National report
Indonesia

CHILD POVERTY AND DISPARITIES IN INDONESIA: CHALLENGES FOR INCLUSIVE GROWTH

LEMBAGA PENELITIAN SMERU RESEARCH INSTITUTE

KEMENTRIAN PERENCANAAN PEMBANGUNAN NASIONAL/
BADAN PERENCANAAN PEMBANGUNAN NASIONAL (BAPPENAS)

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The cover design of this report was inspired by the Global Study on Child Poverty and Disparities, a multi-country initiative to leverage evidence, analysis, policy and partnership in support of child rights. The overlapping, multi-coloured frames symbolize the national, regional and global contributions to the Global Study, which form the basis for exchanging experiences and sharing knowledge on child poverty.

The design encapsulates three central tenets of the Global Study: ownership, multidimensionality and interconnectedness.

Ownership: Although children's rights are universal, every country participating in the study has its own history, culture and sense of responsibility for its citizens. The analyses aim to stimulate discussion and provide evidence on how best to realize child rights in each country.

Multidimensionality: No single measure can fully reflect the poverty that children experience. A multidimensional approach is therefore imperative to effectively understand and measure children's well-being and the various forms of poverty that they experience.

Interconnectedness: Today's world is increasingly interconnected through economic, social, technological, environmental, epidemiological, cultural and knowledge exchanges. These exchanges have important implications for child poverty – and can also help provide avenues for its reduction.

Equity: The Analyses aim to influence policies that reduce disparities, in order to protect the future of children living in poor, vulnerable households, unsafe circumstances, and/or disadvantaged communities.

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Foreword

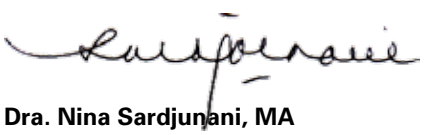
A nation comprising around 81.3 million children, Indonesia has made substantial advances towards putting children at the centre of the country's development agenda. Progress on some of the Millennium Development Goals (MDGs) such as those on reduction of extreme poverty, attaining universal primary education and gender equality has been positive. Some of this success can be attributed to the series of political reforms undertaken by the nation, such as the decentralization agenda, supported by the strong economic recovery Indonesia witnessed in the last decades.

Notwithstanding the success, huge inter-provincial, rural-urban and wealth disparities continue to exist. The face of poverty in Indonesia is predominantly that of children, with nearly 13.8 million children living below the national poverty line. Within individual provinces, the inter-district variations in child poverty rates are remarkably pronounced, especially within the provinces of Papua, West Papua, Aceh, North Sumatra, West Sumatra and Maluku. On wealth disparities, it appears that there is a correlation between income poverty in children and aspects such as the size of households, gender of the household head, educational levels of the household head and a household's geographical (urban/rural) location. And while deprivation suffered by children in rural areas is more severe than those living in urban areas, there is an alarmingly high growth of urban poor.

There are key dilemmas and contradictions attached to tackling disparities in Indonesia. For instance, evidence shows that children in the eastern region of Indonesia are proportionately at a disadvantage when compared to children from the western region of Indonesia. However, when we observe the concentration of population, the highest numbers of poor and vulnerable children are found in Java. It is here that the importance of achieving the MDGs with equity becomes critical to ensure that the rights of every Indonesian child are protected. And this will require the sustained and collaborative efforts of all government and non-government stakeholders and development partners in Indonesia towards reducing existing disparities, improving necessary legal and policy frameworks, and expanding the scope of the poverty reduction and social protection frameworks in the country.

Thus to move forward on an evidence-based understanding of the multi-dimensional nature of child poverty in Indonesia, this study was conducted under the leadership of BAPPENAS with UNICEF's technical and financial support and SMERU as the implementing organization. The study is an adaptation of the Global Child Poverty research methodology that has been supported by UNICEF worldwide across many other countries. The process of undertaking this study has been a comprehensive and arduous one, and has involved several rounds of consultations and discussions with researchers and other stakeholders before reaching its completion.

We are confident that the data and insight present in this study will contribute towards better understanding of the nature of inequities that are impeding the nation's progress on the MDGs, particularly on the complex issue of child poverty and deprivation. We also hope that the information contained in this report will aid the government and its development partners as well as the media and civil society organizations in their efforts on planning, decision-making and implementation of programmes that will advance the rights of all Indonesian children.



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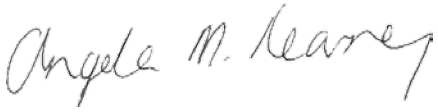

Angela Kearney
UNICEF Representative in Indonesia

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- Statistics Indonesia and Demographic Institute – University of Indonesia (LD-UI).

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Widjajanti Isdijoso – Research Coordinator, the SMERU Research Institute

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List of abbreviations

ABPP	Anggaran Belanja Pemerintah Pusat	Central Government Budget Expenditure
ADB		Asian Development Bank
AFC		Asian financial crisis
ANC		Antenatal care
APBD	Anggaran Pendapatan dan Belanja Daerah	The Provincial/District Revenue and Expenditure Budget
APBN	Anggaran Pendapatan dan Belanja Negara	The National Revenue and Expenditure Budget
ARI		Acute respiratory infection
ART		Antiretroviral therapy
ASEAN		Association of Southeast Asian Nations
Askes	Asuransi Kesehatan	Health Insurance
Askeskin	Asuransi Kesehatan Masyarakat Miskin	Health Insurance for the Poor
BAPPENAS	Badan Perencanaan Pembangunan Nasional	National Development Planning Agency
BCG		Bacillus Calmette-Guérin (antituberculosis vaccine)
BI	Bank Indonesia	Indonesia Central Bank
BKKBN	Badan Koordinasi Keluarga Berencana Nasional	National Family Planning Coordinating Board
BLM-KIP	Bantuan Langsung Masyarakat-Keringanan Investasi Pertanian	Direct Community Financial Assistance for Agricultural Investment
BLT	Bantuan Langsung Tunai	Unconditional Cash Transfer
BMI		Body Mass Index
BNP2TKI	Badan Nasional Penempatan dan Perlindungan Tenaga Kerja Indonesia	The National Agency for Placement and Protection of Indonesian Migrant Workers
BOS	Bantuan Operasional Sekolah	School Operational Assistance
BPS	Badan Pusat Statistik	Statistics Indonesia
BSM	Bantuan Siswa Miskin	Scholarship for Poor Students
BULOG	Badan Urusan Logistik	The National Food Logistics Agency
BUMN	Badan Usaha Milik Negara	State-owned enterprise
CCT		Conditional Cash Transfer
CPI		Corruption Perception Index
CRC		Convention on the Rights of the Child
CSO		Civil Society Organization
CWI		Child Well-Being Index

DAK	Dana Alokasi Khusus	Specific Allocation Funds
DAU	Dana Alokasi Umum	General Allocation Fund
DOD		Dropout Or Discontinuation
DPD	Dewan Perwakilan Daerah	Regional Representative Council
DPR	Dewan Perwakilan Rakyat	People's Representative Council
DPT		Diphtheria, pertussis, tetanus
DSR		Debt-to-Service Ratio
DT		Diphtheria and tetanus
Ebtanas	Evaluasi Belajar Tahap Akhir Nasional	National Final Examination
ECE		Early Childhood Education
FGD		Focus Group Discussion
FITRA	Forum Indonesia untuk Transparansi Anggaran	The Indonesian Forum for Budget Transparency
GDP		Gross Domestic Product
GER		Gross Enrolment Rate
GFC		Global financial crisis
GNI		Gross National Income
GoI		Government of Indonesia
GSC	Generasi Sehat dan Cerdas	Healthy and Smart Generation
HB		Hepatitis B
HIV/AIDS		Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
ICLS		Indonesian Child Labour Survey
IDAI	Ikatan Dokter Anak Indonesia	The Indonesian Pediatric Association
IDHS		Indonesia Demographic and Health Survey
IDR		Indonesian rupiah
IFLS		Indonesian Family Life Survey
ILO		International Labour Organization
IMCI		Integrated Management of Childhood Illness
IMR		Infant Mortality Rate
INAC		Indonesia National AIDS Commission
IOM-Indonesia		International Organization for Migration – Indonesia
IPL		International poverty line
IYCF		Infant and Young Child Feeding
Jamkesda	Jaminan Kesehatan Daerah	Local Government funded Health Insurance for the Poor
Jamkesmas	Jaminan Kesehatan Masyarakat	Community Health Insurance Scheme

Jampersal	Jaminan Persalinan	Birth delivery Insurance Scheme
JURIM	Juru Imunisasi	Vaccination staff
KIA	Kartu Ibu dan Anak	Mother and Child Health Card
KK	Kartu Keluarga	Family Cards
KMS	Kartu Menuju Sehat	Child's Road to Health Card
Komnas HAM	Komisi Nasional Hak Asasi Manusia	Indonesian National Commission On Human Rights
KPAI	Komisi Perlindungan Anak Indonesia	Indonesian Commission for Child Protection
KPAN	Komisi Penanggulangan AIDS Nasional	Indonesian National AIDS Commission (INAC)
KTP	Kartu Tanda Penduduk	(Residential) Identity card
KUR	Kredit Usaha Rakyat	Loan for small business
LKSA	Lembaga Kesejahteraan Sosial Anak	Children's social welfare institution
MA	Madrasah Ahliyah	Islamic senior high school
MDG		Millennium Development Goal
MI	Madrasah Ibtidaiyah	Islamic primary school
MoH		Ministry of Health
MoHA		Ministry of Home Affairs
MoNE		Ministry of National Education
MoSA		Ministry of Social Affairs
MoWE&CP		Ministry of Women's Empowerment and Child Protection
MP-ASI	Makanan Pendamping Air Susu Ibu	Complementary food to mother's milk
MPS		Making pregnancy safer
MR		Mortality rate
MTs	Madrasah Tsanawiyah	Islamic junior high school
NAC		National AIDS Commission
NAC-WFCL		National Action Committee for the Elimination of the Worst Forms of Child Labour
NAD	Nanggroe Aceh Darussalam	Aceh Province
NAP-WFCL		National Action Plan for the Elimination of the Worst Forms of Child Labour
NER		Net enrolment rate
NGO		Nongovernmental organization
NICE		Nutrition Improvement through Community Empowerment
NPL		National poverty line
NTB	Nusa Tenggara Barat	West Nusa Tenggara Province

NTT	Nusa Tenggara Timur	East Nusa Tenggara Province
OPK	Operasi Pasar Khusus	Special Market Operation
P2DTK	Program Percepatan Pembangunan Daerah Tertinggal dan Khusus	The Development Acceleration Programme for Disadvantaged and Special Regions
P2KP	Program Penanggulangan Kemiskinan di Perkotaan	Urban Poverty Reduction Programme
P2TP2A	Pusat Pelayanan Terpadu Pemberdayaan Perempuan dan Anak	Integrated Services Centre for Women and Children Empowerment
P4K	Program Perencanaan Persalinan dan Pencegahan Komplikasi	Birth Preparedness and Complication Prevention Programme
PAUD	Pendidikan Anak Usia Dini	Early Childhood Education (ECE)
PAMSIMAS	Penyediaan Air Minum dan Sanitasi Berbasis Masyarakat	Community-based sanitation and drinking water provision
PCR		Polymerase Chain Reaction
PD3I	Penyakit Yang Dapat Dicegah Dengan Imunisasi	Diseases preventable by immunization
PHBS	Perilaku Hidup Bersih dan Sehat	Clean and healthy lifestyle behaviours
PIN	Pekan Imunisasi Nasional	National Immunization Week
PISEW	Program Infrastruktur Sosial Ekonomi Wilayah	Regional Socio-economic Infrastructure Development Programme
PKBM	Pusat Kegiatan Belajar Masyarakat	Community Learning Centre
PKH	Program Keluarga Harapan	Household CCT
PKK	Pembinaan Kesejahteraan Keluarga	Movement for Family Empowerment and Welfare
PKSA	Program Kesejahteraan Sosial Anak	Social Welfare Programme for Children
PLHA		People living with HIV/AIDS
PMTCT		Preventing Mother-to-Child Transmission of HIV
PNBAI	Program Nasional Bagi Anak Indonesia	National Programme for Indonesian Children
PNPM	Program Nasional Pemberdayaan Masyarakat	National Programme for Community Empowerment
POLDA	Kepolisian Daerah	Regional police station
Polindes	Pondok Bersalin Desa	Village maternity clinic
POLRES	Kepolisian Resor	District level police office
Poskesdes	Pos Kesehatan Desa	Village health post
Posyandu	Pos Pelayanan Terpadu	Integrated health services post
PPH	Pola Pangan Harapan	Hope Food Pattern

PPIP	Program Pembangunan Infrastruktur Perdesaan	Rural Infrastructure Development Programme
PPKn	Pendidikan Pancasila dan Kewarganegaraan	Pancasila morality and citizenship education
PPL		Provincial poverty line
PPP		Purchasing power parity
PPT/PKT	Pusat Pelayanan Terpadu/Pusat Krisis Terpadu	Integrated services centre/Integrated crisis centre
PUAP	Pengembangan Usaha Agribisnis Perdesaan	Development of rural agribusiness
Puska PA	Pusat Kajian Perlindungan Anak	Centre for Child Protection Studies
Puskesmas	Pusat Kesehatan Masyarakat	Community health centre
Puskesmas keliling		Mobile health centre
Pustu	Puskesmas Pembantu	Village health post
RA	Raudatul Athfal	Islamic kindergarten
RAN	Rencana Aksi Nasional	National Action Plan
RAN-P3A	Rencana Aksi Nasional Pemberantasan Perdagangan Perempuan dan Anak	National Plan of Action for the Elimination of Trafficking of Children and Women
RAN-PESKA	Rencana Aksi Nasional Pemberantasan Eksploitasi Sosial Anak	National Plan of Action for the Elimination of Sexual Exploitation of Children
RAN-PG	Rencana Aksi Nasional Pangan Dan Gizi	National Action Plan for Food and Nutrition
Raskin	Beras Untuk Rumah Tangga Miskin	Rice for Poor Households
Renstra	Rencana Strategis	Strategic plan
RISKESDAS	Riset Kesehatan Dasar	Basic Health Research
RKP	Rencana Kerja Pemerintah	Government Work-Plan
RPJMN	Rencana Pembangunan Jangka Menengah Nasional	National Medium-Term Development Plan
RPK	Ruang Pelayanan Khusus	Special services rooms
RPSA	Rumah Perlindungan Sosial Anak	Social protection homes for children
RPTC	Rumah Perlindungan Trauma Center	Trauma and healing centres
RT	Rukun Tetangga	Neighbourhood units
RTSM	Rumah Tangga Sangat Miskin	Very poor households
RW	Rukun Warga	Unit of local administration consisting of several RT
SAKERNAS	Survei Angkatan Kerja Nasional	National Labour Force Survey
Satpol PP	Satuan Polisi Pamong Praja	Civil service police unit
SBI	Sekolah Berstandar Internasional	International-standard school
SD	Sekolah Dasar	Primary school
SDC		Social Development Centres
SDO	Subsidi Daerah Otonom	Subsidy for Autonomous Regions
Seknas	Sekretaris Nasional	National Secretary

SER		School enrolment rate
SITAN		Situation Analysis
SKTM	Surat Keterangan Tidak Mampu	Relief letter for the poor to get access to health care at hospitals
SMA	Sekolah Menengah Atas	Senior high school
SMK	Sekolah Menengah Kejuruan	Vocational high school
SMP	Sekolah Menengah Pertama	Junior high school
SPM	Standar Pelayanan Minimum	Minimum service standards
SSN		Social safety net
SUPAS	Survei Penduduk Antarsensus	Intercensal Population Survey
SUSENAS	Survei Sosial Ekonomi Nasional	National Socio-Economic Survey
TB		Tuberculosis
TESA 129	Telepon Sahabat Anak 129	Child Helpline 129
TIMMS		Trends in International Mathematics and Science Study
TK	Taman Kanak-kanak	Kindergarten
TKPK	Tim Koordinasi Penanggulangan Kemiskinan	Coordinating Team For Poverty Reduction
TNP2K	Tim Nasional Percepatan Penanggulangan Kemiskinan	National Team for Accelerating Poverty Reduction
TT		Tetanus toxoid
U4		Under-four
U4MR		Under-four mortality rate
U5		Under-five
U5MR		Under-five mortality rate
UAN/UN	Ujian (Akhir) Nasional	National examination system
UC		Universal coverage
UCI		Universal child immunization
UNDP		United Nations Development Programme
UNICEF		United Nations Children's Fund
Unit PPA/ UPPA	Unit Pelayanan Perempuan dan Anak	Women's and Children's Service Unit
UPT	Unit Pelaksana Teknis	Technical Implementation Unit
UPTD	Unit Pelaksana Teknis Daerah	Regional Technical Implementation Unit
UU	Undang-Undang	Law
UUD 1945	Undang-Undang Dasar 1945	The Indonesian Constitution
VCT		Voluntary Counseling and Testing
WFC		World Fit for Children
WFCL		Worst forms of child labour
WHO		World Health Organization

CHILD POVERTY AND DISPARITIES IN INDONESIA: THE CHALLENGE FOR INCLUSIVE GROWTH

Executive Summary

This report deliberates the multiple dimensions of poverty and disparities faced by children in Indonesia. This report also advocates for poverty reduction policies and programmes that are more child-focused. These analyses and recommendations are aimed at supporting the realization of the rights of all children in Indonesia, as formally guaranteed by the Indonesian Constitution (Undang-Undang Dasar 1945, UUD 1945). This report specifically addresses the problem of a inequalities that persist despite progress at the aggregate or national level. There have been intensified efforts and new policies, plans and programmes aimed at fulfilling the rights of children without discrimination during the last decade in Indonesia. But in spite of this, the size of the country, the unequal distribution of natural resources and infrastructure facilities, the decentralized government and political system it adopts, and the poverty problem have all created inequalities and challenges for the fulfilment of child rights in Indonesia.

The analysis presented in this report is based mainly on data available from the 2010 national data sets, which include the 2003 and 2009 National Socio-Economic Survey (SUSENAS), the 2002/2003 Indonesian Demographic and Health Surveys (IDHS), the 2007 and 2010 Basic Health Research (RISKESDAS) surveys, the 2004 and 2009 National Labour Force Survey (SAKERNAS) and the 2009 Indonesia Child Labour Survey (ICLS). In addition, data were sourced as needed from the official statistics of relevant line ministries and non-government organizations, relevant official documents related to the government's policies and programmes, and relevant studies and assessments. Finally, small qualitative case studies were carried out in two *kelurahan* (urban precincts) in Jakarta Utara (North Jakarta) and two rural villages in Sumba Timur (East Sumba), between July 2010 and May 2011. The approach and methods used for this study of child poverty and disparities follow the UNICEF Global Study on Child Poverty and Disparities 2007–2008 Guide (UNICEF, 2008), with some modification to adjust for data availability and the Indonesian context.

Children and development

Indonesia is a large archipelagic country with a predominantly young population. The country covers 3.5 million square kilometres of sea area and 1.9 million square kilometres of land area, comprising more than 17 thousand large and small islands. Administratively, as of the end of 2010, Indonesia consists of 33 provinces and almost 500 districts/cities *(kabupaten/kota)*. Of

Box A: Children in Indonesia – Basic Statistics

Number of children (aged below 18 years): 81.3 million (2010)

- *Residence area: rural 54%; urban 46%*
- *Sex ratio (female : male): 94.6 : 100*

Distribution of population aged 0–19 years (2010):

- *Provinces with the largest number of children: West Java (16.4 million), East Java (12.2 million), Central Java (11.2 million)*
- *Provinces with the smallest number of children: West Papua (329 thousand), Gorontalo (436 thousand), Bangka Belitung Islands (463 thousand)*

Proportion of households (2009):

- *With children: 72% (urban 70%, rural 74%)*
- *Number of children: 1–2 (55%), 3–4 (15%), 5+ (3%)*

Status in relation to household head (2009): Children (83.9%), grand children (12.8%), relatives (2.7%), domestic workers (0.2%), household head and spouse (0.12%), son/ daughter in law (0.09%)

Source: Estimated from SUSENAS (2009) and Population Census (2010)

the total population of approximately 237.6 million people in 2010,[1] about 81.3 million are children aged under 18 years, including 39.5 million girls and 41.9 million boys. Indeed, the proportion of children in Indonesia decreased from 43 per cent in 1990 to 34 per cent in 2010. Regional distribution is an important issue as children (and the population in general) are not distributed evenly across the country; more than half (54 per cent) live in Java, the country's most densely populated island. Also, approximately 54 per cent of all children live in rural areas, which is slightly larger than the 52 per cent of the overall population living in rural areas (2009 data). The trend shows increasing urbanization of children, however, as the proportion of urban children increased from 40 per cent in 1990 to 46 per cent in 2009.

Children have always been at the centre of Indonesia's development agenda, and the efforts towards fulfilling the rights of children without discrimination have been intensified since 200 with the democratization reform process. The past ten years have been marked with the enactment of various laws and regulations pertaining to children's rights. The development of children's well-being has also been one of the priorities of the Government of Indonesia (GoI) in the last two National Medium-Term Development Plans (RPJMN), and the rights of children are now included among the issues to be mainstreamed into the development priorities of the 2010–2014 RPJMN, with emphasis on the areas of education, health and poverty reduction.

The development process for children in Indonesia is clearly influenced by the country's political, economic and social contexts as well as macroeconomic policies. The major national processes and challenges that influence the efforts to fulfill the rights of all children include:

1. A decade of democratization and decentralization reforms in Indonesia that saw a series of amendments to the Indonesian Constitution during 1999–2002. These amendments laid very clear and strong foundations for the promotion and protection of human rights, including the rights of children, as inserted in Article 28B (clause 2) of the Constitution. In general, the democratic reforms are intended to increase the checks and balances in both policymaking and programme implementation. The reforms were also meant to lay the foundation for a more inclusive and equitable development process, including those aspects pertaining to children. In addition, the amended Constitution also rendered a far-reaching

[1] Preliminary result of the 2010 Population Census

Box B: Income poverty in Indonesia

Percentages of people living below:
International povery line (IPL):
- *IPL $1 PPP/capita/day: 5.9% (2008)*
- *IPL $2 PPP/capita/day: 42.6% (2008)*

National poverty line (NPL): 14.2% (2009)
Number of people living below NPL: approximately 32.5 million people (2009)
Poverty indexes:
- *Poverty gap index (P1): 2.5%*
- *Poverty severity index (P2): 0.68%*

Urban:
- *Poverty rate (below NPL): 10.72%*
- *Gini ratio: 0.362*

Rural:
- *Poverty rate (below NPL): 17.35%*
- *Gini ratio: 0.288*

Provinces with the highest numbers of poor people:
East Java (6.2 million), Central Java (5.7 million), West Java (5.0 million)
Provinces with the highest poverty rates:
Papua (37.5%), West Papua (35.7%), Maluku (28.2%)

Source: BPS - Statistics Indonesia

devolution of most government functions to district governments *(kabupaten/ kota)* and provided special autonomy for the provinces of Aceh and Papua. This places on the shoulders of the district governments the responsibility for delivering most public services, including health, education and culture, social welfare and labour force development. Along with the devolution of government functions, the central government has also increased the transference of funds to regional governments – from 13 per cent of central government expenditure in 2000 (before decentralization) to around 30 per cent in 2010.

2. Indonesia has achieved rather limited progress in the rule of law and good governance, despite the major decentralization and democratization reforms aimed at better governance. The existing political institutions are weak, the intergovernmental division of functions is unclear, the capacity of most regional governments is poor, and the capacity of non-government organizations is also lacking. These weaknesses have hindered the realization of good governance and good public service delivery. Governments at the national and local levels often fail to provide the services they are supposed to, especially services to the poor or those targeted at poverty reduction, despite the substantial weight of programmes being allocated specifically for this purpose. This has been further weakened by the widespread movement for provinces and districts to split, which led to the formation of 7 new provinces and 156 new districts between 2001 and 2010, each requiring its own government, and most facing a serious lack of infrastructure, financial and human resources.
3. Good economic progress has been made, but limited capacity in providing adequate job opportunities persists. Indonesia has moved to be one of the lower-middle income countries in 2010 with per capita gross national income (GNI) around US$2,963 (Indonesia Central Bank, 2010). It has also proven resilient, surviving the pressures of the 2008/2009 global financial crisis (GFC). This economic progress has been accompanied by growth in the manufacturing and service sectors, which now account for a larger share of the economy. However, the provision of sufficient job opportunities is still problematic. Although unemployment rates have been kept low, at around 7 per cent in 2010, almost 70 per cent of the employed are working in the informal sector. The proportion of the workforce employed in agriculture is still greater than the proportion involved in manufacturing. And while more women are entering the labour market,

Box C: Children in income poverty in Indonesia (2009)

Distribution of children by household expenditure quintiles: Q1 (poorest) 28%; Q2 23%; Q3 20%; Q4 17%; Q5 (richest) 13%

Numbers of children living below:

- *IPL $2 PPP/capita/day: 44.3 million*
- *NPL: 13.8 million*
- *IPL $1 PPP/capita per day: 8.4 million*

2003–2009 trends in % of children living below:

- *IPL $1 PPP/capita/day: declined from 12.75% to 10.63%*
- *NPL: declined from 23.44% to 17.35%*
- *IPL $2 PPP/capita/day: declined from 63.5% to 55.78%*

Disparities:

- *More than 50% of poor children reside in Java and Bali*
- *Provinces where more than 25% of children live in extreme poverty (below IPL $1 PPP/ capita/day): East Nusa Tenggara (36.2%) and Gorontalo (32.2%)*
- *20% of children in households where the household head did not complete primary school were in extreme poverty, compared to just 2.8% of children in households headed by people who finished senior secondary school, and 0.5% of children in households headed by someone with a university/college diploma*
- *15.8% of children in rural area were in extreme poverty, compared to 4.6% of children in urban areas*
- *13% of children in female-headed households was in extreme poverty, compared to 10% of children in male-headed households*

Source: Estimated from SUSENAS, 2003 and 2009

they are mostly absorbed by the informal sectors. The number of international migrant workers, who are mostly women with limited skills, is also increasing.

4. Indonesia has made good progress in reducing income poverty, but many people are still vulnerable to falling into poverty. At the national level, the number one MDG target of reducing extreme poverty has been achieved. However, more than 40 per cent of the population still lives below the international poverty line (IPL) of US$2 purchasing power parity (PPP) per capita per day and are thus vulnerable to economic shocks which could cause them to fall deeper into poverty. Poverty in Indonesia remains a predominantly rural phenomenon, despite the increasing urban population and the higher income inequality within urban populations. Income poverty also varies across provinces. Although most of the poor are living in the most densely populated island of Java, the poverty rates in the provinces of eastern Indonesia remain among the highest. The provincial performance in terms of reduction in poverty rates also varies considerably and there appears to be no clear correlation between progress in reducing poverty and economic growth at the province level.
5. The macroeconomic policy has focused on maintaining stability in the currency and inflation, and has provided only limited resources to children. Indonesia has also been adopting financial deficit budgets in order to simulate growth, such that the size of the deficit has tended to increase each year. Most government revenue comes from tax, especially domestic taxation; on average tax revenues contribute almost 70 per cent of total annual revenue. Meanwhile, Indonesia's external debt is maintained at a manageable level so that the debt service ratio (DSR), debt to GDP, and debt to export have been steadily declining, and only increasing slightly in 2009. Nevertheless, fuel subsidies still consumed the greatest amount of the central government's budget, peaking at 40 per cent of total expenditure in 2008 when the global oil price increased. A substantial proportion of the central government's budget is allocated to subsidies, interest payments and personnel costs. This has limited government capacity to finance services that directly benefit children.

Children in income-poor households

On average, the number of children in a poor household is higher than in a wealthier household; or in other words, children form a larger proportion of all household members in poor households. Also, the proportion of all Indonesian children who live in income-poor households is higher than the proportion of poor people in the general population, indicating that children suffer disproportionately from poverty in Indonesia. This analysis is based on household level expenditure data, such that the income poverty status of a child is attached to that of the household. The poverty rates that result from this method (see Box C) may slightly underestimate the real level of income poverty among children in Indonesia because a tiny fraction of children living in relatively wealthy households are domestic workers and also SUSENAS data do not include children living on the street or in childcare institutions.

