality holistic support is not currently a reality for most children in Indonesia.
- Strategic challenges to move from the current provision of HI ECD to the integrated holistic vision described in the National Strategy exist at all levels – however, local level challenges are the most profound and require significant support and investment.
- The primary constraint to delivering HI ECD is the lack of an HI ECD development model that enables local level decision-making to effectively mobilize the existing technical and financial resources to deliver holistic-integrated support to children from birth to 6 years of age.
- Effective responses to these strategic challenges will complement the existing governance mechanisms and be consistent with the current structure of the sector.

Despite the institutional and programmatic foundation for the delivery of HI ECD, equitable access to an integrated system of quality holistic support is not currently a reality for most children in Indonesia. In this section we identify strategic challenges that must be addressed to move from the current delivery of ECD to a system of integrated holistic support that is accessible to all children, and in particular children from poor families. These strategic challenges emerge from an analysis of the current performance and characteristics of the primary components of HI ECD, as well as a consideration of how current planning and management practices affect the delivery of ECD as an integrated holistic system.

5.4 Identifying Strategic Challenges at the Local, Regional and National Level

Access, equity and quality of support for children at the point of delivery is dependent in important ways on enabling policies, regulations, and strategies at the national and regional level. However, if children do not have access to the holistic support required to meet their developmental needs at the point of delivery – in their communities – then HI ECD is not being provided regardless of whatever policies, regulations, working groups and standards that might exist.

For this reason we identify strategic challenges to realizing HI ECD starting with how those challenges manifest themselves at the local level and then explore the implications for regional and national responses.

Figure 13. Strategic Challenges at the Local, Regional and National Level

HI ECD is delivered in communities if:		
Skilled antenatal care and safe delivery is provided for all children		
Currently: Approximately 20% of women do not have access to a skilled antenatal care provider. Institutions are widespread but isolated areas of inadequate provision still exist. Utilisation is less prevalent among the poorest households and among women with lower levels of education	Strategic Challenge: How to ensure that women who cannot – or choose not to - access antenatal care and safe delivery are supported through: 1) outreach of antenatal services, 2) awareness raising about the benefits of skilled antenatal support, and/or 3) information about how to access services for low or no cost.	Potential responses: Strengthen the outreach of Posyandus, midwives and health facilities based on local assessment. Develop a strategy to identify women likely to not seek services. Investigate options for provision of services in remote areas.
All new mothers are provided support for the care of children from birth to 2 years of age, which includes growth monitoring, early detection of physical and developmental problems, full immunization, management of childhood illnesses, and early stimulation for development.		
Currently: Full immunization is less than 60%. Cases of severe malnutrition are not identified (high stunting prevalence for a country of Indonesia's wealth and health spending). Up to 50% of Posyandu are not active. Basic Posyandu programs do not include infant stimulation for development. Lack of resources for effective outreach and parent education. Neonatal mortality rates do not compare favourably to other countries in the region. Adverse outcomes are more prevalent in rural regions, among poorer households and among less educated women	Strategic Challenge: As a community structure dependent on volunteers, the quality and consistency of Posyandu are likely to vary considerably. The number of skills demanded for *kaders* is rising as new roles for Posyandu are proposed (PAUD, social services, etc.). However, the support for *kaders* is ad hoc and irregular, posing a threat to the continuity of support for children. A lack of resources contributes to adverse outcomes. Communities need to be better able to sustainably finance local initiatives.	Potential responses: Develop a local process to identify priority Posyandu sites and their status. Provide resources to improve outreach and parental education. Develop an on-going regular program to expand skills of *kaders* to include early stimulation for development. Strengthen the use of early detection tools. Develop / strengthen/formalize links with PAUD so that growth/health/ development monitoring can continue after first 1 or 2 years. Develop local plans for sustainable financial/material support to maintain the continuity of *kaders*.

All children from 3 to 6 years of age participate in a program for early childhood development/ education that is holistic and integrates support for physical, social and cognitive development.		
Currently: About 50% of children aged 3 to 6 do not participate in an early childhood development and/or early education program. Not all programs have a child development orientation and many are not formally linked to other HI ECD services. Opportunities are uneven, with some locations experiencing competition among centers for children while other children remain without service. New innovative practices are promising but usually dependent on a short-term government or NGO project. Many parents are not convinced of the value of a holistic program and are focused on school readiness. The unintended consequences of PAUD funding practices tend to favour investment in better-off, existing centers and may not be effectively targeted to promote equity and sustainability. Public investment of local resources (own resources on the part of District and Village) is generally low.	Strategic Challenge: How is it possible to rapidly expand opportunities with reliance on local resources and community support? Developing an expansion plan that capitalizes on each community's strengths, current assets and programs, and avoids unsustainable investments and duplication. Ensuring that new and existing center-based programs provide holistic attention – either as a one-roof facility or through formal linkages between PAUD and Posyandu and/or an easily accessible health facility. Ensuring that the approach to care-giving in each center-based program is appropriate to the developmental stage of children. Provide on-going capacity development for caregivers and provide sufficient support to caregivers so that continuity of care can be maintained. Develop a strategy for national public investment that provides incentives for local investment that is more specifically targeted to expanding services for the disadvantaged and promoting equity.	Potential responses: Strengthen and support investments. Facilitate community-led processes that identify cost- effective options for expanding access to PAUD. Provide financial incentives for districts to take a more active role in financing PAUD. Identify and develop local ECD leadership. Provide local government and communities well- documented examples of successful strategies applied in other locations. Develop and test community- led targeting strategies for public investment in PAUD.

Regional Government (Province and District) support HI ECD development through		
Technical expertise, tools and materials for HI ECD components		
Currently: Health, Education and other social sector professionals are well qualified. Access to quality, nationally-developed materials and tools. Financial resources to provide training and capacity development in HI ECD components (education, health, social protection, etc.).	Strategic Challenge: Training and tools are usually sector-based as are training programs. As HI ECD requires caregivers to have broader knowledge and skills, there may be a need to develop models of integrated training. Ensure that the manner in which training is funded is pro-poor and improves equity in the provision of services rather than reinforcing disadvantages.	Potential responses: Coordinate training plans developed through a Posyandu working group. Document and disseminate examples of innovation in training for HI ECD to Posyandu working groups. Develop tools and indicators to ensure that training plans promote equity rather than reinforce existing advantages.
Coordinating mechanisms/bodies for HI ECD		
Currently: A working group for integrating social services through Posyandu has been formed (Ministry of Home Affairs Regulation 19, 2011). The composition of this working group includes the major government stakeholders in HI ECD. Participation in the national coordination of policy for welfare through (Coordinating Ministry for People's Welfare) Regional Assistant. Each province is linked to national development planning (BAPPENAS) through Provincial/District Development Planning Agency (BAPPEDA).	Strategic Challenge: While the integrated social services working group has been formed, the process of implementation is still underway. These bodies will require technical assistance and capacity development to support them in developing effective practices for promoting the integration of services at the local level. Other coordinating functions like Mekon Kesra and BAPPEDA will also need technical assistance to develop strategies for supporting HI ECD and to incorporate activities into annual plans that effectively support local village-level integration of services (coordination must result in actions). Also needed is a set of specific well-designed indicators and targets that enable provinces and districts to monitor and report on their progress in implementing HI ECD. (Indicators must be measures of integration of services rather than list of separate sector indicators)	Potential responses: Coordinated technical assistance and capacity development for Posyandu working groups. Strengthen and support with technical assistance, resources and other coordinating structures that include non-government stakeholders (PAUD forums, etc.) Develop more formal links to community-based planning through a HI ECD development model.

Regional Government (Province and District) support HI ECD development through		
Financial/Budgetary Resources		
Currently: Each relevant line ministry has a sectoral budget for supporting sector development activities and for salaries of officials. Provinces and Districts are also conduits for non-sectoral support (Community Empowerment Poverty Reduction -PNPM) and special allocation funds (DAK). While financial resources through sectoral budgets are available, up to 90% of the revenues at provincial and district level are national level transfers through the general allocation (DAU) and deconcentration funds (Dekon) as sectoral transfers for sectoral activities. Numerous studies have highlighted the limited scope of provincial and district decision-making on the allocation of funds to activities, and low levels of resource generation for Provincial and District budgets.	Strategic Challenge: Developing and implementing strategies for ensuring that all communities can provide a network of integrated holistic ECD support is likely to require significantly greater activity and participation of regional governments – both in terms of allocating existing resources from national transfers, and in generating additional resources. Efficient resource allocation will also require greater input from communities so that public support is allocated to priority needs. (For example choosing among investments in existing PAUD centers versus founding new services). Many of the innovations in delivering integrated holistic services for children have depended on additional investments on the part of government or NGOs to support consultation, planning, and capacity development activities (that are typically not funded from current Province or District budgets).	Potential response: Systematic capacity development and awareness raising for local legislative bodies – preferably with presentation of successful models already implemented in Indonesia in order to promote greater investment of own resources at Provincial, District and Village level. Elaboration of a HI ECD development model that systematically assesses needs and identifies assets at the community level as part of a process of building a "bottom-up" plan and estimate of resource requirements.

National Government supports HI ECD development through		
High level national development planning, coordination and monitoring of outcomes		
Currently: ECD has been identified as a priority in national development planning and a vision and direction for ECD delivery has been developed and disseminated (National Strategy for Holistic Integrated Early Childhood Development). National coordinating bodies like the Coordinating Ministry for Peoples' Welfare have initiated formal processes for coordinating national implementation. Formal Posyandu working groups focused on the delivery of integrated services have been formed at all levels of government by the Ministry of Home Affairs. A number of research tasks examining the delivery of HI ECD are currently underway. In some cases, national level line ministries have responded with their own actions – like the Ministry of Education and Culture Regulation 58 2009, and some provinces and districts. Other initiatives – like a pilot project promoting the incorporation of HI ECD into the community based poverty alleviation program (PNPM) - are also in progress.	Strategic Challenge: Development priorities are set at the national level, and national level policies and actions play a fundamental role in promoting equity across the diverse regions of Indonesia. While formal mechanisms of coordination can be established at the national level – with corresponding mechanisms at the regional (Province/District) level, the delivery of HI ECD requires that services be integrated at the point of delivery (community/village). Having a mechanism for coordination that incorporates local/village planning is a significant strategic challenge in the current environment of Indonesia's evolving decentralization.	Potential response: Link national development planning and coordination with effective local (village/community) planning will require the development of new knowledge and approaches. Establish a national Task Force to support the development and testing of mechanisms for promotion of HI ECD can inform and strengthen the existing formal coordination bodies. Tasks of the Task Force would include research and analysis, publications and communications and policy advisement to the national government. Develop a limited number of indicators to monitor progress on HI ECD in addition to the current sector-specific indicators

National Government supports HI ECD development through		
Strategic investment of public resources to promote access, equity and quality of integrated holistic services for ECD		
Currently: National line ministries have significant technical capacity for the on-going development and dissemination of tools for the delivery of HI ECD. Taken as a whole, HI ECD spending is a significant percentage of national spending (which encompasses nutrition, maternal and child health, early childhood development/ education, social protection, child protection and other sectoral spending that supports young children). In addition to line ministry spending, other non-sectoral spending like special allocation funds (DAK) and community development (PNPM) – are also potentially important sources of support for HI ECD. The public finance system includes "balance funds" intended to compensate for differences in capacity among the regions (provinces and districts) to generate own revenues.	Strategic Challenge: While investment in HI ECD is significant, it is delivered through channels that are separately budgeted and managed (primarily line ministry budgets). Effective coordination of investment in HI ECD at the point where it must be coordinated – the point of delivery - is only possible when regional and local level actors take a much more active role in allocation of available resources. The case of PAUD investment is especially important as PAUD provision must increase significantly to meet the demands of HI ECD. Investment in PAUD must carefully negotiate the need to provide resources to promote equity while at the same time expanding new opportunities. In the current environment the direction of PAUD investment is not clear. In some locations PAUD central funding is seen as regular operational support, while in other locations central PAUD funding is one – off development funding. In field work the research team found it was not uncommon for households and communities to be reluctant to provide support for PAUD centers because of the expectation that funding was being provided on a regular operational basis – as it is in basic education (which is not the case). With PAUD funding being limited –it is critical that an investment strategy that is explicitly focused on promoting equity be clearly identified and communicated to all stakeholders.	Potential response: Regional and local governments must be encouraged and provided incentives to take a more active role in allocating resources to HI ECD. It is only at the local level where decisions can be made as to how to most effectively link services in a given village, what kind of PAUD (*KB*, *Pos PAUD*, *Taman Posyandu*, *TK*) best capitalizes on existing investments and facilities, how to best support caregivers and other decisions that require local level deliberation. This new activism on the part of regional and local authorities will require technical support in the form of training and providing examples of tested strategies. Increasing local investment can also be promoted by using financial incentives to reduce the short term risk of trying new solutions and to support new processes for incorporating local (village/ community) planning for the delivery of HI ECD. In the case of PAUD, a strategic investment policy should be defined and the role of central level funding for PAUD delivery be clarified for local stakeholders.

5.5 Strategic Options for Developing HI ECD in Indonesia

This section outlines strategic options for developing HI ECD in Indonesia. Options are proposed at the national, provincial/district and local levels. The proposals laid out in this section vary significantly in scope, feasibility to implement, and resource requirements. They are nevertheless presented as a menu of options that could be considered, and it will be incumbent upon decision makers to choose a 'best-mix' that suits the available resources, political feasibility, and time available.

To develop the strategic options for HI ECD we have made the assumption that, at least inthe medium term, *PAUD* will remain non-compulsory and without a commitment for centrally funded *PAUD* provision with National, Provincial and District governments who nonetheless play an important role of developing the sector, providing expertise and acting to ensure equity and quality. We highlight this assumption because - as noted in our field work and examination of current delivery -much of the recent growth in *PAUD* provision has been the result of national level action, and financial support, along with the current tools used for this expansion, may not be sustainable or consistent with a community-led and community-resourced model.

We also note two key considerations that inform our proposed strategies. Firstly, our strategies complement/strengthen existing governance mechanisms. Examining strategic challenges and identifying potential responses for addressing these challenges must be informed by recent and/or soon-to-be launched initiatives on the part of the Government of Indonesia. Two ministerial decrees (Ministry of Home Affairs 54 2007 and Ministry of Home Affairs 19 2011), as well as a pending presidential decree, formalize processes and the establishment of formal coordinating bodies for the delivery of holistic-integrated services for young children. These initiatives are at various stages of development and implementation. The strategy options offered in this paper have been developed with consideration of what additional actions can strengthen these governance bodies and other existing HI ECD development and coordination initiatives, rather than creating new structures and mechanisms. Secondly, strategies must be consistent with the current structure of the sector.

Finally, where relevant, we bring in brief examples of international best practice which show how similar recommendations have been implemented internationally.

5.5.1 Strategic Options at the National Level

1. Create a flexible 'Development Model' as a resource for districts and villages to draw upon

While the delivery of maternal and child health is supported by an existing network of health centers, meeting the needs for *PAUD* requires a significant expansion in the number of center-based programs. Considering the entire 3 to 6 years of age population, center-based programs will need to almost double their capacity to ensure that all children have the opportunity to participate.

This need to expand the *institutions* of *PAUD* is taking place in an environment of administrative and fiscal decentralization.

HI ECD cannot be realized without addressing the governance/management constraints through an informed systematic process of decision making at the local level. But it must be at the national level where those standardised resources are developed, and they can then inform and guide local level development. Creating a methodology and system for this process – referred to here as the HI ECD development model – is a key option to be considered.

The HI ECD development model, distributed to provincial and district offices, enables communities to assume leadership in ensuring that GOI development goals for ECD are met through the equitable provision of holistic integrated support to children under 6 years of age.

The HI ECD development model includes techniques for:

- Socialization and mobilization of a community with respect to the benefits of HI ECD
- Identification of underserved children and services that are not accessible and developing a plan to address the problem
- Establishment of the appropriate linkages between the services (including how to manage and support the linkages both logistically and financially)
- Identification of caregiver requirements (capacity and support) and developing a strategy for meeting capacity development and financial/material support needs

- Identifying the available public resources and allocating them in a manner that promotes equity in access to HI ECD
- Explicitly recognising the role that NGOs can play in supporting the development of HI ECD
- Developing an overall financing strategy that ensures sustainability, taking into account available public funding

This model should take into account the different development strategies available in different communities depending on their history and activism in ECD, their access to resources, and whether the development model is driven by a community or with external support.

As identified in the F2H research, locally-driven efforts generally require a longer and more intensive investment in mobilization, planning, awareness-raising, advocacy and other activities before they produce improvements in participation rates. These processes also require skilled facilitators and meaningful collaboration of regional and local authorities.

2. Create a challenge or innovation grant fund for implementation of HI ECD in innovative, replicable ways

The creation of grant awards to local government (Province, District, Village) that demonstrate promising and sustainable strategies for establishing one-roof or holistic- integrated early childhood development delivery will incentivise the use of innovative, replicable models.

As suggested by the field research – many of the promising small scale examples of HI ECD delivery required NGO investment in processes not typically funded by government line budgets. The challenge grant program provides funds for actions that can accelerate the HI ECD development process and encourage regional and local government to be more active in planning and development of HI ECD, even before formal resource allocations to support HI ECD are implemented.

Funding for this challenge fund could be obtained from a combination of government (non-sectoral), corporate, and international development partner funds.

The fund could be managed by an ECD Task Force with a committee to evaluate proposals comprised of representatives of fund contributors, key line ministries and BAPPENAS. Awards would be for 1 to 2 years and would not be used to meet regular operating costs of government entities or build infrastructure. The objectives of the awards are to enable local government and communities to undertake processes to develop a sustainable delivery model for HI ECD.

Examples of the use of the grants could include: 1) local consultation and research activities leading to the elaboration of a local regulation that enables HI ECD, 2) capacity development for local NGOs in the concepts of HI ECD, 3) training of stakeholders in resource mobilization strategies, 4) non-infrastructure start-up costs for one–roof service delivery, 5) short-term training and capacity development for village heads and members of legislative bodies.

3. Identify and manage a specific research and policy analysis agenda for the promotion of HI ECD

In collaboration with the research and development unit of the Ministry of Education and Culture, a specific research agenda can be developed to identify key issues arising in the sector. The research agenda would provide evidence for data-driven policy development and strategic planning. Examples of research tasks could include: research on the role of local legislation/regulation on HI ECD development, methods for local targeting strategies for subsidizing services for poor children, evaluation of alternative schemes for providing material/financial support to caregivers and others, as identified by the national co-ordinating bodies.

4. Provide regular periodic capacity development for HI-ECD coordinating bodies

Local communities repeatedly state that one of the key problems with delivering integrated services is a lack of coordination amongst the line ministries at the district and local levels. Regular periodic capacity development and information sharing for relevant HI ECD stakeholders - particularly the established government coordination bodies (*Posyandu* working groups and the Coordinating Ministry for the People's Welfare) is essential. The role of these coordinating bodies in supporting the delivery of integrated ECD provision is extremely important. Coordinating bodies should be able not only to fulfil their function at their own level of government, but they should also be able to develop and support activities being undertaken by their provincial, district and local offices.

5. Define a strategic investment policy and clarify the role of central level funding for PAUD delivery at local levels

Regional and local governments must be encouraged and provided incentives to take a more active role in allocating resources to HI ECD. It is only at the local level where decisions can be made as to how to most effectively link services in a given village, what kind of *PAUD* (*KB*, *Pos PAUD*, *Taman Posyandu*, *TK*) best capitalizes on existing investments and facilities, how to best support caregivers, and other issues that require local level deliberation.

This new activism on the part of regional and local authorities will require technical support in the form training and providing examples of tested strategies. Increasing local investment can also be promoted by using financial incentives to reduce the short-term risk of trying new solutions and to support new processes for incorporating local (village/community) planning for the delivery of HI ECD.

In the case of *PAUD*, a strategic investment policy should be defined and the role of central level funding for *PAUD* delivery should be clarified for local stakeholders.

Figure 14. ECD Finance

Financing ECD Internationally - Direct Cash Subsidies to target poor or disadvantaged areas

One characteristic that stands out when comparing Indonesia to other countries with greater participation in ECD is that planning is undertaken and a much greater share of the financing is allocated at the local level.[1] The relative mixture of national level transfers and local revenues varies from country to country, but the general pattern is that the resources are allocated locally - typically in accordance with national level guidelines or standards.[2] In almost all systems with a significant amount of public financing (either national or local) household contributions still comprise the largest source of funds. In these advanced systems, public investment is targeted for poor children as a direct cash subsidy to the household to purchase privately provided ECD, as a reimbursement to a provider for services to a targeted child, or by geographical targeting of poor or disadvantaged areas.[3]

1 See Belfield, Clive R.; Financing early childhood care and education: an international review. UNESCO. 2006
2 There are exceptions where public financing is much more important than household contributions. This would include the Nordic countries, France, Cuba and Russia.
3 One of the most well know examples of this type of support is "Head Start" in the USA where states governments are reimbursed from the national government for providing services to children who qualify due to poverty.

6. Create a National Task force for HI ECD

A National Task Force to support the development and testing of mechanisms for promotion of HI ECD can inform and strengthen the existing formal coordination bodies, is an option that the Government of Indonesia should strongly consider. Tasks of the Task Force would include research and analysis, publications and communications, policy advisement to the national government, and developing a limited number of indicators to monitor progress on HI ECD (in addition to the current sector specific indicators).

Figure 15. ECCE Policy in Jamaica

Streamlining ECCE policy in Jamaica

Jamaica's approach to creating a long-term vision for comprehensive, integrated delivery of early childhood programmes and services is instructive. First, in 1998 the Ministry of Education, Youth and Culture assumed responsibility for the Day Care Unit from the Ministry of Health in addition to its own Early Childhood Unit. An inter-agency group representing health, education, community development, planning, NGOs, service clubs and the University of the West Indies was formed to guide the integration process. In 2002, legislation established the Early Childhood Commission, which brings together all policies, standards and regulations pertaining to day care and early childhood development under one institutional umbrella. Comprehensive regulations now cover health, safety and nutritional requirements, and there are guidelines for fostering both children's social development and a positive learning climate. Overall, Jamaica's integrated approach maximizes limited resources by reducing duplication and fragmentation.

Source: Jamaica Ministry of Education and Youth (2003)/UNESCO EFA Report .

The National Task Force for HI ECD could serve as a coordinating and advisory body for the development of strategies and capacity to implement HI ECD, with a role of supervising many, if not all, of the previous recommendations. The Task Force would be funded for a 5-year period. The funding sources would include Corporate Social Responsibility (CSR) and international development donor assistance. Government counterpart contribution would be in the form of participation of officials and staff (possibly secondment of staff to the secretariat) in Task Force activities – including line ministry funding for necessary travel of government officials and staff and in provision of office space for a secretariat. The chair of the Task Force would be an echelon 1 government official from BAPPENAS or Mekon Kesra. Membership in the executive committee would include a senior representative from relevant line ministries, representation from national and international NGOs, multilateral development institutions and major private sector contributors to the Task Force's funding. .