The proportion of children living in income poverty declined between 2003 and 2009, by all poverty benchmarks, i.e., the international poverty lines (IPL) below US$1 and $2 PPP per capita per day (extreme poverty and decent life standard), and the national poverty line (NPL). The rate of reduction of children living below IPL $1, however, was less sensitive to the reduction of extreme poverty in general. Despite the decreasing rate, it was estimated that in 2009 around 44.3 million children were living on less than the equivalent of $2 per capita per day, of which 13.8 million lived below the NPL and 8.4 million children lived in extreme poverty (below $1 per capita per day). Efforts to address income poverty among Indonesian children invariably raise a geographical dilemma because the largest number of poor children (more than 50 per cent of Indonesia's poor children) resides in Java, while the provinces in the eastern part of Indonesia have the highest rates of poverty, including child poverty, but smaller populations. The variations in child poverty rates across districts within provinces are even more pronounced. Inequalities were particularly high within the provinces of Papua, West Papua, Aceh, North Sumatra, West Sumatra and Maluku.

The prevalence of income poverty in children correlates with household size, gender of the household head, educational background of the household head and urban/rural location. Child poverty rates tend to increase with household size. Around one out of every four children, who live in households that have four or more children per adult, or that have elderly dependents aged 70 years or more, fell below the NPL in 2009. Poor children are more likely to be found within female-headed households. Notably, girls are less likely than boys to live in income-poor households. The educational background of the head of household is also positively associated with improved status of household members with regard to poverty, including children. The child poverty rates were higher in rural areas than in urban areas. The urban/rural poverty gap is more pronounced in terms of child poverty than it is when one looks at overall population poverty rates.

Children experiencing multiple deprivations

The analysis of the multiple dimensions of deprivation among children – education, labour participation, health, shelter, sanitation, and water – uncovers an even more challenging picture. An analysis using 2009 SUSENAS data shows that only approximately 18.3 per cent of Indonesian children were free from all six deprivation dimensions. Approximately 30.6 per cent of children were deprived in one dimension, 29.1 per cent in two dimensions, 18.5 per cent in three dimensions, 6.6 per cent in four dimensions, 1.3 per cent in five dimensions, and 0.07 per cent deprived in six dimensions. The most common type of deprivation suffered was being deprived of sanitation followed by clean water.

This analysis is based on several important indicators available in the 2009 SUSENAS Panel data (a sub-set of the full data) that most closely represent the six dimensions of child poverty. The education dimension is measured among children aged 3–6 years who are not enrolled in early childhood education (ECE) and among

children aged 7–17 years who are not enrolled in formal primary or secondary school. The labour participation component measures children performing economic work but not going to school and children performing economic work and also attending school. The health dimension is measured from self-reported work/school disruption due to ill health, and self-reported diarrhea and/or asthma. The shelter indicator is measured by assessing the numbers of children living in a house with a floor area less than 8 square meters per person, children living in a house with an earth floor, and children living in a house without access to electricity. The sanitation dimension is measured by the number of children without access to a proper toilet. The water dimension is measured by the number of children without access to clean water.

The analysis on the proportion of children deprived in each dimension by household income quintiles confirms the link between monetary and non monetary poverty. The proportion of children deprived in any dimension decreases as the household income level increases (from children in the poorest quintiles (Q1) to children in the richest quintiles (Q5)). Furthermore, the proportion of children who were free from any deprivation increased along with the quintiles of households' income. There were only 4.95 per cent of children in quintile 1 who were free from any deprivation, while in contrast there were 39.76 per cent of children in quintile five who were free from any of deprivation.

Deprivation in shelter, water and sanitation

Considerable progress has been made in children's access to proper shelter and sanitation, but not in terms of access to improved and protected water sources. During the period from 2003 to 2009, the percentage of children deprived of adequate shelter has steadily declined: earth-floor houses (-8.6 per cent), inadequate house area (-28.7 per cent), and lack of electric connection (-51.7 per cent). Similarly, in the same period, the proportion of children living in houses without proper toilets decreased by 33.7 per cent. The proportion of children living in houses without access to improved and protected water sources increased by approximately 19.9 per cent. Indeed, around one out of three children in Indonesia has no access to proper sanitation or a safe source of water.

Provincial disparities in terms of shelter, water and sanitation are significant (Box D). Additionally, the within-province disparities are even greater. The gap between the averages of the worst twenty and the best twenty districts with regard to children's access to clean water was the widest (87 percentage points), followed by sanitation (83 percentage points) and shelter (80 percentage points). Certain districts in Papua were among the worst performers in regard to children's access to clean water and sanitation.

Box D: Child deprivation in shelter, sanitation and water

Trends (2003–2009):

- *Live in house <8m2/person: declined from 25.15% to 23.9%*
- *Live in house with earth floor: declined from 15.09% to 10.76%*
- *No electricity: declined from 15.5% to 7.49%*
- *No proper toilet: declined from 53.67% to 35.6%*
- *Without access to improved and protected water sources: increased from 29.3% to 35.1%*

Disparities across provinces:

- *Live in house <8m^2/person: 66.5% (Papua) – 7.3% (Central Java)*
- *Live in house with earth floor: 38.6% (NTT) – 1.18% (Bangka Belitung)*
- *No electricity: 53% (Papua) – 0.11% (Jakarta)*
- *No proper toilet: 63% (West Sulawesi) – 5.5% (Jakarta)*
- *No access to clean water: 85% (West Kalimantan) – 23% (Jakarta)*

Source: Estimated from SUSENAS 2003 and 2009

Deprivation in shelter, sanitation and water were all strongly associated with: (1) the economic status of the household; (2) the urban/rural gap; (3) the education level of the household head; and (4) the household size. The gender of the household head was not significantly associated. The gap between the poorest and richest quintiles was the most obvious. More than half of the children in the poorest welfare quintile lived in inadequate shelter and had no access to sanitation, while only 10 per cent of children in the richest quintile suffered from shelter deprivation, and 5 per cent had no access to proper sanitation. An urban/rural disparity also persisted, particularly in regard to sanitation. The poor children living in urban areas, however, are also severely deprived, almost to the same extent as those living in rural areas. Meanwhile, the differences between deprivation among children from households headed by graduates from university/college and those from households headed by less educated people were also quite striking. On the other hand, household size did not seem to affect deprivation in terms of sanitation and access to improved and protected water sources.

Non-material deprivation

Non-material well-being represents an important aspect of children's rights and Indonesia's 2003 Child Protection Law asserts that children are entitled to adequate rest and leisure time, to play with their peers, to have recreation time, and be creative in accordance with their interests, talents and capacity, in order to grow up well (Article 11, Clause 3). Unfortunately, few indicators of non-material dimension are captured in the available national data sets. An aspect of deprivation that is available in the SUSENAS data is the interaction between children and parents. The 2009 SUSENAS data revealed that the most frequent activities conducted by children with their parents are watching television and eating, followed by studying and playing. In addition, the IFLS captures the frequency of children meeting with both parents and other means they use to communicate (if not face to face). The IFLS data for 2000 and 2007 shows that only a small proportion (around 10 per cent) of children met with both of their parents on a daily basis, while around 20 per cent of children did not meet at all with either of their parents. In rural areas, the percentage of children who met with both parents only once a year increased from 23.6 per cent in 2000 to 31.9 per cent in 2007. This might be related to increasing numbers of domestic workers and international migrant workers from Indonesia, causing many Indonesian children living in rural areas to be separated from their parents.

Some aspects of non-material deprivation can be inferred from other available dimensions, such as child engagement in paid and unpaid labour, children who are victims of criminal acts, and child marriage. Child marriage can be considered as a form of non-material deprivation since marriage will entail new responsibilities and limit a child's opportunity to enjoy many aspects of their childhood rights. The 2010 RISKESDAS data reveal the following interesting facts: around 7.4 per cent of girls aged 10–14 and around 15.8 per cent of girls aged 15–19 were pregnant at the time of the survey (2010); 0.1 per cent of boys and 0.2 per cent of girls aged 10–14 years were already married; and at the age of 15–19 years, 1.6 per cent of the boys and 11.7 per cent of the girls were also married. The age group disaggregated data show a decreasing proportion of married girls amongst younger age groups. The prevalence of child marriage seems to correlate with household economic background. The proportions of women from the poorest quintile who were married before the ages of 15 and 18 years were double the proportions in the richest quintile; and a larger proportion of child marriage was found in households with at least one child labourer and in single-parent households.

Indeed, children are not a homogeneous group. An exploration of non-material deprivation from the children's own perspectives gathered during qualitative case studies conducted in North Jakarta and East Sumba revealed that children's perceptions of what makes them feel deprived varies according to their age and their living conditions. Most of the poor children aged 7–18 years who participated in the discussion experienced non-material deprivation in the form of unfair treatment from their parents, peers, teachers and communities, as well as

poor services due to the limited or lack of public facilities. Poor children in the rural study area (East Sumba) experienced more material problems than poor children in the urban area (North Jakarta) due to inadequate basic facilities (education, health care, etc.) and their remote locations. Even so, some aspects of non-material deprivation are generated from other material deprivation, such as the lack of physical access to education and health facilities. Overall, in both East Sumba and North Jakarta, the most prominent non-material deprivations facing poor children were related to inadequate leisure time and vulnerability to potential violence from their parents, elder siblings, teachers or community members. The children's feelings of happiness and discontent also varied across seasons and events. The non-material components of well-being are more varied than the material components. Among the non-material components, affection from their parents and good relations with their extended family are quite dominant, followed by achievement in and outside of school, and recognition for this.

Health and nutrition

Indonesia has made some considerable achievements in improving the health status of children. The infant mortality rate (IMR) and under-five mortality rate (U5MR) in Indonesia have significantly declined and are on track to achieve the 2015 MDG targets. However, efforts to further reduce these rates are likely to be more challenging since the speed of the reduction has been decelerating: the IMR reduction slowed down from an annual average of 3.9 per cent during 1990–1999 to 0.5 per cent during 1999–2007; and the U5MR annual average reduction declined from 4.4 per cent during 1990–1999 to 2.8 per cent during 1999–2007. In addition, the reductions are not evenly shared across regions. Out of the 33 provinces in Indonesia, 26 provinces had IMR and U5MR higher than the national level. In addition, the rates were also higher among lower income groups and among rural children.

Improved child survival has been supported by improvements in immunization coverage. Yet still around 44 per cent of children did not have complete immunizations in 2007, and specifically 25.5 per cent of children aged 12–24 months did not receive measles immunization in 2010. Overall, rates of immunization against communicable diseases such as tuberculosis, diphtheria, polio and measles improved during 2003–2007. But worryingly, the 2012 RISKESDAS data showed a decline in the percentage of children immunized against measles from 81.6 per cent in 2007 to 74.5 per cent in 2010. The

Box E: Child survival and health

Trends:

- *IMR (1990–2007): declined from 71 to 34 (per 1,000 live births)*
- *U5MR (1990–2007): declined from 99 to 44 (per 1,000 live births)*
- *Infants <6 months not exclusively breastfed (2002/2003–2007): increased from 60.5% to 67.6%*
- *Children without complete immunization (2002/2003–2007): declined from 48.5% to 41.4%*
- *Children aged 12–24 months without measles immunization (2007–2010): increased from 18.4% to 25.5%*
- *Under-fives suffer from stunting (2007–2010): declined from 38.8% to 35.6%*
- *Under-fives suffer from wasting (2007–2010): declined from 13.6% to 13.3%*

Disparity across provinces:

- *IMR (2007): 74 (West Sulawesi) – 19 (Yogyakarta)*
- *U5MR (2007): 96 (West Sulawesi) – 24 (Yogyakarta)*
- *Measles immunization coverage (2010): 47.4% (Papua) – 96.4% (Yogyakarta)*

Gender disparity (2007):

- *Neonatal MR: 19 (girls) – 24 (boys)*
- *Post-neonatal MR: 16 (girls) – 19 (boys)*
- *U5MR: 46 (girls) – 59 (boys)*

Source: IDHS 2002/2003; RISKESDAS 2007 and 2010

rural/urban gap also persisted, with coverage of complete immunizations in urban areas being two percentage points higher in 2009, while the gap for measles immunization was around seven percentage points in 2007, increasing to nine percentage points in 2010. The coverage of complete immunization was slightly better for children from households headed by females than males. Additionally, the size of the household, the educational background of the household head, and the socio-economic status of the household were associated with the proportion of children receiving complete immunization, and measles immunization in particular.

Regarding the status of children's nutrition in Indonesia, despite progress at a national level, disparities between urban and rural areas and between households with different levels of wealth are still apparent. On all indicators – underweight, stunting and wasting – the proportion of deprived children was higher in rural areas when compared to urban areas. The incidence of these types of deprivation indeed was especially high among children under the age of five (under-fives) in the poorest households during 2007–2010. There is also a tendency for girls to be better off than boys for all three nutritional status indicators. No less important than the problems of malnourishment, Indonesia is also facing a problem of overweight children, which is also experienced by poor households. However, the prevalence of overweight children was higher in urban than in rural areas.

Other factors that might affect a child's health and survival include access to clean water and proper sanitation, breastfeeding practices, and general nutritional condition. Many children still suffer from a lack of access to clean water, sanitation and healthy shelters, making them vulnerable to hygiene-related diseases. The 2003 and 2009 SUSENAS data indicate an increasing prevalence of diarrhea, asthma, flu, cough and fever, as well as self-reported disruptions due to ill health among children. Diarrhea and asthma, as well as acute respiratory infections, are among the main causes of infant and under-five mortality and the prevalence of these diseases is higher among children of households that are male-headed, headed by someone with a low educational background, located in rural areas, large, and with low consumption levels. There was also evidence of a trend for exclusive breastfeeding becoming less common.

This evidence shows that while various policies and programmes have successfully improved child health and survival at the national level, special attention and assistance is still needed for children in income-poor households, and in rural and remote areas. Thus, more resources and collaborative efforts still need to be directed at the most deprived children. On the supply side, the government needs to not only increase the health budget – which was still less than 5 per cent of the national budget and less than 10 per cent of most regional budgets – but also to prioritize the budget allocation for increasing the availability of health services in remote areas and making them accessible at a lower cost to poor households. Regional disparities in terms of access to health services – both quantity and quality health facilities and personnel – need to be addressed. There is also a need to improve the housing conditions as well as access to proper sanitation and safe water for the poor. More effective and inclusive monitoring and evaluation of health and nutritional conditions of children are needed, in combination with appropriate and intensified intervention and response. In addition, to support the demand side, there needs to be an increase in awareness-raising activities about health and nutrition, particularly targeted at parents with low education levels, in order to reduce child mortality. Mainstreaming of male roles in caring for under-fives is also needed, especially during pregnancy and postpartum care of the mother.

Education

Indonesian girls and boys have enjoyed major improvements in rates of enrolment in schools at all levels - from early childhood education (ECE) to senior secondary school. Considerable progress has been achieved in terms of both school enrolment and gender equality among primary school aged children (7–12 years old) with minimal disparity among provinces except

Box F: Child deprivation in education (2009)

1.4% children aged 7–17 years never enrolled in school

32% children aged 16–17 years drop out of school

Trends in school enrolment rates (SER) (2003–2009):

- *Aged 3–6 years: increased from 23.7% to 32.25%*
- *Aged 7–12 years: increased from 96.07% to 97.05%*
- *Aged 13–15 years: increased from 79.26% to 86.49%*
- *Aged 16–17 years: increased from 59.59% to 67.21%*

Disparities in SER across provinces:

- *Aged 3–6 years: 33.1% (Papua); 66.7% (Yogyakarta)*
- *Aged 7–12 years: 78.5% (Papua); 99.1% (North Sulawesi)*
- *Aged 13–15 years: 77.2% (Gorontalo); 94.7% (East Kalimantan)*
- *Aged 16–17 years: 46% (Bangka Belitung); 79.1% (Yogyakarta)*

Among children aged 5–17 years:

- *25% had no access to textbooks*
- *60% had no access to science books*
- *85% had no access to story books*
- *95% had no access to newspapers and magazines*
- *92% had no access to art practice and art shows*

Source: Estimated from SUSENAS, 2003 and 2009

for Papua, which lags behind. At all levels of schooling, female enrolment rates were slightly higher than those for males. However, despite the rapid increase in school enrolment rates, those for children aged 3–6 years and 16–17 years are still too low; at 32 and 67 per cent, respectively. The rate of school dropout or discontinuation (DOD) starts to increase among children aged 12 years – the age of a primary school graduation – and steeply increases further among those aged 16–19 years old – during and after senior secondary school age. In 2009, it was estimated that one out of every three children aged 16–17 years dropped out of school. Financial difficulties were the main reason for failure to enroll in senior secondary school, as stated by more than 60 per cent of both male and female junior secondary school students in rural and urban areas. Additionally, a lack of awareness among parents about the importance of education is still a problem, especially with regard to education beyond junior secondary school, since completion of junior secondary school satisfies the GoI's compulsory nine years of basic education.

Improvement in school enrolment rates did not apply equally across all provinces and districts. The disparities were most pervasive at the senior secondary school level. The 20 worst performing districts in terms of their senior secondary school aged enrolment rates averaged only 35 per cent, while the 20 best performers reached 85 per cent. Children's deprivation in terms of education correlates to the characteristics of the household and urban/rural residency. The proportion of children aged 13–17 years from female-headed households who were not enrolled in junior and senior secondary school was 3–4 per cent higher than among those from male-headed households. Education deprivation increased with household size, but decreased with an increasing level of education of the household head. Rural households only outperformed urban households in terms of enrolment of children aged 3–6 years in ECE, but the school enrolment rates of rural children from other age groups were lower than in urban areas. The proportion of rural children not enrolled in primary school is still three times higher than urban children. Meanwhile the proportion of 13- to 17-year-olds not enrolled in school in rural areas was around double the proportion in urban areas. The persistent problem of unequal distribution of education facilities and teachers is likely to be one factor contributing to this urban/rural gap.

The achievements in education at the national level have been supported by strong government commitment to implement an 'education for all' policy and the constitutional demand to commit up to 20 per cent of the national budget to education. However, there is a need for the government to: expand the availability of ECE services; devote more attention to children living in the poorest households in Indonesia and those living in disadvantaged regions (especially Papua) to guarantee their participation in formal education at least at the primary level; help communities overcome the problem of distance by providing more 'one roof schools' (primary and junior secondary in one building), and by providing a dormitory or free school transport for students living in areas far from schools. The government also needs to increase secondary school enrolment rates by considering more progressive efforts to significantly reduce school fees, either by providing a subsidy like the 'BOS' programme (school operational funding) or by providing a massive scholarship programme. Overall, improving and standardizing the quality of schools and teaching is also very critical. This can be done by closely monitoring student performance (through national examinations) as well as improving the quality and distribution of teachers. Finally, the involvement of civil society, including non-government institutions and the community, is very important in all these efforts. Increasing parents' awareness of the importance of education, especially at the early childhood and secondary school levels, should be increased through a massive awareness-raising campaign.

Child protection

The GoI has increased its focus on child protection through a comprehensive multi-sectoral child protection system. The system comprises three interlocking components – a social welfare system, the justice system and prevention efforts – all functioning in a symbiotic manner. Furthermore, there is a growing recognition that protecting children from violation of their rights is not only beneficial to families and children, but also more cost-effective in the long run. Accordingly, Indonesia now uses a more holistic definition of child protection that expands the scope of child protection into all aspects of national development, including basic health and education. This has been realized by the incorporation of child protection issues in other related laws, including the 2009 Health Law, the 2003 National Education Law and the 2003 Labour Law, as well as by adopting a more integrated approach to child protection in the current National Medium-Term Development Plan; RPJMN 2010–2014.

The following passages only cover selected aspects of child protection, based on the availability of data, rather than level of importance. These issues include: birth registration and certificates, working children and child labour, violence against children, and children outside of parental care.

Birth registration

The GoI, through the Ministry of Home Affairs (MoHA), set a target to achieve universal birth registration by 2011. However, this has been impossible to achieve since only 48.8 per cent of under-fives had birth certificates in 2009, which was a slow increase from 40 per cent in 2000. There are also significant disparities in the possession of birth certificates across regions and by household wealth level. The low coverage of birth certificates is rooted in several problems, including: economic hardship, unofficial marital status, and a lack of parental knowledge about the importance of obtaining a birth certificate. Most low income households cannot afford the cost of a birth certificate, so the proportion of under-fives who have birth certificates in households in the poorest consumption quintile is less than half from the proportion in the richest quintile. The requirement to show the parents' marriage certificate before obtaining a birth certificate can be an obstacle for children born outside of marriage or within a marriage that was performed according to local custom but not officially certified. Parents are often not aware of the importance of a birth certificate until they attempt to enroll their child in school; having a birth certificate is one requirement for school registration, especially at state schools.

Distance to the government unit responsible for birth registration – the civil registration office – can also be an obstacle. To overcome this, the government at all levels should seek innovative ways to bring the service closer to the people. The midwives and traditional birth attendants, for example, could be assigned to assist the process of recording and registering births. In order to accommodate poor households who cannot afford the cost of birth registration, the central government should require local governments to implement free birth registration, but decentralization in Indonesia has posed new challenges for the universal birth registration target. If necessary, the central and local governments can also pay the transport costs for birth registration for families in remote areas. Laws and regulations that potentially discriminate against children born outside of an officially registered marriage should also be reviewed. The government also needs to raise public awareness about the importance of birth registration, especially in poor communities.

Working children and child labour

The latest data on the prevalence of working children and child labour in Indonesia revealed a modest number of working children in Indonesia. In 2009, about 7 per cent of children aged 5 to 17 years are working children and 43 per cent of those could be categorized as 'child labour'. Among the estimated 1.76 million child labourers, there were more boys than girls – with a ratio of 126 boys for every 100 girl child labourers. Of all working children, 21 per cent worked in hazardous situations, where they had to work for more than 40 hours per week. This figure is worrying since those children worked longer hours than most adults, indicating a high prevalence of the worst forms of child labour (WFCL). The average working hours among child labourers was also alarming, at around 35.1 hours per week. The available national data sets – SUSENAS and SAKERNAS – contain information regarding the economic activity of children aged 10 years and above. The data revealed a decreasing proportion of children who only work (and do not attend school) between 2004 and 2009. However, the proportion of children with multiple activities – performing a combination of economic work, household chores and schooling – was increasing. The proportion of working children tended to be higher amongst children from households with lower consumption levels, headed by males, headed by household heads with low education levels, households with larger numbers of members, and those located in rural areas. There is also variation across provinces, with Papua standing at the highest extreme with 16 per cent of children working, while all other provinces recorded rates of less than 8 per cent, and North Sulawesi recorded the lowest proportion of only 0.9 per cent.

The performance of the government in reducing the numbers of working children and eliminating the WFCL has been influenced by the implementation of various laws and regulations as well as efforts to implement the National Action Plan for the Elimination of the WFCL. However, enforcement of the legal framework to protect children from child labour remains inadequate and needs dedicated support from other elements of society. To further reduce child labour, the government should focus more attention on children with multiple activities. This phenomenon needs comprehensive or multi-pronged interventions focusing on efforts to keep children at school (prevent them from dropping out) while also providing households with assistance to increase a income generating capacity and reduce the 'push factors' which encourage children to engage in paid and unpaid work. In addition, it is essential to improve data collection, so that more specific data are made available, including data on hazardous work and items which accommodate the International Labour Organization's definition of child labour. It is also critical to increase the budget allocation for programmes designed to reduce child labour and child trafficking, including prevention and oversight measures, and also to increase coordination among government institutions, non-government organizations and community leaders, in order to prevent and also rescue children from hazardous work and human trafficking. Furthermore, the government needs to improve the welfare of poor households in

general, through social protection programmes and income generating activities, which will help to prevent children from becoming child labourers.

Violence against children and child trafficking

Reliable statistics on violence against children and child trafficking are still lacking. The SUSENAS data show that the number of children who were victims of criminal acts decreased from 2007 to 2009, while the number of children not suffering from any criminal acts increased from 97.2 per cent to 99.5 per cent. However, the same data set also revealed that only 14.9 per cent of cases were reported to the police in 2009. Data from the National Commission for Child Protection (Komisi Nasional Perlindungan Anak) have shown an increase in reported cases of violence against children from 1,736 cases in 2008 to 1,998 cases in 2009, and this is expected to increase significantly in 2010 as 1,649 cases had been reported during the first half of the year alone. These are staggering statistics as they represent only 'the tip of the iceberg', since most women and children do not report criminal acts committed against them due to deep feelings of shame, stigmatization, and a fear of negative consequences. Furthermore, the victims often lack information on how and where to report a crime. Data collection on violence in schools, either teacher-on-student or student-on-student, have been largely ignored. The reliance on data from reported cases only has limited the capacity for developing, monitoring and evaluating the various policies and programmes to reduce violence against children, which has mainly been approached under the guise of domestic violence reduction. Thus, conducting a consistent, periodical, national study on violence against children using reliable methodologies is much needed.

In regard to the handling of the victims of violence, the availability of facilities where supportive social and health care services are linked closely together is essential. Therefore, the government should not only increase the number of institutions handling violence against children at the provincial and district levels but also develop efficient links between the institutions that receive reports of violence and the institutions that are responsible for following up such reports. The government also needs to strengthen the monitoring system for all activities related to the prevention and handling of violence against children by its various ministries and agencies, in addition to monitoring their overall implementation.

Children outside parental care

According to data from the Ministry of Social Affairs (MoSA), during the period from 2006 to 2009, the numbers of neglected infants increased from 618,000 to 1,187,000 and the numbers of neglected children increased from 2.8 million to 3.2 million. Similarly, the numbers of children living or working on the street also increased from around 60,000-75,000 in 2004 to 230,000 in 2008 (UNICEF, 2011). The coverage of social assistance services provided through the Ministry of Social Affairs is very limited; in 2009 these covered only 0.1 per cent of the neglected infants, 4.7 per cent of the neglected children, and 15 per cent of children living or working on the street.

The GoI, through the Ministry of Social Affairs, has implemented a new paradigm focusing efforts on providing support to families to fulfill their children's basic rights. Referring to the Minister of Social Affairs Decree No. 15 A/HUK/2010, the Ministry of Social Affairs implemented the Social Welfare Programme for Children (PKSA) applying a new paradigm for child care policies, emphasizing the roles and responsibilities of the family and community. For families experiencing social problems that cause children to be deprived of their rights, support and social assistance in the form of conditional and unconditional cash transfers were provided to allow them to adequately care for their children. However, in cases where care within the child's family is not possible, removing children to a type of foster family household was the next alternative, before taking children to a childcare institution. Efforts to support provision of social services for disadvantaged children include childcare institutions for children's protection *(panti sosial perlindungan anak)*, Social

Development Centres (SDC), social protection homes for children *(rumah perlindungan sosial anak, RPSA)*, the Subsidy Programme for Social Care Institutions *(Program Subsidi Panti)*, and some social rehabilitation programmes.

In relation to the obligation of the state to provide child protection and assure the fulfillment of the rights of the child, improvement is needed in enhancing efforts to provide social services to children. This can be done by: maintaining and improving the capacity of the existing childcare facilities; improving the availability of comprehensive and accurate data on disadvantaged children and children outside parental care, which is a fundamental step for the formulation of well-targeted efforts to increase the number of neglected children being served and rehabilitated; improving capacity building activities, not only for social workers but also for children, so that they are prepared to re-enter society, and; improving and supporting the capacity of private and informal childcare institutions, as Indonesia has a large number of such institutions. While embarking on these improvements, it is important to begin by restoring the main function of childcare to families as the primary caretakers of children, with childcare institutions serving only as a last resort service. Finally, enhancing the personal and economic capacity of parents and other caregivers is also very important for neglected children who need financially stable and caring families.

Social protection

Child welfare has been increasingly integrated into the general discourse of social protection since the well-being of children is inseparable from the well-being of the household and a policy that provides social assistance to a parent is likely to benefits the children. Therefore, child-sensitive social protection has been advocated worldwide as the strategic approach to breaking the inter-generational poverty traps and advancing investment in human capital. Over the last decade, the Indonesian social protection programmes, in the form of targeted household income support from the government, have increased in scope, coverage and budget allocation. Of the three clusters of poverty reduction programmes, social assistance programmes have received the largest budget allocation. Most existing social assistance programmes are in the form of family or household-based income support which directly and indirectly addresses the needs of children as important family/household members.

Several household-level surveys have shown that most of the assistance received by households from the government was used to meet the needs of children, both directly and indirectly. However, some issues were raised about the use of the assistance by the household/family. A lack of knowledge and awareness among parents about the importance of investment in their children often caused mismanagement in the allocation of household income, including social assistance funds received by the household. In terms of programme coverage, there are still many poor households that fall outside the coverage of poverty reduction programmes due to not possessing an identity card and/or their remote location. Another crucial issue is that of targeted households failing to receive the government assistance they are entitled to, due to lack of access to information.

Although there have been successes, the effectiveness of Indonesia's poverty reduction programmes still faces challenges from persistent problems, especially implementation problems, including programme overlap, mis-targeting of households and under-coverage. Based on focused assessment of the situation, there is a need for the government to: reduce errors and increase the coverage of targeted poor households by improving the targeting of households at risk through improved data quality and adequate verification; more efficiently coordinate the administration and distribution of assistance by simplifying the bureaucracy along the distribution channels; give adequate attention to the more long-term social safety net programmes and income generating activities, through community and micro-enterprise empowerment, as a strategy to break intergenerational cycles of poverty; acknowledge and empower the traditional informal safety net systems in society, as most

of the poor households - especially those in the lowest income quintile - are still outside the coverage of the government's programmes because they live in makeshift houses on illegal land and do not possess an identity card, and; establish improved monitoring and evaluation mechanisms. Training and education in household management are also needed to build parental awareness and accountability with regard to the importance of investing in their children's future.

Addressing child poverty and disparities

This child poverty study has documented the considerable progress that Indonesia has been making in the many dimensions of children's well-being. However, the prevalence of various forms of deprivation suffered by children is still relatively high, including the proportion of children living below the IPL of $2 PPP per capita per day, enrolment in ECE, access to various sources of information (except television), proportion of babies being exclusively breastfed and under-fives having a birth certificate. Thus, greater effort is needed to focus on these dimensions. Indeed, the dimensions that are already progressing well must be maintained and should not be taken for granted, because poverty is a dynamic phenomenon and without sufficient protection any shock could potentially have adverse impacts on children.

Behind the national figures, however, lie the problems of inequality. There are serious disparities in the rate of progress and achievement for children across different levels of household wealth, across regions (provinces and districts), and between children in urban and rural areas. The gap between the best and the worst performing provinces are substantially larger than the urban/rural gap; and the gap between the districts with the lowest and the highest levels of deprivation are even larger. While generally the deprivation suffered by children in rural areas is more severe than in urban areas, the disparities among urban children should not be overlooked, because the conditions of the urban poor children are not so different from those of rural poor children.

The narrative evidence gathered during the qualitative case studies in North Jakarta and East Sumba also draws attention to the local social and cultural aspects as well as local government policies that also affect the progress and levels of well-being for local children. Although the central government should consider an equity policy to facilitate a more equitable distribution of intergovernmental transfers, the fact that location-specific problems also affect the multiple dimensions of child poverty poses a big challenge for regional governments – at the provincial and district levels – as they work to continuously improve coordination of service delivery under the decentralized system.

Among the government programmes that have made significant contributions to the well-being of children are the poverty reduction and social protection programmes, which are interconnected. These programmes have directly and indirectly benefited children by increasing the capacity of households and communities to secure and improve children's well-being. Some of the achievements in improving children's well-being can also be attributed to a decade of advocacy for the acknowledgement of children's rights, and to the various devoted efforts by both government and non-government actors in developing, implementing and overseeing various programmes related to the fulfillment of the Convention on the Rights of the Child. All of these efforts have provided the necessary foundation for fulfilling the rights of the child but they are not sufficient to ensure the implementation at the local and grass-roots levels. The rather limited involvement of regional governments, and the limited efforts devoted to addressing unsupportive local customs, may explain some of the persisting disparities.

Further reduction of child poverty and disparities in the current context of Indonesia will need intensive collaborative efforts from all government and non-government stakeholders as well as from all levels of government. In many respects, the democratic decentralized setting has provided both challenges and opportunities for the improvement of children's well-being, the reduction of poverty and deprivation, and the realization of the rights of the child. Therefore, regional (provincial and district) governments as

well as non-government actors at the regional level should be at the forefront of the efforts to reduce child poverty and disparities. In addition, further efforts to reduce child poverty and disparities should build on existing initiatives, including the development of legal frameworks for the fulfillment of children's rights, the adoption of holistic approaches to child protection, the expansion of poverty reduction frameworks, and the latest initiatives to unify data used for social protection targeting. Some general recommendations to further reduce child poverty and disparities in Indonesia include:

1. Continue strengthening the legal foundations at all levels of government for ensuring the fulfillment of children's rights without discrimination, and continue strengthening the monitoring of programme implementation.

2. Enhance the focus of poverty reduction programmes by mainstreaming children's issues into policy/programme development and implementation, both at the national and regional level, by increasing the profile of children in the planning, implementation, monitoring and evaluation of all poverty reduction programmes, and by ensuring that there will be no harmful impact on children but rather that the programmes will provide the maximum possible benefit to affected children.

3. Expand and improve social protection programmes to make them more child-sensitive. In addition to the second recommendation, a strategic approach is needed to increase the child-sensitivity of the existing social protection programmes. Some successful programmes that produce the maximum benefit for children should be expanded, taking care that the imposition of any conditions should not lead to systematic exclusion. Other social protection programmes, including those provided by regional governments, should be made more child-sensitive.

4. Focus on efforts to reduce regional disparities by devoting more effort and resources to strengthening awareness and capacity at the regional government level for optimal reduction of child poverty and disparities in their own regions, by adopting policies and programmes appropriate to the local context when possible. This can be done by: (i) paying more attention to the regions that are lagging furthest behind, and concentrating efforts to understand and overcome any specific local challenges to reducing the multidimensional poverty problem facing children in these regions; and (ii) adopting different approaches of targeting in different regions.

5. Increase the utilisation of the existing data and increase the availability and quality of data, particularly with regard to child protection and non-material deprivation.

This very first child poverty study conducted in Indonesia provides a new assessment of the quality and progress of development across the country, from the perspective of children's rights and well-being, with particular emphasis on the equality of benefits enjoyed by children, and the effectiveness of development in facilitating the fulfillment of children's rights without discrimination. However, this study has also stimulated important discourse on a range of issues that will require further research, including deeper analysis of the effectiveness of specific on policies and programmes (including budget analysis), analysis that looks more deeply into the disparities within regions, and also analysis of correlations between various dimensions of deprivation using data other than the SUSENAS data set.

CHAPTER 1

Children and Development

"Every child has the right to survive, grow up and develop,
as well as be protected against discrimination and violence."
—Indonesian Constitution 1945 (Article 28B, clause 2)[1]

1.1 Introduction

The Government of Indonesia (GoI) has provided a strong legal basis for the realization of the rights of all children, affirming that all children have the right to be part of and benefit from the country's development. Article 28B, clause 2 of the Indonesian Constitution (*Undang-Undang Dasar 1945*, UUD 1945) cited above asserts the rights of every child in Indonesia. In addition, as stated in Article 34, clause 1 of the Constitution, "poor and abandoned children shall be under the custody of the state". These statements show official endorsement of the view that no child in Indonesia is to be deprived or left behind. In addition to this, Indonesia is bound to international commitments related to children's rights and protection. In 1990, the GoI ratified the United Nations Convention on the Rights of the Child (CRC), which demanded that children's rights to survival, protection, development and participation be upheld.[2] Then, during the 27th United Nations General Assembly Special Session on Children in 2001, the GoI also signed on to a commitment for the declaration of 'A World Fit for Children'. This commitment relates to the four specific issues of: promoting healthy lives; providing quality education; protecting against abuse, exploitation and violence; and combating HIV/AIDS. Meanwhile, the GoI is also committed to meeting the Millennium Development Goals (MDGs), which include targets for eradicating extreme poverty and hunger, achieving universal primary education, promoting gender equality and empowering women, and reducing child mortality rates.

The welfare of its children has been at the focus of Indonesia's development, as reflected in the fact that child development has been one of the GoI's priorities in the last two national medium-term development plans. Improving child well-being and child protection were among the priorities in the 2004–2009 National Medium-Term Development Plan (*Rencana Pembangunan Jangka Menengah Nasional*, RPJMN). Subsequently, in the 2010–2014 RPJMN, the fulfillment of the rights of the child was identified

1 *"Setiap anak berhak atas kelangsungan hidup, tumbuh, dan berkembang serta berhak atas perlindungan dari kekerasan dan diskriminasi"*
2 Presidential Decree No. 36/1990

as one of the issues to be mainstreamed into several development priorities, including improvements in education and health, and poverty reduction. Concurrently, the past 10 years have been marked by the promulgation of various laws pertaining to children's rights, including laws on child protection (Law No. 23/2002), elimination of domestic violence (Law No. 23/2004), civic administration system (Law No. 23/2006), eradication of human trafficking (Law No. 21/2007) and social welfare (Law No. 11/2009).

These efforts have resulted in remarkable progress in several development outcomes related to children. The 2010 MDGs report (BAPPENAS, 2010) highlights some of these achievements, including those related to nutrition, education and health (Table 1.1). At the national level, the prevalence of underweight children below five years of age decreased from 18.4 per cent in 2007 to 17.9 per cent in 2010. A further reduction of approximately 2.4 per cent is required to achieve the MDGs target of 15.5 per cent by 2015. Meanwhile, an improvement in education outcomes can be observed from the increase in the net enrolment ratio at the primary school level, the increase in literacy rates among men and women aged 15–24 years, and the increase in the proportion of girls participating in all levels of school. With regard to health, there have been decreases in mortality rates among under-fives, infants and neonates, and an improvement in shelter conditions, including access to basic sanitation and improved water sources in rural areas. The 2010 MDGs report, however, also highlights major challenges, including how to achieve the targets for reducing the national poverty rate (8–10 per cent of the population living below the national poverty line by 2014), maternal mortality (102 per 100,000 live births by 2015), the prevalence of HIV/AIDS, and the level of greenhouse gas emissions.

Table 1.1: Progress on key MDG indicators related to child well-being

Pillars	Indicators	Baseline	Current achievement	MDG target 2015
Nutrition	Prevalence of underweight children under five years of age	31.00% (1989)	17.90% (2010)	15.50%
Health	Under-five mortality rate per 1,000 live births	97 (1991)	44 (2007)	32
	Infant mortality rate per 1,000 live births	68 (1991)	34 (2007)	23
	Neonatal mortality rate per 1,000 live births	32 (1991)	19 (2007)	decrease
	Proportion of one-year-old children immunized against measles	44.50% (1991)	74.50% (2007)	increase
	Prevalence rate of tuberculosis per 100,000 people	443 (1990)	244 (2009)	
	Proportion of households with sustainable access to an improved water source, urban	50.58% (1993)	49.82% (2009)	75.29%
	Proportion of households with sustainable access to an improved water source, rural	31.61% (1993)	45.72% (2009)	65.81%
	Proportion of households with sustainable access to basic sanitation, urban	53.64% (1993)	69.51% (2009)	76.82%
	Proportion of households with sustainable access to basic sanitation, rural	11.10% (1993)	33.96% (2009)	55.55%
Education	Net Enrolment Ratio (NER) in primary education	88.70% (1992)	95.23% (2009)	100.00%
	Literacy rate of women and men aged 15–24 years old	96.60% (1990)	99.47% (2009 – women) 99.40% (2009 – men)	100.00%
	Ratio of girls to boys in primary schools	100.27 (1993)	99.73 (2009)	100.00
	Ratio of girls to boys in junior high schools	99.86 (1993)	101.99 (2009)	100.00
	Ratio of girls to boys in senior high schools	93.67 (1993)	96.16 (2009)	100.00
	Ratio of girls to boys in higher education	74.06 (1993)	102.95 (2009)	100.00

Source: National Development Planning Agency (BAPPENAS),Republic of Indonesia, Jakarta, 2010, pp. 9–12.

Nevertheless, fulfilling the rights of all children without any discrimination in Indonesia – a large country that has adopted a system of decentralized government – remains challenging. Indonesia covers 3,544,744 square kilometres of ocean and 1,910,931.32 square kilometres of land, and comprises 17,504 islands. Administratively, Indonesia consists of 33 provinces (Table 1.2) and 483 autonomous districts and cities (*kabupaten* and *kota*). Unavoidably, regional variation in natural resources, infrastructure development and the socio-political landscape, compounded by poverty and disparities, hold back the rate progress towards realizing children's rights equally across regions, urban/rural locations, socio-economic status and community groups. While both children and poverty have always been the focus of Indonesia's development, there has been no analysis of the condition of children living in poverty in Indonesia. This report is intended as an initial step to fill this gap by presenting and discussing the findings of the Child Poverty and Disparity Study in Indonesia. This report consists of seven chapters. This first chapter, 'Children and Development', serves as an introduction to the whole report. An explanation of the background of the study is then followed by a description of the contextual background of the demographic, political, socio-economic and macroeconomic policy settings that potentially influence children's well-being in Indonesia. Chapter 2, 'Children and Poverty', presents the findings of an analysis of children's poverty and deprivation based on available national data sets in addition to qualitative case studies. This chapter portrays the conditions and trends in child poverty in terms of income, non-income and non-material deprivation. This chapter also contains an analysis of the incidence of multiple-deprivation and the correlations among the various forms of deprivation. The four following chapters – chapters 3 to 6 – present information on the four pillars of children's well-being, analysing the links between policies and outcomes relating to each of the four pillars, namely: 'Health and Nutrition' (Chapter 3), 'Education' (Chapter 4), 'Child Protection' (Chapter 5), and 'Social Protection' (Chapter 6). Finally, Chapter 7, 'Addressing Child Poverty and Disparities', presents proposed strategies for addressing inadequacies in existing policies and efforts to reduce child poverty and narrow the disparities.

Table 1.2: List of provinces in Indonesia

	Province	Area (thousand km^2)	Population (millions)*	Number of districts		Province	Area (thousand km^2)	Population (millions)*	Number of districts
1	Aceh	56.50	4.49	23	18	West Nusa Tenggara	19.71	4.50	10
2	North Sumatra	72.43	12.98	30	19	East Nusa Tenggara	46.14	4.68	20
3	West Sumatra	42.22	4.85	19	20	West Kalimantan	120.11	4.40	14
4	Riau	87.84	5.54	11	21	Central Kalimantan	153.56	2.21	14
5	Jambi	45.35	3.09	11	22	South Kalimantan	37.53	3.63	13
6	South Sumatra	60.30	7.45	15	23	East Kalimantan	194.85	3.55	14
7	Bengkulu	19.80	1.72	10	24	North Sulawesi	13.93	2.27	15
8	Lampung	37.74	7.61	11	25	Central Sulawesi	68.09	2.64	11
9	Bangka Belitung Islands	16.42	1.22	7	26	South Sulawesi	46.12	8.03	24
10	Riau Islands	8.08	1.68	7	27	Southeast Sulawesi	36.76	2.23	12
11	Jakarta	0.74	9.61	6	28	Gorontalo	12.17	1.04	6
12	West Java	36.93	43.05	26	29	West Sulawesi	16.79	1.16	5
13	Central Java	32.80	32.38	35	30	Maluku	47.35	1.53	11
14	Yogyakarta	3.13	3.46	5	31	North Maluku	39.96	1.04	8
15	East Java	46.69	37.48	38	32	West Papua	114.57	0.76	9
16	Banten	9.02	10.63	7	33	Papua	309.93	2.83	27
17	Bali	5.45	3.89	9					

Source: Badan Pusat Statistik (BPS) – Statistics Indonesia and Ministry of Home Affairs, 2011
*Note: * 2010 Population Census, preliminary figures*

1.2 Methods

This report is developed based on a study of child poverty and disparities in Indonesia that was conducted from July 2010 to June 2011. The study serves as a pioneering effort to provide a holistic assessment of children living in poverty in Indonesia. Addressing and focusing more attention on the poorest and most disadvantaged children will provide significant support to strengthen policy formulation aimed at fulfilling the rights of children, increasing children's well-being, and achieving more sustainable long-term poverty reduction.

The main objectives of the study were two-fold. The first was to present evidence-based analysis of the conditions of 'children living in poverty' using available quantitative and qualitative data, including narrative evidence from children and other stakeholders. The second was to identify the gaps and opportunities in national, and to a lesser extent regional, institutional settings and policies in order to more effectively support the fulfillment of the rights of children. By analysing outcomes and policies together, particularly the links between them, the aim of the study was to generate knowledge on what policies and programmes have most effectively supported the rights of all children, girls and boys, in different contexts. At the same time, by exploring different dimensions of poverty, the results contribute to the understanding of how progress in reducing one aspect of poverty could promote progress in others.
The term 'poverty' used in the study refers not only to the monetary dimension but also to a multidimensional condition of deprivation. According to UNICEF, as stated in *The State of the World's Children 2005*, the working definition of child poverty is as follows:

> "Children living in poverty experience deprivation of the material, spiritual and emotional resources needed to survive, develop and thrive, leaving them unable to enjoy their rights, achieve their full potential or participate as full and equal members of society." (UNICEF, 2005, p. 18)

Regarding the definition of 'child', the study follows Indonesian Law No. 23/2002 on Child Protection and the United Nations Convention on the Rights of the Child (CRC), which both state that a child is a person below the age of 18 years.

The focus of the study is at the national level, although disaggregated data from the provincial and district levels are presented where possible. Most of the analysis was conducted using the available national data sets, particularly the National Socio-Economic Survey (known in Indonesia by the acronym SUSENAS), in addition to the Indonesian Demographic and Health Surveys (IDHS, known in Indonesia by the acronym SDKI) and Basic Health Research (known in Indonesia as RISKESDAS). Additional data and information were also collected from the official statistics of relevant line ministries and non-government organizations (NGOs). These included government regulations, policies, programmes and budgets, as well as relevant studies and assessments. Furthermore, primary data were collected by way of small qualitative case studies carried out in two *kelurahan* (urban precincts) in the district of North Jakarta and two rural villages in the district of East Sumba. The case studies were merely intended to provide snapshots of the realities facing poor children and poor communities in urban and rural settings; they are not representative of conditions across the whole country. The approach and methods of the study followed the UNICEF *Global Study on Child Poverty and Disparities 2007–2008 Guide*, with some modification to adjust for data availability and the Indonesian context.[3] A detailed explanation of the approach and methods is presented in Appendix 1, and descriptions of the qualitative case study areas are presented in Appendix 2.

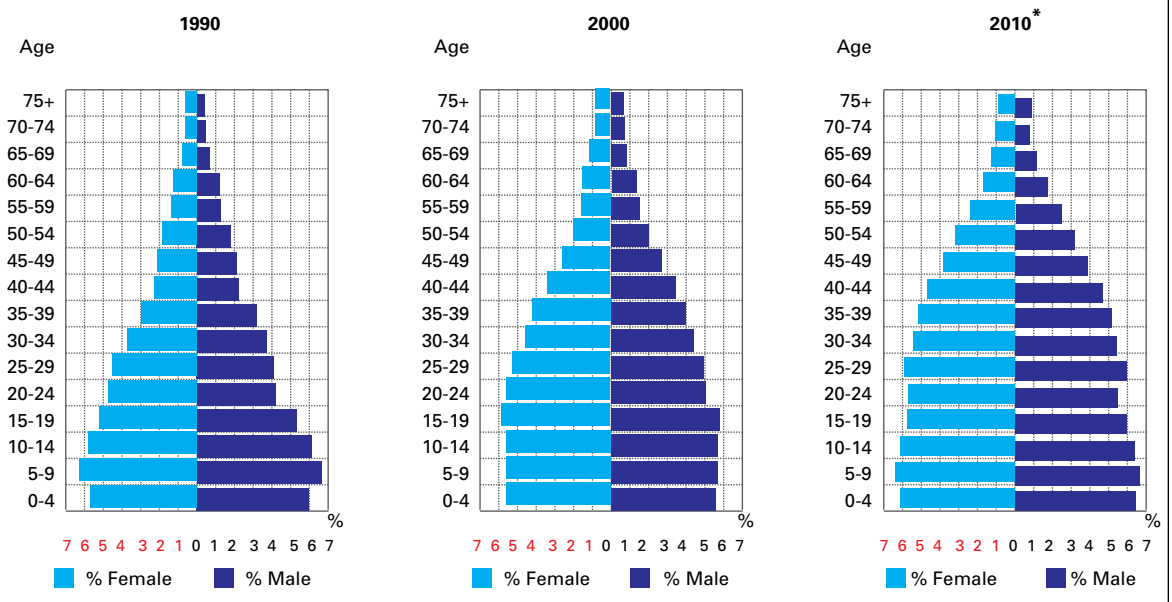
[3] United Nations Children's Fund, *Global Study on Child Poverty and Disparities 2007–2008 Guide*, Global Policy Section, UNICEF, New York, 2007 (available at: www.unicef.org/socialpolicy/files/UNICEFGlobalStudyGuide.pdf, last accessed 19 June 2012)

1.3 Children in Indonesia: Demographic context

Indonesia is a populous country characterized by a young age structure. According to the preliminary results of the 2010 population census, the population of Indonesia is approximately 237.6 million people. It is the fourth most populous country in the world, after China (1.33 billion), India (1.17 billion) and the United States (310 million). During the past decade, Indonesia's population increased by an average of 1.58 per cent annually; slightly more slowly than the annual average increase of 1.63 per cent during 1990–2000. The population pyramids for 1990, 2000 and 2010 (Figure 1.1) show that the Indonesian population remains predominantly young, although the proportion of youth has tended to decrease. The proportion of children (aged under 18 years) has continuously declined from 43 per cent in 1990 to 37 per cent in 2000, and to 34 per cent in 2010. Nevertheless, the absolute number of children has increased during the last decade: from 74 million in 2000 to around 81.3 million in 2010.[4] As reflected in Figures 1.1 and 1.2, the largest proportion of children is within the age group of 5–9 years, and the proportion of boys is always larger than girls under the age of 18 (Figure 1.3).

The regional distribution of population, including children, is very uneven and Java is still home to most of Indonesia's population, as shown by the data in Table 1.3. Although the proportions of the population living in Sumatra, Sulawesi, Kalimantan, Maluku and Papua have increased, by 2010 those living in Java still accounted for more than half of the total population. Moreover, Java remains the most crowded island, while Papua is the least crowded. On average, Indonesia's population density in 2010 was 124 people per square kilometre. Among the provinces, the densest population was recorded in Jakarta, which had 14,440 people per square kilometre. West Papua, meanwhile, had the least dense population with only eight people per

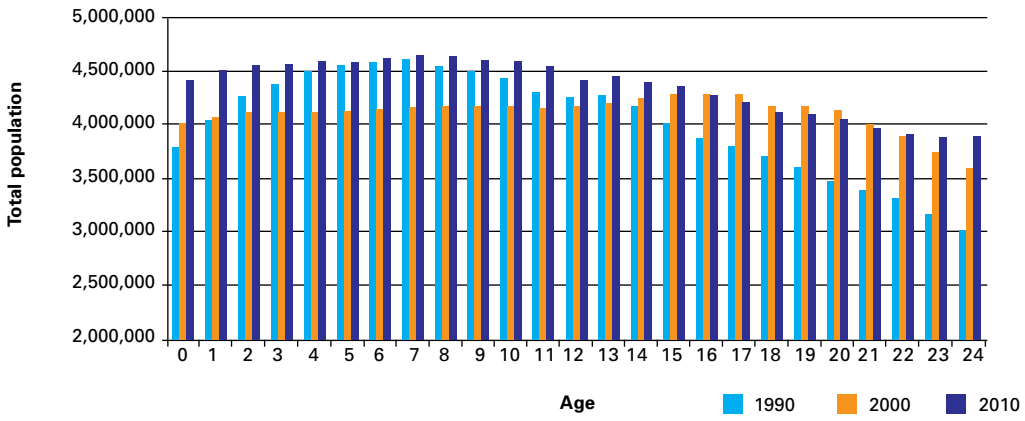
Figure 1.1: Age structure of the population by sex, 1990, 2000 and 2010



Source: BPS – Statistics Indonesia, various years
*Note: * Preliminary figures from the 2010 Population Census*

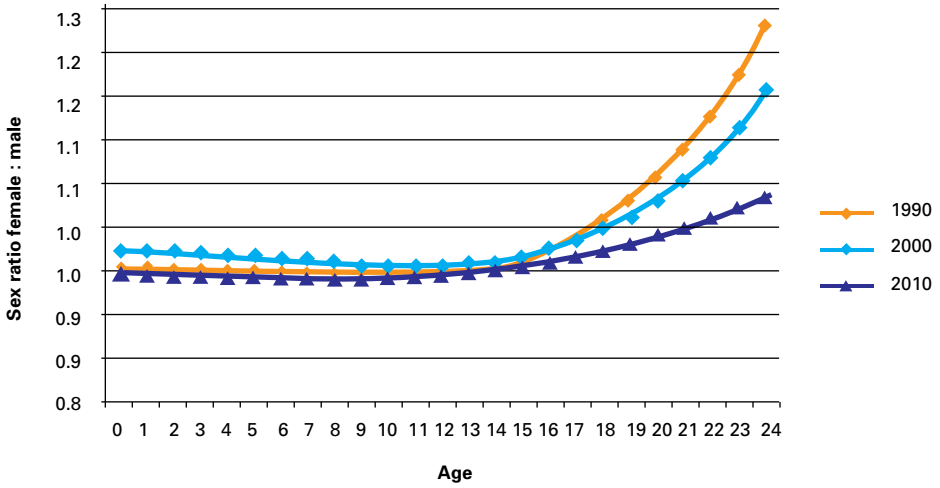
[4] According to estimation based on data from the 2009 SUSENAS (National Socio-Economic Survey), which will be used for most of the analysis in this study, the total number of children was 79.418 million (around 37 per cent of the total population). One possible reason for the difference between the two estimates is that SUSENAS does not cover children in special circumstances (institutional childcare, dormitories, non-permanent residences, etc.). See further explanation in Appendix 1.

Figure 1.2: Population estimates by single age, 1990, 2000 and 2010



Source: Estimates based on BPS – Statistics Indonesia data (Figure 1.1)

Figure 1.3: Sex ratio estimates by single age, 1990, 2000 and 2010



Source: Estimates based on BPS – Statistics Indonesia data (Figure 1.1)

square kilometre. More than half of Indonesia's children also live in Java, and the provinces with the largest numbers of children are West Java, East Java and Central Java. However, the provinces with the largest proportions of children in their populations are located in eastern Indonesia, including provinces in Maluku, Papua and Sulawesi, and especially the province of East Nusa Tenggara (Figure 1.4).

The regional distribution of population, including children, is very uneven and Java is still home to most of Indonesia's population, as shown by the data in Table 1.3. Although the proportions of the population living in Sumatra, Sulawesi, Kalimantan, Maluku and Papua have increased, by 2010 those living in Java still accounted for more than half of the total population. Moreover, Java remains the most crowded island, while Papua is the least crowded. On average,

Table 1.3: Distribution of population by major island, 1971–2010 (%)

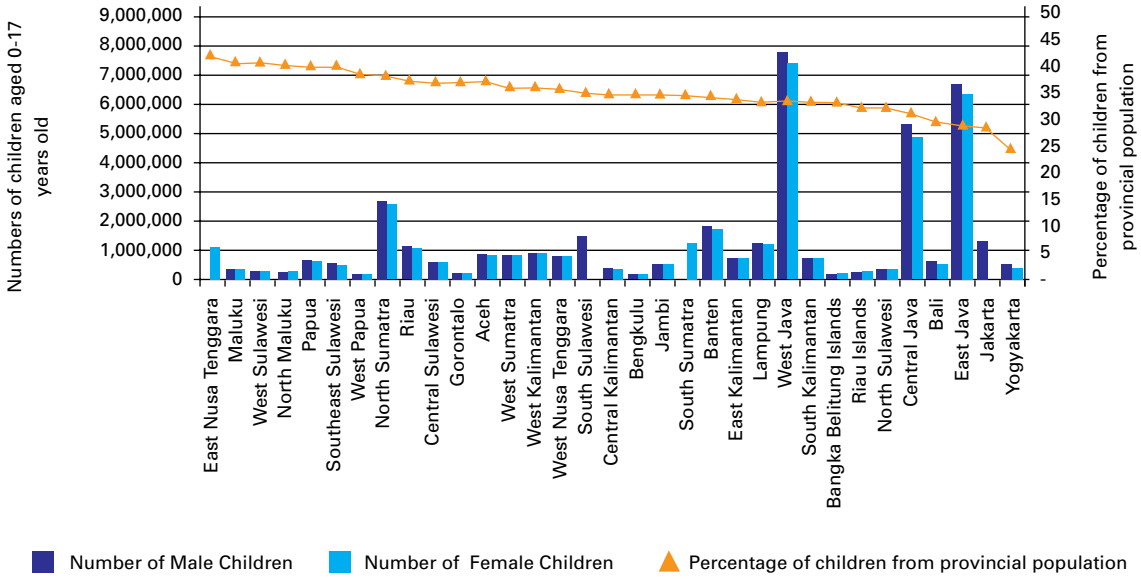
	1971	1980	1990	2000	2010
Sumatra	17.6	19.1	20.4	21.0	21.3
Java	63.9	62.1	60.2	58.9	57.5
Jakarta	3.9	4.4	4.6	4.1	4.0
West Java	18.2	18.7	19.8	17.4	18.1
Central Java	18.4	17.3	16.0	15.2	13.6
Yogyakarta	2.1	1.9	1.6	1.5	1.5
East Java	21.4	19.9	18.2	16.9	15.8
Banten				3.9	4.5
Bali and Nusa Tenggara	5.6	5.4	5.3	5.3	5.5
Kalimantan	4.3	4.6	5.1	5.5	5.8
Sulawesi	7.2	7.1	7.0	7.2	7.3
Maluku and Papua	1.4	1.8	2.0	2.0	2.6
TOTAL	100.0	100.0	100.0	100.0	100.0
Indonesia's Population (millions)	119.2	146.9	178.6	205.1	237.6

Source: BPS – Statistics Indonesia, 2010, p. 7–14

Indonesia's population density in 2010 was 124 people per square kilometre. Among the provinces, the densest population was recorded in Jakarta, which had 14,440 people per square kilometre. West Papua, meanwhile, had the least dense population with only eight people per square kilometre. More than half of Indonesia's children also live in Java, and the provinces with the largest numbers of children are West Java, East Java and Central Java. However, the provinces with the largest proportions of children in their populations are located in eastern Indonesia, including provinces in Maluku, Papua and Sulawesi, and especially the province of East Nusa Tenggara (Figure 1.4).