A small technical secretariat would be established to manage the technical and administrative tasks of the Task Force and report to the executive committee. The composition of the technical secretariat would include experienced national and international professionals with appropriate experience and training. The secretariat would have a professional designated as the technical lead advisor. The Task Force is not a statutory body, or a new coordination mechanism, but rather an entity that enables stakeholders to build knowledge and strategies for implementing HI ECD. As an external entity – and not reliant on regular line ministry budgets – the Task Force enables a process of building knowledge and strategies for HI ECD without competing for resources currently allocated to service delivery.

The overall mission of the Task Force would be to develop, test and disseminate effective practices for the implementation of HI ECD and to provide capacity development for relevant government entities – especially the formal coordinating bodies and regional/local government.

These recommended actions to address strategic challenges to the realization of the National Strategy for HI ECD are not quick fixes. The nature of the challenges themselves is complex and requires the development of new policy tools and strategies for promoting national development goals in a decentralized administrative and fiscal environment. The development of these new approaches would require time and investment but the realization of the National Strategy for HI ECD cannot become a reality without them.

5.5.2 Strategic Options at the Provincial/District Level

1. Establish 3 to 5 regional resource centers with multi-year funding envelopes

One of the most important functions that a central government operating in a decentralised system has regarding quality and development is that of knowledge broker. Developing a series of regional resource

centers which combine demonstration models of effective HI ECD practice with an ambitious and adequately funded outreach and on-site training program could leverage a relatively limited amount of resources to provide support for local communities as they implement ECD. These centers could:

1. Develop and document successful community-driven HI ECD models in their regions
2. Provide short-term training courses using demonstration project sites for caregivers, local level officials, governors, village heads, and legislators
3. Provide technical assistance regionally

Each Regional HI ECD Resource Center project award would be chosen on the basis of a proposal process. Suggested criteria would include:

- Consortium of NGOs, University, District and/or Provincial government. Regional governments would be expected to provide some amount of matching funds or in-kind equivalent (facilities, seconded staff, etc.)
- A proposal that demonstrates an understanding of the concept of HI ECD and a promising strategy for sustainable HI ECD at the community level
- A proposal that demonstrates the capability for delivering quality capacity development programs to a wide variety of stakeholders
- The lead implementers of the demonstration projects would collaborate with national ECD coordinating bodies to develop materials, publications and capacity development programs based on demonstration of project experiences.

2. Develop a resource bank within each district office to include materials that capture best practice in development, financing, and provision of HI ECD.

One of the key roles that a district should be playing in a decentralised system is as a knowledge broker, that is, an organisation that collects and shares best practice where it is needed. District offices should regularly document and disseminate examples of innovation in training for HI ECD to *Posyandu* working groups. District officers responsible for quality can champion the dissemination of the information available, and advocate for local communities to have access.

3. Identify and support a range of 'Model Centers' in districts, and provide resources for community level stakeholders

We have proposed that the Ministry of Education and Culture develop regional resource centers to lead on the technical development of ECD centers. Another key option for Districts would be to identify a range of high-performing integrated ECD centers and publicise their existence to local communities. With support from District offices, best practices can be shared at little or no extra cost to the state.

4. Develop and test community-led targeting strategies for local investment in PAUD and techniques for self-financing initiatives

By far the greatest challenge that local communities face in starting ECD centers is a lack of financial resources. But there are many communities who have overcome this barrier to start successful and sustainable provision for their children and mothers. In their visits to schools across districts, government officials have the opportunity to observe, collect and compile information from schools about strategies that have resulted in successful investment in *PAUD* initiatives.

5. Create a capacity development and awareness-raising plan for local legislative bodies to promote greater investment of local government resources into ECD

The degree of local level (village) decision-making in the allocation of public resources for HI ECD is also quite low, reflecting the still evolving decentralization process in Indonesia, and the lack of capacity and

systems for effective local planning. This weak capacity and system for local planning and management has resulted in a continuing reliance on systems and tools for centrally-funded and directed initiatives. This reliance on centralized decision-making (even at the province and district level) is a significant constraint on the holistic integration of services for children at the point of delivery.

6. Develop an action plan for supporting local provision of ECD services in remote areas

Data from our research shows that it is the most remote communities which have the least access to skilled early childhood development provision. This is not only because there are greater distances between centers, but also because poverty is more widespread in more remote areas. A comprehensive plan to provide ECD services to the most marginalised must be a key element of ECD development in Indonesia.

Figure 16. Development of ECD in Canada

Decentralised, Integrated Service Provision in Ontario, Canada

In order to reinforce province-wide, integrated ECD provision, in 2005 the Government of Ontario:

- Established three demonstration communities to implement the full 'Best Start' vision (an integrated ECD program) at an accelerated pace.
- Created 47 Best Start Networks and four Regional French-language Best Start Networks to lead the planning and implementation of Best Start at the local level.
- Created almost 15,000 new licensed child care spaces.
- Began work on an income test model to determine eligibility for child care fee subsidies. The new model would allow more families access to regulated child care.
- Established three expert panels – an Expert Panel on home Visit for all 18-Month old babies, an Expert Panel on Quality and Human Resources and an Expert Panel on an Early Learning Framework.
- Strengthened infant hearing and preschool speech and language programs that identify, treat and support children with communications disorders.
- Undertook home visits for mothers of newborns with developmental or other risk factors.

Source: Government of Ontario, 2006. Accessed Online 14/12/2012.

5.5.3 Strategic Options at the Community Level

1. Identify and allocate resources to a local ECD leadership/coordination function

One of the reasons that institutionally driven ECD centers are successful at local levels is that projects have included resources for local level co-ordinators who receive a salary to make cross-sectoral linkages and bring health and education institutions together. With community-led initiatives, this role is seldom explicit, and there are rarely funds allocated for it even if it is recognised.

Supported by districts, local communities could develop plans for new or existing provision that explicitly recognise the importance of this function if an integrated model is desired. This will result in the desired linkages being made between health and education provision.

The natural link, if it exists, is through the community level '*Posyandu* working groups' which should exist under the Ministry of Home Affair's designation. The working groups, with the support from the district, can identify a co-ordinated training plan for the local community, as well as develop local ECD strategies that promote equity rather than reinforce existing inequalities. The group can also maintain contact with the appropriate district officials to receive technical assistance and capacity development, and in turn strengthen and support other local coordinating structures that include non-government stakeholders (*PAUD* forums, etc.).

2. Strengthen the outreach of *Posyandu*, midwives or health facilities based on local assessments

The relatively large number of women who do not have professional birth support, and a lack of clear information on the status of a large number of *Posyandu*, are two key issues which research findings illustrate. The development of the *Posyandu* is seen regionally as a success story and with funding support from the district resources and a strong outreach program,they have the potential to significantly improve health outcomes for Indonesian mothers and children. They also have the potential to reinforce integrated provision if they are part of a 'one-roof' ECD center. Strengthening the functioning of the *Posyandu* through a locally-led identification and assessment process, and development of the *Posyandu* through community and district support, is one of the key recommendations that this report makes at the local level.

3. Become familiar with development models, resources, regulations and tools available from District offices

As mentioned with regards to financing at the district level, some local communities do not take the initiative when it comes to developing ECD provision in their areas. Decentralisation is by now not a new concept, and communities have the responsibility to become informed, seek help, and advocate for support when it is needed. As a strategy, we are aware that this is difficult to implement, and that the incentive for communities to become involved is not necessarily in place. Districts will play a large role in advocating for community action, and communities must take their civic responsibilities seriously.

4. Develop strategies to identify women who are not likely to seek services, and children who are at risk of not attending ECD; and conduct local advocacy and rights awareness campaigns, including Parenting Education

Research findings show geography, education, and wealth all play a factor in whether women seek ECD services for themselves or their children. It is only at the community level that the identification of hard-to-reach women can be done, and only at the community level that planning and measures can be taken to ensure that every Indonesian child has the opportunity to benefit from ECD services. Rural appraisal techniques need to be made available to communities by districts, and sensitization must take place and be replicated so that communities are aware of the importance and existence of ECD services. NGOs are usually skilled in this type of exercise and often can bring resources to bear if they operate in the geographic zones. Parenting Education programmes can also greatly increase the likelihood of children attending and remaining in formal and non-formal settings, and remaining healthy.

5. Involve community members in the management of ECD centers to ensure sustainability

Community management of Integrated ECD centers ensures a sustainable future for schools and health centers in communities. F2H research has shown that institutions managed by committees made up of community members result in a willingness to resource schools, engage with local issues that affect the center, and commit to ensuring the success of the center. Transparent management of schools and health centers allows communities to see how fees are spent, and provides opportunities to hold authorities accountable for poor performance.

Chapter 6
Conclusion

The options presented in the preceding chapter have been organised at local, district and national level, as a means of presenting discrete opportunities for the government of Indonesia to consider each on its own merit and judge to what extent it will result in the desired development HI ECD. We make two final points regarding this. Firstly, that each of the interventions will require varying amount of social, political and economic capital to implement. What we have presented is a range of options which on one end of the spectrum are small, will have a small effect, and which will be relatively easy to implement, and on the other end of the spectrum are large, will have a larger effect, but will require significantly larger inputs in terms of money, management and time for implementation. Figure 17 outlines our assessment of the financing required, political and logistical feasibility, and potential impact of each of the options proposed. We have used a traffic light system of Green (low cost, large impact), amber (moderate difficulty or cost, moderate impact), and red (high cost, small impact) to rank each option.

Figure 17. Feasibility of ECD Strategic Options

	Financing Required (Large-Medium-Small)	*Political Feasibility (Easy-Moderate-Difficult)*	*Logistical Feasibility (Easy-Moderate-Difficult)*	*Potential Impact (Large-Medium-Small)*
National				
Create a national development model	Small	Easy	Easy	Large
Create a challenge fund	Large	Moderate	Difficult	Large
Identify and undertake a research agenda	Medium	Moderate	Easy	Medium
Provide capacity development to coordinating bodies	Medium	Easy	Moderate	Medium
Define a strategic investment policy	Small	Moderate	Easy	Medium
Create a national Task Force	Large	Difficult	Moderate	Large
District/Provincial				
Establish regional resource centers	Medium	Moderate	Difficult	Medium
Develop a resource bank in each district	Medium	Easy	Moderate	Medium
Identify and support model centers	Large	Moderate	Difficult	Medium
Develop community led targeting strategies	Medium	Moderate	Easy	Medium
Develop a capacity development plan for local legislative bodies	Large	Easy	Easy	Large
Develop remote areas action plan	Medium	Difficult	Moderate	Small

	Financing Required (Large-Medium-Small)	*Political Feasibility (Easy-Moderate-Difficult)*	*Logistical Feasibility (Easy-Moderate-Difficult)*	*Potential Impact (Large-Medium-Small)*
Community/Village				
Create a local level coordination function in every village	Large	Difficult	Moderate	Large
Strengthen Posyandu Outreach	Large	Easy	Difficult	Medium
Strengthen ties with District offices	Small	Easy	Moderate	Large
Identify Strategies to identify hard to reach women an Children	Medium	Easy	Moderate	Medium
Promote community involvement in ECD management	Medium	Moderate	Easy	Large

Two options in the table above deserve commentary. The first is the creation of a 'national development model'. In our view this option has low costs, is politically feasible, and will have a large impact. It provides local administrations with options to develop their own ECD models, depending on particular circumstances. This will require some resources to disseminate at the local level, but it has the potential to have a significant impact. The second option we will comment on is the 'creation of a National Task Force'. In our view, this is a key step to rationalising ECD in Indonesia as is moves forward. It may require significant political capital to implement, but it has the potential to have a significant impact.

Our final point to make is that the options are not intended to be undertaken as single interventions. A strategic choice of a selection of actions that are possible within the current political and economic constraints will have the maximum effect, by leveraging support given at one level to maximise impact at another, and ultimately lead to better quality implementation at the local level.

For the authors of this report, that 'best-mix' option includes the creation of the National Task Force, whose role it would be to develop, test and disseminate effective practices for the implementation of HI ECD and to provide capacity development for relevant government entities – especially the formal coordinating bodies and regional/local government. That role would include managing several of the other options proposed in this report, including identifying and managing a research and policy analysis agenda, establishing regional resource centers, managing a challenge or innovation grant fund for implementation of HI ECD, providing regular periodic capacity development for HI ECD coordinating bodies, and liaising with regional actors to gather and disseminate best practice.

Appendix A. List of Persons Consulted

ACDP
Team Leader/Operational Management Specialist
Education Sector Governance and Capacity Development Advisor
Operation Manager for Procurement and Supervision of Subcontractors
Ministry of Education and Culture
Director General of Early Childhood Non Formal and Informal Education Prof Dr. Lydia Freyani Hawadi
Secretary of Directorate General of Early Childhood Non Formal and Informal Education Dr. Gutama
Director for Guiding ECD Dr. Erman Syamsuddin, SH, M.Pd
Sub Directorate for ECD - Program and Evaluation Dr. Sukiman, M.Pd
Sub Directorate for ECD - Learning and Students Dra. Enah Suminah, M.Pd
Center for Assuring Education Quality Dr.Jawane Malau
Sub Directorate - Curriculum and Books Dr. Nanik Suwaryanik
National Education Standard Board (*BNSP*) Prof Dr. HA Mungin Eddy Wibowo, M.Pd Kons
National Accreditation Board for Non Formal Education (*BAN-PNF*) Prof. Dr. Komang
National Accreditation Board for School/Madrasah (*BAN S/M*) Dr. Suharto
Sub Directorate for Teachers and Teaching Personnel for ECD Drs. Nasruddin M.Pd
Coordinator for ECD Education and Development Nugroho
Ministry of Health
Sub Directorate for Child Halth dr. Rinni Yudhi P. (Head) dr. Asteria
Sub Directorate for Maternal Health dr. Lukas
Sub Directorate for Nutrition Drs. Nazir
Sub Directorate for Immunization Dr. Theresia Sandra dr, MHA
***BAPPENAS* – National Development Planning Agency**
Director for Education and Religion Dr. Subandi, M.Sc.
Director for Population, Women Empowerment and Child Protection Dr. Sanjoyo Indah (staff)
Ministry of Religious Affairs
Sub Directorate for *RA* and *MI* Studentship Drs. Sastra Juanda M. Si.

Sub Directorate for *RA* and *MI* Curriculum and Evaluation
Drs. Nanang Yunus
Farhila Ladia, S.Sos, M.Si.

National Family Planning Coordinating Board (*BKKBN*)

Head of *BKKBN*
Dr. Fasli Djalal
Director for Child Health
Drs. Burhanuddin, M. Ed.

Ministry for Women Empowerment and Child Protection

Assistant to Deputy for Child Education Right
Dra. Ninin Nirawaty, M.Ed., PA

Coordinating Ministry for People's Welfare

Assistant to Deputy 6 for Family Affairs and Children Welfare
Dra. Yutik

Ministry of Home Affairs

Direktorat Pemberdayaan Masyarakat & Desa, Sub Dit Kesejahteraan Keluarga Direktorat Pemberdayaan Masyarakat & Desa, Sub Dit Kesejahteraan Keluarga
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Himpunan Pendidik dan Tenaga Kependidikan Anak Usia Dini Indonesia (HIMPAUDI)
Dr Sofia Hartati, M. SI – Kepala
Dra. Kamsanah M. SI – Head - Partnership Division
Ir. Yayah S – General Secretary

LSM, Universitas dan Badan Independen

UNICEF

Spika Yona Utoyo – Education Specialist
Sheema Harding – Chief of Education
Karen Manda – Chief of Child Protection

Bank Dunia

Rosfita Roesli – Education Operation
Djoko Hartono – Monitoring and Evaluation

Plan Indonesia

Sri Marpinjun (ECD Specialist)
Wahdini Hakim (Health Specialist)

World VIsion Indonesia

Susana Srini (Education Team Leader)
Elfrieda Sinaga (ECCD specialist)
David Kia, S.Pd (Basic Education Specialist)

Save the Children

Rini Mintarsih,S.Psi (ECCD Specialist)
John Lundine (Program Director)

Child Fund

Irene Ratih, S.Psi (PO Fonterra)
Ferdic Febian (ECD Associate)
Joanne Hasyim (Pogram Director)

Frontier for Health

Prof. Anna Alijahbana
dr. Annisa Rahmalia

Appendix B. Methodology and Data

During the inception period the research team had extensive consultations with stakeholders across a wide range of government sectors that support the physical, psycho-social and cognitive development of young children. The study team also met with many additional non-government actors with experience in the development and history of ECD in Indonesia (see annex A). In addition the research team gathered and analyzed a wide array of laws, decrees, guidelines and reports that were identified by respondents as key documents that provided the legal framework, institutional structure and guiding policies in the sectors included in HI ECD.

In the inception period it became clear that a consensus strategy for ECD in Indonesia already existed in the form of the National Strategy for Holistic Integrated Early Childhood Development and the companion document, the General Guidelines For Holistic-Integrated Early Childhood Development. The National Strategy and the General Guidelines were elaborated in 2008 under the coordination of BAPPENAS and drew widely on the cooperation and input of the national ministries and other stakeholders involved in promoting early childhood development. The process of developing the National Strategy and General Guidelines was supported with technical and financial assistance from development partners in the area of early childhood development. The strategy and guidelines describe the principles, policies and types of services that are the components of HI ECD in Indonesia. The strategy and guidelines also outline an implementation structure including the organization of planning and development and specify the roles of the various stakeholders in the delivery and management of services. The strategy and guidelines were officially disseminated in 2009.

The existence of this consensus view on the desired direction for ECD enabled the research team to use the National Strategy as the foundation for the research plan and to more narrowly focus the ECD Strategy Study resources on a research plan to target a better understanding the opportunities and constraints for implementation of this national vision. The research methods enable the team to analyze opportunities and constraints for implementation of the National Strategy at each level (national, provincial, district, local) as well as potential modifications to the strategy that demonstrate promise for improving access, equity, quality and management of Holistic Integrated ECD.

Holistic Integrated ECD services are implemented at the local (village/sub village) level. The budget for the strategy development study permits only relatively limited number of field observations at the district/village level. Given the diversity of Indonesia and the variation in ECD delivery across communities a limited number of randomly selected field visit sites cannot produce a representative picture of ECD delivery in Indonesia. For this reason the study team utilized a purposive sampling framework for selecting sites for local level research. Potential field study sites were identified through the application of criteria relevant for generating useful lessons for effective implementation of the National Strategy. These criteria include identifying sites characterized by different levels of economic development, different geographical challenges, different (low and high) current levels of participation in ECD and sites that have experimented with different types of models for delivering holistic integrated ECD.

Cost effective methods for addressing systems wide opportunities and constraints rely on the new analysis of existing data sources. These sources are used to:

- Estimate participation rates and how they vary relative to administrative regions
- Analyze the individual and household factors that influence participation in ECD
- Map opportunities for HI ECD and how those opportunities vary by administrative region

The sources for this information includes operational reporting from the Ministry of Education and the Ministry of Health, the national household survey (*SUSENAS*), the survey of village potential (*PODES*) and others.

Since field visits will be limited to 6 sites because of resource constraints they cannot provide useful quantitatively generalisable insights into access and equity. Local field research will provide insights into how resources are mobilized for HI ECD, differences in the coordination of delivery of HI ECD, promising strategies for delivery of HI ECD, the nature of constraints on access and equity, the roles of various stakeholders in ensuring quality and other important and relevant issues. Given the importance of understanding how these opportunities and constraints manifest themselves at the point of delivery (village/sub village) the research team applied a community case study methodology for the field visits. In the final research product, the HI ECD Strategy Options paper, these insights will be placed into the context of a coordinated national plan with accompanying financial/budgetary implications.

Table 1. Systems level assessment of access and equity

Descriptive analysis of participation in ECD at district level	Participation rates by relevant age groups and gender using SUSENAS provides a picture of how participation varies by region.
Alternative method for calculating participation rates in ECD	Estimates of participation in ECD using administrative data (enrolment reporting) and age populations (when possible disaggregated by gender) as a complement to sample based estimates using household data.

Table2. Demand for ECD:

Causal modelling of determinants of participation in ECD	Using SUSENAS raw data and applying multivariate methods the research will estimate the net impact of individual and household characteristics on the likelihood of participation in ECD. The use of multivariate analysis (conditional probabilities) allows the disentangling of policy relevant variables. For example, a multivariate method should permit understanding the relative importance of gender, age, household wealth, the educational level of parents, and the number of children in the family, the type of economic activity of the household and geographical location. Understanding the relative importance of demand side factors supports the development of well-targeted strategies and policies for improving access and equity.

Table 3. Supply of opportunities for HI ECD:

Distribution of HI ECD components	Utilizing PODES to estimate the current supply of HI ECD components and services in relation to the relevant population

Financial and economic analysis

To be useful for policy and planning purposes the financial and economic analysis combines:

- an understanding of current spending,
- a description of current funding mechanisms
- estimates of resource requirements to effectively deliver policy goals and
- an analysis of how current and potential alternative funding mechanisms promote or impede access, equity and quality.

Community case studies

Participation in HI ECD is dependent on multiple factors. While national, provincial and district regulations and decrees clearly have an impact; HI ECD is for the most part provided at the community level. Understanding how local conditions and local decisions affect participation in ECD is critical to developing workable and effective strategies to promote wider, more equitable access, improved quality and efficient management. Community case studies allow for the investigation of ECD provisioning and participation within its real life context in targeted communities. The use of multiple case studies provides an opportunity to consider how local differences and perceptions have different effects on participation in ECD.

The community case studies are comprised of two types of research activities:

1. An assessment of the opportunities and constraints for HI ECD at the district/village level through engagement with stakeholders (government officials, *Kaders*, private providers, NGOs, FBOs, etc) using Appreciative Inquiry activities and methods
2. Observations of ECD provisioning including characteristics of centers and caregivers as well as the quality of support for children.

The ECD Strategy Study team identified *HIMPAUDI* (The Association of Early Childhood Teachers and Personnel of Indonesia) as key collaborators in realizing the field studies. *HIMPAUDI* encompasses a number of key ECD stakeholders including teachers, caregivers, ECD center managers and owners as well as academics, teacher educators and other interested parties. *HIMPAUDI* has a presence in most of Indonesia – including at the local level. The incorporation of *HIMPAUDI* into the field study teams provides access to professionals with local level expertise and knowledge in the field study sites. The incorporation of *HIMPAUDI* into the research activities also provides an opportunity for supporting capacity development of *HIMPAUDI* and strengthening their advocacy and technical role in expanding quality ECD in Indonesia.

The community case studies involve two phases – the research training and socialization phase and a field work phase. Phase one – research training and socialization - involved a two day training for local level research collaborators from *HIMPAUDI* (2 for each district to be visited) in Jakarta. In this training the local level collaborators (as well as core team researchers) received an orientation and work plan for the field research – including pre field study information and socialization tasks in their home districts. Training was also provided in Appreciative Inquiry by a premier provider of AI in Indonesia. Appreciative Inquiry will be used in the design and realization of interviews and with focus groups during the case study research.