The proportion of children living in rural areas is higher than those living in urban areas, although the proportion of children in urban areas is increasing. Based on data from the 2009 SUSENAS, it is estimated that around 42.7 million children (54 per cent of the total number of children) lived in rural areas, which was slightly larger than the proportion of the rural population itself (52 per cent). The remaining 36.7 million children (46 per cent of the total number of children) lived in urban areas. Indeed, in line with recent urbanization trends, the proportion of children in urban areas has steadily increased. In 1993, it was estimated that only around 40 per cent of children lived in urban areas. In almost all provinces the numbers of

Figure 1.4: Numbers and proportions of population aged 0–17 years by province, 2010



Source: Preliminary figures from the 2010 Population Census
Note: The rank of provinces from left to right is based on descending proportion of population aged 0–17 years (age range is based on data availability)

children in rural areas are larger than in urban areas. In addition to Jakarta – where there are no rural areas – only the provinces of West Java, Banten and East Kalimantan have fewer children living in rural areas than in urban areas.

Around 72.44 per cent of households in Indonesia are households with children, and most of them care for more than one child (Table 1.4). The remaining 27.56 per cent (30.20 per cent in urban areas; 25.80 per cent in rural areas) of households do not include children. Most households have between one and three children, although some have up to seven or more. As in other parts of the world, urban households generally tend to have fewer children than rural households.

Table 1.4: Households by number of children, 2009 (%)

Number of children (<18 years) in household	Urban	Rural	Total
0	30.2	25.8	27.56
1	28.87	30.19	29.67
2	25.56	25.75	25.68
3	10.8	11.62	11.29
4	3.25	4.41	3.95
5	0.98	1.47	1.27
6	0.24	0.5	0.4
7 or more	0.08	0.23	0.18
Total	100	100	100

Source: Estimates from SUSENAS Panel, 2009 (sub-sample of SUSENAS, covers 67,174 households and 268,313 individuals)

Most children in households (83.91 per cent) are the children of the head of the household (Table 1.5). Meanwhile, 12.77 per cent are grandchildren and 2.69 per cent are other relatives of the head of the household. These figures indicate the presence of extended family structures. It is quite common in Indonesia for people who migrate to the cities to leave their children in the village in the custody of their grandparents or other relatives, due to the high cost of living in cities. On the other hand, children whose parents reside in remote areas often have to stay with relatives in or closer to urban areas, in order to be closer to schools. This is commonly referred to as *menumpang*. Interestingly, about 0.12 per cent of children (under 18 years) held the status

Table 1.5: Composition of Indonesian households by relationship to the head of household, 2009 (%)

No	Relationship to head of household	Age category (% of each age category)		Total
		Children (<18 years)	Adults (≥18 years)	
1	Head of household her/himself	0.08	38.61	25.04
2	Spouse	0.04	30.91	20.03
3	Child	83.91	19.39	42.13
4	Son/daughter-in-law	0.09	3.59	2.36
5	Grandchild	12.77	0.53	4.84
6	Parent/parent-in-law	0.00	3.07	1.99
7	Relatives	2.69	3.13	2.98
8	Domestic worker	0.20	0.41	0.33
9	Others	0.21	0.35	0.30
	Total	100.00	100.00	100.00

Source: Estimates from 2009 SUSENAS (Panel)

of household head or spouse, meaning that they were already married. Meanwhile, 0.20 per cent of children in households were working as domestic workers or helpers.

For Indonesian families in general, children are regarded as valuable resources that will bring good fortune. Although there is no nationwide survey to quantify the value Indonesian families place on children, ethnicity and religion play a role. The 2000 Population Census (BPS – *Statistics Indonesia*, 2001) revealed that 97.14 per cent of Indonesians identified themselves as followers of Abrahamic religions (Muslims 88.22 per cent; Christians 8.92 per cent), while the rest were followers of Asian religions (Hindus 1.81 per cent; Buddhists 0.84 per cent; other religions including Confucianism and indigenous religions 0.20 per cent). From the perspective of ethnicity, more than 50 per cent of Indonesians are Javanese or Sundanese, while those who identify as Malay, Maduranese, Batak, Minangkabau, Betawi, Buginese and Bantenese each account for less than 5 per cent of the population, are other ethnicities make up less than 2 per cent of the population (Suryadinata, Arifin and Ananta, 2003). Theoretically, all of these religions and ethnicities place a high value on children. For example, the Abrahamic religions perceive children as heritage from the Almighty (see for example Quran *Surah* 8:27–28; Psalm 127:3), and the ethnic majority of

Indonesians (the Javanese) view children as able to bring her/his own fortune (Albert et al., 2005).[5] Several GoI documents[6] refer to children as 'gifts from God' and their rights are consequently God given. Children are considered to be the future of the nation as well as the future of the family.

However, Indonesian families usually grant children little independence. Indonesian culture and society is very traditional, with strong and rigid family structures. Children are expected to be respectful and obedient. They have limited roles in family decision-making although they are expected to directly or indirectly contribute to the livelihood of the family (International Bureau for Children's Rights, 2006, p. 30). When constrained by low income or lack of socio-political power, it is possible that the potential value of children is not realized within households and communities, making children in these situations more vulnerable than adult household members and more vulnerable than their counterparts from more privileged backgrounds.

1.4 The political context: Democratization and decentralization in Indonesia

In the past decade, Indonesia has undergone a vibrant, but relatively peaceful, democratization and decentralization reform process that has influenced the country's policymaking and development processes, including those pertaining to children. Following the fall in 1998 of the stable but very centralized and autocratic New Order Government of 32 years, the 1945 Constitution that provides a basis for the rule of law and the political system in Indonesia was amended four times between 1999 and 2002. Three important features of the amended version of the 1945 Constitution are:

(1) Formation of the basic institutional structure of the new democratic decentralized government by adopting a more internally consistent presidential system, including: direct election of the president; election of all members of the national legislature, the People's Representative Council (*Dewan Perwakilan Rakyat*, DPR); establishment of an elected upper house to represent regional interests from across Indonesia, the Regional Representative Council (*Dewan Perwakilan Daerah*, DPD); and creation of a Constitutional Court (Eric, Liddle and King, 2008. p. i, 8–9).

(2) Inclusion of a key chapter containing the provision of the Universal Declaration on Human Rights and the two human rights covenants, including Article 28B, clause 2, on the rights of children. This provides a very clear and strong foundation for the promotion and protection of human rights, thus providing a basis for more elaborate and extensive provisions on human rights set down under Law No. 39/1999 concerning Human Rights as well as in a number of laws on specific human rights issues, including Law No. 23/2002 on Child Protection.

(3) Far-reaching devolution of most government functions to district/city *(kabupaten/kota)* governments, and special autonomy for the provinces of Aceh and Papua.

Generally, analysts agree that the political transition process in Indonesia has been quite successful in establishing the essential elements of democratic government. The country has successfully held relatively peaceful and fair national, provincial and district legislative elections in 1999, 2004 and 2009, including direct presidential elections in 2004 and 2009, and many direct elections for provincial governors and district executive heads since 2005. An assessment of democracy and governance conducted in 2010 concluded that of the five key elements of democracy – consensus, inclusion, competition, rule of law and good governance – Indonesia has been progressing well on the first three but lags behind in terms of the latter two (Eric, Liddle and King, 2008).

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5 For example, a well known saying in Indonesia is *"banyak anak, banyak rejeki"* (the more children you have, the more fortune you receive).

6 For example, the 'Foreword' of the Presidential Decree No. 87/2002 on the National Plan of Action for the Eradication of Commercial Sexual Exploitation of Children, by the Minister for Women's Empowerment.

The Indonesian democratic transition is also considered to be progressing in the right direction towards democratic consolidation, at which point a reversal to authoritarian rule would be impossible (Supriadi, 2009, p. 15–16). Indonesia has become the only country in Southeast Asia ranked as 'free' with regard to political rights and civil liberties by the 'Freedom in the World 2010' survey (Freedom House, 2010).[7] In addition, gender participation in local politics has been broadening.[8] National unity has been maintained, and the ethnic and religious violence that blemished the early days of the so-called 'Reformation' era (known as *Reformasi*) in Kalimantan, Central Sulawesi and Maluku has subsided. The trend towards conflict resolution in recent years is likely to continue, despite the persistence of low-intensity conflicts in Papua and the fragility of the peace that has been achieved in Aceh (Supriadi, 2009).

Alongside the democratization reforms, decentralization measures have fundamentally altered the relations and power structures in Indonesian government, and have largely placed issues pertaining to children and poverty in the hands of district government. The implementation of Law No. 22/1999 on Regional Governance and Law No. 25/1999 on Fiscal Balance between Central and Regional Government marked the beginning of Indonesia's era of decentralization or regional autonomy. In addition, in response to the threat of separatism based on perceived economic and political inequality, the provinces of Aceh and Papua were granted 'special autonomy', by way of Law No. 18/2001 for Aceh and Law No.21/2001 for Papua. These regions were granted special autonomy budget allocations (known as *Dana Otsus*)[9] and a substantially larger portion of revenue sharing. Four years after their initial implementation, the decentralization laws were amended in an effort to clarify the structure of governmental authority and functions, as well as to improve the local accountability system. Law No. 22/1999 was replaced by Law No. 32/2004,[10] and Law No. 25/1999 was replaced by Law No. 33/2004. The new laws reaffirm the main responsibilities of district government in terms of service delivery including: public works, health, education and culture, agriculture, transportation, industry and trade, social welfare, investment, environment, land management, cooperatives and small and medium enterprises, and labour force development. However, the existing regulations do not yet provide clear grounds for assigning specific functions to the district government, particularly because many central government service departments have continued implementing programmes that had already been devolved to the regions, such as health and education (Calavan et al., 2009; World Bank, 2007). Indeed the devolution of central government functions and the new system of intergovernmental transfer of funds from central to regional levels, together with the elimination of central government involvement in the election of district heads, caused the central government to lose a large part of its control over regional development.

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7 The 'Freedom in the World 2010' survey contains reports on 194 countries and 14 related and disputed territories. The political rights and civil liberties categories contain numerical ratings between 1 and 7 for each country or territory, with 1 representing the most 'free' and 7 the least 'free'. The status designation of 'free', 'partly free', or 'not free', which is determined by the combination of the political rights and civil liberties ratings, indicates the general state of freedom in a country or territory. In 2010, Indonesia was granted a score of 2 in political rights and 3 in civil liberties, and thus received an overall freedom rating of 2.5 and was assigned the status of 'free' (country report available at http://www.freedomhouse.org/report/freedom-world/2010/indonesia, last accessed 19 June 2012).

8 During 2005–2006, women contested positions as the executive or deputy in 53 provinces, cities and regencies spread across the country. One woman was elected as governor in Banten, and another as deputy governor in Central Java. In six districts women were elected as district heads *(bupati)*, and in 11 other districts, women were elected as deputy heads (Calavan et al., 2009).

9 The central government general allocation fund (DAU, *dana alokasi umum*) is a block grant to local governments forming the basis for payments for civil servants and the general provision of services. The special autonomy budget allocation for Papua is 2 per cent of the total DAU pool and Aceh has also received the same amount beginning in 2008.

10 Similar to Law No. 22/1999, Law No. 32/2004 (as clarified further under Government Regulation No. 38/2007) assigns district government the authority to cover all sectors except foreign policy, defense, security, monetary and fiscal policy, religion and 'others'. However, the new law further elaborates the term 'others' to include national development planning, fiscal distribution, state administration, national economic institutions, human resources, natural resource exploration, strategic technology, conservation and national standardization. Law No. 32/2004 also introduced direct elections of provincial governors and district heads (which were implemented for the first time in 2005) and reinstated provincial oversight functions with regard to district annual budget proposals through a review mechanism to investigate whether the proposed budgets are in accordance with the public interest and not in conflict with higher level regulations.

Although the newly democratized and decentralized Indonesia formally acknowledges children's rights, the implementation of relevant policies and programmes faces the challenge of a more complex process involving not only the central government's executive institutions but also the increasingly important new players, such as political parties, civil society (media, NGOs and the general public) and the sub-national governments, particularly the district governments. On one hand, the involvement of more stakeholders in public policymaking opens up a window of opportunity for rights-based advocacy and a better system of 'checks and balances' that will support a more equitable and inclusive type of development. On the other hand, most of the new players in the political decision-making process still suffer from limited capacity. The following passages highlight the challenges facing the political parties, elements of civil society, and the district governments in Indonesia.

The number of political parties in Indonesia has been increasing and they have become increasingly important players in the shaping of public policy. More than 48 political parties – a sharp increase from only three parties formerly legalized during the New Order Government – participated in the first democratic election in 1999, during the *Reformasi* era. In 2004, 24 political parties participated in the general election and this number increased to 34 in the 2009 elections. However, the fact that only four parties obtained more than 10 per cent of the vote during the 1999 general election, and only three parties achieved this during the 2004 and 2009 elections, reflects the fact that real political power is still in the hands of a few political elites. Political parties are often criticized for lacking internal democracy and accountability, and for being plagued by widespread corruption (Eric, Liddle and King, 2008), and also for remaining very centralist, and having a tendency to operate according to the political elite's own narrow interests. To overcome this problem, in the 2009 election an open list system based on the popular vote was introduced for the first time.[11] This alteration compounded by the lessons learnt from the direct election of the president, provincial governors and district chief executives, has potentially caused party leaders and legislative members to be more responsive to the demands of their constituents and civil society groups in particular. Thus, while internal party factors still determine stances on some issues, ongoing developments are providing for a more participatory and responsive political process.

In addition, civil society groups, including the media, universities and organizations such as NGOs, unions, charitable foundations and religious and cultural groups, have become more important players in development, providing checks and balances to the government and working alongside it to bring about change. They have also created a link between political parties and the masses (Forum for Democratic Reform, 2000, pp. 7–8).[12] Freedom House's 'Freedom of the Press in 2010' survey ranked the Indonesian media as 'partly free'.[13] Currently, the Indonesian public has access to a wide variety of information delivered via numerous types of communication media, including radio, television, newspapers and magazines. In addition, it is estimated that in 2009 around 30 million people (8.7 per cent of the population) had access to the Internet without substantial government restrictions; although use of the Internet as a news source outside of major cities is restricted by the lack of high-speed Internet infrastructure (Freedom House, 2010). On the supply side, however, the media has been

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11 The 'open list with popular vote' system was introduced following revision of the Electoral Law No. 10/2008, Article 214. It was done to make the process of seat allocation fairer. The open list system provides the voter with a choice in that it contains the names of candidates as well as parties, making it compulsory for the voter to choose either a candidate or a political party or a combination of both, failing which the vote will be regarded as invalid (Supriadi, 2009, p. 8).

12 For example, it was an NGO coalition collaborating with the media that, during an early phase of the transition period, mobilized public support for a constitutional amendment for the direct election of the president, and was successful in asserting this idea even though it was against the interests of the major ruling political parties (Eric, Liddle and King, 2008).

13 The 'Freedom of the Press 2010' survey covers 196 countries and territories. Based on 23 questions that assess the degree a country permits the free flow of news and information, countries are given a total score from 0 (best) to 100 (worst). Each country is then classified as 'free' if it has a score of 0–30, 'partly free' if the score is 31–60, and 'not free' if the score is 61–100. In 2010, Indonesia had a total score of 52 (legal environment – 18; political environment – 19; economic environment – 15). Available at http://www.freedomhouse.org/template.cfm?page=251&year=2010&country=7841 (last accessed 8 June 2012)

criticized for provoking controversy more than it provides political education to the public (Eric, Liddle and King, 2008), and has been accused of being under the control of large corporations and powerful individuals, and of only providing a limited contribution to improving democracy and governance at the local level beyond Java (Freedom House, 2010). Similarly, in terms of sheer numbers and levels of activity, NGOs are weaker in rural than in urban areas and are weaker in the outer islands of Indonesia when compared to Java. Since most NGOs are founded with the support of donor interest and funding, they have not been able to build a broad base of support to reduce dependency on foreign donors, and therefore their ability to develop their own agendas or long-term strategies and to maintain sustainability is somewhat limited (Freedom House, 2010).

The direct participation of members of the public is increasing, but certain groups in the community are often still excluded due to administrative difficulties or cultural barriers. The amendment of the 1945 Constitution that took place in August 2000 asserted that no segment of the Indonesian population is excluded from participating in government, the political process or public life.[14] The large number of television stations, newspapers and other communication media, as well as the expansion of Internet availability, provides great opportunities for civil society organizations and the community in general to take part in public discourse. The national legislature, despite shortcomings, also operates largely in the open and increasingly seeks public input through commission hearings and other means (Eric, Liddle and King, 2008, p. 4). In addition, community participation is encouraged through the massive expansion of a variety of community driven development programmes. Indeed, during the 2009 general election, for example, some people who did not have identification cards were unable to register as voters, and voter registration efforts were also inadequate when it came to accessing remote areas, all of which led to a strong call to improve voter registration systems (Supriadi, 2009). The inclusion of the poor in the decision-making process and in public discourse – even at a local level – is also very limited due to complex circumstances, including persistent cultural barriers to participation in public meetings, a lack of access to modern information technology, and citizenship/residency issues; many of the poor are not officially registered as residents because they live in illegal settlements.

After a decade of decentralization reforms, district governments have taken up new roles and responsibilities, but vertical coordination of the central–provincial–district levels of government in Indonesia remains problematic. Despite hasty implementation in 2001,[15] the decentralization transition went quite smoothly and caused no significant disruption to public service delivery. Within several years, some regions had progressed with innovations in service delivery while others had initiated major civil service reforms. Overall, more than 40 per cent of Indonesians perceived that public services had improved after decentralization (World Bank, 2003). Part of this progress was supported by a more lively civil society that emerged at the local level, including the press that critically monitored events in local politics (World Bank, 2003). Although still limited in number, more and more district and provincial governments have been continuously progressing with innovations or reforms in public service delivery. The direct election of regional heads has triggered more populist policies, such as the provision of local government funded health insurance for the poor (*Jaminan Kesehatan Daerah*, Jamkesda[16] and education subsidies. In addition to the

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[14] Article 28H, clause 2 states, "every person shall have the right to receive facilitation and special treatment and to have the same opportunity and benefit in order to achieve equality and fairness"; and Article 28I, clause 2 says, "every person shall have the right to be free from discriminative treatment based upon any grounds whatsoever and shall have the right to protection from such discriminative treatment". In addition to the Human Rights Law No. 39/1999, public participation has been mainstreamed in various technical regulations. For example, public participation in the development planning process at all levels of government is outlined in Government Regulation No. 40/2006 on national development planning procedures.

[15] By March 2001 a total of 239 provincial offices (Kanwil), 3,933 district level offices (Kandep) and 16,180 implementing units (UPT) of the central government, as well as around 1.5 million civil servants, were administratively transferred to the regions. In 2001, the central government transferred more than 25 per cent of the national budget to the regions with this accounting for more than 5 per cent of GDP (Suharyo, 2002).

[16] It is estimated that around 200 district governments have provided Jamkesda, according to an informal source in the Ministry of Health, 2010.

opportunity for local citizens to vote in local elections, an increasing number of district governments have established direct contact with the people through councils or commission meetings as well as through the media. These actions provide an increase in the opportunities for ordinary citizens to critique local service delivery and to influence – sometimes through intermediary civil society groups – local policies, thus bringing more autonomy to the people (Calavan et al., 2009). Nevertheless, difficulties in coordination across levels of government remain a major development concern. Central government line ministries and provincial government units still complain about difficulties in obtaining data and information from district government working units as well as securing meetings with district heads. It is also still very difficult for the central government to ensure that national policies are being properly implemented at the local level.

Meanwhile, the fiscal power of district governments has been increased. Law No. 22/1999set the 'general allocation fund' (DAU, *dana alokasi umum*) for district governments to at least 25 per cent of the net domestic revenue, and Law No. 35/2004 increased it to 26 per cent. In the first year of decentralization in 2001, financial transfers to the regions more than doubled from their initial value – from IDR 33.9 trillion (million million) in 2000 to IDR 82.4 trillion in 2001. This accounted for 15 and 23 per cent of total central government expenditure, respectively. These transfers have continuously increased and, as depicted in Figure 1.5, have reached more than IDR 300 trillion in 2010 (around 30 per cent of total central government expenditure). The largest proportion of the funds is the DAU (more than 50 per cent) followed by revenue sharing. The amount of revenue sharing fluctuates depending on, amongst other factors, the price of oil and gas. Meanwhile, in 2010 the 'special autonomy fund' and the 'adjustment fund' accounted for around 3 and 4 per cent, respectively. Until 2007, only Papua received a special autonomy fund; but since 2008, Aceh has also received this fund.[17] The adjustment fund was initiated in 2001 as a 'hold harmless' mechanism; so as to prevent a district from receiving a DAU of less than the previous year. However, this has been expanded to cover ad hoc measures such as providing for the 'thirteenth month' salary[18] of civil servants and extra funds to assist new districts. The 'specific allocation fund' only accounts for a very small fraction of the central government transfers to the regions – less than 10 per cent – thus the largest part of the transfer was not earmarked, which means that the regional governments had full authority to determine their own budget allocations. The largest portion of the specific allocation funds were for infrastructure, education and health (Figure 1.6).

Despite the increase of central government transfers to the regions, the fiscal decentralization still faced the challenges of lack of local government capacity to generate its own revenue and to manage its finances. Regional governments, particularly at the district level, have very limited taxing power (Calavan et al., 2009).[19] Due to the base for their own resource revenues being low, the transfers to local governments had been covering more than 80 per cent of district revenues; and the DAU could become increasingly dominant in the future due to reduced oil and gas production (World Bank, 2007). In addition, even if transfers to the regions have increased over time, many regional governments have difficulty spending the available resources. The unspent reserves have been rising rapidly and reached a record 3.1 per cent of gross domestic product (GDP) by November 2006 (World Bank, 2007). More than half of the DAU was being used to pay the civil service wage bill of provinces and districts (Calavan, 2009; World Bank, 2007). The core

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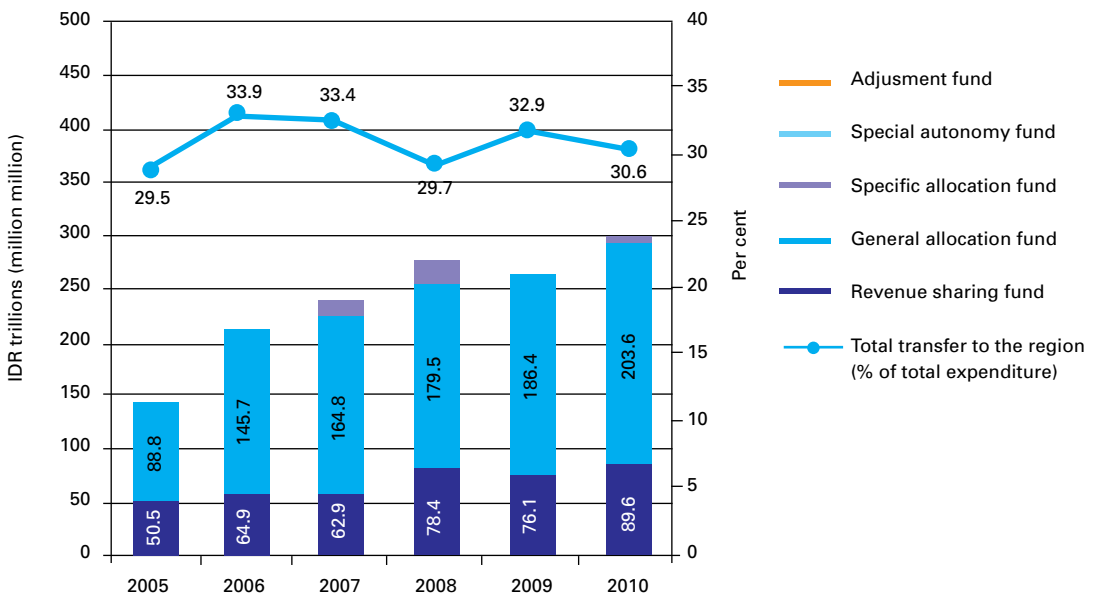
17 Since 2008, Aceh received a 'special autonomy fund' equal to 2 per cent of the DAU allocation. This will remain in effect for 15 years, and from year 16 to year 20 the allocation will be reduced to 1 per cent of national DAU allocation (Law No. 11/2006).

18 The 'thirteenth month' salary refers to a bonus provided by the government to all civil servants at an amount of one month's salary and usually disbursed in the month of June or July, close to the start of the academic year.

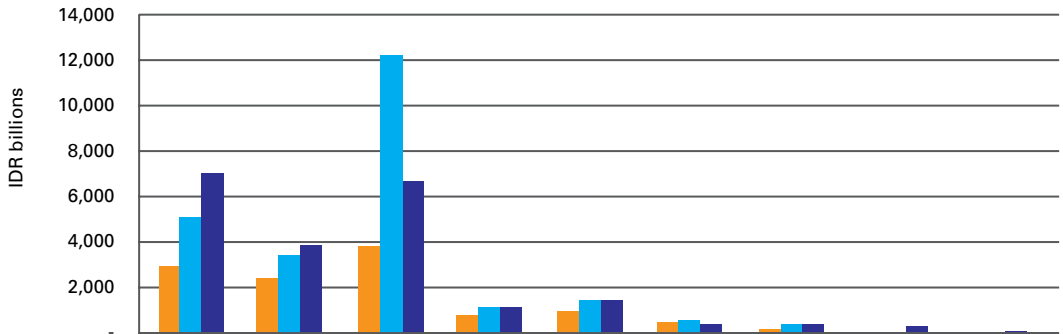
19 Sub-national governments' own-source revenues include local taxes, user charges and fees. Despite a trend towards increase, in 2005 total sub-national own-source revenue remained low at only 8.5 per cent of the total (national, provincial and district) revenue. Efforts to increase sub-national revenues are facing the problem of inefficient local tax administration and the tendency to enact economically harmful user charges and fees.