Phase two – the field research phase –took place over a one week (5 days) period in each field site (6). The first day of the research focused on meetings and interviews at the provincial level using the "appreciative interview" method. Day 2 included district level interviews and focus group discussions. In Days 3 and 4 the team (including *HIMPAUDI* collaborators) undertook village level assessments (observations, focus groups). Day 5 was utilized for follow up debriefing at provincial level and return travel for research team to Jakarta.

Appendix C. Supply of HI ECD components

Percent of 0 to 3 population without active *Posyandu*		Percent of 3 to 5 population without PAUD in village			Percent of 4 and 5 population without *TK* in village		
Province	%	Province	% population without PAUD in village	% of villages without PAUD	Province	% pop. without *TK* in village	% of villages without *TK*
Bangka Belitung Islands	0%	DI Yogyakarta	1%	2%	Di Yogyakarta	0%	0%
Riau Island	0%	DKI Jakarta	4%	6%	DKI Jakarta	2%	4%
Central Java	0%	West Java	10%	15%	East Java	2%	4%
DI Yogyakarta	0%	West Nusa Tenggara	19%	26%	Bali	4%	8%
Banten	0%	Gorontalo	24%	31%	Central Java	4%	7%
Bali	0%	Banten	17%	31%	East Kalimantan	10%	43%
West Java	0%	Riau Islands	16%	34%	West Java	12%	19%
East Java	0%	East Java	24%	36%	Sulawesi Selatan	13%	22%
Riau	0%	Jambi	23%	36%	Kalimantan Selatan	13%	27%
West Nusa Tenggara	0%	Central Java	28%	38%	Riau	13%	28%
East Nusa Tenggara	0%	Bangka Belitung Islands	33%	38%	West Nusa Tenggara	14%	21%
South Sulawesi	0%	Bali	29%	40%	Riau Islands	15%	44%
DKI Jakarta	0%	Lampung	38%	53%	Central Kalimantan	16%	37%
Lampung	1%	Riau	36%	55%	Gorontalo	17%	27%
Gorontalo	1%	Kalimantan Selatan	40%	58%	North Sulawesi	19%	30%
South Sumatera	1%	South Sumatera	42%	58%	Central Sulawesi	19%	32%
Sumatera Barat	1%	Nusa Tenggara Timur	46%	59%	Banten	20%	35%
North Sulawesi	2%	Bengkulu	47%	61%	Lampung	20%	33%
Jambi	2%	Central Sulawesi	46%	61%	West Sulawesi	21%	37%
Nanggroe Aceh Darussalam	2%	West Sulawesi	33%	63%	Southeast Sulawesi	23%	42%
Kalimantan Selatan	2%	Sulawesi Selatan	51%	67%	Jambi	24%	42%
Central Sulawesi	2%	North Sumatera	42%	67%	Bangka Belitung Islands	25%	38%
Bengkulu	2%	North Sulawesi	62%	68%	North Sumatera	35%	69%
Southeast Sulawesi	3%	Kalimantan Barat	45%	70%	Maluku	35%	63%
West Sulawesi	4%	East Kalimantan	30%	71%	South Sumatera	39%	61%

Percent of 0 to 3 population without active *Posyandu*		Percent of 3 to 5 population without PAUD in village			Percent of 4 and 5 population without *TK* in village		
Province	**%**	**Province**	**% population without PAUD in village**	**% of villages without PAUD**	**Province**	**% pop. without *TK* in village**	**% of villages without *TK***
Maluku Utara	4%	Maluku Utara	59%	72%	Papua Barat	42%	85%
North Sumatera	7%	Maluku	55%	75%	Bengkulu	43%	63%
Central Kalimantan	9%	Central Kalimantan	58%	82%	Nusa Tenggara Timur	46%	59%
Kalimantan Barat	10%	Nanggroe Aceh Darussalam	74%	86%	Kalimantan Barat	46%	72%
East Kalimantan	14%	Papua Barat	58%	87%	Maluku Utara	50%	67%
Maluku	17%	Southeast Sulawesi	76%	88%	Nanggroe Aceh Darussalam	53%	71%
Papua Barat	45%	Papua	78%	93%	Papua	68%	92%

Appendix D. Estimating Model for ECD Participation

SUSENAS 2010

Estimation terminated at iteration number 3 because Log Likelihood decreased by less than .01 percent.

-2 Log Likelihood	4875155.97
Goodness of Fit	4056646.63
Cox & Snell - R^2	.145
Nagelkerke - R^2	.195

	Chi-Square	df	Significance
Model	634505.369	15	.0000
Block	634505.369	15	.0000
Step	634505.369	15	.0000

Variable	B	S.E.	Wald	df	Sig	R	Exp(B)
FEMHEAD	-.0955	.0072	176.5798	1	.0000	-.0056	.9089
HLTPRI	-.2625	.0035	5475.037	1	.0000	-.0315	.7692
MLTPRI	-.5463	.0038	21074.08	1	.0000	-.0618	.5791
FEMALE	.0825	.0022	1426.070	1	.0000	.0161	1.0860
URBAN	.2780	.0024	13056.62	1	.0000	.0487	1.3204
SUMATERA	-1.0128	.0028	129441.8	1	.0000	-1.533	.3632
BALNUMA	-.6806	.0042	25969.75	1	.0000	-.0687	.5063
KALIMA	-.8376	.0046	33596.00	1	.0000	-.0781	.4327
SULAWES	-.2865	.0042	4756.976	1	.0000	-.0294	.7508
PAPUA	-2.0440	.0087	55253.20	1	.0000	-.1001	.1295
QUINT	.2838	.0010	88505.61	1	.0000	.1267	1.3282
HDWK	-.0920	.0036	647.5190	1	.0000	-.0108	.9121
MOTWK	.2404	.0026	8843.348	1	.0000	.0401	1.2718
RASKIN	-.1916	.0025	5926.406	1	.0000	-.0328	.8256
AGECHILD	-.2809	.0011	60960.10	1	.0000	-.1052	.7551
Constant	.4979	.0055	8184.312	1	.0000		

Dependent variable = EVRPAUD (ever participated in PAUD)
N = 22,859 (unweighted)

Appendix E. Child Interaction Scale

Taken from U.S. Department of Health and Human Services website:
http://www.acf.hhs.gov/programs/opre/ehs/perf_measures/reports/resources_measuring/res_meas_impa.html

Downloaded on 23 July 2012

ARNETT Caregiver **INTERACTION SCALE, 1989**

Authors:
Jeffery Arnett
Publisher:
None.
A copy of the scale can be found in Jaeger and Funk (2001)
Cost:
None
Representativeness of Norming Sample:
None described.
Languages:
English

Type of Assessment:
Observation
Age Range and Administration Interval:
Caregivers of early childhood classes
Personnel, Training, Administration, and Scoring Requirements:
To be a certified Arnett Caregiver Interaction Scale observer requires achieving a .70 inter-rater reliability coefficient for two consecutive visits. (Jaeger and Funk). No recommended length of observation. Arnett observed *caregivers* in two 45-minute sessions, while Jaeger and Funk observed *caregivers* in a 2.5-hour session.
Summary
Initial Material Cost: 1 (> $100)
Reliability: Internal consistency and inter-rater reliability: 3 (.65 or higher)
Validity: Concurrent: 3 (mostly .5 or higher)
Norming Sample Characteristics: 1 (none described)
Administration and Scoring: 3 (administered and scored by a highly trained individual)

[1] The scale is also referred to as the Arnett Scale of Caregiver Behavior.

Description: The 26-item Caregiver Interaction Scale assesses the quality and content of the teacher's interactions with children. The scale was designed to provide information on various socialization practices that have been identified in research on parenting. The scale can be used without modification in both center and home-based settings. The items measure the emotional tone, discipline style, and responsiveness of the caregiver in the classroom. The items are usually organized into the following four sub-scales: (1) positive interaction (warm, enthusiastic, and developmentally appropriate behavior), (2) punitiveness (hostility, harshness, and use of threat), (3) detachment (uninvolvement and disinterest), and (4) permissiveness.

Uses of Information: The scale can be used to assess caregiver's interactions with children and their emotional tone and approach to engaging and disciplining children.

Reliability: (1) Internal consistency: Layzer et al. obtained Cronbach alphas of .91 for warmth/responsiveness (positive interaction) and .90 for harshness (punitiveness), while Resnick and Zill obtained alphas for the total scale of .98 for lead teachers and .93 for assistant teachers. Jaeger and Funk reported coefficients of .81 and higher for the sensitivity (positive interaction), punitiveness, and detachment subscales. (2) Inter-rater reliability: Jaeger and Funk reported inter-rater reliability coefficients ranging from .75 to .97 between a certified observer and trainees.

Validity: (1) Concurrent validity: Layzer et al. reported correlation coefficients of .43 to .67 between the Arnett and the Early Childhood Environment Rating Scale (ECERS), Assessment Profile for Early Childhood Programs, and the Description of Preschool Practices. The authors did not expect the coefficients to be large because the Arnett scale focused more narrowly on an aspect of teacher behavior not directly measured by the other three observation instruments. However, Phillipsen et al. reported a correlation of .76 between the Arnett and the ECERS.

Method of Scoring: The observer rates the extent to which the caregiver exhibits the behavior described in the item on a 4-point scale, ranging from not at all (1) to very much (4). Averages can be calculated for each subscale.

Interpretability: Depending on the program's needs, individual caregiver scores can be compared to the scores of other caregivers or the mean scores of a group of caregivers compared against the means of other groups of caregivers. Statistical tests have been frequently utilized to assess the differences between scores.
Training Support: None described.

Adaptations/Special Instructions for Individuals with Disabilities: None described.
Report Preparation Support: None described.

References:
Arnett, Jeffery. "Caregivers in Day-Care Centers: Does Training Matter?" Journal of Applied Developmental Psychology. Vol. 10, 1989, pp. 541-552.

Jaeger, Elizabeth, and Suzanne Funk. The Philadelphia Child Care Quality Study: An Examination of Quality in Selected Early Education and Care Settings. Philadelphia: Saint Joseph's University, October 2001.

Layzer, Jean I., Barbara D. Goodson, and Marc Moss. Observational Study of Early Childhood Programs, Final Report, Volume I: Life in Preschool. Cambridge, MA: Abt Associates, Inc., 1993.

Phillipsen, Leslie, Debby Cryer, and Carollee Howes. "Classroom Process and Classroom Structure." In Cost, Quality, and Child Outcomes in Child Care Centers, edited by Suzanne W. Helburn. Denver: Department of Economics, Center for Research in Economics and Social Policy, University of Colorado at Denver, 1995, pp. 125-158.

Resnick, Gary, and Nicholas Zill. Is Head Start Providing High-Quality Education Services? "Unpacking" Classroom Processes. Albuquerque, NM: Biennial Meeting of the Society for Research in Child Development, April 15-18, 1999.

U.S. Department of Education. National Center for Education Statistics. Measuring the Quality of Program Environments in Head Start and Other Early Childhood Programs: A Review and Recommendations for Future Research, Working Paper No. 97-36, by John M. Love, Alicia Meckstroth, and Susan Sprachman. Jerry West, Project Officer. Washington, DC: 1997.

Appendix F. ECD Center Observation Checklist

Notes for researchers:

Before conducting an interview to fill in the form, please introduce yourself and explain to the caregiver that the purpose of the observation and this interview is not to evaluate the implementation of early childhood development, but to document various existing services in order to improve the quality in the future.

Gather the caregivers in one group and conduct the interview.

When the interview is over, say thank you for the caregiver's participation in this research.

1. Information of Interviewer			
01.	Name of Interviewer		
02.	Date of Interview		
03.	Time of Interview		
04.	Name of data entry person		
2. ECD Information			
01.	Province	(11) Nanggroe Aceh Darussalam (32) West Java (35) East Java (61) West Kalimantan (73) South Sulawesi (94) Papua	☐☐
02.	District	(1171) Banda Aceh City (3205) Garut District (3513) Probolinggo District (6101) Sambas District (7311) Bone District (9403) Jayapura District	☐☐☐☐
03.	Sub district (*kecamatan*)		
04.	*Kelurahan*/Village		
05.	Name of ECD		
06.	Address of ECD (street name, *RT/RW*)		
07.	Starting year of operation		☐☐☐☐

08.		*Taman Posyandu* *Taman Adituka* *Taman Paditungka* *Posyandu Plus* *Posyandu* *PAUD HI* *RPSA* Kindergarten *RA/TA* *Pos PAUD* *BIA (Bina Iman Anak)* *Bina Anak Sholeh*	Playgroup *TPA* *BKB* *BA* *Polindes* Sunday School *Puskesmas* *Pustu* *Rumah Bersalin* *TPQ* *Puskesdes* *Mention* (_____)	☐☐
09.	Child's presence	Present Not present		☐☐ Male: _____ person(s) Female: _____person(s)
10.	Children age	0-2 year 3-4 years 5-6 years Other (mention_____)		☐☐ Male: _____ person(s) Female: _____person(s)
11.	Caregiver's presence	Present Not present		☐☐ Male: _____ person(s) Female: _____person(s)
12.	Other adult presence	Present Not present		☐☐ Male: _____ person(s) Female: _____person(s)
4. Checklist of Observation and Short Answers **4A. ECD Information**				
01.	Owner of ECD	1. Private 2. Community 3. NGO 4. FBO 5. Government		☐
02.	Status of ECD	(circle the answer) 2a. Have principle permit from the District Education and Culture Office:		Y N
		2b. Have operational permit from the Provincial Education and Culture Office or notary signed article of association		Y N
		2c. Accredited:		Y N If Kindergarten (*TK*) or *RA*, go straight to question 2d
		2d. Accreditation rank		Y N

03.	Does this ECD have the following administrative requirements?	(mark with 'x')	
		ECD Efforts	
		Formal Vision Mission Purpose (in writing?)	
		Formal job description (in writing?)	
		ECD development plans	
		Formal management structure	
04.	ECD Location	1. Private home 2. Particular building as ECD location 3. Community owned building 4. Rented house If answer is no. 03 = (1) and (2), continue to question no. 05	☐
05.	Is the community owned building, where the ECD is located, used for other purposes?	1. Yes 2. No Specify for what: _____	☐
06.	Normally, how many children come (in a day)?		_____person(s)
07.	Normally, how many caregivers come (in a day)?		_____person(s)
08.	Can the caregiver point out or identify the activity plan?	1. Yes 2. No If the answer is no. 07= (2), continue to question no. 09	☐
09.	Who is the source for ECD activity plan?	1. NGO 2. Government 3. Caregiver 4. ECD Explain: _____	☐
10.	Frequency of ECD activities	1. More than 4 times/week 2. 3-4 times/week 3. Less than 2 times/week 4. Less than 4 times/month 5. Once a month 6. When needed/impromptu	☐ _____ hours/day
4B. ECD Funding			
01.	Is there a collection of fees? 1. Yes, routine 2. None		☐
02.	a. If it's routine, how frequent? 1. Monthly 2. Weekly 3. Daily		☐
	b. Amount of fee		Rp _____

03.	a. Is there a one-time payment fee? 1. Yes 2. No	☐
	b. Nominal pungutan c. The purpose of this one-time payment is for paying:_____	Rp _____
04.	Does ECD receive the following types of support: 1. Free rent 2. Land (where the ECD is located) 3. Operational cost (in cash) 4. Other materials (toys, books, food, etc.) 5. Material support from NGO Dukungan materi dari LSM or support If receive financial support for operations (name the NGO): _____ _____	Y N Y N Y N Y N Y N
	1B. Receive public funds: 1. Yes 2. No	☐

4C. Education and Caregiver Resource

01.	How many staff have the following criteria: Staff, who are regularly paid (have salary) Staff, who receive incentives Staff, who receive support in goods (non cash) Volunteers (do not receive material support)	 : _____ person(s) : _____ person(s) : _____ person(s) : _____ person(s)
	What is the funding source to provides incentives/salaries/non financial support for staffs?	

02.	Funding source	Frequency in receiving money 1) Regularly; (2) Sometimes; (3) Once
	1.	
	2.	
	3.	

4D. Caregiver Information

01. How did you start working in ECD?
(mark with 'x')

	CG1	CG2	CG3	CG4	CG5
Started off as cadre for *Posyandu*					
The ECD manager chose me					
The village head or government institution chose me					
My own initiative					
Community encouragement					

02.	Caregiver education background (mark with 'x')					
		CG1	CG2	CG3	CG4	CG5
	Did not graduate SD					
	SD-SMP					
	SMA/K					
	Diploma					
	S1-S2					
03.	Did the caregiver receive training regarding children growth and development for the last two years? (mark with 'x')					
		CG1	CG2	CG3	CG4	CG5
	Training for child growth and development 1. Yes 2. No					
	If yes, who held the training?					
	Length of training (day):					
	Training topic: _____ _____					
04.	Did the caregiver receive training in management in the last 2 years?					
		CG1	CG2	CG3	CG4	CG5
	Management training 1. Yes 2. No					
	If Yes, who held the training? NGO Government Others					
	Training topic: _____ _____					
05.	Did the caregiver receive training other than the above trainings in the last 2 years?	(circle the answer) CG1 : Y T CG2 : Y T CG3 : Y T CG4 : Y T CG5 : Y T				

06.	Rank based on priority scale, what is needed to improve the caregiver's skills? Priority scale: First and most important; (2) second most important; (3) third most important						
			CG1	CG2	CG3	CG4	CG5
	1	Continue to higher education					
	2	Follow the instructions of ECD manager					
	3	Continue to ECD vocational education/diploma					
	4	Training for special needs children					
	5	Training on health/child nutrition					
	6	Training to improve teaching skills (school readiness)					
	7	Training regarding children growth and development					
	8	Others: _____					
	9	Others: _____					
07.	Rank based on the priority scale, what are the managerial skills needed by the present ECD caregiver/ manager? Priority scale: (1) – highest priority, (2) - lower priority, …, (n) (lowest priority)						
			ECD Priority				
	1	Fund raising/economic improvement					
	2	Financial management					
	3	Program/activity development					
	4	Activity management					
	5	Planning and reporting					
	6	Others: _____					
	7	Others: _____					

4E. ECD Access			
01.	Where do the children come from, who are currently participating in this ECD?	1. The same ward 2. 1 to 3 wards 3. More than 3 wards	☐
02.	Are there any special need children or suspected as having special needs present in the ECD?	1. Yes 2. No	☐
03.	Do special need children or suspected as having special needs come to this ECD?	1. Yes 2. No	☐
04.	If the answers are no. 02 and 03 are yes, what kind of special needs do these children have or suspected of having?	_____ _____ _____ _____	
05.	Approximately, how many children aged 0-6 years living around this ECD participate in the ECD?	1. Not many (<25%) 2. Average (26-50%) 3. Many (>51%)	☐

06.	In your opinion, what may be the reason for the children not to participate in ECD? (rank the reasons based on priority scale 1, 2, 3)		
		Reason	ECD Priority
	1	Parents do not have funds to pay service	
	2	Parents do not want their children going to ECD	
	3	Parents do not see the benefits of ECD	
	4	There are no adults accompanying the children to ECD	
	5	Special needs children	
	6	Children go to other ECD to access this service	
	7	It is hard to access this ECD	
	8	The child doesn't want to participate in this ECD	
	9	Others:	
07.	If the children that are not enrolled in the ECD would like to participate, would this ECD be able to serve all children living around the ECD?	1. Yes 2. No If No, continue to question no. 09.	☐
08.	If unable, what would the ECD need to be able to gather more children?	Mark based on priority scale (1,2,3)	
		ECD Needs	
		ECD needs larger location	
		ECD needs more teachers/caregivers	
		ECD needs funding source	
		ECD needs facility and materials for playing and learning	
		Others:	
09.	What activities does ECD carry out to encourage more children to participate in ECD in the last year?	Mark with 'x' (may answer more than one)	
		ECD Efforts	
		Visit families, who have children but not participating in ECD	
		Provide socialization during community meetings	
		Provide socialization in the form ECD festivals	
		Provide socialization in women group meetings, e.g. *PKK*	
		Involve religious figures to ask families, whose children are not participating in ECD	
		Involve community figures and village government structure	
		None	
		If none, what is the reason:_____	

4F. Holistic Integrated Early Childhood Development Service (for children LIVING in this ECD location)							
No.	Location	In this ECD	Outside the ECD, in the same village	In another village, in the same sub district	In another sub district	None/Don't know	Organizations/ individuals providing service/activities
		'X' if Yes	'X' if Yes	'X' if Yes	'X' if Yes	'X' if Yes	
1	Counseling and health check ups during pregnancy						
2	Provide support to process birth certificate						
3	Counseling for starting early breastfeeding and exclusive breastfeeding						
4	Immunization						
6	Providing vitamin A and iron						
7	Prevent infectious disease and integrated management for young children (*MTBS*)						
8	Provision of supplemental food (e.g. mung beans porridge)						
9	Treatment of malnourished 0-5 year olds						
10	Stimulation for growth and development						
11	School preparedness (examples of introducing letters and numbers)						
12	Counseling for parents						
13	Intervention for special needs children						
14	Identification and reference for special needs children						
15	Early detection and monitoring of child growth and development						
16	Character education (e.g. taught about honesty, modesty and tolerance)[50]						
17	Religious guidance						

50 Heritage Indonesia Foundation (2000), Character education covers 9 pillar, i.e. to love God and Nature, Responsible, Disciplined and Autonomous, Honest, Respectful and Polite, Loving and Cooperative, Confident, Creative, Hard working and Perseverant, Justice and Leadership, Kind and Humble, Tolerant, Love Peace and Unity. If the caregiver teaches one of these 9 pillars, then the ECD is conducting character education.

4G. ECD Management

Does ECD provide information (report) on activities and finances to the following parties? (mark with 'x' for columns 2, 3 and 4)

	Activity information	Financial information	Frequency per year
(1)	(2)	(3)	(4)
Owner			1 2 3 4 >4
Parents			1 2 3 4 >4
NGO/Foundation/FBO			1 2 3 4 >4
01. Education Office (e.g. Technical Unit of Education Office, inspector, supervisor)			1 2 3 4 >4
MoRA District Office			1 2 3 4 >4
Health Office (e.g. midwife, *Puskesmas* staff/head)			1 2 3 4 >4
Village Head Office			1 2 3 4 >4
Others:_____			1 2 3 4 >4
Others:_____			1 2 3 4 >4

02. a. Is the ECD visited by the following parties? (mark with 'x')

	Monthly	Every 3-6 months	Every year	Seldom
Owner				
NGO/foundation/FBO				
Education Office				
MoRA District Office				
Health Office				
Village Head				
Others:_____				
Others:_____				

b. What kind of activities are held during the ECD visit by the above party? (mark with 'x')

Activity	Visitor
Look around	
Provide inputs regarding program or finances	
Review	
Inquire about children	
Inquire about financial information	
Look at equipments and materials	
Supervise	
Inquire about teachers/caregivers	
Others:_____	
Others:_____	

4H. ECD Facilities				
01.	ECD type of building:	1. Entirely covered with wall 2. Partially exposed walls		☐
02.	Type of widest roofing:	1. Concrete 2. Roof riles 3. Shingles 4. Zinc roof	5. Asbestos roof 6. Straw 7. Others	☐
03.	Type of broadest walls	1. Cement 2. Wood	3. Bamboo 4. Others	☐
04.	Type of most floors:	1. Earth 2. Not earth		☐
05.	Lighting source	1. Natural light (sunlight) 2. Electricity 3. Oil lamp 4. None		☐
06.	Are there separate ECD rooms based on age group?	1. Yes 2. No		☐
07.	Ventilation:	1. Poor 2. Sufficient 3. Good		☐
08.	Type of toilet:	1. Toilet 2. Squat toilet 3. Others (specify_____) 4. None		☐
09.	a. Water source:	1. Packaged water 2. Refilled water 3. Pipe water 4. Well with pump 5. Covered well 6. Open well 7. Protected spring 8. Unprotected spring 9. River water 10. Rain water 11. Others		☐
	b. If the answer to No.08 is (4)—(8) (pumps, wells, springs), how far is it to the nearest septic tank?	1. < 10 m 2. ≥ 10 m 3. Don't know		☐
10.	Are handwashing facility available (and accessible) from the location of the ECD?	1. Yes 2. No		☐

11.	Does the ECD have the following materials/equipment: (mark with 'x')			
	Plant measuring tool		Mother and child health book	
	Indoor education tools		Poster on growth and development	
	Outdoor education tools		Material on stimulation, detection and early intervention for growth and development (*SDIDTK*)	
	Pencil/marker/crayon		Cutlery	
	Whiteboard/blackboard		Child development card	
	Health kit		Food for children	
	Tables for children		Storybooks	
	Chairs for children		Coloring books	

Appendix G. Observation Results of ECD Centers

G.1. Preliminary Observation Result: Opportunity and Potential for HI ECD in Garut District, West Java

G.1.1. Model

There are already ECD Models in the Village of Sukawening, Sukawening District with one stop service model for *Poskesdes* (*Pos Kesehatan Desa*), *Posyandu*, *Taman Posyandu* and community library built together by the village community, village leaders and religious leaders on Sukawening village ground.

Relevance to HI ECD

The one stop service at Sukawening Village is a typology of one stop complete integrated service in accordance to the National Strategy, which is to provide complete service of child care, from a safe and healthy labour, immunization, vitamin A, weighing, maternal and infant guidance, *SDIDTK*, play stimulation in accordance to the age of infant to the time of learning to read at community library.

Supporting Facts

Based on the observation and interviews with the early childhood development caregivers from 10 locations in 4 chosen villages, in Garut District in 2012, the average child of 0 to 6 years obtained 60 to 100% of early childhood development service at village level as mentioned in the HI ECD Strategy which are:

- Counselling and pregnancy check
- Birth certificate process,
- Early breast feed and exclusive breastfeed initiation,
- Immunization, administration of vitamin A and iron
- Supplementary feeding
- A child's growth simulation
- School preparation
- Counselling for parents
- Early detection and monitoring of children development

G.1.2. Interaction

There's a good interaction between caregivers and the children in every type of early childhood services where the caregivers have access to training on children growth and development.

Relevance to HI ECD

The caregivers understand the need of every group age children from 0 to 6 years old and able to provide stimulations of proper games according to the child's development age. This is a potential in increasing the quality of holistic and integrated early childhood development in accordance to National Strategy.

G.1.3. Methods and Curriculum

There are methods and curriculum which are proper to cadres and educators of early childhood development with various educational backgrounds.

Relevance to HI ECD

The method applied by the *UNINUS* (*Universitas Islam Nusantara*) *LPPM* (*Lembaga Pengabdian Pada Masyarakat*) and the existence of *UNINUS LPPM* are potential to increase the quality of all the integrative holistic early childhood development service

Supporting Facts

From the same data source both the formal *PAUD* Caregivers from Garut and Probolinggo states that the main priority of the training is the child development training and the main priority for non formal *PAUD* is training for children preparation to enter elementary school.

G.1.4. Partnership

The partnership between the people and the religion community social organization such as Dewan Masjid Indonesia, Aisyiyah and Muslimat are social capital in the implementation of early childhood development.

Relevance to HI ECD

By increasing the role of the community in the implementation of early childhood development, this partnership asset may be developed to increase access, equality and adequateness of holistic integrative early childhood development types of services with the strategy of implementing equal and affordable service in accordance to the National Strategy.

Supporting Facts

From the observations and interviews with the administration and caregivers at 10 locations of early childhood development in 4 selected villages, 50% of the administration was managed by the community and 20% was by religious social institution.

G.1.5. Modifications

Modifications on the types of early childhood development services such as *TAAM*, *TBAA*, *BAMBIM*, in Garut District is in accordance to the local values and needs of the local people.

Relevance to HI ECD

This modification is a potential to integrate the religious and cultural values to the materials of counselling, education and games in early childhood development and the achievement in identifying and socializing constructive religious and cultural values in children care.

G.1.6. Fulfilling the Dream of Affordable and Quality HI ECD in Garut

G.1.6.1. Dream

"It is expected that in the next five years every early childhood development service institutions

(educational service, or health) is available in every *RW* and able to accept every early years children, with strong financial support from the regional government, proper training to the teachers/caregivers/ health officers/cadres and also proper incentive"

- Is this dream consistent with the HI ECD?
- Is this dream built on assets, opportunities and potentials of Garut District in HI ECD?

G.1.6.2. Design/Plan

- Mapping and collecting data (database) on ECD
- Advocate and socialize to all related element of policy makers on executive or legislative level to obtain budget support
- Prepare a grand design of planning and developing ECD that involves research institutions and universities
- Raise community and organizations support who are concern about ECD
- Integration and synergy between related technical institutions in the ECD Program

Question

Is this plan specific enough is it measurable, doable, and realistic and has a clear timeframe?

G.1.6.3. Dreams/Visions of Garut District

1. Establishing partnership with educational institutions in order to obtain resources willing to work voluntarily (Internship Program of *KKN*) to provide coaching to cadres
2. The same reporting format from various agencies (Health, *BKKBN*, education, social) so that it would be easier for the cadres
3. Improving the ECD facilities & infrastructures to become a kindergarten
4. More ECD caregivers with proper competencies
5. HI ECD service that is understood by the administrators and caregivers of ECD centers
6. More Integrated independent *Posyandu* with various other ECD services
7. Every pregnant mother and labour process are served by health officials, no more infant without immunisation and higher average marital age
8. Laws that obligate parents to send their infants to growth and development services, and there will be consequences for disobedient.
9. Community and parents understand the need for ECD (no longer forcing parents' wishes to their children)
10. Every health service will have nurses, midwives, dental care, nutritionist and trained administrative officer.
11. *SDIDTK* is conducted properly periodically by trained staff of *Puskesmas* to all ECD in various services in coordination with other related sectors
12. Expanding ECD access by empowering *PUS Pokja* and conducting training to educators
13. ECD has strong legal basis
14. Performing maternal classes in villages with low coverage
15. No difficulties in obtaining operation permit/license
16. Produce innovations for unique ECD program which is appropriate with the character and need of the community
17. No more maternal and infant fatality.

G.1.6.4. Discussion regarding realising the dream

Choose three of the above dreams/visions to be discussed in three groups.

- Is this dream consistent with the HI ECD?
- Is this dream built on assets, opportunities and potentials of Kupang District in HI ECD?

What are the requirements and actions that need to be taken to realize thos dreams?
(Specific, measurable, realistic, and has clear timeframe)

The discussion result to be presented to the plenary.

G.1.7. Results of Validation Workshop and Enrichment Study on Early Childhood Development Strategy in Bappeda of Garut, July 9, 2012 involving various Stakeholders

There are 3 points of Visions of ECD agreed by the stakeholders
- Legal basis for ECD from National Level to Regional Level
- Improvement in the quality of Human Resources, Facilities and Infrastructure of ECD
- HI ECD Service may grow and develop optimally in the community

G.1.7.1. Vision 1 and relevance to National Strategic

Legal basis for ECD from National Level to Regional Level consistent with the HI ECD, and developed with focus on the providing legal basis on District Level.

Perda (Local Regulation) or *Perbup* (Head of District Regulation) on:

- Cross sectors coordination (*Bappeda, Dinkes, Disdik, Mapenda, BPPKB, PKK, Dinsos, Pemda*)
- Local CSRs are directed to the ECD Services
- Operational incentive to the Educators and Cadres
- Provision and maintenance of ECD Facility – Infrastructure in every *RW*
- Before entering elementary school a child must attend ECD service
- Midwives active involvement in every ECD services
- Follow up from various training attended by the Cadres or Educators
- No regulation on giving incentive based on level of education of the Cadres/Educators
- No difficulties in obtaining operation permit

Actions to be Done

- Apply a "hearing" and draft Regional Regulation to *DPRD* (Provincial House of Representatives), children's Education and Health department.
- Approach to "*Bunda PAUD* (ECD Mother) District's to support the issuance of local regulation or
- Increase the role of Bappeda to bridge cooperation and coordination across sectors
- Socialize and advocate ECD Service in Planning and Development Meetings at Village level, Sub-district level, and district level
- Socialize and advocate actively to the community regarding ECD services to encourage Regional Government to issue a local regulation

Pre-condition Required

- Active involvement of all the stakeholders, not "passing the bucks"
- A coordination forum is formed across sectors related to the drafting of the regulation of ECD Services
- Eliminate or decrease sectors ego
- Arrangement between sectors regarding the best way to administer the service to the children and not just implementing the service of each sectors

G.1.7.2. Vision 2 and Relevance to National Strategic

Improvement in the quality of Human Resources, Facilities and Infrastructures of ECD consistent with the National Strategic to improve the quality of services base on the local potentials and condtition.

- Training and competencies for ECD teachers and education funding aid to Package A, B, C and S1.
- Refresh training for Cadres and health officers on children's growth and development
- ECD and *Posyandu* activity venue integrated under one roof
- Furniture: *APE* inside and out, complete set of balance scale, tension, stethoscope, scale, SIP *Posyandu*, Lila ribbon, full body scale
- Routine Supplementary feeding with balanced diet.

Actions to be Done

- Utilize the fund from the *APBN*, *APBD*1, *APBD*2, and CSR stated in the *RKP* (Government Work Plan)
- Routine cross sectors Coordination and communication, in order for each sectors to understand regarding the "updated" implementation program of other sectors
- Routine coordination for all ECD administrators at village level, exchanging information and support
- Proactive in socializing and advocating to the businesses who possess a location in Garut such as Chevron, Chocodot, Hotel Association, Heated Water Companies, dodol picnic etc. to provide support in the effort to increase quality, human resources, and facilities of ECD
- Activate the social solidarity charity. Gather donor around us to donate what they can and distributed to the ECD Services
- Socialize and advocate to the community to be actively participated in ECD services, not just deliver their children to the ECD Services

Pre-condition Required

- Mapping of sectors duties, "who does what", budget, hence clear roles
- The implementation of sectors programs should complement each other sectors instead of no relation to each other
- Minimum Service Standard as reference in Human Resources quality improvement, facilities and infrastructure
- Routine Cooperation and coordination for all ECD Services related LGUW (Local Government Unit of Work
- Active support from the local government
- Active support from every community level

G.1.7.3. Vision 3 and relevance to National Strategic

HI ECD Service may grow and develop optimally in the community consistent with the development of HI ECD in the framework of expanding access to ECD services to all level of society
Service to ECD may grow and develop optimally in the community

- Health, Education, Nurture, and Child Protection services are inseparable in ECD Service
- All ECD service in the community are in the form of holistic integrative
- At least every *RW* will have one HI ECD Service
- ECD Services run by the community with the support National government and Local Government

Actions to be Done

Socialize and advocate massively to all level of community to raise awareness and to become concern about the significance of ECD service

- Cross sectors coordination and cooperation from village level to district level
- *SKPD* to form a team to monitor and evaluate the ECD service involving various agencies
- Advocate to the local government so that the ECD will be included into RPJMD
- Improve the cooperation of NGOs in the field of ECD to support the community in implementing ECD Services
- *SKPD* coach the community in planning and managing the system which will encourage the independence of ECD service, hence the services will still run without aid.

Pre-condition Required

- A strong will from the Stakeholders based on meeting the basic essential need of children from the time in pregnancy up to 6 years of age
- Available facility to conduct routine coordination on village level to district level
- Available legal basis in the form of *Perda* and also financial support to the administrators of ECD in the community
- Awareness of every stakeholder (related agencies, pemda, community, NGO, etc) towards the development of ECD services.

G.2. Preliminary Observation Result: Opportunity and Potential for HI ECD in Probolinggo District, East Java

G.2.1. Opportunity in Province Level

The Government of East Java has launched the "10.000 *Posyandu* Park Movement" until 2013
The Governor Regulation No 63/2011 is the legal foundation in coordinating sectors related to HI ECD, followed by the preparation of juknis (petunjuk teknis/Technical Guidance) and also socialization in order for the Regional, City/District Government to be committed to the ECD program.
Training to 3500 PURI *Posyandu* Cadres throughout East Java on HI ECD service (2012) with the *APBD*1 funding.
ToT to the Head of Pokja two and four *PKK* from each Kabupaten regarding HI ECD Development with the UNICEF funding support.

Relevance to the ECD National Strategy

The four provincial policies related to ECD are already in accordance with the National Strategy, in terms of:

"Implementing equal and affordable ECD service, especially to poor families or families with special need"
"Strengthen and harmonize the legal basis of HI ECD service implementation"
"Increase the commitment coordination and cooperation between government institutions, service implementer institutions and related organizations"
"Increasing the quality of ECD service". Tot for *PKK* members in the district is a facility to maintain and improve service quality, since after the Tot they will coach the Cadres personally in the process of building and developing HI ECD service in *Posyandu* in each areas.

G.2.2. Improve Cadres/Teachers Competencies

To improve the competencies and education of ECD teachers The State University of Surabaya has conducted a three months training program, which then the Cadres may be able to continue to an S1 Program with a conversion system (The three month training material is equal to 12 credit time of college). Every year there is allocation for scholarship from the *APBN* for 36 people.

The Faculty of Psychology of the University of Airlangga has provided a weekly free lecture on children growth and development for ECD Cadres for three months and a coaching program for ECD teachers in handling troubled children.
Various trainings and seminars conducted by Partnering organizations targeted on ECD Teachers, for example from *BKPRMI*, *HIMPAUDI*, Indonesia Dentist Association, Erlangga Publisher.

Relevance to HI ECD National Strategy

Various efforts to increase the capacity and capacbility of the cadres/teachers of ECD is in accordance to one of the goals of National strategy which is "the increasing competence of the ECD service officers".

G.2.3 Integrated Service

There is a complete integrated one stop service (*Taman Posyandu*) in the village of Wonorejo and Sumber Poh and a complete integrated service in Maron Kidul Village and Maron Wetan.
There are 28 *Taman Posyandu* in Kec. Maron spreaded through out five villages they are: Maron Wetan, Satreani, Pusapan, Sumber Poh, and Wonorejo.
Providing handicraft skill training to the expecting parents

Relevance to HI ECD National Strategy

The National Strategy mentioned the typology of HI ECD service adjusted to the local community's condition and need, not forcing the condition to provide one stop service. Although different on type, the service is complete, covering meeting the need to health service, nutrition, education, care, and protection and also carried out in an integrated manner by several parties.

Supporting Facts of available ECD service in the village VS services accessed outside the village or not yet available)

Available services in the village (100%)	Services still accessible outside the village or not yet available
Counseling during pregnancy check up	Support to process birth certificate
Immunization	Counseling on how to initiate early breastfeeding and exclusive breastfeeding
Providing vitamin A and iron	Prevention of infectious diseases and integrated management of sick 0-5 year olds
Providing supplemental food	Treatment of malnourished 0-5 year olds
Stimulation for growth and development	Intervention for special needs children
School readiness	Identification and reference for special needs children
Guidance for parents	Early detection and stabilizing child's growth and development
Religious guidance	Character education

Source: Checklist, N=9 ECD service

G.2.4. Parents and Family (*BKB*)

- There are currently 258 *BKB* group in the entire district. And there's one Pilot *BKB* (one on each sub district)
- The activities in *BKB* improve the parents' knowledge in parenting and the development of children 0 to 6 years of age.
- Creativity in implementing *BKB*, that is by inserting activity such as "*arisan*" or savings and loan to lure parents to keep attending.

- *BPPKB* has collected data of children to make sure no child is left out during *Posyandu* process
- The Community has become more educated on how to be parents and to give better parenting; "we use to educate our children with violence, but now that has been much less, dealing with children must have more patience than ever"

Relevance to HI ECD National Strategy

One of national strategic goals is "The increasing capability of parents and family in nurturing children" the result of the FGD I the community has shown consistency in achieving that goal.

One of the strategies from national strategic is the increasing understanding and capability of parents in the principle, knowledge, attitude and good parenting skills.

G.2.5. Community Involvement

- "I think the characteristic of East Java community of high level of devotion and struggle can become an important factor in sustaining ECD in the community." – Province Education Dept.
- "The cadres here have high level of devotion and religious determination that what they do here now in terms of ECD will be rewarded in the after life" – Province *BKKBN*
- "The cadres here are just noble souls, doing a lot of good to the village even with very small reward" – Village Head Maron Kidul
- "The cadres always attended the trainings on how to develop ECD even on their own expense" - Cadres

Relevance to HI ECD National Strategy

In the principle of NATIONAL STRATEGY implementation it is said that the community must be involved in the stage of planning, implementation, monitoring and evaluation of ECD program. The people participation especially cadres/tutors is the spearhead of ECD implementation. Acknowledgement on the cadres hard work should rise from regional level to village level. The spirit of devotion and religious conviction are main capital to cadres to continue to give service to Early Years Children.

G.2.6. Impacts (Benefit of HI ECD)

- "Children are more focused during games, independent, capable of interacting with other people politely, behaving healthy and sanitary, knows numbers, letters, colours and praying" – parents
- "Children are more prepared to enter elementary school and the low number of repetition in elementary school for children who attended the ECD program" – Elementary School teacher
- "Children's play used to be unstructured now its more constructive, every game has positive values" – Service Provider
- "Children can easily access health service and examination, and socialization on living clean and healthy" – midwife and cadres

Relevance to HI ECD National Strategy

From the impacts of ECD services various goals of NATIONAL STRATEGY has been achieved, that is to increase the degree of health and nutrition of ECD, children preparation for school, internalize religious values and local wisdom to form the character of children. Other than that the services the children are receiving also showed holistic and sustainable service.

G.2.7. Financial Support (Public and Community)

- Four villages in Maron sub district provided support through ADD. The ADD funding is used to aid the welfare of the cadres, purchase of supplementary food, or other operational expenses.
- PNPM provide infrastructure support for ECD building or *Posyandu*, while the land must come from NGO, in grants for example.
- The fee that the community pay to access *Posyandu*. The collected fund is used to aid the transportation expense of parents with ill children to access health care or to buy baby first need, such as clothes, blanket, etc (*Dansoskes/Dana Sosial Kesehatan* and *Tabulin/Tabungan Ibu Bersalin*).

Relevance to HI ECD National Strategy

It is stated in the NATIONAL STRATEGY that an effort to improve the quality of ECD service is the empowerment of resources in all level of administration. Routine fee based on the initiative and commitment of the people also showed active involvement of the people in order to facilitate the improvement of people health especially for mothers and infants.

G.2.8. Dissemination

Related socialization on the early childhood development conducted by several parties:

- Provincial Government conducted socialization to District/City Government to groom their commitment in realizing 10,000 *Taman Posyandu*
- The Government and *HIMPAUDI* conducted socialization to all of the community in relation to the importance of ECD to a child's development. One of the form of socialization is by having early childhood highlights through a series of contests.
- Community organizations conducted socialization on the importance of ECD through Islamic religious groups involving the village's midwife
- The district's health department conducted socialization to Kindergarten/ECD teachers to grow the awareness related to *SDIDTK* .
- *IGTKI* conducted socialization on ECD through routine *PKK* meeting
- Community organizations (*Muslimat* and *Fathayat*) conducted seminars regarding children parenting every month and on public holidays

Relevance to HI ECD National Strategy

To improve access to ECD services, NATIONAL STRATEGY encourages socialization activities to the community (Community leaders, NGO, and Enterprises)

Supporting Facts on the socialization conducted to increase the number of ECD accessing the Service:

- For Non Formal ECD services, the most frequent activities are:
  - Socialization in Community meetings
  - Socialization in *PKK* meetings
  - Involving community leaders and village government officials

- For formal ECD services, the most frequent activities are visiting families with children but no longer participated in ECD services

G.2.9. Distribution of ECD Services

ECD Services has distributed to almost all of the villages in Probolinggo District (total 330 villages), which are:

- 463 kindergarten (354 of them are under *PKK*)
- 370 *RA*
- *Posyandu* in every *RW*
- Minimum 1 ECD service in each village
- The pilot *Taman Posyandu* in sub distrsict of Maron and Tongas (in Maron sub district there are 28 *Taman Posyandu*)
- 258 *BKB* groups and Pilot *BKB* in each sub district

Relevance to HI ECD National Strategy

NATIONAL STRATEGY encouraged the implementation of equal and affordable early childhood development service with activities to improve the adequateness of types and distribution of early childhood development service.

G.2.10 Fulfilling the Dream of Affordable and Quality HI ECD

G.2.10.1 Dream

Parents' active involvement in the activities of education, development, and child parenting. Currently parent's involvement limited only to taking their children to access the ECD service and not to be actively involved in the stimulating the child's growth and development.

- Is this dream consistent with the HI ECD?
- Is this dream built on assets, opportunities and potentials ofProbolinggo District in HI ECD?

G.2.10.2 Design/Plan

- A Task Force is formed for ECD Growth and Development coordinated by the Regional Government in every level, starting from the Province to the Village
- Involving the network of *PKK* in every area. As large mass organization and has strong network from national level to the village level, hence the active involvement role of the parent is to perform stimulation to children in each *PKK* meeting at all level.
- Training for school committee of Kindergarten and ECD. The School committee consist of students' parents; hence the knowledge and skills obtained by the school committee will be distributed to other parents.

Question

Is this plan specific enough is it measurable, doable, and realistic and has a clear timeframe?

G.2.10.3 Several Dreams/Vision of Probolinggo District

1. All ECD services are in the form of Holistic Integrative.
2. Proper and dignify incentive to teacher so that they may focus to the service for children and community
3. Qualified educators from the supervisors/inspectors, principals, school janitor, and others in the environment of the service. They should have good understanding of ECD so that they may provide proper interaction in ECD.
4. Each Sub district has consultation centers for children development by involving various professionals (doctors, midwives, psychologist, therapists, etc).

5. Developing the role of early childhood education forum, not only to socialize, but began doing research and development of HI ECD
6. The proportion of the ideal budget from various levels, starting from the family, the village, *APBD* 2, *APBD* 1, and *APBN*
7. Each village has 1 service ECD HI
8. Finding a clear framework to attract entrepreneurs/companies provide service support to ECD
9. Legal umbrella (*Perbup*) related to integration between sectors, between *BKB*, early childhood, kindergarten, *RA*, and *Posyandu*
10. The existence of poly *SDIDTK* (Stimulation, Detection, Early Intervention for Growth and Development) throughout the clinic. Now in the district only one health center with this poly. Poly *SDIDTK* must be separated with poly KIA in order to focus on providing and developing services
11. Skills training for parents and volunteers that can be used as a source of income
12. *Posyandu* facility improvement, ie there are special rooms for examinations of pregnant women. So far, most conducted in the village hall
13. Competence and early childhood education cadres could fit with the Permendiknas (Minister Education Regulation) no 58
14. All ECD teachers and health workers trained on *SDIDTK* . Now only 5% of officers who attended the training *SDIDTK*

G.2.11 Discussion regarding realising the dream

Choose three of the above dreams/visions to be discussed in three groups.