Figure 1.5: Central government transfers to the regions, 2005–2010



Source: Ministry of Finance, Republic of Indonesia

Figure 1.6: Specific allocation funds by sector, 2006–2008



	Education	Health	Infrastructure	Marine & Fisheries	Agriculture	Goverment & Infrastructure	Environment	Population	Forestry
2006	2,920	2,407	3,811	776	1,095	439	113		
2007	5,195	3,381	12,211	1,100	1,492	539	352		
2008	7,015	3,817	6,684	1,100	1,492	362	352	279	100

Source: Ministry of Finance, Republic of Indonesia

government administration absorbed around 32 per cent of all sub-national expenditures, and this represented the largest spending item of sub-national governments. The large proportion of administrative spending has crowded out spending in other key sectors, particularly health, agriculture and infrastructure (World Bank, 2007). To make matters even worse, the financial management of the spending has been tarnished by the proliferation of corruption cases involving regional legislative councils and executives.[20] Additionally, the formation of new administrative regions and their local governments[21] has become a critical issue. In addition to increasing the administrative budget (salaries and operational) at the expense of the development budget, most of the newly formed districts had inadequate human resources and infrastructure and higher levels of poverty than the districts they separated from. Therefore these districts have struggled and are still performing at a relatively lower level than the more established districts. This is partly due to the poorer initial socio-economic conditions, the lack of civil servants with sufficient qualifications and experience to perform public services, and the lack of capacity to manage the available financial resources (BAPPENAS and UNDP, 2008). In many parts of Indonesia, these weaknesses have impeded the benefits in terms of welfare for the people that were expected to ensue from fiscal and political decentralization.

In summary, despite substantial progress, the dividends of democracy and decentralization reform enjoyed by the general public have been corrupted by minimal progress in the areas of rule of law and good governance. Indonesia is still facing serious challenges in regards to the justice sector that includes the judiciary, prosecutors, police and lawyers (Eric, Liddle and King, 2008). Corruption within the legal system is endemic, and this translates to the general poor performance in law enforcement.[22] Pressure from civil society has created momentum for improvements in law enforcement. Correspondingly, though improvements have been made, effective governance at national and local levels often remains elusive in Indonesia; there are weaknesses in the performance and responsiveness at all levels of government. Governments at national and local levels often fail to provide the services they are supposed to, especially services to the poor and services targeted at poverty reduction, despite the substantial weight of programmes being dedicated to this purpose.

1.5 Economic growth, poverty and inequality

Children are among the most vulnerable groups in society as they depend on their families, their communities, and the state in general. Their welfare is highly affected by their environment and the level of care received from their nuclear and extended families as well as the communities where they live. A country's economic upturn can benefit children, while an economic downturn will inevitably put children at risk. The revenue windfall during the oil boom era of the New Order Government, for example, allowed the government to allocate substantial resources to education, including the Presidential Instruction Programme (Program Inpres) to build primary schools in every village throughout Indonesia (described in Chapter 4). This programme increased primary school enrolment rates and provided the necessary foundation for universal coverage of primary education. While economic downturns put many children at risk of withdrawal or non-enrolment in school, these conditions also often equate to children not receiving sufficient amounts of nutritious food and a lack of adequate health care during periods of illness. Family economic distress

[20] In the early decentralization phase, corruption cases involving newly empowered regional legislative councils were reported in West Sumatra, Southeast Sulawesi, West Kalimantan and Lampung. In 2006, there were 265 corruption cases involving local legislative bodies with almost 1,000 suspects handled by prosecuting offices across Indonesia. In the same year, the same offices had 46 corruption cases implicating 61 provincial governors or district heads (Rinaldi et al., 2007).

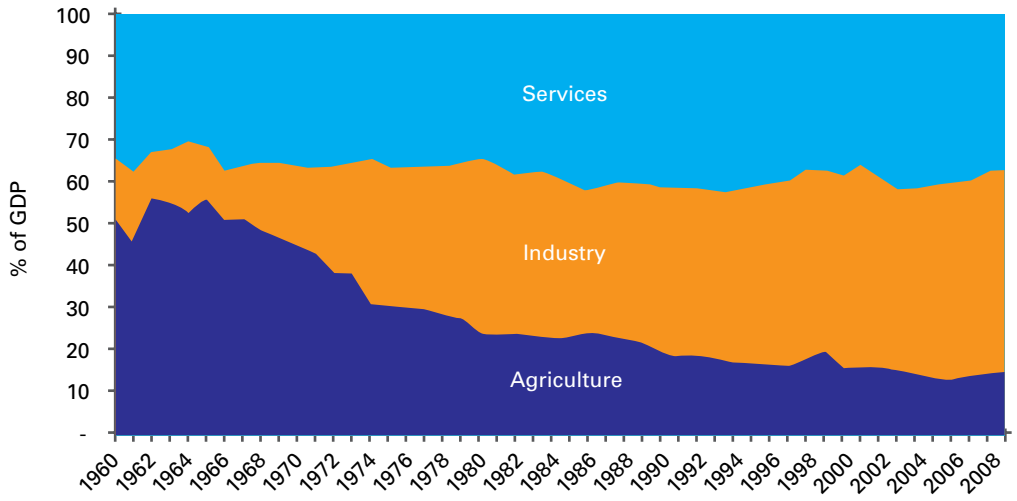
[21] The number of new administrative regions rose rapidly from only 341 districts and 26 provinces in 1999, to 497 districts and 33 provinces in 2009.

[22] In 2010, Indonesia was ranked 110 out of 178 on the Corruption Perception Index (CPI), with a score of 2.8 (0=highly corrupt; 10=low level of corruption) (Transparency International, 2010). The CPI score had slowly but steadily improved from 2.3 in 2007 to 2.6 in 2008, but has leveled out at 2.8 since 2009.

also often leads to children being neglected by their parents, forced to enter harmful jobs, or becoming victims of trafficking and violence.

The Indonesian economy has grown significantly during the past decade and is now categorized as a lower-middle income country with an economy that is now dominated by the manufacturing sector. The country's per capita gross national income (GNI)[23] increased from US$580 in 2000 to US$1,170 in 2005, and is estimated to further increase to US$2,963 in 2010 (Bank Indonesia, 2010). With a GDP valued at around US$695.059 billion in 2010, Indonesia was ranked as the fifth largest economy in Asia – after Japan, China, India and Korea. This economic growth was accompanied by industrialization, with the manufacturing sector accounting for an increasing share of the Indonesian economy. During its early independence, Indonesia was predominantly an agriculture-based country, with the agriculture sector contributing around 51.5 per cent of the GDP in 1960, compared to a relatively small 15 per cent contribution from the manufacturing sector. Since 1966, when the New Order Government came to power, the share of the GDP originating from agricultural sector has declined over time. Although agriculture was still the top development priority and the sector recorded considerable growth that led to the success of the 'green revolution' and food self-sufficiency, yet the manufacturing sector grew even faster and outpaced the agriculture and service sectors during the period up until the mid-1980s. Then, the sharp fall in the oil price in 1982 forced the government to rein in the national budget and shift its priorities towards manufacturing sectors and away from agricultural development. Since 1987 this has caused the contribution to the GDP from the agricultural sector to decline even further (Booth, 2000). Meanwhile, during the 10 years before the 1997–1998 Asian financial crisis, the service sector expanded significantly and contributed on average to around 40 per cent of the GDP (Figure 1.7). The Indonesian economy is now dominated by manufacturing, which in 2009 contributed 47.6 per cent of the GDP, followed by services (37.1 per cent), and agriculture (15.3 per cent).

Figure 1.7: Composition of Indonesia's gross domestic product (GDP) by sector of origin, 1960–2009



Source: BPS - Statistics Indonesia, various years

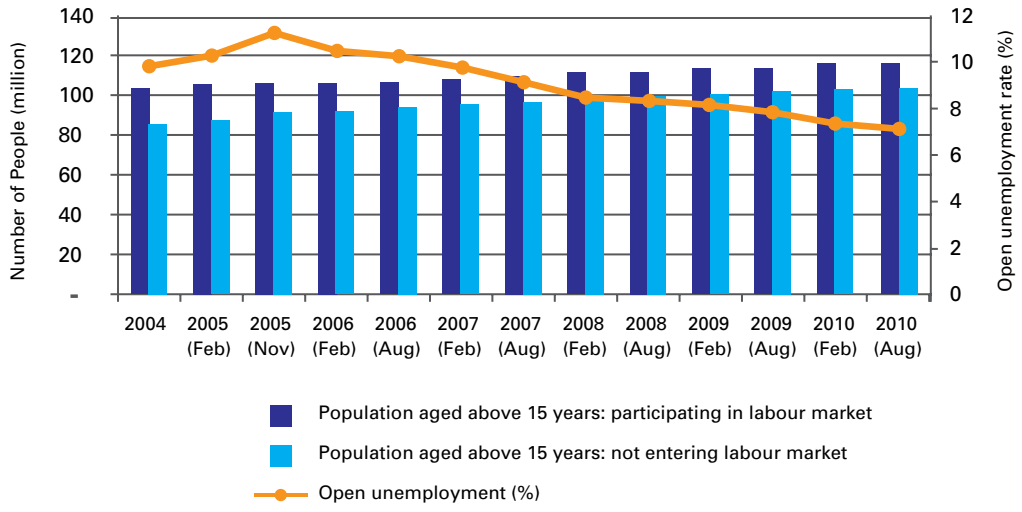
[23] Formerly known as per capita gross national product (GNP)

Despite the rapid economic growth and industrialization process, providing sufficient employment opportunities remains a constant challenge. The number of people aged over 15 years, who were legally able to work, increased by an average of around 2 per cent annually from 153.9 million in 2004 to 172.1 million in 2010. Of these, around two thirds participated in the labour market. In general, Indonesia has been quite successful in controlling unemployment. As depicted in Figure 1.8, after reaching the highest unemployment level of 11.24 per cent in November 2005 – due to the spike in oil prices that resulted in the removal of the government subsidy for fuel prices – the unemployment rate declined steadily down to 7.14 per cent in August 2010. A closer look at the composition of the employed, however, presents a worrying picture. Despite the declining contribution of the agricultural sector to GDP, many people continue to work in this sector. In 2010, around 38.3 per cent of the workforce was employed in the agricultural sector, while manufacturing industries only absorbed 12.8 per cent of the workforce, and the rest worked in the service sector. In addition, almost 70 per cent of these people were working in the informal sector. In 2010, only 30 per cent of the workforce were permanent employees and 3 per cent ran their own businesses with the assistance of permanent workers, while 39 per cent were self-employed or ran their own business with the help of non-permanent or unpaid workers, 10 per cent were non-permanent workers, and 17 per cent were unpaid workers (including family members).

The latest developments are also marked by an increasing proportion of women entering the labour market. These women are mostly working in the informal sector, although the growth rate of women entering the workforce has outpaced men in both the formal and informal sectors (Figure 1.9). Another important development is the increasing number of international migrant workers who are mostly motivated by the lack of job opportunities in their home towns. The available data show that most international migrant workers are women and their numbers are continuously increasing (Figure 1.10). However, it is estimated that the unregistered numbers are even larger, and this could involve child trafficking.

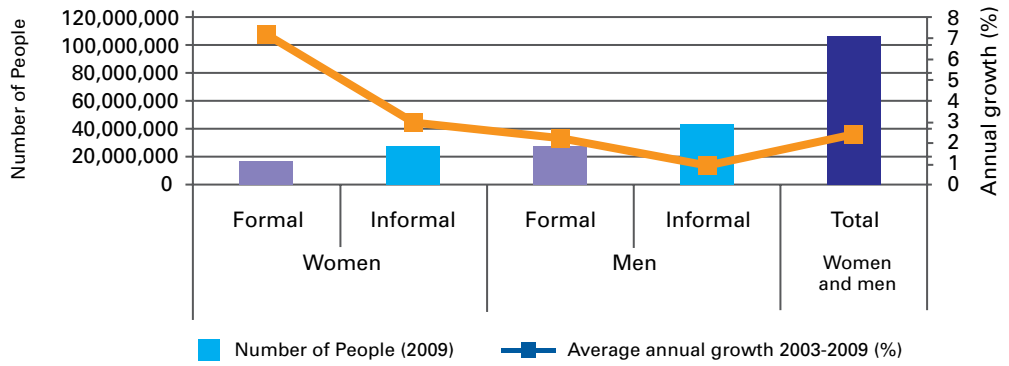
Despite the relatively slow economic growth since the 1997–1998 Asian financial crisis (AFC), Indonesia has recently survived the pressure of the 2008–2009 global financial crisis (GFC)

Figure 1.8: Participation of the population aged over 15 years in the labour market, and unemployment rates, 2004–2010



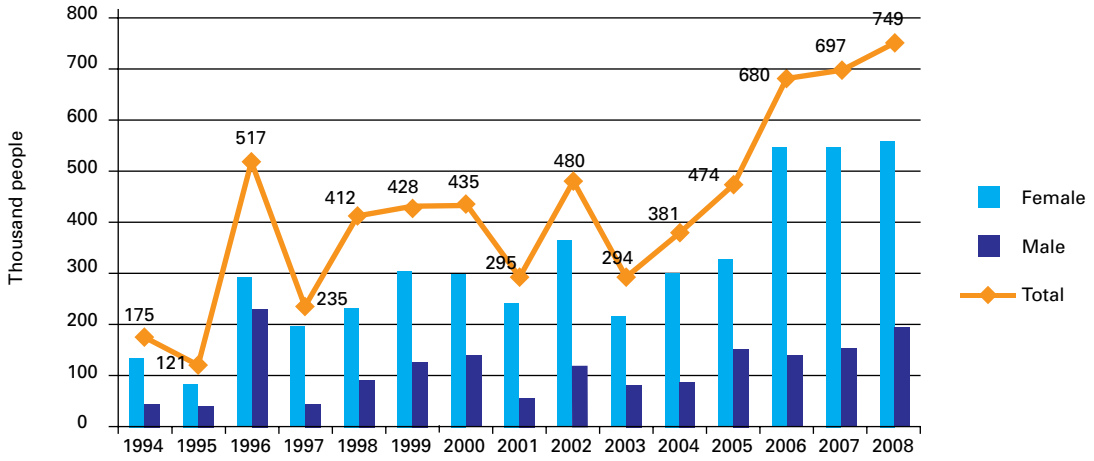
Source: BPS – Statistics Indonesia

Figure 1.9: Workforce in formal and informal sectors in 2009 and average annual growth 2003–2009, by sex



Source: Estimated from the National Labour Force Survey (SAKERNAS), 2003 and 2009

Figure 1.10: Placement of international migrant workers by sex, 1994–2008



Source: Badan Nasional Penempatan dan Perlindungan Tenaga Kerja Indonesia (BNP2TKI) [National Board for the Protection and Placement of Indonesian International Migrant Workers], 2009

(Figure 1.11). Indonesia's economic resilience during the GFC was due to a combination of relatively low international economic integration since the aftermath of the AFC, increased government spending in the form of direct cash transfers to the poor in early 2009, a fiscal stimulus package, and strong increases in private expenditure.[24] Although overall Indonesia was not severely affected by the GFC, manufacturing, and the trade-hospitality sectors, and to some extent finance, were hit by the crisis (Table 1.6). The communities that relied upon automotive, electronics and exportable plantation products (such as palm oil and rubber) also suffered, with a disproportionately greater impact on the poor (Isdijoso, 2009). Although labour markets in general were not significantly affected and unemployment continued to decline (see Figure

[24] The increase in private expenditure came primarily from money spent during the legislative and presidential elections in 2008 and 2009.

Table 1.6: Quarterly gross domestic product (GDP) growth by sector, 2008–2010

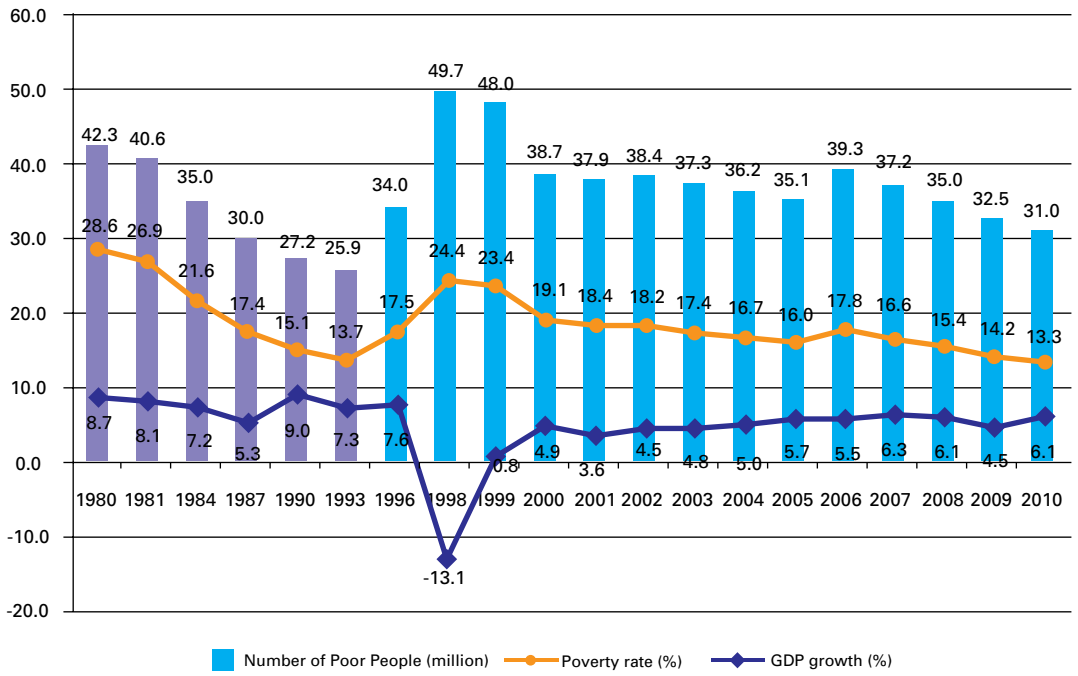
	2008*				2009**				2010***		
	I	II	III	IV	I	II	III	IV	I	II	III
Agriculture	6.44	4.81	3.25	5.12	5.91	2.95	3.29	4.61	3.00	3.08	1.80
Mining and quarrying	(1.62)	(0.37)	2.32	2.43	2.61	3.37	6.20	5.22	3.12	4.01	2.83
Manufacturing	4.28	4.23	4.31	1.85	1.50	1.53	1.28	4.16	3.71	4.35	4.08
Electricity, gas and water	12.34	11.77	10.41	9.34	11.25	15.29	14.47	13.99	8.18	4.66	3.16
Construction	8.20	8.31	7.76	5.88	6.25	6.09	7.73	8.03	7.05	6.93	6.42
Trade, hotels and restaurants	6.75	7.68	7.59	5.47	0.63	(0.02)	(0.23)	4.17	9.37	9.67	8.78
Transport and communication	18.12	16.57	15.64	16.12	16.78	17.03	16.45	12.22	11.95	12.94	13.33
Finance, renting and business service	8.34	8.66	8.60	7.42	6.26	5.33	4.90	3.77	5.28	6.03	6.34
Other services	5.52	6.51	6.95	5.93	6.70	7.19	6.04	5.69	4.62	5.25	6.44
Gross Domestic Product	**6.21**	**6.30**	**6.25**	**5.27**	**4.53**	**4.08**	**4.16**	**5.43**	**5.69**	**6.19**	**5.82**
GDP excluding oil and gas	**6.70**	**6.72**	**6.73**	**5.70**	**4.93**	**4.46**	**4.51**	**5.85**	**6.20**	**6.59**	**6.24**

Source: BPS – Statistics Indonesia, 2008–2010
*Notes: *Preliminary figure; **Very preliminary figure; ***Very-very preliminary figure*

1.8), further disaggregated analysis indicates that the crisis brought an increase in the proportion of people working in the informal sector and an increase in the unemployment rate for youth (aged 15–25 years), while reducing real wages of employees aged 18–25 years (McCulloch and Grover, 2011). The impacts on the affected communities were to some extent eased by the availability of several social protection programmes, particularly in the education and health sectors, that were expanded from the social safety net programmes created as a response to the AFC (Hastuti et al., 2010).

Indonesian economic progress has been accompanied by a steady decline in income poverty, but many people are still vulnerable to falling into poverty. At the national level, the first MDG target – reducing extreme poverty (people living below the international poverty line on less than $1 purchasing power parity per capita per day) by half of the 1990 level – was achieved in 2000. The AFC experience, however, provided an important lesson on the potential impact of crises on poverty. As can be seen in Figure 1.12, this particular target had been achieved during 1995–1997, but then the AFC and the subsequent political, social and economic crises reduced the welfare (i.e., consumption level) of substantial numbers of people so that during 1998–1999 the proportion of people in extreme poverty actually increased to a level higher than the target of 10.3 per cent. Figures 1.11 and 1.12 show the close association between income poverty and various economic shocks. The AFC caused extreme poverty to increase by 9 per cent during 1996–1997. It then increased again by 8.5 per cent in the following year and peaked at 13.4 per cent in 1998. Meanwhile the proportion of people below the national poverty line (NPL) increased by around 7 percentage points (to 49 per cent) during 1996–1999. Thereafter, the poverty levels steadily declined until 2005. Unfortunately, the sharp increase of global oil and gas prices in 2005 caused the government to slash fuel subsidies and raise the regulated prices by a weighted average of 29 per cent in February and again by 114 per cent in September of the same year (Bazzi, Sumarto and Suryahadi, 2010). This increased the proportion of people in extreme poverty by 1.4 percentage points (to 23 per cent) during 2005–2006. The proportion of people below the NPL also increased by 2 percentage points (to 13 per cent), while the proportion of people living on less than $2 PPP per capita per day increased by 4.4 percentage

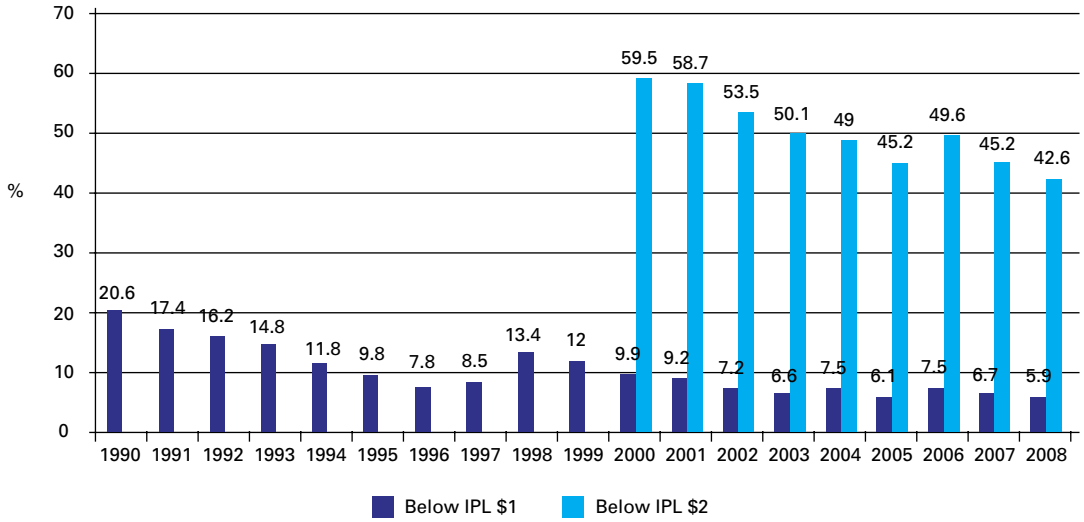
Figure 1.11: Gross domestic product (GDP) growth, poverty rate and number of poor people in Indonesia, 1980–2009



Note: The poverty rates during 1980–1993 are not comparable to the rates from 1996 onward due to changes in the method of calculation for the national poverty line.

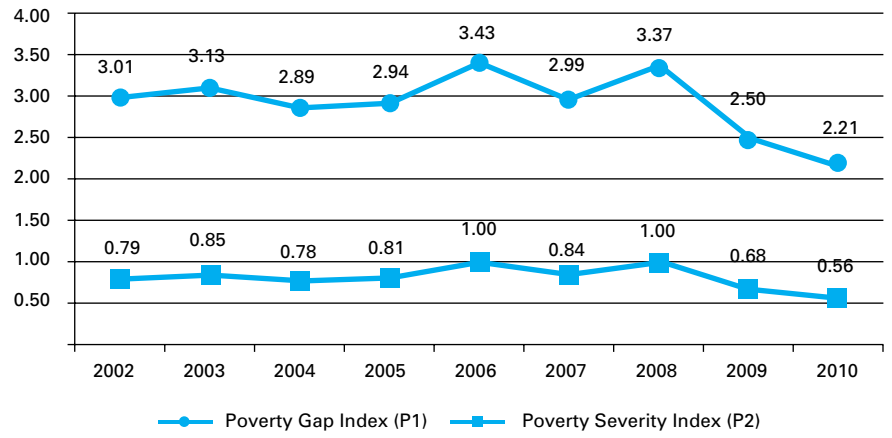
Source: BPS – Statistics Indonesia (various years)

Figure 1.12: People living below $1 PPP and $2 PPP per capita per day, 1990–2008 (%)



Source: BAPPENAS and BPS – Statistics Indonesia, 2009

Figure 1.13: Poverty gap and poverty severity indexes, 2002–2010

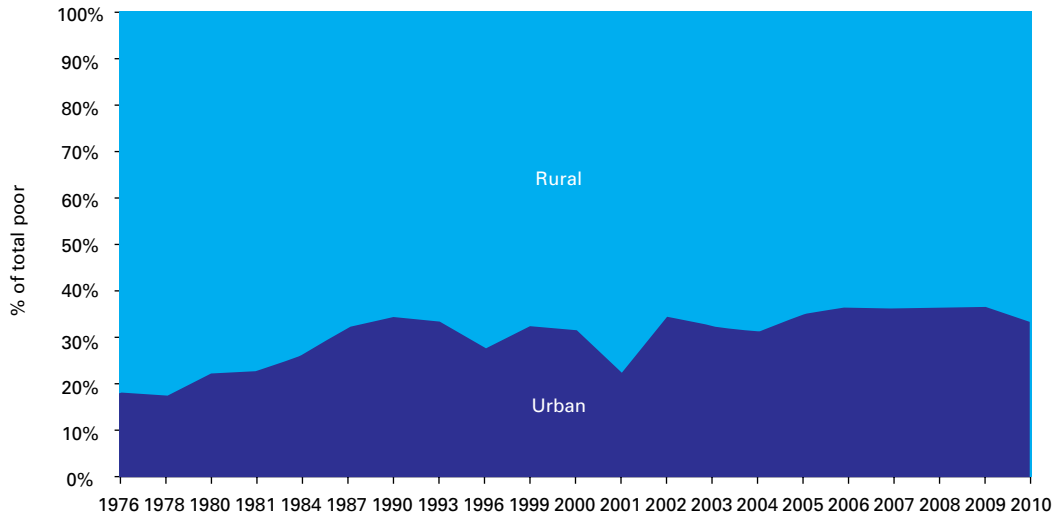


Source: BPS – Statistics Indonesia (various years)

points (to 10 per cent). The GFC, luckily, did not lead to an increase in the poverty rate based on the NPL standard, and the rate steadily declined from 15.42 per cent in 2008 to 14.15 per cent in 2009 and 13.33 per cent in 2010. The poverty gap index (P1) and poverty severity index (P2), however, indicated that the GFC might be associated with an increase in the value of both indexes to a level similar to 2006 (Figure 1.13). This suggests an increase in disparities among the poor, with the poorest of the poor being badly affected by the crisis.