- Is this dream consistent with the HI ECD?
- Is this dream built on assets, opportunities and potentials of Kupang District in HI ECD?
- What are the requirements and actions that need to be taken to realize thos dreams? (Specific, measurable, realistic, and has clear timeframe)

G.2.12 Results of Validation Workshop and Enrichment Study on Early Childhood Development Strategy in Bappeda of Probolinggo, July 12, 2012 involving various stakeholders

There are 3 points of Visions of ECD agreed by the stakeholders

All ECD services are in the form of Holistic Integrative.

Providing legal framework (local regulation or Head of District regulation); integration between sectors (*Posyandu*, early childhood, kindergarten/*RA*, *BKB*)

Provision of poly *SDIDTK* across health centers in the district budget Probolinggo through ideal proportions from various levels (national budget, *APBD* 1/province budget, *APBD* 2/district budget) and involved the participation of entrepreneurs/companies through CSR funds

G.2.12.1 Vision 1 and relevance to NATIONAL STRATEGY

All ECD services are in the form of Holistic Integrative Consistent with the HI ECD, and developed by using the potential and opportunity in Probolinggo District.

ECD services in the form of holistic integrative in each ECD services there are various activities to meet the essential needs of the child, the child in the womb until the age of 6 years. These services form of prenatal care, immunization, nutrition and nutrition, behaviour and promotion of healthy, *SDIDTK* , education, parenting, and child protection.

Actions to be Done

- Cooperation 3 main sectors, namely health (volunteers and health workers), education (cadres, teachers, caregivers), and child care sector (cadres) to design and manage activities together

- Increasing the active involvement of parents and parents to conduct debriefing of the new school year, monthly meetings, giving homework for parents, played daily with parents facilitated by service providers, visit the elderly, parent programs to help in the classroom, providing educational books and parenting
- Refresher training on the growth and development for all ECD service providers
- Active and regular coordination with the government from the local level, villages, districts, and counties
- Dissemination and advocacy to all levels of society routinely, if necessary, make home visits to parents who have access to services for children

Pre-condition Required

- Active participation of all stakeholders of the sector related agencies, the government, and society
- Availability of adequate public facilities, making it easier for people to access services, eg, availability of roads connecting all parts of the village, a permanent place to provide a safe
- Availability of cadres who are ready to serve continue to provide the best services for children
- Assistance from relevant agencies as well as the transparency of the program of each agency.

G.2.12.2 Vision 2 and relevance to NATIONAL STRATEGY

Providing legal framework (local regulation or Head of District regulation); integration between sectors (*Posyandu*, early childhood, kindergarten/*RA*, *BKB*) Consistent with the focus of developing HI ECD legal basis availability at the district.
Regulation that governs:

- Location services; least 1 ECD HI services in every village
- ECD minimum capacity in each of the services available, if it does not meet the minimum number will be merging services
- The clarity of the status of land and buildings/building services ECD HI
- Financing assistance service operations ECD HI
- The authority and responsibilities of each sector and the establishment of a working group (working group) as a facility for the coordination and communication
- CSR of companies in the Probolinggo

Actions to be Done

- Creating a task force (task force) or working group (working group) who coordinated the development of ECD each level of government (county-district-village-*RW*)
- Task force or working group to draft the draft regulation (Law/*Perbup*)
- Task force or working group process "hearing" to the Parliament or the regents of the needs of availability legal services for the development of ECD
- Regular coordination meetings of all members of the task force or working group, at least 1 month
- Entering the importance of developing ECD in musrenbang service from the village to district
- Advocacy is active in the village, to make local rules while waiting for the legalization or regulation in district level
- Improve coordination and communication active among *SKPD* (Satuan Kerja Pemerintah Daerah/ Local government working unit), Parliament, and others institutions of the implementation of the program and its benefits so that the budget can be increased

Pre-condition Required

- Idealism and commitment of all stakeholders to fulfill all the needs of child development
- Awareness of the government and the public about the importance of service ECD as an investment in human resources in the future
- ECD Services listed in MUSRENBANG (*Musyawarah Rencana Pembangunan* = Development Planning

Discussion) and District RPJMD (*Rencana Pembangunan Jangka Menengah Daerah* = Local Medium development planning)
- The lack or less of ego of sectors, all sectors work together and complement each other in the implementation of the program

G.2.12.3 Vision 3 and relevance to NATIONAL STRATEGY

Availability of poly *SDIDTK* across health centers in the Probolinggo distsrict is Consistent with the development of HI ECD with the focus on the availability of accessible and affordable *SDIDTK* to the community.

SDIDTK (Growth Early Intervention Detection Stimulation) Poly which is separated from the Maternal and Neonatal health Poly with trained health officers which have had *SDIDTK* Training. The availability of this service in each *Puskesmas* will accelerate the handling of child development disturbance cases. This Poly is made through an ideal budget proportion from various levels both *APBN*, *APBD*1, *APBD*2 and also involving CSR.

Actions to be Done

- Preparation: the preparation of funding proposals by the health department, the establishment of team work (health sector, national education, kadin, *BPPKB*), meeting technical and non-technical coordination, site survey, made the proposal for the poly *SDIDTK*
- Implementation: The dissemination of the importance of poly *SDIDTK* its funding requirements to the head of government, DRPD, and the heads of various companies in the Probolinggo, fundraising through EO, sharing *APBD* 1 and 2, the state budget, and CSR, the realization of the activities at each clinic
- Refresher training for health workers and the cadres of the *SDIDTK*
- Monitoring and evaluation done by 4 agencies
- The ingredients needed: administration (KMS, KAA), playground equipment (*APE*/*BKB* kit, carpet), tables, chairs, cabinets, scales, height gauges, head, and body weight
- *SKPD* regular coordination meetings to discuss the development of poly *SDIDTK* at each location.

Pre-condition Required

All stakeholders have the same awareness of the functions and benefits of poly *SDIDTK*

- The existence of local regulations that bind the local company's commitment to CSR funds development services ECD
- Common understanding that the poly *SDIDTK* is to serve the community, especially for the development of AUD, not solely belong to the health department
- Availability of funds and qualified health workers do *SDIDTK*.

G.3. Preliminary Observation Result: Opportunity and Potential for HI ECD in Banda Aceh City, Aceh

G.3.1. The emerging of various types of development services are socialized ECD widely in the community

- The establishment of ECD agencies that have Day Care programs, playgroups and kindergartens.
- *Posyandu* Plus has started to rise combined with *BKB* and early childhood education.

- *Posyandu* program activities integrated with *BKB* and love mother movement with financial allocation support of funds for the provision of *APE*, SIDDTK Training, and A Thousand Days for Nation program (SUN).

Relevance to HI ECD Relevance to Developing HI ECD:

To integration of services that include health, nutrition, parenting, education and protection activities ECD is defined in the Strategy:

"Increased completeness and the distribution of types of early childhood development services."
"The integration of the activities of early childhood development from relevant institutions."

G.3.2. The existence of local government support related to the development ECD

- There Qanun Health and Child Protection Qanun (Aceh province).
- Aceh Education Development Coordination Team (*TKPPA*) to help drive improvement and development of ECD development services.
- Pilot funding to facilitate the establishment ECD development services to remote village.
- There is a huge attention from the Mayor and Wife related to ECD development activities (Mayor's wife became Chairman of the ECD Forum)
- The existence of cross-sector collaboration (weekly meeting).
- City Government in the process of design ECD development Qanun

Relevance to HI ECD

Stranas encourages the attempt to enforce and harmonize the legal foundation and increase the commitment, coordination and cooperation between institutions in implementing HI ECD.

G.3.3 Training of caregivers/volunteers/teachers/staff of ECD

- Caregiver training, funded by the provincial APBA.
- Caregiver training organized by the Center for Learning Development (reg) to improve the competence of teachers for the educational background of the majority of high school teachers' development of ECD.
- Training managers held by various government and non-government agencies.
- Increased capacity *Posyandu* centers and carers development workers in the field ECD *SDIDTK*.

Relevance to HI ECD

Stranas's Policy is the "Improvement of Quality of early childhood development service" with activities such as "Utilization of every resource in all level of administration".

G.3.4 The support of the community in the development of ECD

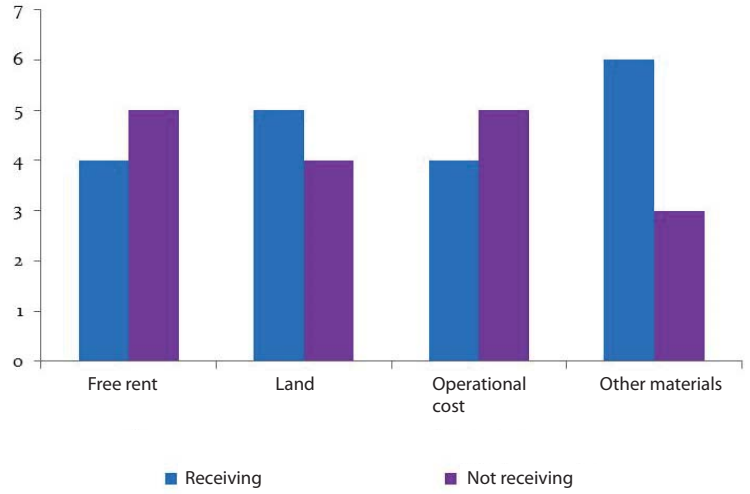
- Quite a lot of people who given their land and home loan for the development of ECD
- Caregivers/volunteers/teachers working full sincerity and patience in nurturing Early Age Children, despite low incentives.
- The existence of the *PKK*, which manages *Posyandu* and *BKB*. Besides being able to entrust the child, parents can also find assistance through *BKB* care.

Relevance to HI ECD

Community's role in ECD is quite significant; however national strategy is still encouraging the effort "Empower the Community and Businesses" through "Increasing number, quality, and officers welfare)".

Supporting Data

Number of ECD based on the received Non-Financial Support



G.3.5. Community participantion in providing HI ECD

The existence of *Musrena* (*Musyawarah Rencana Aksi Perempuan*/Women's Action Plan Congress) has accommodated the suggestion of the women group to Musrenbang (local developmet plan) and subsequently to *SKPD*:

- The role of Musrena is regulated by Perwali No 52/2009 on General Guideline To Musrena
- The City Government is in the process of designing a Regulation on ECD
- There is a Health Regulation (Qanun) and Children Protection Regulation (Province of Aceh)
- The District/City has *ASI* (Breast feeding) Counsellors and every village has breast feeding mothers map
- Breast Feeding campaign, because Islam encourage mothers to breast feed their children up to two years old.

Relevance to HI ECD

It is stated in the principles of National Strategic implementation: "The people may freely take part in designing and formulating related policies and regulations".

G.3.6 Community respond to ECD services

There is an increasing need for people to entrust child care to ECD institutions. There is a shift in preferences: "Better to leave the child to ECD than to the maid."

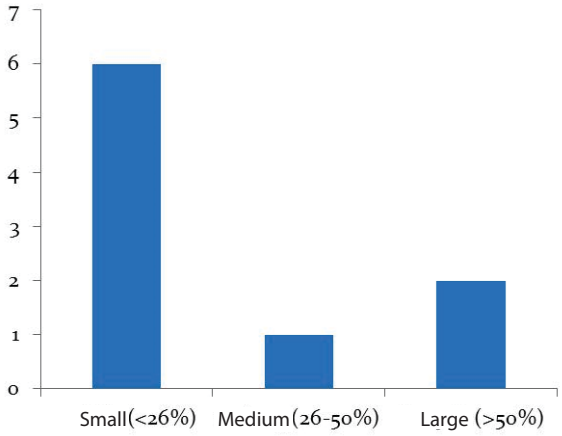
Relevance to ECD HI

In relation to this The STRANAS formulate the below activities:

- "Identification and dissemination of religious values and culture of constructive (local and global) in childcare".
- "The implementation of the study, the study of cultural values expedient for the development of optimal early childhood".

Supporting Data

Number of ECD based on the number of children surrounding Early years Children not participating in ECD



G.3.7. Fulfilling the Dream of Affordable and Quality HI ECD in Banda Aceh

G.3.7.1 Dream

In less than four years over 75% of the infants may access integrated ECD institutions with affordable costs.

G.3.7.2 Design/Plan

- Cross subsidies for poor families to obtain services development by paying ECD 50% or even free.
- Potential contribution and participation is high. This potential needs to be directed in the future to build good quality Al quran Day Care with a variety of other services.
- Organizing Mosque Congregation socialization.
- Official regulations from the government (village/town) so that parents must access the service for the infants.
- *Posyandu* plus *BKB* is open for at least twice a month.

G.3.7.3. Several Dreams/Vision

- ECD has Day Care, *KB*, and kindergartens as well as the provision of health services on a regular basis to visit a doctor or other health care worker.
- Need merger TP Alquran and development agency ECD so integrated between religious knowledge and general knowledge or TPAlquran equipped with *TPA* (care) and the children's playground filled with religious values.
- Development of "*RA* Plus" which provides services for children aged 0-6 years because Islam provides guidance so that children have access to education even in the womb.
- Lack of synchronization health care, education, and child protection through *Posyandu*, *BKB*, *TPA*, family planning, ECD, and *TK/RA*.
- ECD integrated curriculum development between religious knowledge and general knowledge.

- The implementation of the concept of 'group' in ECD development, every 8 institutions consists of a core and 7 ECD ECD impact.
- Establishment ECD laboratory testing as a means of research and development institutions ECD supported by a variety of experts on a variety of service needs care, treatment, education and protection of children aged 0-6 years.
- Provide child care assistance to parents who drove their children to ECD development agency that there are similarities between the institutions and home treatment.
- Making a clear legal framework related to the allocation of development funds ECD to set a budget so that the area is more significant.
- Musrena more enhanced role as an alternative source of strategic referral spawned numerous important policies to improve services for the ECD
- Foundation/owner services to ECD should receive guidance in line with the government for the purpose of service, especially for the development of ECD whose establishment is booming.
- Intensive socialization on the development of ECD and encourage community participation for more attention and help finance the development of ECD to be more independent.

G.3.7.4. Discussion regarding realising the dream

Choose three of the above dreams/visions to be discussed in three groups.

- Is this dream consistent with the HI ECD?
- Is this dream built on assets, opportunities and potentials of Kupang District in HI ECD?

What are the requirements and actions that need to be taken to realize thos dreams?
(Specific, measurable, realistic, and has clear timeframe)

G.3.8 Results of Validation Workshop and Enrichment Study on Early Childhood Development Strategy in Bappeda of Banda Aceh, July 11 2012 involving various stakeholders

There are 3 points of Visions of ECD agreed by the stakeholders:

- Integrating TP Al-Quran with ECD Institution to integrate the religious knowledge and general knowledge or *TPA* (Child Care) and Children Playgroup which is filled with religious values.
- Synchronize the services of health, education, and child protection through *Posyandu*, *BKB*, PA, *KB*, PECD, and *TK/RA*.
- Equality of access to ECD services for children of poor family and children with special need.

G.3.8.1. Vision 1 and Relevance to National Strategic

Integrating TPAl-Quran with ECD Institution to integrate the religious knowledge and general knowledge or *TPA* (Child Care) and Children Playgroup which is filled with religious values The integration of religious knowledge and general knowledge consistent with HI ECD

- Cross-sector coordination meetings; education, health, Department of Islamic Law, and related partner organizations to create a strong commitment in organizing the development of ECD based mosque
- Socialization-based service delivery in developing ECD mosque
- Mobilized in an effort to advocate for government (executive and legislative) to the availability of legal protection for the development of mosque-based ECD
- *PKK* utilize Musrena (Council of Women Action Programme) as a means of strategic alternatives to deliver a variety of policies related to the development of ECD
- Encourage the preparation of an integrated curriculum using curriculum combined results education and religion

- Mobilize to push gradually merging with the development of ECD TP Qur'an more and increase budget allocations
- Governor/mayor presents awards to volunteers, caregivers, teachers, organizers, villagers in the developing of ECD HI program

Pre-Condition Requirement

1. Adequate budget and enough for early childhood development
2. Cadres competence, and community support
3. Good monitoring and training conducted by related agencies.

G.3.8.2 Vision 2 and relevance to STRANAS

Synchronize the services of health, education, and child protection through *Posyandu*, *BKB*, *TPA*, *KB*, PECD, and *TK/RA*. The synchronization is consistent with HI ECD.

- Bappeda held a coordination meeting to issue an agreement among relevant *SKPD* in order to improve service of HI ECD
- Department of Education and the Religious Affair Ministries with partner organizations (*PKK*, *HIMPECDI, PRMI, IGRA, IGTKI*, etc.) programmatically and extensively socialize about the importance of ECD
- Office PP and FP collaboration with BPM and by attracting the support of all organizations mita campaign and encourage community involvement to be active in the development and implementation of activities *BKB* ECD HI
- Cadre training program development is planned ECD based on cross-sector collaboration

Pre-Condition Requirement

1. Commitment and cooperation and also legal coverage to encourage target achievement in ECD
2. A strong and integrated joint forum and cooperation based on the main duties (Tupoksi) and avoid sectors ego
3. Similarities of perceptions regarding the vision and goals related to efforts of early childhood development whether its cross sectors or within a sector.
4. Less turnover of officials/Staffs

G.3.8.3 Vision 3 and relevance to STRANAS

Equality of access to ECD services for children of poor family and children with special need is consistent with the Strategy of HI ECD.

- Social services in collaboration with Bappeda and other SKPD as well as related partner organizations development of ECD organizes coordination meetings in order to arrange joint work plan, particularly related to infants dr poor families and infants with special needs
- Cooperation partner agencies and organizations related to to the motion urging the government to allocate funds in the state budget, APBA, and APBK for village/rural/urban neighbourhoods is intended to help open/improve service delivery in developing ECD HI for all children
- Mayor and social services programmed to approach foundations owner/operator ECD to enact policy development subsidy for poor families that receive services
- Forum ECD, mosque officials and PKK movements mobilize donations to help the implementation of the development masyarakar ECD expand access for the poor
- Training of parenting children with special needs at the village level

Pre-Condition Requirement

1. The integration and improvement of strong commitment from all stakeholders at government level, NGO or even community to jointly handle the matters especially related to early childhood development.
2. Support from the people and *DPRD* and other stakeholders with interest to jointly seek for ECD success.

G.4 Preliminary Observation Result: Opportunity and Potential for HI ECD in Sambas District, West Kalimantan

G.4.1. Increasing of Children Participation

- Sharp increase in the number of ECD in the district. Sambas's 200 in 2009 to 324, an increase of 67% in 2012. The majority of ECD is *KB* (75%), followed by *TK* (20%), SPS (4%) and *TK* (1%). In the sample villages in the Sajingan sub district since 2010 there have been 6 ECD services.
- ECD participation rate in the majority of ECD services in *KB* which account for 66% of the total 10,416 children in 2012. Age of children who access the type of family planning services is the age of 4-6 years
- One engine development services in West Kalimantan is ECD Coordination of Women's Organizations (*BKOW*) who received help 10 groups of early childhood education and has begun post 5 years ago. Early childhood under the shadow of military, police and Gabunga Women's Organization also helps the development of ECD.

Relevance of HI ECD Policies, Strategies and Main Activities

Delivery of equitable, affordable ECD Service, and improve the quality of ECD through the following main activities: increased completeness and distribution service types ECD and the number and quality of ECD providers

G.4.2. Caregiver Quality

- Each year held 4 times a technical orientation of learning for 120 caregivers from all districts/cities.
- The process of working with *P2PTK* for a scholarship program for volunteers to continue their education. This year three of the district caregiver. Sajingan continuing education degree in early childhood education. Tutor under WB aid already received training ECD 200 hours.
- Kalimantan Provincial Government provides support for the development of ECD through courses and training cadres on life skills education program (*PKH*) in each *BKB*.
- Department of Health in Province level (MCH field) provide training in IMCI, Nutrition, PMTA Vit A, at the district level for health staff for 2 times a year.

Relevance of HI ECD Policies, Strategies and Main Activities

Improve the quality of ECD through the following main activities: improving the quality and preparation of SPM organizers ECD ECD development.

G.4.3 Types of Services of HI ECD

- There are 16 SPS, ie integrated services (health, parenting, education, child protection/care)
- Formed Plenary *BKB* groups (pilot) at the village level. Integration implementation *BKB*, *Posyandu*, and early childhood education is supported by the presence of cadres. To ensure that parents

remain at the site, created a local policy that *BKB* activities performed first and followed *Posyandu*.
- Monitoring and inspection of child health in early childhood education is now easier with the integration of the service (at least once a month) in early childhood. Physical examination of pregnant women on ECD services are performed onsite at the neighborhood health center 1 x month, which is not a roof was 1 x 6 months.

Relevance of HI ECD Policies, Strategies and Main Activities

Increased ability of the prospective bride, parents, family and caregiver in care through basic activities such as guidance and counseling, outreach and advocacy for parents about the division of roles, improving the completeness and the distribution of types of ECD services

Type of Service is integrated in each center (source; checklist)

G.4.4 Provide Information and Coordination

- *BKKBN* Kalbar are building Family Information Center (*PIK*) to help teens know the issues related to HIV/AIDS, abstinence, and *NAFSA*.
- Doing coordination meeting integrated socialization at least 4 times per year. Socialization is done at the community level and management, for example in the *BKB*
- Improvement Program Organizing Role of Women Healthy Family Welfare (*P2WKSS*) with a foster family medicine plants, *Posyandu*, women group in village level.

Relevance of HI ECD Policies, Strategies and Main Activities

Improved ability of the prospective bride, parents, family and caregiver in care through basic activities such as guidance and counseling, outreach and advocacy for parents about their roles.

G.4.5 Financial and Other Support

- Incentives for the cadres of the funds obtained from national budget (deconcentration), Sambas district budget, and the World Bank
- Development of ECD in the sample villages Kec. Sajingan strongly supported by Wahana Visi Indonesia, especially training for caregivers about child development, vocational skills, and the development of local resources in the development of *APE*
- Development of ECD in the sample villages in the district. Sambas supported by the World Bank, by providing training as well as the team management activities.

Relevance of HI ECD Policies, Strategies and Main Activities

Improve the quality of ECD with principal activities: welfare workers (caregivers), human resource development, and use of local resources

G.4.6 Policy Availability

- Kalimantan Governor Decree No. 237/Didik/2010 on the establishment of a forum for all levels of education involving related *SKPD*, HimpECDi, *IGTKI*, Forum ECD, Education Specialists, Head HIPKI, PGRI, Board of Education and others (50 people)
- In RPJMD Kalbar 2008-2013 in Chapter VII of the Regional Development Priority Program, West Kalimantan province committed to improving services for the ECD. Also listed in Sambas District Strategic Plan in order to arrange grand design for children's participation in services obligations ECD.

- Sambas decree No. 72 Year 2012 on the organizing committee and the Energy Education Activity Management Program ECD Sambas district to village level committee with members of the 132 people 262 people and educators.

Relevance of HI ECD Policies, Strategies and Main Activities

Increased commitment, coordination and cooperation among government agencies, the providers and related organizations

G.4.7 The HI ECD Benefit

What did the people in the sample villages say about the benefits of ECD for Individuals, Families and Communities as listed in ECD HI:

- "Children are now more diligent: they get up early and take a morning shower; they are more independent and practice better hygiene".
- "Prior to the early childhood, to conduct a national immunization week course was difficult. But since the early childhood, PIN implementation easier".
- "Before entering early childhood education, children's play is not directed, in the river, playing in mud, etc but with ECD they become more focused and educated"
- "There is readiness for entry into primary education and low levels of repeat in SD in children who had attended early childhood program"
- "Cases of malnutrition decreased by 20-30% after the introduction of neighborhood health center and early childhood services' (the relevanceof ECD HI)".
- "ECD caregivers are sufficiuently advanced because they receive training and guidance from WVI (Wahana Visi Indonesia)".

Relevance of HI ECD Policies, Strategies and Main Activities

From the description of the effects arising from the development services ECD various targets of the Strategy have been achieved, namely increasing the health and nutrition ECD, children's readiness for school, improving the quality of service received by caregiver.

Fulfilling the Dream of Affordable and Quality HI ECD

G.4.8 Dream

Available cadre/qualified tutors who are able to communicate to parents, and also of course the commitment of the parents to actually get involved in the interaction to educate and care for their children

- Is this dream consistent with the HI ECD?
- Is this dream built on assets, opportunities and potentials of Garut District in HI ECD?

G.4.9 Design

- We are currently in the process of working with *P2PTK* for a scholarship program for volunteers to continue their education.
- This cooperation should definitely involve universities in Pontianak
- Currently government is exploring Tanjungpura State University. ('Without the support of university the need for funding will be greater especially when we need access areas outside the province of West Kalimantan")

Question

Is this plan specific enough is it measurable, doable, and realistic and has a clear timeframe?

G.4.10 Some Dreams/Visions

- *APK* Kalbar can reach 80% at 5 years to come with the support of the parent, society, NGOs or donor agencies and governments
- Having a cadre/qualified tutors who are able to communicate to parents, and also of course the commitment of the parents to actually get involved in the interaction to educate and care for their children.
- There is a strong legal framework regarding service integration ECD. In particular there should be regulations that set the budget in a clear and consistent so that the development process can continue running ECD
- Establish a working group with the governor's decree on early childhood as well as for sharing issues related to early childhood
- Procurement 'car heading early childhood' which toured the villages to show the public services for early childhood education and the essential needs of children and how services are implemented.
- There is a one-stop early childhood to elementary school so starting from *KB* continues to kindergarten and then school is in one location. The service is expected to exist at least in each district as a pilot
- The flexibility (50%) use so *DAK* can be tailored to the needs of each region.
- Children can begin to be introduced to the developments in the outside world through the internet facility
- Costs in early childhood education should be cheaper and more effective than in the park include child care or tutoring
- ECD without outside help keep it running because people are able to start many participating early childhood
- Seek budget increased by about 10% per year, as well as establish good communication with the central authorities
- In 2017 early childhood education has been equipped with computers, internet, TV, etc..
- Building Puskesdes be larger for health becomes more leverage
- In 2017 all early childhood education should be better and equipped with adequate facilities and infrastructure

G.4.11 Discussion regarding realising the dream

Choose three of the above dreams/visions to be discussed in three groups.
- Is this dream consistent with the HI ECD?
- Is this dream built on assets, opportunities and potentials of Kupang District in HI ECD?

What are the requirements and actions that need to be taken to realize thos dreams?
(Specific, measurable, realistic, and has clear timeframe)

G.4.12 Results of Validation Workshop and Enrichment Study on Early Childhood Development Strategy in Bappeda of Sambas, July 31, 2012 involving various stakeholders

There are 3 points of Visions of ECD agreed by the stakeholders
- *APK* Sambas district reached 80% at 5 years to come with the support of parents, communities, NGOs or donor agencies and governments

- Having a cadre/qualified tutors who can provide the best services for children and are able to communicate on the parents to bring the commitment of the parents to be actively involved in the interaction of educating and nurturing children
- The availability of a strong legal framework regarding the integration of early childhood services in particular must have a set budget *Perda* clearly and consistently so that the development process can continue running ECD

G.4.12.1 Vision 1 and relevance to the Strategy

APK Sambas district reached 80% at 5 years to come with the support of parents, communities, NGOs or donor agencies and governments Consistent with the development of ECD HI in business service deployment equitable and accessible

APK Sambas have reached only 13% and only able to serve 10% of the total dr that need intensive cooperation of all parties to work together to improve the service. There are two districts that have not had services ECD HI because of its location which is very remote and difficult to reach. In these places there is only an implementation *Posyandu* also not regular. Two of the area should be a prime target to be reached by services ECD HI

Action to be taken

1. Develop a shared commitment to the development of pre-marital ECD begins, pregnant women, children up to 6 years old
2. Socialization in the community about the importance of developing ECD
3. Prepare qualified human resources in all development services ECD
4. Advocating for government support in terms of funding
5. Preparation of regulations in the form of regulations to support the development of ECD
6. Revitalization *Posyandu* to support the development of ECD, especially in the 20 villages that do not have early childhood services

Prerequisite Conditions required

- Reliable data on couples of childbearing age, pregnant women, and ECD
- The availability of support facilities in rural development services ECD
- Availability and commitment of educators, volunteers, and managers
- Public awareness of the importance of early childhood education
- **Cooperation and coordination across sectors actively to organize development services ECD**

G.4.12.2 Vision 2 and relevance to the Strategy

Having a cadre/qualified tutors who can provide the best services for children and communicate to parents to bring up the commitment to be actively involved in the interaction of educating and caring for children Consistent with the development of ECD HI in improving the quality of service

Currently volunteer tutors mostly just high school education, and some have only graduated from elementary school. To improve the quality of these aspects must be addressed and improved so that they are able to provide the best services for children and be able to perform an intensive communication with parents. Increase the training is the best option because if all had in S1, most of whom live in areas that do not have equal educational facilities S1.

Action to be taken

- Selecting members of the community who have good quality as a volunteer tutor

- Dissemination to the public of the need for a cadre of qualified and need the support of all members of the community
- Regular trainings for volunteers on a variety of issues related to the ECD (at least once/6 months)
- Enhance and support improved educational qualification of cadres/tutor (equality program package and scholarships S1)
- Active cooperation of all stakeholders to deliver inter-related, each of them does not stand alone

Prerequisite Conditions required

- Kader/tutors have appropriate educational background. But now is not the priority, more focus on how volunteers can reach children who do not access the ECD services
- The commitment of institutions and parents
- Cooperation between the parents and the community in promoting the development of ECD services

G.4.12.3. Vision 3 and relevance to the Strategy

Availability of a strong legal framework regarding the integration of early childhood services in particular must have a set budget local regulation clearly and consistently so that the development process can continue running ECD Consistent with the development of HI ECD in order to increase the commitment, coordination, and cooperation among government agencies and institutions

Services ECD HI involving multiple sectors of government, from health, education, family, and the protection of children is very important so that the availability of a local ordinance in the district that became the framework of cooperation, coordination, and most importantly, regarding financing ECD HI that each sector did not throw the responsibility for service delivery

Action to be taken

- Maintain active communication with legislators across sectors, particularly Council committee on education and health
- Establish executive and legislative commitments to immediately implement the draft regulations to be *Perda* education, a maximum of 2013
- Mobilize support from various stakeholders (between the public and civil society organizations concerned on ECD) to encourage the legislature to realize the regulations.
- Comparative studies that have applied to the local regulations on development of ECD education or regulations that have been successful in improving the ECD services

Prerequisite Conditions required

1. The data is valid and accurate, especially education and health sectors
2. There is an active and ongoing socialization of the important role of early childhood and *Posyandu* in all level of community and business
3. Commitment together from elements of society and government that cares about the adoption regulations.

G.5. Preliminary Observation Result: Opportunity and Potential for HI ECD in Kupang District, NTT

G.5.1. KIA (Maternal and Neonatal Health) Revolution Movement

In the provincial level, the Regional Government of NTT has launched the KIA Revolution Movement

(*KIA = Kesehatan Ibu dan Anak*/Maternal and Neonatal Health) since 2009 which has the purpose to provide insurance and protection of maternal and neonatal health service to become equal and non discriminative and upholding the highest value of humanity. (Article 6 of Governor Regulation No. 42/2009) this program is considered to be one of the major breakthroughs in the effort to accelerate the decrease in the number of maternal and neonatal fatality with remarkable ways by conducting labour in proper health facilities. The significance decrease in the number of maternal and newborn fatality was allegedly due to the program as well.

On District level, Kupang District has planned the Birth Control Management Board Program from Village (*MP2D*) since 2011 in every village office. This program's objective is to develop family based health service information. This *MP2D* lead the officials and community to understand and to be involved whenever a member of the community is pregnant and would require assistance. In one of the village sample, the team found the board and on the board was information on the condition of the expectant mothers in the village.

Relevance to HI ECD

In the principle of the implementation of HI ECD National Strategy it is mentioned that the community must be involved in the planning, implementation and evaluation stage of the ECD program. Community's involvement in monitoring and supporting safe and healthy labour is one of the assets in ECD.

G.5.2. NICE Program

The NICE (Nutrition Improvement through Community Empowerment) Program by the support from AusAid and ADB since 2008 – 2012 in 4 districts/cities in NTT (in 280 villages) with the purpose to increase the level of health of the maternal and infant through the empowerment of local potential with *Posyandu* as one of the target of NICE program through maternal and infant nutrition class, *Taman Posyandu*, kebun gizi (nutrion garden), and the *PMT* (*Pemberian Makanan Tambahan/*Supplementary Feeding) demo from local ingredients for pregnant mothers and infants is considered to be a significant help to most part of the NTT people. This program is considered to be fit because the local empowerment effort with local resources has become the most important way to increase independence of NTT people and may be considered for other regions.

Relevance to HI ECD

An integrated service that covers health, nutrition, nurture, education and ECD protection are activities formulated in the National Strategy of Integrated Holistic Early Childhood Development as an effort to increase the type requirement and distribution of early childhood development services and integrating the development activities of early childhood development activities from related institutions.

G.5.3. AIPMNH Program

Other than the NICE Program, there is also the AIPMNH Program (Australian Indonesia Partnership Maternal and Neonatal Health) in 14 Districts/Cities in NTT. This activity involves the *pokjanal* (*kelompok kerja nasional* = team from several institution with primary task for Maternal and Neonatal Health (including *Posyandu* service). This program's working field includes Desa Siaga/alert village, KIA revolution, etc.

Relevance to HI ECD

An integrated service that covers health, nutrition, nurture, education and ECD protection are activities formulated in the National Strategy of Integrated Holistic Early Childhood Development as an effort to

increase the type requirement and distribution of early childhood development services and integrating the development activities of early childhood development activities from related institutions.

G.5.4 Regulations

There are two products of the legislation which are relevant to early childhood development, especially related to KIA Revolution Program at NTT Province Level: they are the Governor Regulation No. 42/2009 on the Revolution of Maternal and Neonatal Health in NTT.

At district level, in the framework of supporting mother and infant health program, the government of Kupang District launched a program of Village Labour Control Management board (*MP2D*), the government of Kupang District issued the Regent Regulation No 16/2010 on the Acceleration of Maternal and Infant Health Service in Kupang District which has already been socialized to all villages and some villages have already followed this up to the Village Government.

Relevance to HI ECD

The National Strategy for Integrated Holistic Early Childhood Development supports the legal foundation enforcement and increasing commitment, coordination and cooperation between institutions in implementing the HI ECD.

G.5.5 Partnership

Partnership with Church organizations, Catholic & Christian Foundations and *MUI* (*Majelis Ulama Indonesia* = Islamic leader association) in the implementation of early childhood development and the support from related agencies in ECD, including religion office, Catholic and Christian Community Guidance.

Relevance to HI ECD

By increasing the role of the community in the implementation of ECD service, this partnership asset may be developed for access improvement, equality and the adequateness of types of ECD services with the strategy of implementing equal and affordable in accordance to the National Strategy of Integrated Holistic Early Childhood Development.

G.5.6 Fulfilling the Dream of Affordable and Quality HI ECD

G.5.6.1 Dream

"NTT will be able to decrease the maternal and neonatal fatality to about 1 – 2%, The Gross Participation Rate of quality ECD increases and solid coordination between sectors in order to measure the HI ECD indicators"

- Is this dream consistent with the HI ECD?
- Is this dream built on assets, opportunities and potentials of Kupang District in HI ECD?

G.5.6.2 Design/Plan

- Increase the coordination cross sectors
- Include the government in every process of increasing access and quality of HI ECD
- Gather important evidences regarding the impact of HI ECD
- Develop a comprehensive monitoring system of every sectors involved in HI ECD
- Distribute equal duties and authorities to regional and central in HI ECD

Question

Is this plan specific enough is it measurable, doable, and realistic and has a clear timeframe?

G.5.6.3 Several Dreams/Vision of Kupang District, NTT

- Every Village is expected to implement early childhood education to improve children development
- Regional Government supports the administrators by providing incentives and support and *BOP* assistance provided to ECD Groups who applied for assistance
- The *TK/RA* are equipped with proper facilities, teachers are developing properly hence the children are developing in accordance to their age and nature.
- The Government no longer differentiate in providing guidance and financial support for private school or public school, including in the efforts to increase the quality and competency of service
- The existing *BKB* groups will become sustainable and the group becomes a necessity for the parents who understands children development
- Continuous NICE Program, in the village which have been involved with technical support from other parties and local government and the program is replicated else where
- Increase in the quality educators and proper incentives that will encourage the teachers and will then raise the people's interest in contributing to the ECD services
- Hopefully in the future *PAUD* service (Non Formal *PAUD* and SPS) will be able to cover health service up to the next 5 years minimum more than 20% of *PAUD* (ECD) will be able accept health service as in kindergarten.

G.5.6.4 Discussion regarding realising the dream

Choose three of the above dreams/visions to be discussed in three groups.
- Is this dream consistent with the HI ECD?
- Is this dream built on assets, opportunities and potentials of Kupang District in HI ECD?
- What are the requirements and actions that need to be taken to realize thos dreams? (Specific, measurable, realistic, and has clear timeframe)

G.6 Preliminary Observation Result: Opportunity and Potential for HI ECD in Bone District, South Sulawesi

- A vigorous socialization of the importance of ECD and the presence of *Paditungka* ECD services alleged to have encouraged an increase in GER ECD from the 26.23% in 2007 to 60.80% in 2012
- The increase GER in ECD is also driven by the presence Referral Center Family Center for Development Services (Baruga darling) who has spread almost throughout the province. Number Baruga Unfortunately reached 304 from 45 units in 2008. Baruga dear *SKPD* formed to integrate activities and proposed community through local planning process.
- Accessibility in ECD also increases with increasing number from the *BKB* 1708 pieces in 2011 and increased to 1940 in 2012, an increase of 14%. Contained the greatest number of Bone and Bone became one of the considered successful in the development of *BKB*. Sulawesi and Aceh Local Government and representatives from the the Dutch Government've been for a comparative study.
- Formed Working Group Education for All (EFA/Education for All) with the SK governor to pengembganan ECD EFA is the chairman of the governor's wife is the main focus of remote areas such as Kab Selayar, Jeneponto, North Toraja, and Pangkep.
- Now available Perdasi about breastfeeding and hospitals are encouraged not to provide formula.

Relevance to the ECD HI

Policy: Increasing Access, equity and comprehensiveness of its services infants Development.

Strategy: Holding equitable and affordable and infants development services to improve and enhance commitment, coordination and cooperation antarinstitusi government, service providers and related organizations.

G.6.1 Preliminary Observation Result: Opportunity and Potential for HI ECD (2)

- ECD services in *Paditungka*, especially in Bone regency, was considered successful because it is integrated with the health care sector such as weighing activities, fostering mother toddler, child stimulation. *Paditungka* ECD pilot in 2 districts in Bone received strong support from the community and became an attraction to be replicated in other regions. Replication of this model has been developed in two other districts in the Bone.
- Through Rice Tungka ECD services, strengthening the social capital of the more developed with the use of existing local facilities, such as the loading of local lagu2 *Paditungka* hymns. As *Paditungka* in the district. Bone, Unicef also encourage the development of Siola in Kabupate Mamuju.
- Unicef role in the initiation pengembagnan *Paditungka* both at the village and at the elite level as advocates to the regent to make a declaration about developing a infants as *Paditungka*, and at the village level to encourage awareness and participation masyarakt to donate land, *Paditungka* construction with local materials, etc. (especially in villages that do not have ECD services. UNICEF also encourages partnerships midwife and healer in some districts/cities in South Sulawesi, with the presence of local legislation on partnerships midwives and herbalists as in Takalar.

Relevance to the ECD HI

- Policy (item 1) "Increased access, equity and comprehensiveness of ECD services".
- Principal Activity "Improved learning facilities and health care facilities and nutrition" and (point "increase community participation in the delivery of development services infants".
- "Increasing commitment to coordination and cooperation among government agencies, institutions and related organizations."

G.6.2 Preliminary Observation Result: Opportunity and Potential for HI ECD in Bone District (3)

The existence of Baruga Sayang has prompted an increase in access and quality of ECD services and integration of services such as education, health, nutrition, and parenting/child protection in various ECD services. This is reflected in the function and objective function Baruga Sayang as family planning and health empowerment through guidance to pregnant women, breastfeeding, immunization, provision of nutritious food, and all the needs of child development, develop *BKB*, ECD, supporting *Posyandu* revitalization, supporting the practice of midwives and empowerment cadres. In the case of basic education, Baruga Sayang also acts to ensure that all school-age children can be schooled well in ECD, kindergarten, elementary and junior high school.

Relevance to HI ECD

Policy: Improved coordination and cross-sectoral cooperation and partnership between institutions, and related organizations. Strategy: increase commitment, coordination and cooperation inter stakeholders.

G.6.3 Preliminary Observation Result: Opportunity and Potential for HI ECD in Bone District (4)

- In Goa district, there is a typical ECD service referred to as Soleh Children's Education Studio (SPAS)

for children six years and under. In 167 SPAS spread throughout Goa district, children are introduced not only to common knowledge but also moral guidance.
- Support from the provincial government for the development of infants sulsel.htm reflected in the increased budget allocation in 2012 is quite significant, amounting to Rp26 billion. Whereas the previous 2 years were no funds available for the development of ECD
- South Sulawesi Provincial Government, through the Department of Education, from kindergarten services encourage all coaches who there in all districts/sub-districts in South Sulawesi to menyedian and organize an integrated ECD with a minimum of two courses are the Day Care or *KB* or SPS. It is hoped this will encourage an increase in ECD GER to 75% by 2015.
- MORA through *IGRA* (*Raudathul Athphal* Teachers Association) continues to drive quality improvement of educators or managers of *RA* through 3 months regular training with funding from provincial and train 30 people head *RA*. IGRA to accommodate teachers' associations *RA*.

Relevance of Policy, Strategy, and Main Activities of HI ECD

The implementation of equal, affordable ECD and the improvement in quality of ECD implementation through main activities: improvement of type comprehensiveness and ECD service distribution and the number and quality of ECD administrators.

G.6.4 Preliminary Observation Result: Opportunity and Potential for HI ECD in Bone District (5)

- To monitor the health of mothers and children in the village, health officials conducted a survey to track the presence of malnutrition. This role is performed by trained nutrition in the district through the *Posyandu*. It also conducted a survey of iodized salt. Until the year 2011, the use of iodized salt in the Bone has reached 90% and is supported by regulation No.7/2003 on iodized salt consumption
- Support for the use of exclusive breast milk is also done with the regulation No. 6/2010 and the new Bone achievement in the district about 75%.
- Promote cooperation and partnership between traditional midwives and birth attendants with the primary task of the midwife and healer as supporters.
- Improved support for ECD service like *Paditungka* from the community evidenced by the donation of land (waqf), labor for construction and wood *Paditungka*. In fact, a resident in the Village District Salonpe Ponre Bone willingly chop chocolate plant in order to build a facility for infants *Paditungka* in his village.

Relevance of Policy, Strategy, and Main Activities of HI ECD

Improvement of ECD quality through main activities: Improving the quality of ECD administrators.

G.6.5 Preliminary Observation Result: Opportunity and Potential for HI ECD in Bone District (6)

- Bone local government support is also reflected in the provision, and an increasing number of incentives for cadres *Paditungka* increasing from 65,000 per month in 2008 and increased to 90,000 in 2012 for a total of 225 cadres.
- Strong encouragement and motivation of the volunteer and a strong expectation or appointed civil servant will be made increasingly eager volunteers. Moreover, there is evidence of some former cadres have been appointed by the government as civil servants. They also became excited because some of them had the opportunity to attend training to the provincial level.
- Strength of ECD through *Paditungka* besides the participation of the community is the management of open and transparent management who always announced in the mosque or on the bulletin board of any such aid received from the UNICEF to fund initial construction.

- In addition, there are some villages that provide the village budget (ADD) to help maintain *Paditungka* ECD service such as study sample villages (villages Solo) or additional incentives for educators.

Relevance of Policy, Strategy, and Main Activities of HI ECD

Organizing equitable and affordable ECD services and improve the quality of early childhood development and increase the quality of ECD with principal activities: improving the welfare and quality of workers (caregivers).

G.6.6 Preliminary Observation Result: Opportunity and Potential for HI ECD in Bone District (7)

- Immunization services in the village (sample villages) continues to increase and with the facilities service building *Poskesdes*/*Posyandu* assisted by PNPM
- The presence of ECD service *Paditungka* and kindergarten in the village helped smooth the health service to be more efficient, dynamic and easy for children and mothers have been collected on a regular basis in every activity on *Paditungka*.
- Service *Posyandu* become more crowded and full. Services DDTK (weight, height, and test power to hear and see) also regularly easy to infants on a quarterly basis. Immunization and worm medication assistance from the district also became more fluent done
- Cases of malnutrition in the village became increasingly reduced and controlled and if there easily terdekteksi because other than through an examination by a midwife or health worker, as well as through the cadres who have been trained to monitor the child's primary health conditions.

Relevance of Policy, Strategy, and Main Activities of HI ECD

Improving the quality of ECD through the principal activities: improving learning facilities and health and nutrition service facilities

G.6.7 Preliminary Observation Result: Opportunity and Potential for HI ECD in Bone District

- Since 2007, service conducted in pregnant women *Posyandu Paditungka* integrated ECD service. Routine screening of pregnant women also includes the cadres, especially in the first trimester by pasting stickers pregnant woman in her home and also sticking P4K (data already filled by pregnant women to explain.Childbirth Preparation and Response Complications Planning/P4K).
- Cadres generally skilled and trained in overseeing and monitoring the child's condition. They can identify if a child is unwell through observation of the tongue (tongue white for example), checking of long nails or teach hand washing to children. The role of volunteers is also important in terms of counseling for pregnant women, especially about the danger signs of pregnancy and maternal nutrition. Guidance by the midwife to the cadre biasaynya *Posyandu* activities performed on the day.
- Services for maternal shaman also included with the main task of helping a midwife and healer just as supporters. This cooperation is long-standing and even shamans will not help if there is no midwife came.
- Management of health care services includes *Posyandu*, examination of pregnant women, screening DDTK and other services.