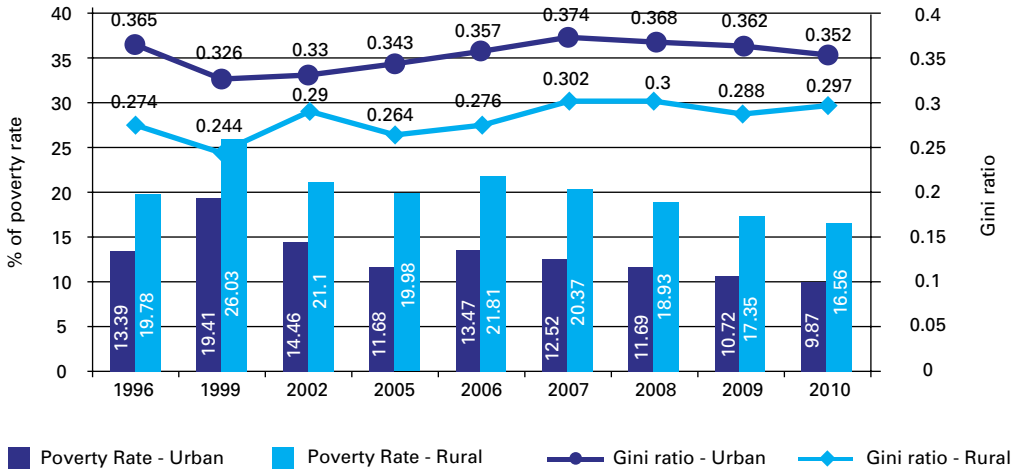
Poverty in Indonesia has always been a predominantly rural phenomenon. Despite the growth of the urban population, which now accounts for almost half of the total population, the rural poor still account for more than 60 per cent of the total poor (Figure 1.14). The most likely reason for this is that most people in rural areas work in the agricultural sector even though, as discussed previously, the economic share of the agricultural sector has been declining. The relatively low education level of the rural poor limits their opportunities

Figure 1.14: Share of urban and rural poor as a proportion of the national poor, 1976–2010



Source: BPS – Statistics Indonesia (various years)

Figure 1.15: Urban and rural poverty rates and Gini ratios, 1996–2010

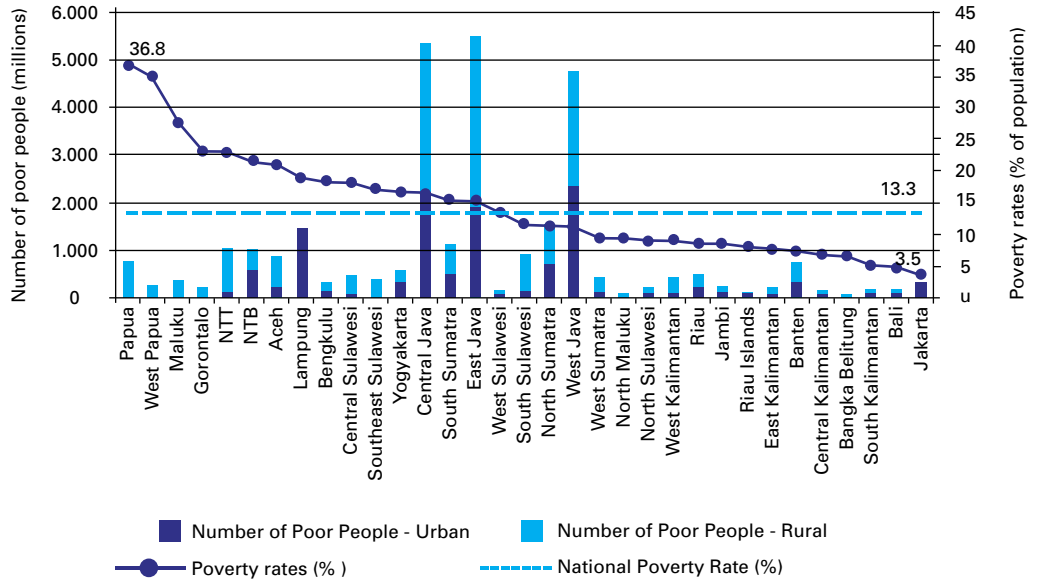


Source: BPS – Statistics Indonesia (various years)

to benefit from increasing labour demand in the manufacturing and service sectors. The fact that most manufacturing establishments and various forms of financial services are located in or near cities also hinders the development of both farm and non-farm businesses in rural areas. Although the poverty rates in urban areas are lower than those in rural areas, the income inequality as reflected in the Gini ratio is subsequently higher. However, while the inequality in urban areas has tended to decline in recent years, the inequality in rural areas has been relatively stagnant, oscillating around 0.3 (Figure 1.15).

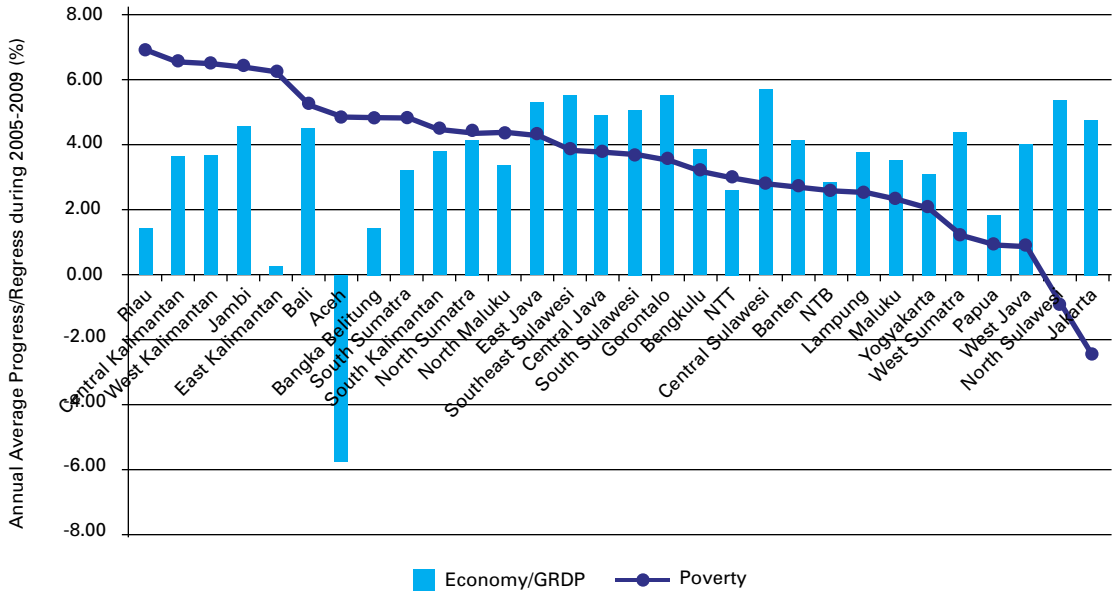
In addition to rural–urban disparities, income poverty also varies across provinces. Although most of the poor are living in Java, the poverty rates in the provinces of eastern Indonesia remain among the highest. In 2010, around half of the poor lived in the three provinces with the highest numbers of poor people: East Java, Central Java and West Java. The variation of poverty rates among provinces is quite high: approximately 35 per cent of the people in West Papua and Papua are categorized as poor, while less than 5 per cent of people in Jakarta and Bali are poor (Figure 1.16). The provincial performance in terms of a reduction in poverty rates also varies considerably. Five provinces recorded the highest poverty reductions during 2005–2010; they were Riau, Central Kalimantan, West Kalimantan, Jambi and East Kalimantan – all rich in natural resources. Meanwhile, two provinces – Jakarta and North Sulawesi – recorded increasing poverty rates during the same period.

Figure 1.16: Numbers of poor people and poverty rates by province, 2010



Source: BPS – Statistics Indonesia

Figure 1.17: Progress in poverty reduction and economic development by province, 2005 – 2010



Source: Calculated using data from BPS – Statistics Indonesia

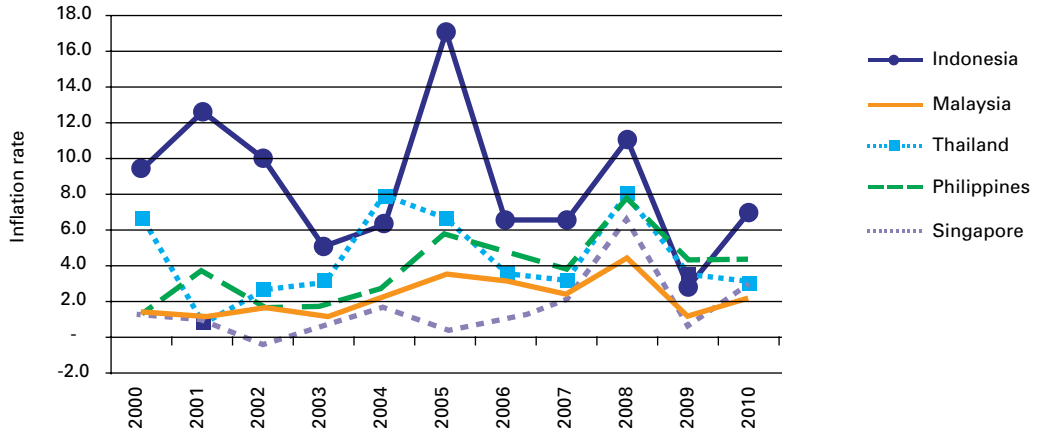
1.6 Macroeconomic policy and budget allocation

The macroeconomic policies adopted by a country affects the capacity of the government and the general community to invest in future generations, namely, children. Changes in commodity prices affect a household's capacity to invest in their children's future (consumption and education) and the government's capacity to invest in the provision of public services.

During the last decade, Indonesia struggled to survive the 1997–1998 Asian financial crisis and other consecutive shocks due to increases in global food, oil and gas prices as well as the latest 2008–2009 global financial crisis. In order to survive these shocks, the government has adapted monetary policy measures to maintain currency and inflation stability, and adjusted the fiscal policy to provide sufficient development stimulus. The Indonesian central bank (BI, Bank Indonesia) is the institution authorized by law to manage the country's monetary policy (Law No. 3/2004 concerning Bank Indonesia). It is mandated to achieve and maintain the stability of the rupiah, defined as the stability of prices for goods and services reflected in inflation, among other factors. To achieve this goal, Bank Indonesia decided in 2005 to adopt an inflation targeting framework, in which inflation control is the primary monetary policy objective, while adhering to the free floating exchange rate system. Exchange rate stability plays a crucial role in achieving price and financial system stability. For this reason, Bank Indonesia also operates an exchange rate policy designed to minimize excessive rate volatility, rather than pegging the exchange rate to a particular level. These measures have resulted in relatively stable inflation and exchange rates during the past five years (Figures 1.18 and 1.19), and have helped the country survive the global financial crisis.

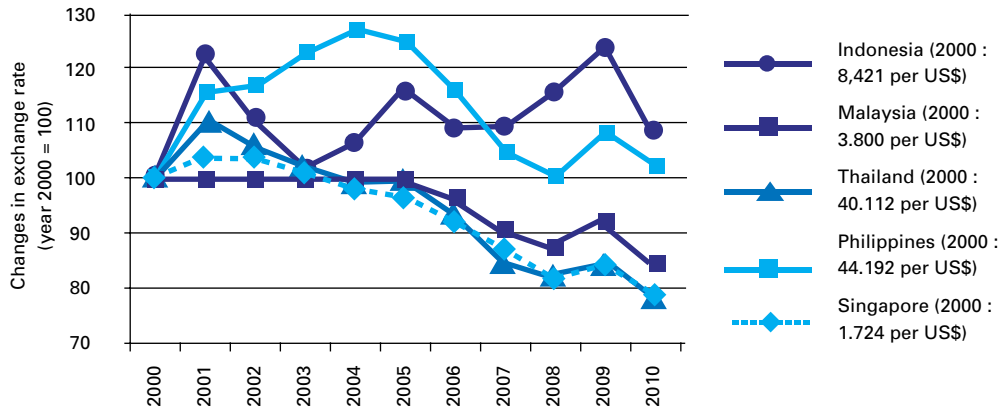
Regarding fiscal policy, Indonesia has adopted a deficit financing budget in order to stimulate growth. From 2005 to 2007 the government's budget deficit tended to increase each year. In 2005 the total budget deficit was IDR14.4 trillion (million million), which increased to IDR29.1 trillion in 2006, and further increased to IDR49.8 trillion in 2007. In 2008, the total budget deficit decreased by IDR4.1 trillion compared to the previous year. In the aftermath of the global financial crisis, which caused an economic slowdown in late 2008, tax revenue decreased in 2009 and caused the budget deficit to rise to IDR88.6 trillion (6 per cent of GDP). The decision to increase the budget deficit in 2009 was also based on an intention to provide fiscal stimulus as a counter cyclical measure to the potential adverse impact of the global

Figure 1.18: Annual inflation in Indonesia and neighbouring countries, 2000–2010



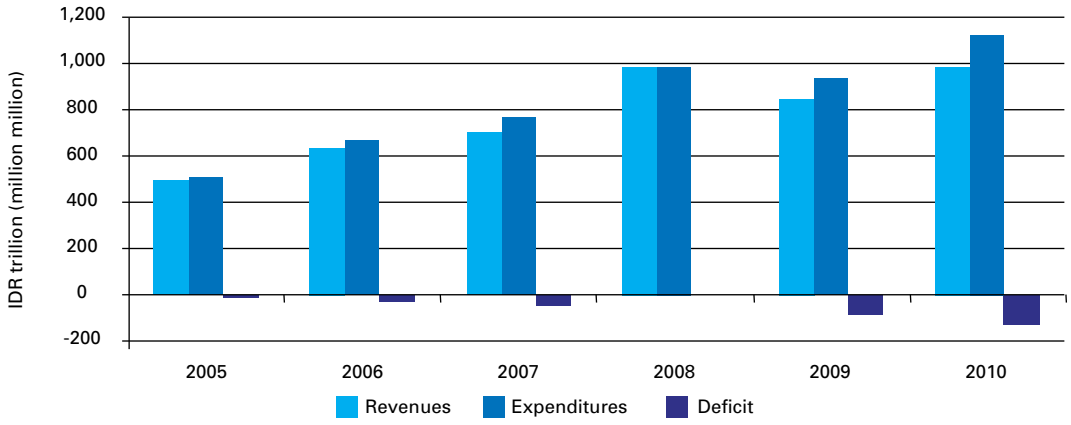
Source: Indonesia Central Bank (Bank Indonesia) and Department of Statistics Singapore

Figure 1.19: Changes in exchange rates in Indonesia and neighbouring countries, 2000–2010 (year 2000=100)



Source: Calculated from International Financial Statistics [http://elibrary-data.imf.org/DataReport.aspx?c=1449311&d=33061&e=169393]

Figure 1.20: Central government revenues, expenditures and deficits, 2005–2010



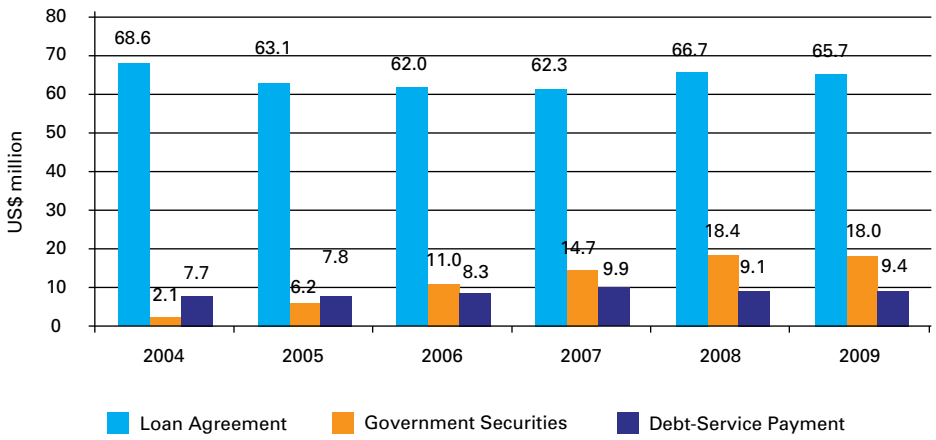
Source: Budget Statistics 2005–2011, Ministry of Finance

financial crisis. In this fiscal year, the government allocated IDR73.3 trillion (1.4 per cent of GDP) to a fiscal stimulus programme that consisted of tax reduction (58.7 per cent), subsidies for import taxes and duties (18.1 per cent), and additional subsidies and government expenditures (23.3 per cent) used to finance labour intensive infrastructure developments and the expansion of the community driven development programme (Program Nasional Pemberdayaan Masyarakat, PNPM) and other measures. In 2010 the budget deficit was set at IDR133.7 trillion (8 per cent of GDP).

Most of the government's revenues come from tax, especially domestic taxation. On average, tax revenues account for almost 70 per cent of total revenues each year. In addition, oil and gas contribute around 20 per cent on average each year. The remainder comes from various means of budget financing. Most budget financing is from domestic sources in the form of government obligations, and from foreign sources such as foreign debt.

Indonesia's external debt is maintained at manageable levels. The level of debt based on loan agreements was relatively constant,

Figure 1.21: Levels of government external debt and debt-service payments, 2004–2009

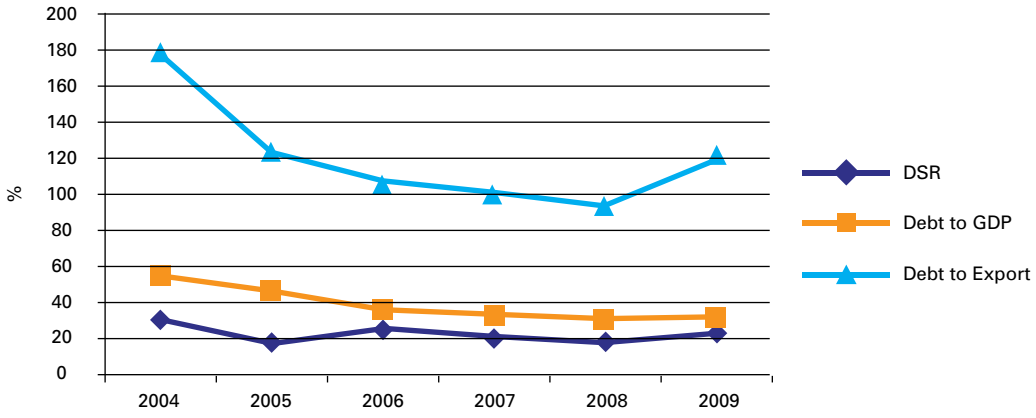


Source: Indonesia Central Bank (Bank Indonesia), 2010

but government securities also increased considerably (Figure 1.21). Thus, the total debt-service payments also increased. Most government debt in 2009 was a result of financial leasing and financial services (38 per cent), followed by other categories (16.6 per cent), services (17 per cent), and construction (13.5 per cent). The indicators of external debt burden indicate that Indonesia's debt is still manageable. The debt service ratio (DSR), debt to GDP and debt to export earnings have been declining, although they did increase slightly in 2009 (Figure 1.22).

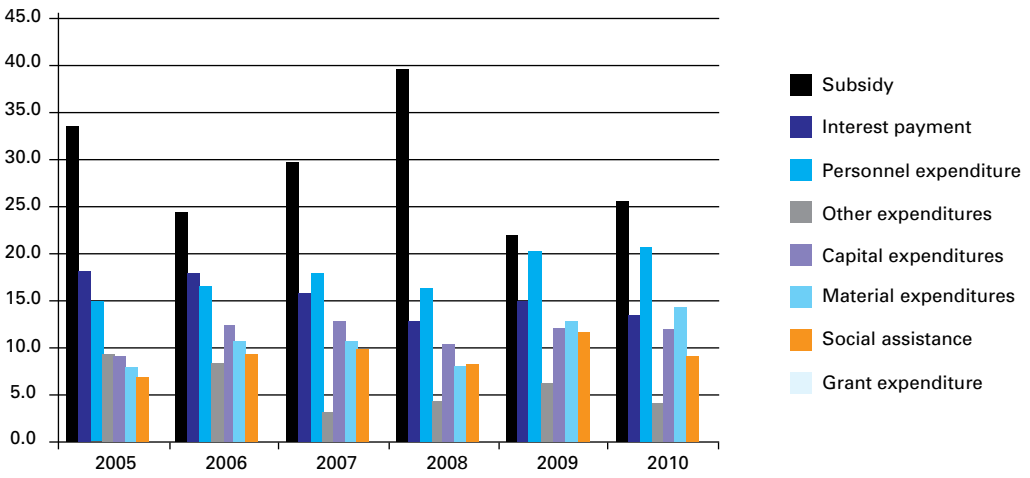
Regarding central government expenditure, subsidies still account for the biggest proportion of expenditure during 2005–2010. At their highest point, subsidies amounted to 40 per cent of total expenditure in 2008 (Figure 1.23) when the global oil price escalated, placing a heavier financial burden on the government. However, the proportion of the budget spent on subsidies decreased to 22 per cent in 2009 and was 26 per cent in 2010. Among the subsidy components, fuel subsidies were the most dominant (Figure 1.24), followed by subsidies for electricity.

Figure 1.22: Indonesia's external debt burden indicators, 2004–2009



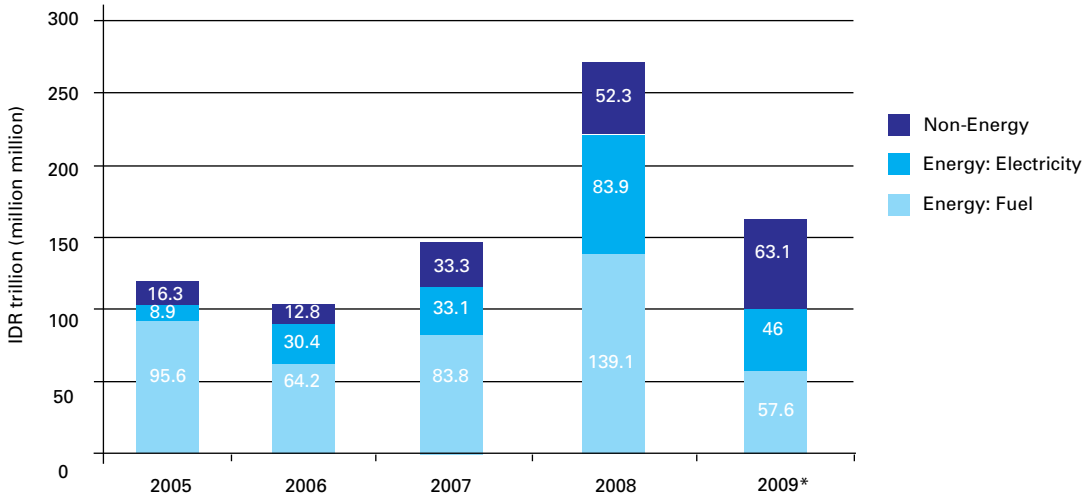
Source: Indonesia Central Bank (Bank Indonesia), 2010
Note: DSR, debt service ratio

Figure 1.23: Allocation of central government expenditure, 2005–2010



Source: Ministry of Finance

Figure 1.24: Components of the subsidy expenditures, 2005–2009



Source: Budget data, Ministry of Finance
*Note: * Budget allocation data (APBN 2009); for 2005–2008 realization data are used*

[25] Details on the budget for the Raskin programme are presented and discussed in Chapter III, section 3.5.

Table 1.7: Allocation of central government expenditure by function, 2005–2010

Government Function	2005	2006	2007	2008	2009	2010
General public services	70.8%	64.4%	62.6%	77.1%	66.4%	67.7%
Education	8.1%	10.3%	10.1%	8.0%	13.5%	12.4%
Economic affairs	6.5%	8.7%	8.4%	7.3%	9.4%	7.8%
Defense	6.0%	5.6%	6.1%	1.3%	2.1%	2.7%
Public order and safety	4.3%	5.4%	5.6%	1.0%	1.2%	2.2%
Health	1.6%	2.8%	3.2%	2.0%	2.5%	2.5%
Housing and communities amenities	1.2%	1.2%	1.8%	1.8%	2.3%	2.8%
Social protection	0.6%	0.5%	0.5%	0.4%	0.5%	0.5%
Environmental protection	0.4%	0.6%	1.0%	0.8%	1.7%	1.1%
Religion	0.4%	0.3%	0.4%	0.1%	0.1%	0.1%
Tourism and culture	0.2%	0.2%	0.4%	0.2%	0.2%	0.2%
Total central government expenditure (trillion IDR, Indonesian rupiah)	**360.99**	**440.04**	**504.68**	**693.36**	**628.81**	**781.53**

Source: Ministry of Finance

Meanwhile, the largest non-energy subsidies were for fertilizer and food subsidies, including the programme to finance the 'Rice for Poor Households' programme (Raskin).[25]

Tracing and estimating the budget allocated specifically for children is not easy since it is spread over many ministries and in many cases is included as part of specific programmes or activities. Based on a sketchy approximation, it is estimated that the proportion of the budget that directly benefits children is quite limited. As presented in Figure 1.23, a substantial proportion of the central government's budget has been allocated to subsidies, interest payments and personnel expenditure. Although subsidies may indirectly benefit children, these types of expenditures are not really associated with children. In addition, Table 1.7 shows that more than 60 per cent of the central government budget is allocated for 'general public services' that consist of various government facilities and law and order. Even though the government is committed to allocating 20 per cent of its budget for education, in 2009 and 2010 the realized budget was just 13.5 and 12.4 per cent, respectively. Since this budget also covered higher education, the budget for children was actually lower than these proportions. The allocation for the health sector was even smaller, at around 2.5 per cent of the total budget in 2010, while the budget for nutrition was only a fraction of the health budget. The budget trends of the sectors related to the four pillars for children's well-being will be discussed in greater detail in chapters 3 to 6 of this report.

[25] Details on the budget for the Raskin programme are presented and discussed in Chapter III, section 3.5.

CHAPTER 2

Children and Poverty

"I live with my father and two older siblings in a rented wooden house on a garbage pile, with no bathroom or toilet. If we need to wash or use the toilet we have to go to the public toilet and pay 1,000 rupiah per entry. We buy water costing 2,500 rupiah per container for cooking. After school I have to help my father collect bottles and other scrap. None of us have either an identity card (KTP) or a birth certificate."

—a 12-year-old boy, 6th grade, North Jakarta

This chapter profiles child poverty and deprivation in Indonesia. It adopts a multidimensional approach to try and capture a range of indications of children's well-being. Basing analysis at the child level and looking at the conditions of children's lives provides a foundation for monitoring a range of outcomes and understanding the interrelationships among the various factors that contribute to children's overall well-being. This approach is designed to contribute most effectively to optimal policymaking for the benefit of children (Bradshaw, Hoelscher and Richardson, 2006) and to help reorient Indonesia's policymakers to recognize and better appreciate children's needs and rights.

This chapter is organized in four sections. The first section discusses child poverty using a monetary approach based on household consumption levels. National trends in poverty rates are discussed as well as regional disparities and the association of poverty risk with various household characteristics. The second section discusses a multidimensional approach to the assessment of deprivation using indicators in the domains of education, children's employment,[1] health, shelter, sanitation, water and income. Using data from the National Socio Economic Survey (SUSENAS), the incidence of and correlations among deprivation in these various dimensions of children's well-being are explored and discussed. The third section takes three elements of this multidimensional approach – shelter, water and sanitation – and provides more in-depth profiling and analysis. Finally, section four explores the subjective and other non-material aspects of children's well-being using a limited set of statistical data alongside material from qualitative case studies in four villages/precincts that report the issues raised by children, described in the context of the communities where they live.[2] Further analysis on health, education and several child protection issues will be presented in chapters 3, 4 and 5.

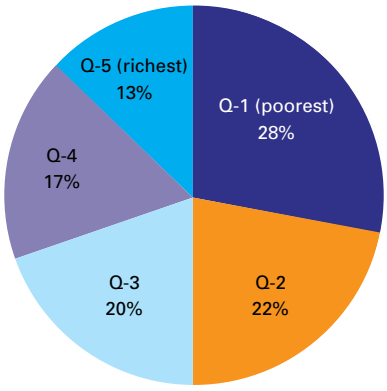
1 In order to avoid confusion between the BPS – Statistics Indonesia term 'child labour' and the ILO term 'working children', this chapter uses the term 'working children' (also see Chapter 5, section 5.3).

2 The approach and methods are presented in Appendices 1 and 2.

2.1 Child poverty

Headcounts of children suffering monetary poverty are higher than those of adults. Children's risk of poverty is largely determined by their position in the overall distribution of the population in terms of income and consumption. The 2009 SUSENAS data reveal that children are more likely than adults to live in the lower section of the distribution. Figure 2.1 shows the proportion of the 79.4 million Indonesian children living in each quintile of the overall distribution of household expenditure in 2009. If children were distributed equally across the distribution then 20 per cent would be in each quintile, but the distribution of children is clearly skewed towards lower income, with 28 per cent present in the poorest quintile, 22 per cent in the second poorest, and just 13 per cent living in the richest quintile. One of the reasons for this is the fact that poorer households tend to have larger families (fertility declines with the education status of the mother, and higher education status is linked to higher earnings). Some care needs to be taken in interpreting the relationship of household size in terms of the consumption distribution, since it will be partly determined by what equivalence scale is used; for instance, a 'per capita' assumption as used in the measurement of the international poverty line at $1 PPP (purchasing power parity) per capita per day treats children as having equal needs to adults and allows for no economy of scale in larger households.

Figure 2.1: Distribution of children by per capita household expenditure quintiles, 2009



Source: Estimated using data from 2009 National Socioeconomic Survey (SUSENAS)

Using international poverty lines (IPL) set at $1 and $2 PPP per capita per day, with their per capita consumption; Figure 2.2 shows the change over time in child poverty and overall poverty in Indonesia between 2003 and 2009. Child poverty rates are consistently higher than overall poverty rates, but both rates fell during this period. Child poverty rates fell from 12.8 per cent of children in 2003 to 10.6 per cent in 2009 when measured at the $1 a day level, and from 63.5 to 55.8 per cent when measured at the $2 a day level. Based on this method of measurement, while 50.7 per cent of the population lived on less than $2 per day in 2009, the same was true for 55.8 per cent of children.