Relevance of Policy, Strategy, and Main Activities of HI ECD

Improve the quality of early childhood development and increase the quality of ECD with principal activities: improving the welfare and quality of workers (caregivers).

- Before *Paditungka* ECD service was presence generally, children who enter primary school should sit down with parents in class for about 2 weeks. However, after the presence of *Paditungka*, children become bolder and no longer need parent's accompaniment at the beginning of elementary school.
- In the early years of establishment *Paditungka* ECD service, only 50% participated in both growth monitoring sessions and in education services. But a year later, and two years later the number had risen to 7-80% and now almost all of the children enrolled in the existing *Paditungka* didesanya.
- They used to come to *Posyandu* only those who want to immunization, but with the *Paditungka* ECD service, parents and toddler worked harder.
- The awareness movement of 'husbands on standby' has already implicated in the village. The presence of the husband during his wife's and proactive inspection asking is a common symptom started and this situation is different from the previous years.

Relevance to HI ECD

Policy: Increased access, equity and comprehensiveness of ECD services

G.6.8 Preliminary Observation Result: Challenges and Obstacles in HI ECD

- Incentives for the welfare of the cadres to keep upbeat and motivated. Cadres ECD and *Posyandu* generally receive very limited incentives, while cadres *BKB* did not receive incentives.
- The lack of attention at the institutional level ECD especially for children under the age of 3 or 2 years of which should be a large portion of the *BKB* service due to various limitations, including limitations and welfare of the cadre.
- Not fully integrated ECD services especially for efforts such as child care and protection, which are generally *BKB* work through parenting. Generally still limited to education and health services.
- The main obstacle in addition to ECD implementation issues of infrastructure, medical personnel and the availability of institutional and human resource issues who less educated.
- Raising or advocacy of increased budget allocation at the provincial level is constrained by the rule that says that ECD is an asset of the district/city and therefore do not have the right to manage the assets.
- Toddlers and mothers in labour inspection service are often hampered by old beliefs that the child is not allowed to be brought out of the house when not yet '*hakikah*' (initiated). It is often that the child is 2 months old and then brought to the midwife for a check-up or the midwife would have to come to the patient's home.

G.6.9 Fulfilling the Dream of Affordable and Quality HI ECD

G.6.9.1 Dream

ECD Cumulative Enrolment Rate (GER) and integrated services is increasing and have even reached 75% of children across the SulSel Province.

- Is this dream consistent with the HI ECD?
- Is this dream built on assets, opportunities and potentials of Bone District in HI ECD?

G.6.9.2 Design

- ECD services like *Paditungka* replicated and made a priority with legal support at both the provincial and district level and municipal
- Building the capacity of stakeholders, child budgeting, child protection regulations, and completed 12 years of basic education
- Promote cooperation among sectors and inter-level (provincial and district/city) and encourage community participation
- Increasing budget allocations at provincial level to encourage training, coordination, socialization and at the district level for the development or additional means of access.
- The division of tasks and clear authority between *HIMPAUDI* and *IGTKI*
- Cooperation with donors for targets and quality improvement

G.6.9.3 Several Dreams/Visions

- Increased number of early childhood learning by involving the government, the public and private sectors. No more non-ECD children going straight into SD, all the children would attend ECD first and then school (Bappeda of South Sulawesi).
- The province through the Department of Education began to encourage all Kindergarten to provide Integrated ECD with a minimum of two programs: Day Care or *KB* or SPS. At a minimum, there are two types of service on each kindergarten. With such program it is expected to encourage the level of GER (Education Department of South Sulawesi).
- Five Years in the future it is expected that the volunteers are paid appropriately, receive counselling and training and upbringing, for creating bright generation (*BKKBN*).
- All *BKB* cadres are trained, all *BKB* cadres receives incentives and *BKB* activities can run continuously (Bappermas Bone)
- All *BKB* cadres are trained, all *BKB* cadres receives incentive and *BKB* activities may run continuously and The Realization of children's health service mechanism improvement at low level. (unicef)
- Improve the quality of early childhood education through trainings and continuous coaching for teachers and caregivers. (Depag Bone).
- Indonesia ECD is able to simulate the ECD model of Permata Bangsa in Malaysia. ECD in Malaysia receives more attention from the government. Even the derivative policy from the central is clear and executed to the lowest level (Bappermas Bone).
- All village in Bone District or 370 villages and Kelurahan has *Paditungka* Park. At least one village has one *Paditungka* (Bone Health Dept.)

G.6.10 Innovations and Pre-requirement suggested by the informant

G.6.10.1 Innovation/Creation

- There should be Pilot ECD in every District/City (in Guiding Kindergarten) There has been pilot ECD in Enrekang District and Barru district since 2010 and has become a model on the approval of the Governor. At the very least this will be an exemplary and can be adopted by other District or City in South Selawasi
- ECD groups need to be established all around the country so that the educators may communicate or discussed with each other to exchange experience and knowledge between fellow educators.
- Every District/City would have a Kindergarten that will be the motor and initiator of HI ECD service.

G.6.10.2 Pre-requirement

- Need to have an inter *SKPD* program planned and focused for each period of time. For example, this year focus is on the development of children's health, and then focus on children's education.
- Adequate budgetary support and also need budget efficiency.

- Cooperation and mutual support among community members, officers, midwives, cadres and all the elements that exist in the community and support from the outside as of the health center, education, health and the district government or the provincial/central.
- Need a change of mind-set and need to have sense of belonging to the program. All this time, for example, it is as if the *Posyandu* program belongs only to the health department, yet in the actual implementation it cannot be separated from the role of *BKKBN*. Department of Education is related as well when ECD is integrated into *Posyandu*.
- Strengthening community organization since the government/officials are not possible to build everything therefore the people's participation is highly needed.
- Develop local for this could help the development of ECD in the future
- Working closely with agencies related to health and maximizing *Posyandu* services (POS ECD) and integrated *Posyandu*

Appendix H. Guidelines for FGD Questions and In-Depth Interview

TUTOR FGD

- What is your understanding of *PAUD/Taman Posyandu*
- From where/whom do you get this information?
- The process of *PAUD HI* establishment
- When was the institution established? (day/month/year)
- Who had the initiative to establish *PAUD*? Explain the process from the very beginning, who were involved?
- Do you know the objectives of establishing *PAUD* (Vision and Mission). Explain.for each *PAUD*
- What/from where is the funding source?
- Facilitator's note.
- Vision: dreams, expectations of *PAUD HI* (ideal child)
- Mission: what steps are taken to achieve that dream
- Training
- What type of training/modules did you received?
- How long is the duration of the training?
- Who provided the training?
- Is the training sufficient for your daily work (very much, enough, less than enough)
- If not, what additional material is needed?
- How was the training method (simulation, participative, one way communication, etc.)
- If it was not sufficient, what is lacking?
- In the implementation of the program, are there any rules that you have to follow?
- Tuition fee, salary or incentives
- Provision of educational tool, building maintenance
- Who decided these rules?
- Note: check whether the requirements are determined in democratic or authoritarian way.
- Is there any rules/requirement for a child to enter *PAUD*
- Birth certificate
- Registration fee
- Tuition fee
- Others, please explain
- Are there any objection from the parents to fulfill the requirement?
- Are there any children with special need participating the *PAUD* program?
- Is there any special treatment for such child? Please explain
- What about children from poor families, is there any dispensation for registration and tuition fee?
- Who is developing the curriculum?
- Any problems in developing and implementing the curriculum?

- Education toys/equipment
- Type of education toys owned
- Is it sufficient ?
- Was it produced by the community or purchased?
- Any regular meetings between the tutor and parents? What topics are discussed?
- Any regular meeting between the village/subdistrict officials to discuss *PAUD* problems? For example weekly meetings, regional planning meeting
- Is the cadre actively involved in this process?
- If yes, what kind of fund/activity proposal came up?
- What are the requirements to be assigned as a *Taman Posyandu*/*PAUD* cadre?
- Selection process?
- Who is conducting the selection?
- Who is determining acceptance/not?
- Is it difficult to source candidates for cadres?
- Government's involvement in *PAUD* activity
- Is there any fund allocation from the government? Specify the item
- Have you ever submitted a proposal, if yes for what?
- Could you explain the process?
- Are there any difficulties? Please explain
- Was it approved?
- How is the collaboration and support from related institution?
- Health sentra (specify the activity/support)
- Office of Education (specify the activity/support)
- *HIMPAUDI* (specify the activity/support)
- *IGTKI* (specify the activity/support)
- What activity has been done or planned for sustainability of *PAUD*
- Expectations?

Note: Holistic, all activities based on the child basic, emotional, and spiritual needs. Every child receives basic services according to his/her needs, e.g.: basic health service (immunization, nutrition), protection (birth certificate), opportunity to study, etc. Integrated: Institutional collaboration for a specific goal. The services available are inter-linked, inter-complementary, and easily accessible.

PARENTS FGD

- PAUD establishment process
- When was the institution established? (day/month/year)
- Who had the initiative to establish PAUD?
- Funding source
- What do you know about PAUD/PAUD HI
- PAUD definition
- Definition of the term holistic and integration
- Source of information
- What motivate to enroll children to PAUD

- Reason
- Who made the decision?
- What are the benefits?
- Change of knowledge and attitude
- What's the requirement to enroll children to PAUD?
- Birth certificate
- Registration fee
- Who determined the amount?
- Tuition fee, how much?
- Are there any objection from the parents to fulfill the requirement determined by PAUD? E.g. amount of fee, activity schedule, etc.?
- Any behavioral change of your child at home environment?
- As parents, do you continue the school lesson at home?
- As parents, did you ever provide inputs/suggestion for the implementation of the program? Explain.
- Is there any regular meeting between parents and tutors/PAUD coordinator? If yes, what are discussed (child development, behavior)?
- Are all activities in PAUD/*Taman Posyandu* considered to be adequate/satisfactory?
- Curriculum
- System/policy
- Building condition, is it good/safe enough for children?
- What improvement will and has been conducted?
- Funding source
- Expectation/suggestion

GOVERNMENT OFFICIALS (VILLAGE HEAD, *BPMD*, HEALTH CENTERS, *HIMPAUDI*, *IGTKI)* FGD

- PAUD establishment process
- When was the institution established? (day/month/year)
- Who had the initiative to establish PAUD?
- Funding source
- What do you know about PAUD/PAUD HI
- PAUD definition
- Definition of the term holistic and integration
- Is the current PAUD already holistic and integrated?
- Is there any allocation of government fund for PAUD activity? Explain
- Village/sub-sub-district (what's the process/system/policy and how it's applied)
- Sub-district
- District
- How is the fund allocation utilized?
- Tutor incentive
- Procurement of education tools
- Building construction

- Building maintenance
- Others (specify)
- Is there any regular meeting with PAUD tutor/coordinator? E.g. weekly/monthly meeting or regional planning meeting, etc.
- Collaboration with related government body
- Health sentra (specify the activity/support)
- Office of Education (specify the activity/support)
- BPMD (specify the activity/support)
- HIMPAUDI (specify the activity/support)
- IGTKI (specify the activity/support)
- Others (specify)
- Any obstacles in coordinating? With which institution and why? Any solution?
- Any regular meeting/institution coordination in relation to the abovementioned? What's the agenda, what's the follow-up?
- Who hosted the meeting? Who's initiative?
- Any policy/regulation from government about PAUD? How was it implemented?
- What's the benefit for children/parents/cadre joining the program?
- Any change of children's behavior/parents/cadre in the program? Specify.
- Is there any children with special need joining the PAUD program?
- Is there any special treatment for such child? Explain
- What about children from poor family, any dispensation/discount for registration and tuition fee?
- Is the government involved in determining the rules for the program (e.g. amount of tuition fee, cadre's honorarium, building maintenance, etc.)
- Is government's support for the program deemed to be adequate?
- Any plan for program improvement? Explain
- What effort/activity has/will be organized to sustain PAUD
- Expectation

COMMUNITY LEADERS, RELIGIOUS LEADERS, *PAUD* MANAGEMENT, FAMILY WELFARE ASSOCIATION, COMMUNITY HEALTH WORKERS FGD

- PAUD establishment process
- Date of establishment (DD/MM/YY)
- Who came first with the idea/initiative to establish PAUD
- Funding source
- Was the establishment of PAUD driven by instruction/regulation from government at higher level (Subdistrict/District/Province/National)?
- Knowledge about PAUD/PAUD HI
- PAUD definition
- Holistic – Integrated definition
- Source of such knowledge.
- Community participation in PAUD establishment (what form).

- Providing tutor's incentive.
- Providing site/building for PAUD facility.
- Providing education material/tools
- Others, specify
- Is there any government policy/regulation on ECD activities? Please elaborate.
- Is there any government funds allocated for ECD activities? Please elaborate.
- Village/sub-sub-district (kelurahan) level (what type of funding and how to get it/what system or policy applied)
- Subdistrict level
- District level
- How is the fund allocation utilized?
- Tutor incentive
- Procurement of education toys
- Building construction
- Building maintenance
- Others (specify)
- Collaboration with related government body
- Health center (specify the activity/support)
- Office of Education (specify the activity/support)
- HIMPAUDI (specify the activity/support)
- IGTKI (specify the activity/support)
- Others (specify)
- What's the benefit for children/parents/cadre joining the program?
- Any change of children's behavior/parents/cadre in the program? Specify.
- Is the community involved in determining the rules for the program (e.g. amount of tuition fee, cadre's honorarium, building maintenance, etc.)
- What's existing community contribution/support for early childhood care and development? What kind of support is not yet available? (written in metaplan).
- Any plan for program improvement? Explain
- What's the ideal community participation to sustain the program? Explain.
- Expectation/suggestion

IN DEPTH INTERVIEW WITH HEAD OF SUB-DISTRICT (*CAMAT*)

- PAUD establishment process
- Community-driven ECD center
- Institution-driven ECD center
- Funding source
- Knowledge about PAUD/PAUD HI
- PAUD definition
- Holistic – Integrated definition
- Is the current PAUD holistic and integrated? Please elaborate
- Is there any policy/regulation from government about PAUD? E.g. 2-6 y.o. children have to enter PAUD prior to primary school; tutor incentive

- Is there any allocation of government fund for PAUD activity? Explain
- Village/sub-sub-district (what's the process/system/policy and how it's applied)
- Sub-district
- District
- How is the fund allocation utilized?
- Tutor incentive
- Procurement of education toys
- Building construction
- Building maintenance
- Others (specify)
- Is there any regular meeting with tutor and/or PAUD coordinator? E.g. weekly/monthly meeting, regional planning meeting, etc.
- Collaboration with related government body (is it working well?) If not, what's the constraint factor?
- Health center (specify the activity)
- Office of Education (specify the activity)
- HIMPAUDI (specify the activity)
- IGTKI (specify the activity)
- Others (specify)
- Is there any regular coordination meeting among the institution/office stated above? What's the agenda? Is the result implemented? Specify and example. If not, what's the obstacle?
- Who hosted the meeting, what's the role of each institution?
- Is the government involved in determining the rules for the program (e.g. amount of tuition fee, cadre's honorarium, building maintenance, etc.)
- Is there any children with special need joining the PAUD program?
- Is there any special treatment for such child? Explain
- What about children from poor family, any dispensation/discount for registration and tuition fee?
- What's the procedure to propose government's support for PAUD coordinator/tutor?
- Any plan for program improvement? Explain
- What effort/activity has/will be organized to sustain PAUD
- Which institution (at which sector) deemed most influential/determining in implementing HI ECD?
- How was the implementation of health programs?
- How does the sub-district government determine priority for programs? Who make the decisions?

Appendix I. Case Reports

1. Sumedang Sub District: Soft Loan for Cadre Group of *Taman Posyandu* or *Pinjaman Lunak Kelompok Kader Taman Posyandu (K2TP)* as the Basis for Establishing ADITUKA Cooperative for Cadres of *Taman Posyandu*

The idea for *Posyandu* Center (*Taman Posyandu*) was mentioned in September 1999 by Frontiers for Health (F2H), previously known as WHO Collaborating Center for Perinatal Care Maternal and Child Health (WHO CC PMC), which was headed by Prof. Dr. Anna Alisjahbana, Sp. A. *Taman Posyandu* is similar to a play group, which would be implemented in villages (the implementation would be adjusted to the village's condition). During the initial stage, F2H would prepare and socialize to 27 villages in Tanjungsari, which were spread out in 3 sub districts (*Kecamatan* Tanjungsari, Sukasari and Pamulihan). Out of the 27 villages, pilot villages would be selected based on certain requirements, some of them were:

1. Must have active/ongoing *Posyandu*
2. Have a minimum of 5 active cadres
3. Cadres are cheerful and fond of children
4. Cadres are patient and friendly

Fourteen *posyandu* were spread out in the villages of Sukarapih, Tanjungsari, Margaluyu, Gudang, Pasigaran, Cilembu, Sukasari, Banyuresmi, Citali, Kutamandiri, Raharja, Margajaya, Ciptasari and Cijambu.

The *Taman Posyandu* ran as expected and in 2002 out the 14 *Taman Posyandu* only 8 *Taman Posyandu* were (6 were inactive). The reason behind the 6 inactive *Taman Posyandu* was variable, some of them were the lack of community support, parents preferred *TK* instead of *Taman Posyandu*, no support was given by parents (they preferred their children to help in the field) and there was no cooperation with *TK*.

In 2005 *Taman Posyandu* started to develop again, thanks to the support and socialization carried out by F2H by engaging community participation, thus in 2012 all 14 *Taman Posyandu* were back in operation and spread out in three sub districts (*Kecamatan* Tanjungsari, Sukasari, dan Pamulihan)

In addition to continuous mentoring and guidance, F2H also facilitated all cadres through a program designed for creating income, by developing potential business source within the vicinity of *Taman Posyandu* itself using a Program called "Soft Loan for Cadre Group of *Taman Posyandu* or Pinjaman *Lunak Kelompok Kader Taman Posyandu (K2TP)*" which originated from Prof Dr. Anna Alisjahbana, Sp. A, Rotary Club in Bandung Kota Kembang RI District 3400, Mr. Rian Alisjahbana, and Frontiers for Health.

This program was carried out in four stages. Each active cadre of *Taman Posyandu* was provided a capital loan of Rp 300.000 (three hundred thousand rupiah) with a 12-month payment period and a 1% monthly interest and had to sign a written agreement on a stamp duty of Rp 6.000.

Starting off from the loan, an idea to establish a cooperative took form. The cooperative was named *ADITUKA* Cooperative. It started off with a stage four *K2TP* loan by allocating Rp 6.000 that derived from stamp duty and used as the "Capital Saving" of the cooperative.

With the full support and agreement of all active cadres, who also became the members of the cooperative, in addition to the discussion and agreement, the basic regulation for decision making was established:

1. Type of Savings and Loans Cooperative
2. Capital saving of Rp 6.000 (derived from the stamp duty for the *K2TP* agreement)
3. Obligatory saving of Rp 3.000/month/member
4. Discretionary savings
5. 2% service fee from the total loan
6. Payment period for loans:
   a. Less than Rp 300.000, to be paid in 3 (three) months or 3 installments
   b. More than Rp 300.000, up to unlimited amount (3 times the deposit of discretionary savings), loan period of 5 (five) months of 5 installments.
7. Loan must be made known to the head of *Taman Posyandu*, and should there be late payment, it would be born together
8. Annual member meeting shall be conducted after the cooperative is established

To date, the ADITUKA Cooperative has an asset of Rp 50.263.300 (fifty million two hundred sixty three thousand three hundred rupiah) with a total member of 65 people. The cooperative is managed by the cadres of *Taman Posyandu*. The following is the organization structure of the cooperative:

Person in charge	:	Elis Hendrawati (F2H)
		Hidayat (F2H)
Supervisor I	:	Syarifah (TP *Mandiri*)
Supervisor II	:	Ati (TP Barokah)
Supervisor III	:	Sa'adiah (TP Harum Manis)
Head I	:	Hj. Nani Heryani (TP Az Zahra)
Head II	:	Hj Lies Neni (TP R.A. Kartini)
Secretary I	:	Tia Widia Utami (TP Az Zahra)
Secretary II	:	Yanti (TP R.A. Kartini)
Treasurer	:	Tuti Budiarti (TP Cut Nyak Dien)
Mentor	:	*Yayasan* Frontiers for Health (F2H)

2. Sumedang Sub District: Ibu Syarifah, Accomplished Cadre in Tanjungsari

It started when a mother of a student, Iman Maulidin (4 years old), attended an ECD activity and was moved to assist the cadres in caring for the children. Later on Ibu Syarifah became a cadre in TP Melinjo, Citali Village, Pamulihan Sub District in 2002.

In 2004 F2H conducted a refreshment training for ADITUKA, which was attended by representantives from *Taman Posyandu*, especially those who have not received training. Ibu Syarifah is one of the representatives from TP Melinjo, Citali Village, Pamulihan Sub District.

The result of the training was reported by Ibu Syarifah to head of the cadres and the village head. She also asked for permission to socialize the *Taman Posyandu*/ADITUKA. Ibu Syarifah socialized the program to the community during meetings, Alquran recitals (*pengajian*), *Posyandu* activities, and other meetings, where the community gathered.

Her journey was not without challenges. She received humiliation and even threats, someone would bring a hatchet, threatening to ransack her house and saying: "Someone, who knows about child

development is not like Ipah, who is uneducated, poor and without title." However, Ibu Syarifah did not lose hope, and was even more passionate to prove that she would be able to put children into *Taman Posyandu* (TP). The community gave plenty of reasons for objecting, such as some felt the TP was far out of reach. Bu Syarifah kept on socializing the program, persuading religious and community figures and local government.

After several years being a cadre in TP Melinjo and feeling that the citizens in her village did not receive the care according to the TP program (supervised playing) then in 2003 Ibu Syarifah opened a branch in her village. With perseverance and sincerity, the *PAUD* started with 2 children, then grew to 6 students (from her own family), then back to 4, because the 2 went to *SD*. The TP program kept on going and the number of students grew, even people from outside the village and sub district registered in the TP that was established by Ibu Syarifah.

Finally, in June 2004, TP *Mandiri* was officially launched. It was called *Mandiri*, because for 8 months, Bu Syarifah bear the cost and taught by hereself. The activities in TP *Mandiri* was conducted twice a week, because at the time Ibu Syarifah was still teaching in TP Melinjo.

Since Ibu Syarifah lived close by Sukawangi Village, in 2006 Ibu Syarifah started to let go of TP Melinjo as there were new workers and at the same time there was a request by the *RW* of Sukawangi Viilage to build a TP. Ibu Syarifah mentored the cadres in TP Al-Makmur of Sukawangi Village for a year. In May 2007, there was another remote area where she mentored in *RW* 9. By engaging the local citizens to build a TP, the activity was implemented with the assistance of 2 core cadres and has a sufficient number of students to date.