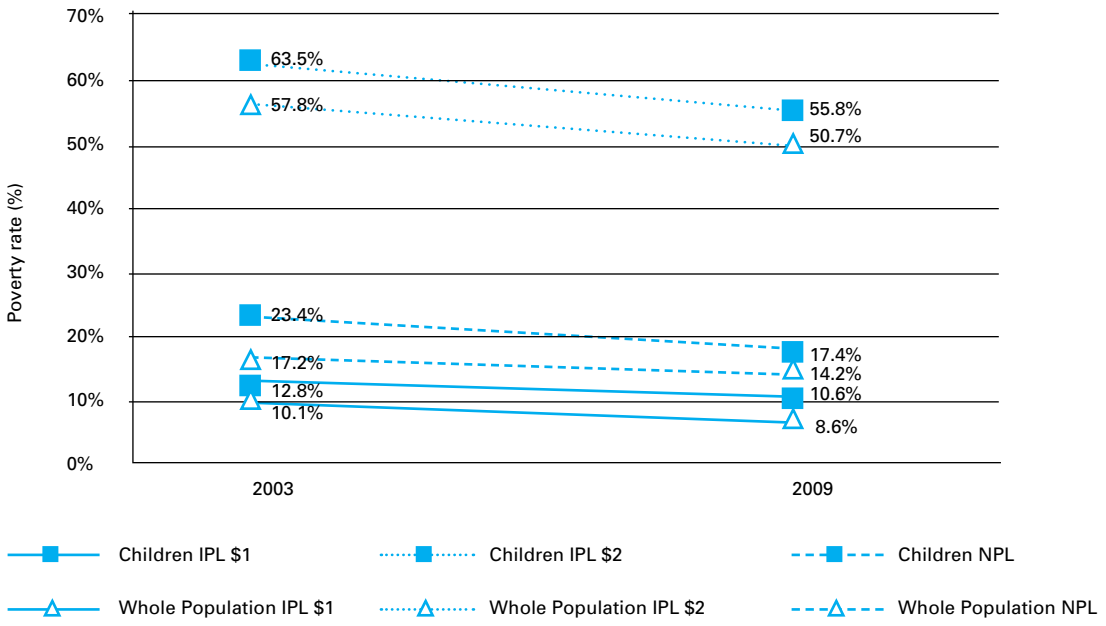
Figure 2.2 also shows similar profiles of overall and child poverty using the Indonesian national poverty line (NPL), which is calculated based on a basic needs standard. As with the IPL rates, the NPL data also show child poverty to be higher than overall poverty, with the rate also falling during the same period. The NPL is calculated each year based on the cost of consuming a selection of basic foods by a reference population, amounting to approximately 2,100 kilocalories per person per day, in addition to other non-food basic needs estimated using an angel curve.[3] Based on the NPL, child poverty fell from 23.4 per cent in 2003 to 17.3 per cent in 2009, whereas general population poverty rates fell from 17.2 per cent to 14.2 per cent.[4]

By all measures, both child poverty and total poverty declined during the period 2003–2009, but child poverty declined at a faster rate than overall poverty (Table 2.1). This implies that reducing overall poverty lifts a greater proportion of children out of poverty. Furthermore, there

3 The national poverty lines in 2003 were IDR138,803/capita/month for urban areas and IDR105,888/capita/month for rural areas; and in 2009 they were IDR 222,123/capita/month for urban and IDR179,835/capita/month for rural areas. An 'angel curve' describes how a consumer's purchase of goods varies as the consumer's total expenditure varies.

4 The child poverty rate was also higher than the poverty rate among households with children, which was around 15 per cent in 2009.

Figure 2.2: Child poverty and overall poverty using international poverty lines (IPL) and the national poverty line (NPL) definitions, 2003 and 2009



Source: Estimated using data from the 2003 and 2009 SUSENAS

has been faster decline in the rates of more extreme poverty (NPL and less than $1 per day), as compared to the proportion of those living on less than $2 per day. Table 2.1 shows both the absolute levels of change between 2003 and 2009 as percentage point changes and also the relative change as percentages of children in poverty, showing that the reductions in absolute poverty (IPL $1) were larger than the reductions at the level of IPL $2. This indicates that reducing extreme poverty benefited more children. While a 1 per cent decline in IPL $2 overall poverty corresponded to a child poverty reduction of approximately 0.98 per cent, at the same time a 1 per cent decline in IPL $1 overall poverty corresponded to a child poverty reduction of approximately 1.09 per cent.

However, the child population in Indonesia is large and estimates based on the measure that identifies the smallest populations in poverty, the IPL at $1 a day, suggest that around 8.4 million children were living in extreme poverty in 2009. If the NPL is used the estimated number of poor children rises to approximately 13.8 million

Table 2.1: Declining poverty rates, 2003–2009

Poverty line	Children		Total population	
	% point change	Overall decline	% point change	Overall decline
IPL $1 (PPP)	-2.12	17%	-1.54	15%
NPL	-6.09	26%	-3.00	17%
IPL $2 (PPP)	-7.76	12%	-7.17	12%

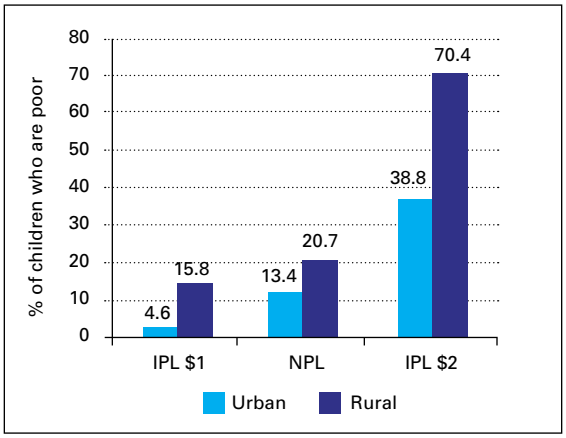
Source: Calculated using data from the 2003 and 2009 SUSENAS

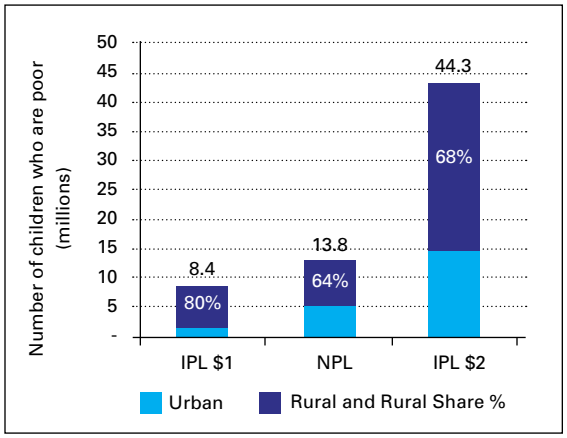
Notes: Percentage point change is 2009 level minus 2003 level; decline is this difference as a percentage of the 2003 level.

while, if the $2 IPL is used, 44.3 million children are categorized as poor (55.8% per cent of all children, as shown in Figure 2.2).

Where do these poor children live? Figure 2.3 shows that the risk of child poverty is much higher in rural areas – child poverty rates in rural areas are almost 16 per cent using the IPL $1, 21 per cent using the NPL and 70 per cent using the IPL $2, whereas the corresponding rates in urban areas are 5, 13 and 39 per cent, respectively. This means that rural child poverty

Figure 2.3: Urban and rural child poverty rates and number of (income) poor children, 2009





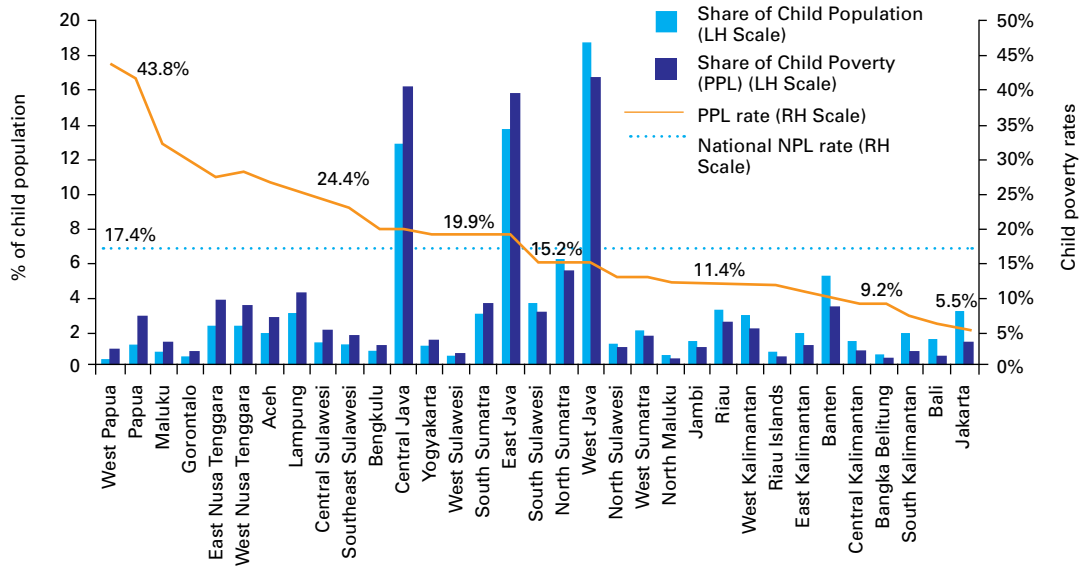
Source: Estimated using data from the 2009 SUSENAS

accounts for the greatest share of child poverty and the highest number of poor children: 80 per cent of the 8 million extremely poor children (based on $1 IPL) live in rural areas. The rural share declines with poverty lines set at higher levels but rural children remain the largest share of poor children: 64 per cent, based on the NPL, and 68 per cent using the $2 IPL. One reason for the higher child poverty rates in rural areas is the higher numbers of children in rural households compared to urban households. There is also the possibility that many poor people who migrate to cities or urban economic centres leave their children in their home village to avoid higher living costs in the city. In addition the likelihood of uncounted poor children in urban areas is higher than in rural areas.[5]

The regional differences in population concentration and socio-economic conditions mean that there are crucial geographic factors to consider in child poverty. The Indonesian national poverty line (NPL) estimates consumption needs at an aggregate level across the country, but price and other differences mean that it would be more accurate to estimate consumption poverty using local prices. Provincial poverty lines (PPLs), which reflect local prices and preferences, are available only as sub-components of the Indonesian NPL because purchasing power parities (PPP) for the IPLs are only set nationally. Provincial child poverty profiles are shown in Figure 2.4. The orange solid line shows the provincial child poverty rate and all provinces are ranked left to right in descending order according to this rate. The national child poverty rate using the NPL (17.4 per cent) is shown as a dotted light-blue line for comparison, indicating that approximately half of the provinces have child poverty rates above that national level. This figure additionally shows each province's child poverty share (percentage of all Indonesian children in poverty) represented by the light-blue bars, alongside its corresponding share of the country's child population represented by the dark blue bars. Due to population size and density, Javanese provinces dominate both population and poverty shares: together Java has 54 per cent of all Indonesian children and 46.9 per cent of child poverty. Among those Javanese provinces, only the most populated province, West Java, has a poverty share (16 per cent) lower than its share of the child population (18.6 per cent) because it has a lower poverty rate: 15 per cent compared to 19–20 per cent in the other Javanese provinces. The very highest provincial rates of child poverty are in the eastern provinces – both Papuan provinces have poverty rates of over 40 per cent, although they

5 The SUSENAS does not cover children living in the street and children in institutional care, and both of these circumstances are more common in urban than in rural areas.

Figure 2.4: Child poverty rates and shares by province, 2009 (%)



Source: Estimated using data from the 2009 SUSENAS (Core)
Note: Provincial data is provided in Appendix IV

have very small population and poverty shares due to relatively low population size and density. Slightly lower poverty rates of 25–30 per cent are found across East and West Nusa Tenggara provinces, Maluku, Gorontalo in the east, and Aceh in Sumatra. But if the data for all poor children across all 10 provinces with the highest poverty rates (from West Papua to Southeast Sulawesi, as shown in Figure 2.4) are summed, the resulting share of child poverty in terms of numbers of children would be just 15 per cent of all poor children in the country. These are all provinces where poverty rates and poverty shares are disproportionately high compared to the population share, but they have relatively small populations and low population densities (in Indonesian terms), and include many remote locations, making it more logistically problematic for programmes to reach the poorest people, as compared to Java and other more densely populated parts of the country.

But the highest incidence of poverty occurs at smaller, more local geographic areas, and the SUSENAS provides district level data for 455 districts in Indonesia. Although at this level there are considerable underlying problems of small sample sizes, nevertheless the data suggests high poverty rates (based on PPL) of 70 per cent and above in some districts of Papua and indicate that the 46 poorest districts (the poorest 10 per cent of districts in the country) have an average child poverty rate of 43 per cent, while the poorest 91 districts (the poorest 20 per cent of districts) have an average child poverty rate of 34 per cent or twice the national rate. At the other extreme, the 10 per cent of districts with the lowest incidence of poverty have just a 1 per cent child poverty rate on average, and the least poor 20 per cent of districts have an average child poverty rate of just 2 per cent. Similarly, based on IPL of $2 a day PPP, the average child poverty rates in the poorest 10 and 20 per cent of districts were 84.5 per cent and 79.9 per cent, respectively, while the average rates in the least poor 10 and 20 per cent of districts were 11.2 per cent and 17.9 per cent, respectively.

How does the risk of child poverty differ by household characteristics? Besides, the urban/rural differences discussed in the previous part of this section, Table 2.2 indicates the effect of household size, educational background of the household head, the gender of the household

Table 2.2: Child (income) poverty rate by household characteristics, 2009

Household characteristics	IPL $1	IPL $2	NPL
Gender of the household head			
Female	13.2	55.5	21.3
Male	10.4	59.4	17
Number of household members			
Less than 3	3.9	42.4	6.2
3–4	5.9	47.7	10.3
5–6	11.7	58.8	19.6
7+	19.9	69	29.8
Educational level of the household head			
No school/incomplete primary school	20.1	77.4	29
Finished primary school	12.9	68.4	20.9
Finished junior secondary school	6.3	51.8	13.6
Finished senior secondary school	2.8	31.5	6.9
Finished diploma/academy/university	0.5	10.2	1.3
Geographic location			
Urban	4.6	38.8	13.4
Rural	15.8	70.4	20.7
Work (not mutually exclusive categories)			
Both parents working			15.38
No parents working			15.35
No adult of primary working age (18–54 years)			18.29
At least one child under age 15 working			22.31
Illness and disability in the household			
High dependency ratio (4+ children per adult)			25.71
Elder (age 70+) person in household			23.15

Source: Estimated using data from 2009 SUSENAS (Panel)

head, and whether there are children below the age of 15 years who are working and/or members who are ill or disabled in the household. The proportion of children living in extreme poverty within large households, with more than seven members, is approximately five times greater than those in small households of just one or two members. One out of every four children who lived in households with seven or more members was poor, based on the national income poverty threshold. If the threshold was raised to the $2 PPP per day level, this proportion more than doubled. Similarly, data in Table 2.4 reveal that around one out of every four children in households that have four or more children per adult, or have elderly members aged 70 or over, fell below the NPL in 2009.

A higher level of education is associated with reduced likelihood of being categorized as poor. Overall, the proportion of children in extreme poverty among households whose heads graduated from junior secondary schools or higher, was substantially lower than among the households headed by individuals with lower education levels. However, the difference was less significant when the higher poverty lines – the NPL and the $2 PPP – were applied. Among the households with children, the poverty rates based on the NPL were almost the same, regardless of the educational level of the household heads, when combining the categories of secondary and further education. An analysis of the overall population based on further disaggregation by education level pointed to a significant positive impact associated with the household head being a graduate from senior secondary school or tertiary education. This provides a strong case for expanding educational assistance to poor children even beyond the current policy of nine years of compulsory basic education. While the junior secondary school graduates of the future will help in reducing extreme poverty (below $1 a day PPP) later when they have families, significant reductions in the proportion of children living below the NPL and the $2 PPP levels will be achieved when the heads of

households are graduates of senior secondary or tertiary education.

Poor children are more likely to be found within female-headed households. Among the households with children, the prevalence of children living below the NPL in female-headed households was 3.6 percentage points higher than that of male-headed households. Among all children, the prevalence of extreme child poverty was 2.8 percentage points higher in female-headed households, but the pattern was reversed when the line was increased to $2 PPP as the child poverty prevalence in female-headed households became lower than in male-headed households at this level. This indicates a wide income gap between extremely poor and only moderately poor female-headed households. However, in general, child poverty rates among girls are lower than among boys.

Child poverty is also associated with working children in the household but is less associated with the working status of parents and adults in the household. A low household income often forces children to work, and the child poverty rate in households with at least one member under age 15 years who was working was 22.31 per cent, which was higher than the overall national child poverty rate (17.4 per cent, Figure 2.2). However, the child poverty rate in the households with both parents working and those with neither parent working were almost the same, at around 15 per cent. This might be related to the loose definition of 'work' used in the SUSENAS. The SUSENAS defined work as "doing an income-earning activity for at least one hour during the last week".[6] This reflects neither the type of economic activities being performed nor the source of the household's income. Meanwhile the child poverty rate in the households with no adult of primary working age (18–54 years), in which the children were being cared for by an older person, was slightly higher at 18 per cent.

Certainly, a child's poverty status is affected by the rise and fall of his or her family's general welfare. Various factors, including climate change and global economic downturns have an impact on the welfare of the poor and the near-poor, as portrayed by the livelihoods of the communities in the qualitative case study precincts in North Jakarta and villages in East Sumba (Box 2.1). Such shocks could occur repeatedly and negatively affect household finances as these populations do not have the assets needed to support a speedy recovery. The consequences of such distress will be manifested not only in the monetary aspect of child poverty but also in other dimensions of poverty and deprivations, which will be discussed further in the next sections of this chapter.

Box 2.1: Impacts of external shocks on the poor and near-poor in urban and rural settings

For the poor and near-poor communities in one of the kelurahan *(urban precinct) in North Jakarta, the negative impacts of the tighter control over illegal logging, the proliferation of outsourcing practices after changes to labour laws, and the mass lay-offs that occurred several years ago, are still being felt today. Families affected by the shocks have not recovered. It is also more difficult for male workers to get jobs these days, compared to female workers. Large industrial employers require a minimum educational level of senior secondary school, such that many members of poor families are ineligible. Meanwhile, smaller companies, such as small-scale garment businesses, require skills more commonly possessed by girls. Having no assets or savings, poor urban families with a lack of access to public natural resources and loose family ties are susceptible to external shocks, including seasonal events like flooding and environmental degradation due to pollution by industrial waste along the coast of North Jakarta. A 37-year-old fisherman who makes a*

[6] This definition is stated in the SUSENAS questionnaire.

living from oyster cultivation could do nothing when his oysters died due to pollution from industrial waste and sewage from the East Flood Canal project, which flowed past his oyster cages. The cages were not insured since they were located on public property. The urban poor also suffer from a lack of legal residence status and may also live in illegal settlements. Because of this, they often face forced displacement, and fires are also common due to the over-crowded housing conditions.

The rural poor households in East Sumba face different types of external shocks. The most severe shocks are related to climate change. Over the last two years, agricultural production has continually declined due to the increasingly long dry seasons. Most poor households in East Sumba are subsistence farmers who make a living from cultivating dry crops (dry land rice, corn, peanuts, sweet potatoes, vegetables) and from small-scale livestock rearing (usually pigs and chickens). To cope with the hard times, some have no other choice but to eat different food obtained from the surrounding forests, especially tubers locally known as uwi. The fishing community suffers from poor catches during the west monsoon season. In addition, although extended family members may offer assistance in supporting children's educational expenses as well as household consumption in difficult times, the obligation for contributions during weddings and funerals can become a heavy burden. One of the respondents (a 25-year-old man) revealed that a significant part of his income had been used for such expenses and that these expenses were unavoidable. "We are scared of being cursed if we ignore the traditions, so we have to take care of cultural demands first – schooling needs will be taken care of later."

Source: Case studies in North Jakarta and East Sumba, July–August 2010

2.2 Children experiencing multiple deprivations

This section widens and deepens the analysis of child poverty by looking at additional factors of deprivation that can complement the information gained from a consumption-based monetary approach to poverty assessment. This 'multiple deprivation' approach underpins UNICEF's Global Study on Child Poverty, which was initiated in 2007. Understanding how non-monetary factors affect child well-being allows a more detailed consideration of issues of equity and allows for identification of children with the highest levels of needs without placing undue reliance on a poverty threshold that can be difficult to operationalise in programme interventions. Incorporating other characteristics of deprivation among children, including education and work participation, health status, access to sanitation, adequate shelter and water, can provide a more rounded and holistic appraisal of what children need in order to have the opportunity to realize their full potential.

In the following analysis, we have departed from the multidimensional approach outlined in the original UNICEF Global Study of Child Poverty that was based on the 'Bristol approach' developed by researchers at the University of Bristol (UNICEF, 2007). A full description of the multidimensional approach is given in Appendix I. We modified the approach by excluding monetary measure of deprivation to avoid endogeneity problem across dimensions. The limitations of available survey data in Indonesia prevent a replication of the Bristol method using UNICEF's MICS (Multiple Indicator Cluster Survey) or DHS (Demographic and Health Survey) data to identify child malnutrition. But the SUSENAS data support alternative measures of ill health as well as similar measures of education participation. SUSENAS additionally identifies children's employment participation. At the household level (rather than the individual child level), SUSENAS allows identification of deprivation in terms of access to shelter, sanitation and water. Finally, our approach adapts the Bristol approach not only to accommodate data availability but also to follow

nationally agreed definitions and priorities,[7] ensuring that the analysis is of optimal use for application by Indonesian policymakers.

Each dimension and the resulting multidimensional measure are assessed at the individual child and not the household. Each dimension is made up of one or several indicators, which may be based at the child or household level. The education, working children and health dimensions are all based on individual child-level data. However, the shelter, sanitation and water dimensions are estimated based on household-level data; if a household meets the criteria for deprivation on these dimensions then all children living in that household are assumed to be deprived.

Table 2.3 displays the percentage of children that suffer from selected indicators for each of the six separate deprivation dimensions. Some indicators are only relevant to certain age groups of children. For the education dimension, the percentage of children not enrolled in early childhood education (ECE) is calculated as the number of children aged 3–6 years who do not enroll in ECE divided by the total number of children in this age group. The percentage of children not enrolled in primary or secondary school reflects the proportion of children in the 7–17 years age group who do not enroll in school. The child deprivation in education dimension is then calculated as the percentage of children aged 3–17 years that do not enroll in ECE, primary or secondary school out of the total number of children in that age range.

Another indicator that is age group-specific is working children, because SUSENAS only asks about economic labour activities among children aged 10 years old and above. Thus, both working children indicators shown in Table 2.3 are calculated as a percentage of children aged 10–17 years old. Because both indicators have the same population group and their criteria are mutually exclusive, deprivation in this dimension is calculated by simply summing the two indicators.

For the health dimension, the self-reported work/school disrupted by ill health is relevant only for children who are already enrolled in school or working. However, since the self-reported diarrhea and asthma are applicable to all children, the deprivation in this dimension is calculated as the prevalence of any one or any combination of the three indicators.[8] The same method is also applied for the shelter dimension.

Although the reference populations vary across dimensions and indicators, the child multiple deprivation measure is calculated against the total number of children.[9] The result shows that in 2009 approximately 18.3 per cent of Indonesian children were free from deprivation in all seven dimensions (Table 2.4). This means that around 82 per cent of children in Indonesia were deprived in at least one deprivation dimension. Most children (almost 78 per cent) suffered from deprivation in one to three dimensions, while about 8 per cent of children suffered from four or more dimensions of deprivation. Around 55.5 per cent of children were deprived in at least two dimensions. Few were deprived in five dimensions of child poverty, at 1.28 per cent, and even fewer in six dimensions.

The correlation analysis[10] of the six dimensions of deprivation reveals a strong association across

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7 See Appendix I for a more detailed explanation of the differences and the reason for modification of the Bristol approach.

8 Unfortunately, some important health indicators, such as child nutritional status, cannot be incorporated into this analysis because the data are only available from the Basic Health Research (RISKESDAS) survey.

9 This approach is taken based on the assumption that the children outside the reference population of certain dimensions (such as children aged under three years in the case of the education dimension) do not suffer from this deprivation. Thus, children aged under three years (around 17 per cent of the total number of children) can only suffer from six dimensions of deprivation, and children aged under 10 years (around 57 per cent of the total number of children) can only suffer from a maximum of five dimensions of deprivation.

10 The correlation analysis was done by computing overall and age-segregated pair-wise correlations. The age groups were segregated because the SUSENAS Panel data on education and working children was not available for children under 10 years old. The information on early childhood education for children under three years old is excluded because it is not relevant. Children less than three years old are also excluded from the dimensions of education and working children. Children aged between 3–9 years old are excluded from the dimension of working children. Children aged 10–17 years old are fully included in all of the seven dimension analyses. Each dimension reflects deprivation experienced by children and is calculated with a dummy variable (1=poor in each dimension, or 0=else). The use of a dummy variable simplifies the equation and treats each dimension equally, but it makes the correlation less sensitive to individual variables.

Table 2.3: Selected indicators for each dimension of child deprivation, 2009

Dimension of child poverty	Selected indicators	% of children deprived per indicator	% of children deprived per dimension
Education	Children 3–6 years old not enrolled in ECE institutions Children 7–17 years old not enrolled in primary or secondary school	68.98 11.31	25.9
Working children	Children perform economic labour without going to school Children perform economic labour and also go to school	4.71 1.62	6.3
Health	Self-reported work/school disrupted by ill health Self-reported diarrhea Self-reported asthma	16.59 1.66 0.81	17.2
Shelter	Children living in house with a floor area of less than 8m^2 per person Children living in house with an earth floor Children living in house without electric lighting	27.86 10.43 7.85	37.0
Sanitation	Children living in house without a proper toilet*	51.64	51.6
Water	Children living in house without access to clean water**	37.38	37.38

*Note: * live in house with toilet or have access to communal toilet, which is at least a squat-type facility, and the roof is made of iron sheeting; ** includes piped water, rain water, artesian and dug wells, and protected wells and springs (see also the definitions in Appendix I).*

Source: Estimated using data from the 2009 SUSENAS (Panel)

Table 2.4: Children suffering multiple deprivations, 2009 (%)

No	Number of dimensions of deprivation	%
1	No deprivation	18.28
2	Only one deprivation	30.65
3	Two deprivations	29.12
4	Three deprivations	18.49
5	Four deprivations	6.56
6	Five deprivations	1.28
7	All of any deprivations	0.07

Source: Estimated using data from the 2009 SUSENAS (Panel)

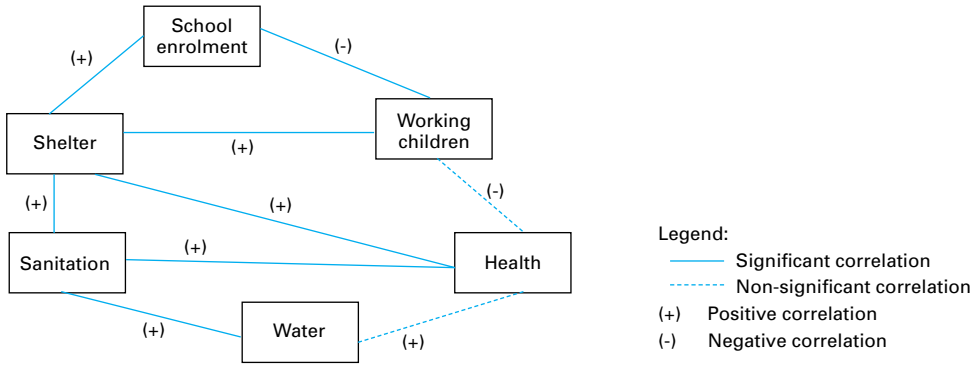
various dimensions (Table 2.6). For children under three years old, deprivation in health was positively and significantly correlated with deprivation of shelter and sanitation but not with deprivation of access to clean water. Deprivation of shelter is shown to be the indirect factor with the strongest association with the health of children under three years of age. In addition, enrolment in formal education prohibited children from performing working children's activities (working was strongly correlated with education deprivation). The analysis also shows that children's participation in the workforce had a small but non-significant negative correlation with health deprivation, potentially indicating no correlation between children's participation in the workforce with their health condition. In contrast, a study using a longitudinal dataset on Indonesia (the Indonesia Family Life Survey, IFLS) found strong negative effects for working children on the growth of both their numeracy and cognitive skills over the a period of seven years, as well as strong negative effects on their pulmonary function as measured by lung capacity (Sim, Suryadarma and Suryahadi, 2011).