In 2008, Ibu Syarifah was entrusted by *Yayasan* F2H to teach/train cadres in Teluk Bintuni District, West Papua Province, using her experience she gained from the TP, which she managed.

In 2010, another cadre wanted to establish a new TP and was assisted to do so and to date has been going well. In total, in the Citali Village, Pamulihan Sub District, there are 4 TPs that were built thanks to the struggle and perseverance of Ibu Syarifah in order to untuk develop the community in her village.

In 2008, cadres from 14 *Taman Posyandu* located in Sumedang District agreed to conduct a routine monthly meeting with the purpose of sharing experience and getting together. In this forum for the TP cadres, Ibu Syarifah was selected as the Head of Forum to date (she has been elected twice, with a 3-year term each).

In July 2010, Ibu Syarifah was considered by *HIMPAUDI* in Pamulihan Sub District and was entrusted and recruited as the Head of the *HIMPAUDI* Forum in Pamulihan Sub District to date. In the same year, she was elected as the person in charge of *POSKESDES* to assist the Village Midwife.

The activities carried out by and the awards, which Ibu Syarifah received are:

- As cadre of *Posyandu* from 1994 to date;
- In 2004, became the Head of the Working Group of Village *PKK*;
- In 2007, runner up for the prestigious cadre at the Sumedang District level – attended the examination of *LPPTKA* (*Lembaga Pembinaan dan Pengembangan TK* Al Qur'an or Institution for Mentoring and Developing Qoran Kindergarten) and received SK to be selected as the member of Verification Team of *PNPM Generasi* (*Program Nasional Pemberdayaan Masyarakat* or National Program for Community Empowerment);
- In 2008 received the award from F2H as a role model cadre, district winner of "*PAUD*" competition and runner up for prestigous cadre at the Sumedang district level;
- In 2010 elected as member of *TPM* (*Tim Pelatihan Masyarakat* or Community Training Team) in PNPM to date;
- In 2010, runner up at the District level for making *APE* (Alat Peraga Edukatif or Educational Tool Kit);

- In January 2011, elected as the head of forum for *Posyandu* cadres at the sub district level, *Puskesmas Pamulihan* to date;
- In April 2012, winner of prestigious cadre at the Sumedang District level; and
- In April 2012, became one of the top ten presitgous cadres at the West Java Province level, where in the same month and year, selected as the extension worker for Mental Wellness (*Kesehatan Jiwa*) at the *Puskesmas Pamulihan* to date.

Ibu Syarifah has attended the following training: Training for managing *PAUD*, Training for Tutors of *PAUD*, Training for *Siaga* Cadres, Training of TPM (*Tim Pelatih Masyarakat)*, Training of *LPPTK* (*Lembaga Pembinaan Pendidikan Taman Kanak Kanak Al-Qur'an*), Training for Extension Worker for Mental Wellness at the *Puskesmas Pamulihan* level.

3. Sumedang District: Observation of Parent-Children Interaction

The child's name was Qiyyella or called Qey for short. She lived with her maternal grandmother. Her parents worked at knitting factory in Binongjati, Bandung (a company owned by her grandmother's relatives). Her parents left for work Monday morning between 9 – 10 am to Bandung and came back to Sumedang Friday night after 6 pm. Qey is thus mostly cared for by her grandmother. She would listen to her grandmother. However, when her parents were home, she become "*ogo*" (spoilt). After school, Qey's grandmother would hug her and ask here what she learnt. She would ask Qey to change her clothes. Initially, Qey didn't want to seeing there is an observer. However, finally her grandmother would take Qey to her room and changed her clothes. The child's daily activity (based on the grandmother's story) is come home from school, change her clothes and play by herself or with her friends outside. At midday Qey would pray with her grandmother then take a nap. At 2 pm she would wake up, eat lunch and play until 4 pm and came back home to shower. At 6 pm, Qey would ask to study and the grandmother would teach how to write letters and numbers. Qey has attended *PAUD* activities since it was first opened, since she was 3 years old, (for three years) in *PAUD*. Sometimes, coming home from school Quey would be excited to do her homework. Qey was happy in *PAUD*, and never skipped school.

Based on Qiyyella father, who was at home at the time: Before starting *PAUD*, there was socialization by the village. Most parents in the community didn't pay much attention to child education. Mostly worked as farmers working in rice paddies. Only three people entered university, including Pak Solichin (manager of *PAUD* Tunas Harapan). Additionally, Pak Solichin liked to hold meetings with the community, particularly if they need assistance of there was a new program, etc.

Sometimes activities that were held outside *PAUD* would not take place, because many parents did not want to join in, so they were cancelled. However there was the quarterly routine swimming event. The would walk (as it is close by) or rent an open pick up truck (colt)

Qey's father was happy about *PAUD*, his child's education was ensured. The father was very supportive of the child's education and would frequently buy activity books that contain various materials, such as connecting the dots for alphabets, coloring, matching letters, etc. The books are frequently bought and usually Qey would take them to her friends and bring them back damaged, wet or even lost. He liked to buy toys, especially Barbie dolls, which Qey like or other toys like house for Barbie doll. There used to posters displaying letters and numbers on the wall, yet they would usually be torn, because they were played a lot with. So, they weren't bought anymore. Any toy he bought for Qey usually were played in the yard and often got damaged as a result. There were actually many toys bought for Quey. However, if the grandmother would tell her something, she would listen. For example, she told Qey not to play certain toys in the yard, and Qey would listen. Qey actually knew there are toys that should not be played in the yard.

When the observer was there, Qey asked her grandmother to cook her egg (she was inspired by the *PAUD* activity in the morning, where they cooked egg and sauted vegetables). Her grandmother said there was no egg, because she didn't go to the market. Qey insisted and held Rp 2,000 in her hand. Her grandmother asked Qey to take another thousand rupiah on top of the TV and went to the shop by herself. Qey came back carrying one egg, five candies and two snacks. Qey asked her grandmother to cook egg. Her grandmother asked Qey to get a round pan, similar to a poffertjes mold, and also to get a bowl, flour and water to mix the flour. Qey then mixed the egg in the liquid flour, seasoned it with salt and stirred it. Afterwards the grandmother helped turn on the stove and pour a small amount of oil and let Qey cook by herself. The child was left alone, while the grandmother talked to the observer until Qey said, "tutung" (burnt), because the fire was too big. The grandmother was not angry and only said that the fire was too big and asked why Qey didn't turn down the stove. Qey was confused. When she heard a vendor shouting outside, Qey asked her grandmother to buy her something. She gave Qey a coin to buy some snacks, yet the vendor was already far away. Qey then came in and put on a CD about West Javanese art, sort of like a Sundanese karaoke. Not long after, she became fussy, while sleeping on her grandmother's lap and was looking for her father. She then went to her room, pulled down the matrass and slept on it for a while. Qey became confused and slightly fussy asking for her father. Her grandmother then told her to find her father at her uncle's house nearby. Qey then went looking riding her bicycle.

4. Garut District: Child from Poor Family Enrolled in *PAUD*

Location: Garut, Sukawening, 25 September 2012

Mother: Ibu Atikah Sukaesih

Has 5 children, husband died four years ago, when the youngest child was a year old.
First child, male, 23 years old, works a tailor in a factory
Second child, female, 15 years old, grade 1 SMA
Third child, female, 12 years old, grade 6 *SD*
Fourth child, male, 7 years old, grade 1 *SD*
Fifth child, male, 5 years old, *PAUD*

Ibu Atikah is a typical mother, who regards highly of her children education. Since here husband died, the family's finance was borne by the first child, who works as a tailor in a factory. The first born is only a *SMP* graduate, because at that time, the father did not have funds to finance his study. Although, he didn't continue to SMA, he took a sewing course, where he finally took a job in Bandung.

With the financial support of her first born, Ibu Atikah could send her four children to school. She wants them to have higher education then hers or her husband's.

They live in a very simple house. The walls are made of bricks, there are three rooms, although in a state of disrepair. When it rains, the roof leaks. They don't have their own bathroom, they share with their relatives and four other households. They use well water. During the draught season, such as now, they would have to wash their clothes at a spring far from home. As such, they have to wake up early in the morning, because they have to take turn using the bathroom. By 5.30 am, everybody is ready and the children are asked to eat breakfast before going to school.

Ibu Atikah enrolled her children in *PAUD*, before attending SD. The first and second children did not attend *PAUD*, because at the time there is not yet *PAUD* in her neigborhood. She would always take them to *PAUD* that is 50 to 100 meters far from home.

According to Ibu Atikah, she felt *PAUD* was very useful, because her children became independent, both in learning and going to school. They didn't even have to be asked to study, because they did it willingly.

This helped the children to socialize and become independent in continuing their study in *SD*. For *PAUD* costs, she would always received assistance. For monthly tuition, she is allowed not to pay. She only paid for uniforms in the sum of Rp 85,000 and Rp 75,000 for books and report card. She could also pay them in installments for a year, which eased their finances.

Meeting with the *PAUD* tutor was usually done at the start of the school year or when there was an activity. She would be asked to meet face to face with the tutor, when the parent needed to focus more on the child's condition at home, such as to repeat certain learning materials taught at school.

In the afternoons, the children attended Qoran recital at at *madrasah* close to home. According to Ibu Atikah, her children always attended *PAUD* activities, they didn't need to be ordered or reminded. However, for recitals, they didn't always like to attend. She usually didn't force them if they didn't want to go.

Other than attending *PAUD*, Ibu Atikah took her children to *posyandu*. Information about *posyandu* activities usually came from the cadres. They would usually weigh, give vitamins and immunization.

All of her children have birth certificates, some were processed when they were newly born and some were processed in the mass at the sub district office. Knowing the importance of a birth certificate for school purposes, she immediately took part when there was a mass process of birth certificates. She forgot how much she paid to make a birth certificate.

Ibu Atikah hopes that her children would attend a better school than her, including for her first born, who wantst to continue to SMA. For that purpose, Ibu Atikah did not give certain obligations for her children, so they could focus on learning at school. During holidays, she would ask them to help her, like washing the clothes or other chores around the house.

From the above case, it can be said that the role of parents is vital for acquiring education for their children; this goes hand in hand with the consideration of the *PAUD* managers in providing equal opportunities for all children to receive *PAUD* education.

5. Kupang District: Poor Family Could Not Enroll Child in *PAUD*

Location : Kaniti Village, Central Kupang
Date : 10 – 09 – 2012

Family identity
Father : Yeremias Olah/aged 55 years old/SMP graduate/farmer
Mother : Herlence Olah/aged 49 years old/did not graduate SD/farmer

Both of them comes from East Penfui Village, *Dusun* 5. They have 12 children. Bapak Yeremias does not remember the order of his children. He only remembers the first and second, namely:

1. Female, aged 31 years old. Currently married to her second husband and lives in West Kupang. Has 2 children from her first marriage (Sirhi Olah/male/5 years old and Abson Olah/male/4 years old) living with him. Bapak Yeremias himself asked for the grandchildren to live with him, because according to traditions, if the grandchildren live with his parents in West Kupang, then by default they will become West Kupang people. Bapak Yeremias does not want that, he wants them to carry the Olah family name.
2. Female, aged 28 tahun. Has 2 daughters (Defrianti Olah/female/3 years old and baby girl aged 3 months) from the first marriage. Her husband left her, so she and her children are staying with Bapak Yeremias.

Bapak Yeremias and his wife work as corn and vegetable farmers. They start working from 7 in the morning until 3 in the afternoon. They are assisted by their children, who do not go to school and their three grandchildren. All eleven of Pak Yeremias' children live in the same house. Every day, he cooks for 24 plates. If there are guests, he cooks more.

The reason why Sirhi, Abson, and Defrianti does not attend *PAUD* is because no one could take to *PAUD*. In the morning, both grandfather and grandmother and other family members are busy preparing to go to the field or school. Another reason conveyed by Bapak Yeremias is that he wants them to be enrolled in *PAUD*. Initially, they attended *PAUD* activities, which were held near their home. However, since the tutor disappeared, the activities stopped, and his grandchildren did not go to school. Even if he wanted to enroll them in another *PAUD*, he wanted to see and make sure that the *PAUD* tutor was permanent and would not leave all of a sudden. (Note: Ibu Nia, tutor in *PAUD* Kaniti just moved in for several months from *PAUD* East Penfui).

The children's daily activity is playing around the house or go with their grandparents to the field. The toys they have at home are dolls dressed in SD uniform, several cars and color pencils. Both their grandparents rarely teach or stimulate them. Usually, the three would write when their older sibling who goes to SMP is studying. Usually the grandmother takes care of Sirhi, Olah and Defrianti. If the grandmother is not there, other children would take care of the little ones, down to cooking for them.

Bapak Yeremias' home is made of stone and cement. The floor is made of cement that is uneven. From the front door, there is a long living room. From the living room, you can see three bedroom doors and one door leading to the backyard. The upper floor is used as a storage for the vegetable produce and daily food stock. The upper floor is made out of dried *lontar* leaves joined tightly together. When looking up from the living room, you can see several corn bulging from the upper floor. Bapak Yeremias also keeps chickens, which run around the upper floor and sometimes swoop down to the lower floor. According to Bapak Yeremias, it's hard to get water in his house. Initially, they would used piped water and collect it in a tub, however it is still difficult. Finally, Bapak Yeremias draws water from the river.

Pak Yeremias said that we much pay attention to our children starting from their health and growth. We should assess it ourselves, as in how they move. As parents, we should know this exactly, since we are the ones taking care of them. It is our responsibility to pay attention. So whatever their grandchildren are doing, we must take heed.

Bapak Yeremias holds a principle in raising children, which is **"On the tip of the rattan stick, there is gold".** The saying means that rigid and strict upbringing will make the children successful. As in this time and age, if there is domestic violence, it would be reported to the police and could lead to imprisonment. In raising his grandchildren, Bapak Yeremias still uses that principle. He also emphasized in teaching his grandchildren manners and respect toward elders. His method of teaching is by portraying proper and decent behavior by himself.

In terms of *posyandu*, Pak Yeremias' family does not have *KMS, KB* and *Askes* card. There are seven grandchildren, but have never been hospitalized. Giving birth is done at home and handled by a midwife. When they fall ill, they just buy off the counter medicine. If it's regular pain, they can just buy *Panadol* or *Decolgen*, which is enough. If it's worse, they would buy *Amoxicilin* antibiotics. Bapak Yeremias said that so far they are fine, nobody has fallen terribly ill. As such they kept doing this habit. One of the reasons, Bapak Yeremias does not want to process the Askes card is because the cost needed to make such card is high, whereas the does not have the funds for it.

According to Bapak Yeremias, the government is not clear on what it wants. The want good things, yet require money or much fees from the community. Meanwhile, the facilities provided to community is not as it should be. Like there, water is difficult.

6. Kupang District: Ibu Nia, Creative and Kind-hearted Tutor

Location: *PAUD* Kaniti, Kupang

Establishing one of the *PAUD*s in East Penfui Village in 2001 started when Ibu Nia saw many children aged 3-5 years in her neigbordhood didn't go to school, only "aimlessly" playing around. Finally, Ibu Nia gathered all the children in her house teaching them how to sing, learning the alphabet, colors and numbers. Most of these children come from poor families, unable to send their children to *TK* or because their parents are busy working every day in the field.

Until one day, she was visited by the head of *BMM* (from Child Fund) and was asked to collect data of all the children living in her neighborhood. According to the head of *BMM*, if number exceeded 35, she could propose to establish a *PAUD* to be funded by Child Fund.

Finally, Child Fund provided help in the form of a building with 3 classrooms, *APE*, inside and outsid as well as incentives. Initially, the amount of incentive she received was Rp 75,000/month and every year it increased Rp 25,000. Now she receives Rp 300,000 per month.

Additionally, she receives 3 day training on how to develop curriculum and how to create *APE* from recycled goods. Such training very much helps her in conducting *PAUD* activities. Previously she managed herself without a curriculum.

At that time she had no colleagues, however after she got married in 2006 and had a maternity leave in 2007, she requested for one colleague.

According to Ibu Nia as to why she was selected as a tutor by CF, it is probably because she had a bit more to offer, she was self confident, patient, especially dealing with toddlers requires patience, she is not harsh but kind. She does like children, eventhough she didn't have her own then. She didn't have the basic technique, she only learnt them from books.

As tutor, she faced many challenges, one of them was *PMT* (school feeding), which was available from Child Fund. The children were used to it, but all of a sudden it was gone and the children stopped coming. They were accustomed to receiving milk etc. *PMT* was held three times a week and *PAUD* was held five times a week. It went one for a year then stopped altogether. To improve the chldren's enthusiasm, she discussed with the parents to make snacks using cheap and easy to get materials, such as fried cassava and other cakes made of cassava or yam. Thus, the children became enthusiastic again to go to school, because there was food again.

According to Nia, another issue is the insufficient number of *APE*, which is lost or usually taken home by the children and never brought back. However, Ibu Nia didn't run out of ideas, she made *APE* from recycled goods using the knowledge she gained from trainings. For example, making cars using leftover wood used for furniture; making flowers using cut out flowers using glue and *serbuk*; we use glue seashells to make animal figures, painted them and hung them on the wall; or make flower stamps made out of banana *batang* colored with *pinang*.

Another effort by Ibu Nia to persuade the children to come to school, since the parents are busy in the field and could not take them to school, as her house is at the top end of the road is by taking all of the children directly to the *SD*. So from 8 to 10 am, the children are the tutor's responsibility. They are then also brought home by the tutor. If for instance, they have not showered, she would wait, because she doesn't want them to walk down to *PAUD* by themselves. It's no use for me to come to *PAUD* if there are no children. So, even we are late in starting the class activities, she would better wait and bring all of the children to *PAUD*. That is her principle.

When asked if one day Child Fund will not provide anymore incentive, what would she do? Ibu Nia replied, "We are already close with the children. Even when we're off duty, the children would call out. "Your wage is great in heaven." Even when her colleague said that if Child Fund departed, so would she.

Ibu Nia only hopes that the government would give more attention so that after Child Fund departs, the government would take over and that the *PAUD* would not close down.

Ibu Nia's love towards the children does not depend on the incentive she receives; even the knowledge gained from the 3-day training can be given and applied for the education of her students. She only wants to have the government's attention.

This case proves that a tutor, who only graduated *SMP*, yet carries a great responsibility for early childhood education, is an important asset in the sustainability of *PAUD*. As such the education level of the tutor does not warrant the sustainability of a *PAUD* program.

7. Bengkulu District: Poor Parents Did Not Enroll Child in *PAUD*

Location : Bengkulu
Date of interview : 9 October 2012

Mother : Darmayati, aged 37 years old, did not attend school
Father : Heryanto, aged 40 years old, attended school until grade 4 SD

First child, female, 17 years old, graduated SMP, married
Second child, female 13 years old, grade 1 SMP
Third child, male, 7 years old, grade 1 SD
Fourth child, male, 6 years old, named Rio

Mother works as labor for makings brick with a maximum wage of Rp 10,000/day (1 brick equals Rp 100). Father works *serabutan*, often working as *kuli bangunan*. Mother works from 7 am until afternoon, however during day time, while waiting for the bricks to dry, she would go home and care for her children.

They live in their own house, which walls are plastered. There is no furniture (such as chairs) in the living room, only a television in the family room and the others room used as bedroom. The kitchen is located on the side. They often use wood to cook. They would use gas when there is money. The toilet is located outside the house and covered with heavy cloth. During rainy season they would use well water and during draught, they would draw water from another place, which is very murky.

Rio does not attend *PAUD* due to lack of funds. The mother says that her children does not attend *PAUD*. She says that attending *PAUD* requires fund, whereas attending *SD*, is relatively costless, only for uniforms and that can be paid in installments. Information regarding *PAUD* was given by the Tutor of *PAUD*, who lives across their house. Rio has been frequently asked, yet felt embarassed, because they don't have money. The mother herself knows that if he attends *PAUD* he will be equipped to smoothly attend *SD*. Nonetheless, so far her children can attend *SD* and does not face any meaningful difficulties.

Rio's daily activities is going to the brick shed with his mother and plays with friends of his age after they come from school. At the shed, Rio would sometime stir or help carry ready bricks. Sometimes, Rio would bring a book and pen and taught how to write by the grandmother, who owns the shed. His mother observes that Rio learns quickly and appears to be more smarter than his older siblings.

Rio is regularly taken to *posyandu* every month, to be weighed, given vitamins, immunized and receive extra feeding. *Posyandu* activities are informed by the village midwife.

If the child is sick, he or she is given *Bodrexin*. If it's worse and there is no sign improvement (like wnen the second child suffered from measles) the child is taken to the midwife for treatment. The total treatment cost is Rp 20,000 (including medicine) and they often have to ask for loan, because they don't have money. Payment is made in installments, when they have money.

They eat rice three times a day, usually with vegetables and sometimes with tofu/tempeh or fish. They rarely eat meat, probably once a year. Children are accustomed to eat regularly, so that their stomachs are full and they would not buy snacks. Even if they do, they would only buy a maximum of Rp 2,000, and that is rarely, because mother often does not have money.

They once received aid after an earthquake, which is used to repair their home in the sum of 7 million rupiah(?). Other aid they receive is rice for the poor or *Raskin* as much as 3,5 glasses each month. Initially it was 7 glasses. It has been 2 months since they last received *Raskin*.

Since living in Bengkulu in 2002, they only went for recreation once with the children, because the lack of funds. They just went for recreation this year to *Taman Remaja*. The money was only sufficient for transport Rp 70,000..

From the above case, the question rises as to "How much has CSR funding has assisted the children from poor families in meeting their rights for education?"

8. Bengkulu District: *PAUD* Al Ikhlas and *PAUD* Mawar

Two *PAUD* that were visited were non World Bank and received training from F2H. The materials from the first training that was held before their establishment on 22 July 2004, are still being used until now, especially the Activity Guideline for *Taman Posyandu*. This book was borrowed for six months by another *PAUD* which received funding from World Bank, because according to the tutors of *PAUD* of WB, the activity book from F2H is easy to understand and use.

Both *PAUD* are tight. Every Saturday, the tutors would gather and excercise together, develop activities, chat and have meals. Every six month they would meet with parent to discuss the children development. The parents are happy for sending their children to *PAUD*, because once they are in *SD* they seem to be independent. According to the parents, in average the children are happy to study again at home. They would ask for homeworks from the tutor (one of the demands of the *SD* principals is when entering grade 1 they have to be able to read and write).

In *PAUD* Mawar, there is one child from a poor family. The mother works as a maid in the morning and day time, as such she could take her child to *PAUD*. The mother fully understands that education is vital for children. Every time the child comes from school, he would tell about his day and happily does his homework. The child lives with his mother only. The father has long left them. The tutors of *PAUD* has relieved the mother from paying tuition.

There is a regulation stating that children of tutors do not pay tuition, and if there are two children in the *PAUD*, only one child pays. The parents like to save money for unexpected events or in case the tutor or child falls sick.

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