Table 2.5: Correlations across dimensions of child poverty deprivation

Age group	Education	Working children	Health	Shelter	Sanitation	Water
Under 3 years						
Education	n/a					
Working children	n/a	n/a				
Health	n/a	n/a	1			
Shelter	n/a	n/a	0.0463*	1		
Sanitation	n/a	n/a	0.0423*	0.3302*	1	
Water	n/a	n/a	0.0099	-0.0155	0.0628*	1
3–9 years						
Education	1					
Working children	n/a	n/a				
Health	0.0531*	n/a	1			
Shelter	0.0453*	n/a	0.0217*	1		
Sanitation	0.0405*	n/a	0.0155*	0.3384*	1	
Water	-0.0126	n/a	0.009	-0.0151*	0.0440*	1
10–17 years						
Education	1					
Working children	0.5950*	1				
Health	-0.0207*	-0.0096	1			
Shelter	0.1362*	0.1087*	0.0254*	1		
Sanitation	0.1738*	0.1430*	0.0197*	0.3399*	1	
Water	-0.0074	0.0063	0.0102	-0.0196*	0.0323*	1
All children						
Education	1					
Working children	0.5950*	1				
Health	0.1164*	-0.0096	1			
Shelter	0.0798*	0.1087*	0.0324*	1		
Sanitation	0.0684*	0.1430*	0.0221*	0.3379*	1	
Water	-0.0123*	0.0063	0.0068	-0.0187*	0.0409*	1

Source: Estimated using data from the 2009 SUSENAS (Panel)
*Note: *significant at p<0.01 level*

Figure 2.5: Pattern of relationships among the six dimensions of child poverty, 2009



Source: Analyzed from Table 2.6

Table 2.6: Children deprived in each dimension by household income quintiles, 2009 (%)

Dimension of Child Poverty	Q1	Q2	Q3	Q4	Q5	Total
Education	35.2	28.6	24.2	20.3	16.6	25.9
Working children	8.0	6.5	6.1	5.0	5.3	6.3
Health	17.2	17.3	17.3	17.6	16.4	17.2
Shelter	60.8	43.2	32.6	23.6	11.4	37.0
Sanitation	78.0	62.8	49.4	33.9	17.9	51.6
Water	41.37	40.34	36.14	32.98	33.63	37.38

Source: Estimated from Susenas Panel, 2009

Table 2.7: Children suffering multiple deprivations by household income quintiles, 2009 (%)

No	Variable	Q1	Q2	Q3	Q4	Q5	Total
1	No deprivation at all	4.95	11.28	18.53	28.97	39.76	18.28
2	Only one (any) deprivation	17.78	27.52	33.47	39.05	44.98	30.65
3	Two of any deprivations	32.37	32.77	29.86	26.79	19.74	29.12
4	Three of any deprivations	29.01	22.03	15.74	11.31	6.32	18.49
5	Four of any deprivations	11.82	7.80	5.27	3.00	1.11	6.56
6	Five of any deprivations	2.47	1.47	0.97	0.46	0.22	1.28
7	All of any deprivations	0.10	0.13	0.02	0.05	0.05	0.07

Source: Estimated from Susenas Panel, 2009

The analysis on the proportion of children deprived in each dimension by household income quintiles confirms the link between monetary and non monetary poverty. Table 2.6 shows that the proportion of children deprived in any dimension decreases as the household income level increases (from children in the poorest quintiles (Q1) to children in the richest quintiles (Q5)). Furthermore, the proportion of children who were free from any deprivation increased along the quintiles of households' income. There were only 4.95 per cent of children in quintile 1 who were free from any deprivation, while in contrast there were 39.76 per cent of children in quintile five who were free from any of deprivation.

2.3 Child deprivation in shelter, water and sanitation dimensions

This section will specifically discuss the shelter, sanitation and water dimensions, to provide a deeper understanding of the related issues and situation. The income dimension of child poverty has been discussed at length in the previous section; while the health, education and working children dimensions will be further discussed in chapters 3, 4 and 5, respectively.

Table 2.7 shows the change between 2003 and 2009 in the deprivation measures for children that relate to household-level standards and amenities: shelter, sanitation and access to clean water. In general, deprivation, in terms of shelter and sanitation, has declined mirroring the declines in monetary child poverty over the same period. However, access to clean water has worsened. Table 2.7 also shows both the percentage point change in these indicators and the underlying growth and decline rates. Given the different units of measurement and the different levels of deprivation at the starting point in 2003, it is most useful to think of changing deprivation levels in terms of the decline and growth rates rather than absolute change. 'Overcrowding', using a measure of 8 square metres per person per household, was the most common deprivation; 26 per cent of children were deprived of adequate space in 2003, reducing 8.6 per cent by 2009. Deprivation of electricity for household lighting fell much more quickly in the same period, by almost 52 per cent, from 15.5 per cent of children deprived to just 7.5 per cent in 2009. Having an earth floor in the house also fell from 15.1 per cent of children in 2003 to 10.1 per cent in 2009, a decline of almost 29 per cent. Turning to sanitation, the proportion of children without

Table 2.8: Children suffering shelter, sanitation and water deprivations, 2003–2009 (%)

Dimension of poverty	Indicators	% Children deprived		Percentage point change	Decline/Growth
		2003	2009		
Shelter	Area <8m2/person	26.2	23.9	-2.3	-8.6%
	Earth floor	15.1	10.8	-4.3	-28.7%
	No electricity for lighting	15.5	7.5	-8.0	-51.7%
Sanitation	No proper toilet	53.7	35.6	-18.1	-33.7%
Water	No access to protected and clean water sources	29.3	35.1	5.8	19.9%

Source: Estimated using data from the 2009 SUSENAS (Panel)

access to a proper toilet is a very common deprivation, which affected a majority of children in 2003 (53.7 per cent) but improved rapidly to 36 per cent in 2009 – a decline of 33.7 per cent in six years for this deprivation.

On the other hand, water deprivations for children have risen during the same period, with the proportion of children having no access to clean water rising from 29.3 to 35.1 per cent – a 20 per cent growth in this deprivation. The definition of 'safe and improved water sources' in this analysis includes piped water, rain water, artesian and dug wells, and protected wells and springs; and the water sources must be located further than 10 metres from any septic tank.[11] Data are derived from items in the SUSENAS regarding the main source of drinking water, which is affected not only by the availability of water sources but also the preference of household members. An analysis using a different approach that defines 'access to safe and clean water' as consuming mineral water, tap water, or water from water pumps, protected wells or protected springs[12] has resulted in the opposite trend, with the percentage of children deprived of access to safe water declining from 30.6 per cent in 2003 to 26.2 per cent in 2009, a decline of approximately 14 per cent. These differences indicate that more households may have shifted to the use of mineral and tap water, but no data are available that might explain the reason behind this shift.

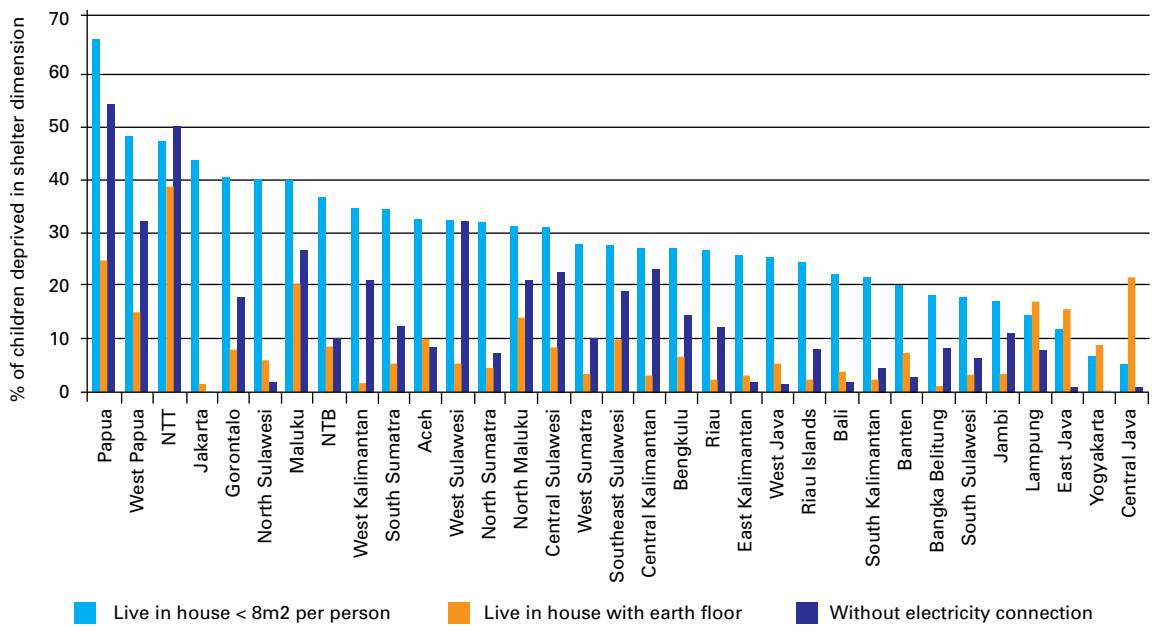
Provincial disparities in terms of shelter, water and sanitation deprivations are shown in Figure 2.6 and Figure 2.7. The shelter deprivations shown in Figure 2.6 show that very high proportions of children in Papua and other eastern provinces live in households with earth floors, lack of electricity and overcrowding. In general, urban and population-dense provinces seem to have lower levels of electricity deprivation, but have higher levels of overcrowding. Children in Jakarta, in particular, suffer more from overcrowding, but are unlikely to have an earth floor or to lack electricity. Housing structure – reflected in space per household member and type of floor – is somehow also associated with local or traditional housing designs. Most traditional houses in East Nusa Tenggara and in Papua, for example, have earth floors.

Water and sanitation deprivations are shown in Figure 2.7. There is less correspondence at the provincial level across these two dimensions, with West Sulawesi and Papua having the highest rates of children living in households without a proper toilet (63.5 and 62.8 per cent, respectively), but children in West Kalimantan having the highest rates of lack of access to clean water (85.8 per cent), followed by Papua (78 per cent).

[11] This definition is the formal definition used by the Government of Indonesia's National Development Planning Agency (BAPPENAS), BPS – Statistics Indonesia, and Ministry of Public Works (Kementerian Pekerjaan Umum) for development programmes.

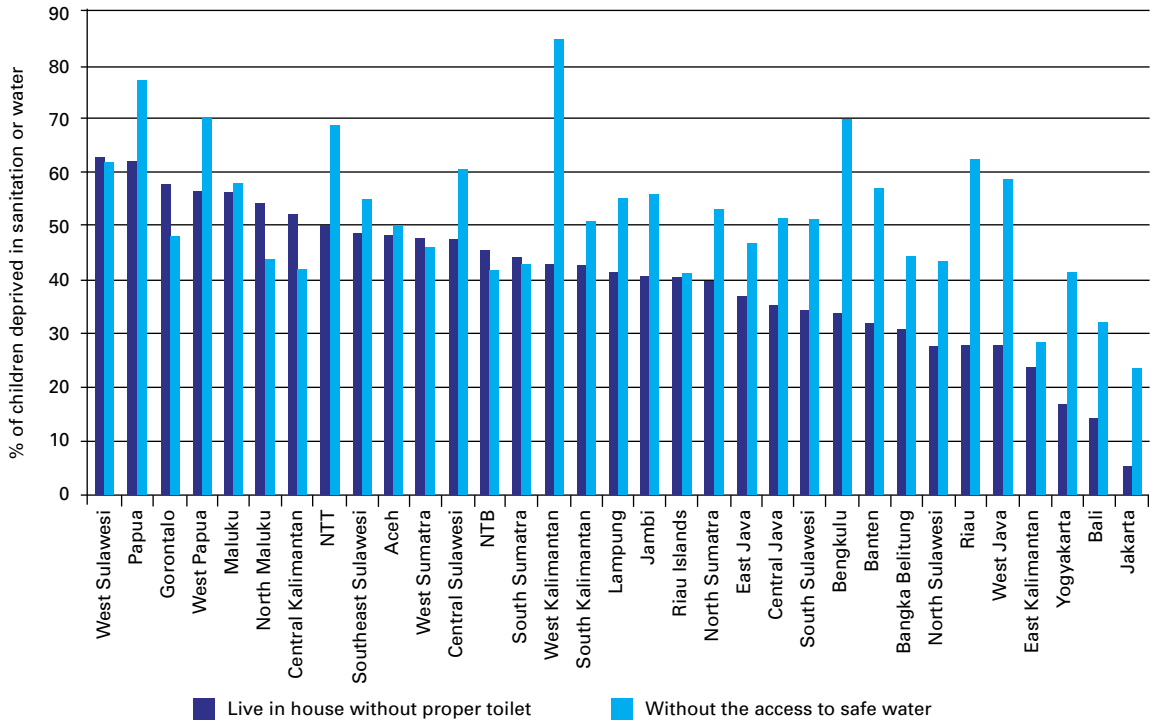
[12] This definition is commonly used by the United Nations Development Programme (UNDP) in Human Development Reports.

Figure 2.6: Children deprived of shelter by province, 2009 (%)



Source: Estimated using data from 2009 SUSENAS (Panel)

Figure 2.7: Children deprived of sanitation and water by province, 2009 (%)



Source: Estimated using data from 2009 SUSENAS (Panel)

At the district level, the variation among rates of shelter, sanitation and water deprivations for children increases. SUSENAS data suggest that local districts in Papua and other remote rural areas may have close to 100 per cent of children living in households that have shelter deprivations (overcrowding and/or earth floors), or no access to clean water or sanitation. Looking across all 455 districts in the country, in each deprivation dimension the most deprived 10 per cent of districts had the following average child deprivation rates: shelter, 82.5 per cent; sanitation, 78.7 per cent; and water, 87.4 per cent. On the other hand, the least deprived 10 per cent of districts had deprivation rates far below average: shelter, 15.6 per cent; sanitation, 5.8 per cent; and water, 15.6 per cent.

Table 2.8 shows the bi-variant relationships between deprivations in shelter, sanitation and water, and selected household characteristics. The levels of child deprivation in these dimensions were strongly associated with the economic conditions of the households (household consumption), urban/rural location, education level of the household head and household size, but not with gender of the household head. The analysis presented in Table 2.8shows that the gap between household deprivations experienced by children in the poorest quintiles and the richest quintiles were the most obvious. More than half of the children in the poorest consumption quintile lived in inadequate shelter and had no access to sanitation, while only 10 per cent of children in the richest quintile suffered from shelter deprivation, and 5 per cent had no access to proper sanitation. Urban/rural disparities also persist, particularly in regard to sanitation. The poor children in urban areas, for example, are still severely deprived of access to sanitation, despite the relatively low overall deprivation levels for urban children. The education level of household heads seemed to be a key factor, and it also correlated highly with households' consumption levels. The differences between deprivation levels among children from households headed by tertiary school graduates and those from households headed by less educated people were quite striking. On the other hand, while household size (number of members) was strongly associated with shelter deprivation (overcrowding), it did not seem to be linked to deprivation of sanitation or access to clean water.

Table 2.9: Children deprived of shelter, sanitation and water by household characteristics, 2009 (%)

	Shelter			Sanitation			Water		
Gender of household head									
Female	32.34			37.37			32.54		
Male	34.25			35.44			35.36		
Number of household members									
Less than 3	27.14			41.4			33.24		
3–4 members	27.1			34.99			35		
5–6 members	33.8			34.41			35.27		
7+ members	52.19			39.48			35.26		
Educational level of household head									
None/incomplete primary school	45.92			57.74			31.2		
Finished primary school	38.42			44.64			32.53		
Finished junior secondary school	33.81			29.4			35.05		
Finished senior secondary school	22.98			12.47			39.68		
Finished diploma/academy/ university	9.39			3.57			45.79		
Geographical location and household consumption level	All	Urban	Rural	All	Urban	Rural	All	Urban	Rural
All	34.09	26.79	40.36	35.6	16.17	52.27	35.13	39.67	31.24
Q1	56.55	49.89	58.72	63	46.06	68.53	30.3	31.68	29.85
Q2	38.82	36.2	40.33	45.29	27.93	55.31	30.71	30.79	30.66
Q3	28.65	28.79	28.53	30.33	15.11	44	33.52	35.47	31.78
Q4	21.71	22.91	19.8	15.48	6.44	29.78	37.97	40.81	33.48
Q5	10.22	9.79	11.7	5.15	1.85	16.65	48.52	52.3	35.34

Source: Estimated using data from the 2009 SUSENAS (Panel and Core)

Box 2.2: Living conditions of poor children

In one of the study precincts in North Jakarta, poor people are living in very crowded settlements constructed on top of a disused garbage dump, including sections of a swamp. In the other study precinct, settlements of the poor are located along the coast, wedged between piles of oyster shells. The sanitation conditions in both settlements are very poor. Discharge from household toilets flows into open canals. Garbage often clogs the canals, causing flooding during high tide or heavy rains. According to local health personnel, the most common diseases among children in this slum area are: diarrhoea, respiratory diseases and skin infections, all caused by the unhealthy environment. Ima (not her real name) is a 14-year-old girl who lives with her younger sibling, mother and stepfather in a two-storey house made of plywood and zinc. Located nearby is a petrol storage facility and she can smell the petrol fumes from her house. To reach her house, she has to walk on pieces of scrap wood because the path is flooded with a mixture of water and garbage. Her house stands on a garbage pile covered over with plywood and low quality wood is used as a floor, which feels soaking wet. Many neighbourhood dogs wander around her house. She says, "living here is both comfortable and not comfortable. It is comfortable because I have many friends, but not comfortable because there are a lot of dogs and drunks."The service from the state water company (PAM) does not reach her house, therefore her family has to buy water from water peddlers, and for bathing they use low quality water from a nearby well. Her family is quite lucky because they have their own toilet. Relatively few families have toilets, while others have to go to a public toilet near the coast and pay 500 rupiah for urination and 1,000 rupiah for defecation or to wash themselves.

In the study villages in East Sumba there are still many houses built on stilts that use the undercroft formed below the house to raise farm animals, such as pigs, chickens and dogs. Meanwhile, poor ex-transmigrants (who relocated there from other parts of the country) still live in the ration houses provided by the government with earth floors. Most poor households do not have a proper toilet or any toilet at all. Those who do not have a toilet will defecate in the farmlands behind their houses. Like in other regions in East Sumba, clean water is scarce because of the very dry climate. Clean water can be obtained from private or communal wells, but these are often dry during the dry season. People living close to the spring can get water from pipes that pump the water from the spring, but this water is only available in the morning and afternoon. The poor condition of these houses is worsened by the large numbers of people staying in each house. Ani, a 16-year-old girl, lives with her parents and five brothers and sisters in a 6x6 square metre house. Her two-bedroom house is board-walled, tin-roofed and earth-floored and is a transmigrant ration house. She accesses an electricity connection from her neighbour using 120 metres of cable and pays 25,000 to 30,000 rupiah for this per month. The bathroom is a cubicle with walls made of coconut leaves and no roof. Nearby is a water container (also a transmigration ration) used to store water from the spring, but most of the time the flow is very weak, particularly during the dry season. Ani has no toilet so she defecates in the farmland behind her house. According to the local leader, the poor sanitation in this area has caused many children to become infected with malaria.

Source: Case studies in North Jakarta and East Sumba, June–August 2010

Regarding access to water, it is important to note that the official definition of clean water in Indonesia does include rainwater[13] as one of the safe sources, while excluding packaged/bottled water (commonly used by wealthier households). This has implications for the interpretation of the data on access to clean water. Based on the official definition, children in the poorest consumption quintile and those living in rural areas are the least deprived, while their counterparts in the richest quintile and urban areas are the most deprived, since they are least likely to use rainwater as their water source.

Deprivations in shelter and lack of access to proper sanitation and clean water, which affect the lives of children in income poor households, also influence children's health as well as their non-material well-being, including their sense of comfort and security. Findings from the qualitative study in Jakarta and East Sumba, as presented in Box 2.2, provide snapshots of these deprivations as they are experienced by children in an urban slum and a poor rural area.

2.4 Non-material deprivation

Evidence from national data sets

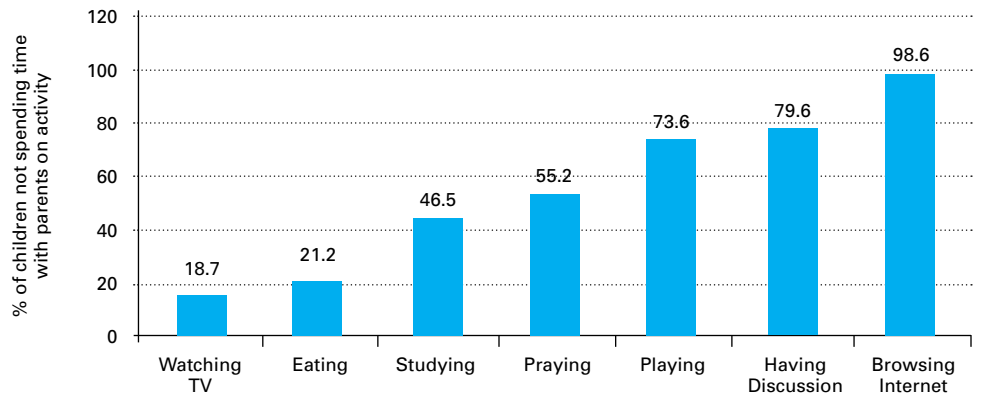
Non-material aspects of well-being are as important as material well-being in realizing a child's rights, as stipulated in Law No. 23/2003 and other relevant laws and regulations regarding child protection. As specified in Chapter 3, Article 11 of Law No. 23/2003, children are entitled to have adequate rest and leisure time to play with their peers, for recreation and creativity, in accordance with their interests, talents and capacities, because this supports a healthy childhood. This section is devoted to exploring the types and extent of non-material deprivation affecting children in Indonesia. The definition of non-material deprivation includes the denial or neglect of children's emotional and spiritual needs, regardless of their socio-economic background. Thus, non-material deprivation embraces a wide range of mental and spiritual insufficiencies faced by children. While many dimensions of material deprivation are clearly documented in the available national statistics, the non-material dimensions are inadequately captured in any national or regional data sets. Material and non-material dimensions of well-being are interconnected such that information on some aspects of non-material deprivation can be inferred from available data on other dimensions, such as children's engagement in paid and unpaid labour, and children's suffering due to criminal acts. However, as discussed further in Chapter 5, reliable statistics related to many aspects of child protection are still lacking.

The non-physical aspects of deprivation represented in the national statistics are very limited. Interaction between children and parents is captured by the socio-cultural module of the SUSENAS, and these data are collected every three years. The 2009 data revealed that the most frequent activities conducted by children aged 10 years and above together with their parents are watching television and eating, followed by studying and playing. As shown in Figure 2.8, 46.5 per cent of children do not study with their parents, and more than half do not pray, play, have discussions or browse the Internet together with their parents.

The Indonesia Family Life Survey (IFLS), a nationally representative data set with a smaller sample than the SUSENAS, also captures the frequency of children meeting with their parents and communicating with them by other means, such as using a telephone or the Internet. The IFLS data for 2000 and 2007 (Figure 2.9) show that only a small proportion of children met their parents (both father and mother) everyday, and that more and more children in rural areas only meet their parents once a year. This type of separation might be related to increasing rural–urban, domestic and international migration. It is also important to note that quite a significant proportion of children 'never' meet their parents, although this proportion has declined over time.

[13] See the definition of safe water in Appendix 1.

Figure 2.8: Children not spending time with their parents in various types of activity, 2009 (%)

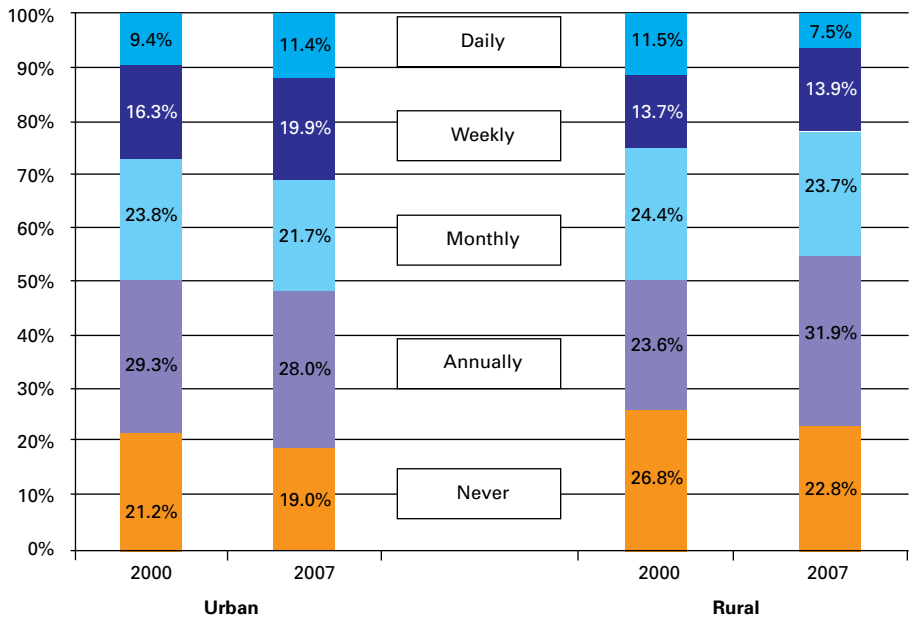


Source: Estimated using data from the 2009 SUSENAS socio-cultural module

In 2007, around 19 per cent of urban children and 23 per cent of rural children had never met with their parents. This figure is slightly higher than the proportion of children not living with their parents (approximately 16 per cent), as estimated from the 2009 SUSENAS (see Table 1.5, Chapter 1).

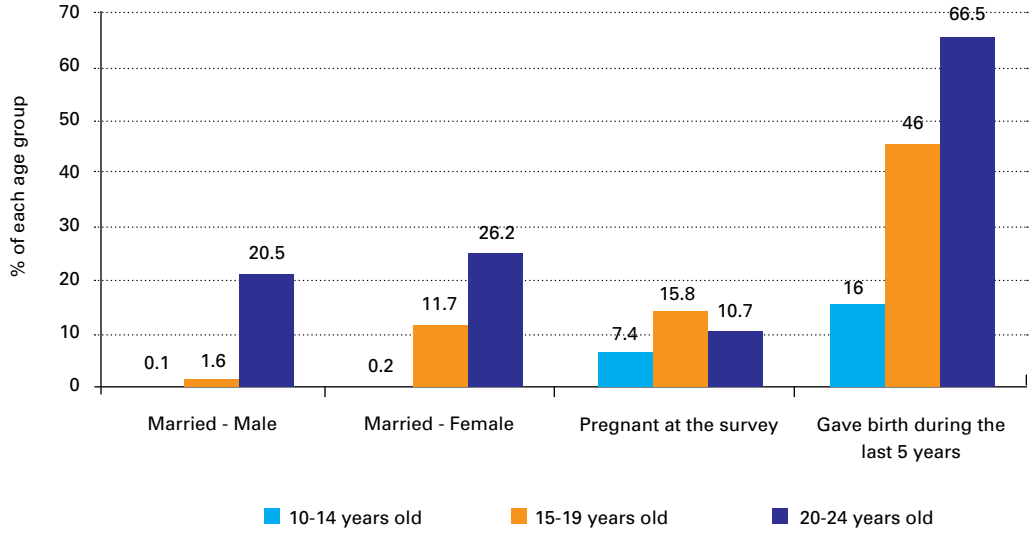
Child marriage can be considered as one form of non-material deprivation since marriage brings new responsibilities and an increased risk of early pregnancy, which limit the opportunities of those under age 18 years to enjoy many aspects of their rights as children. The 2010 Basic Health Research (RISKESDAS) data reveal that 7.4 per cent of 10- to 14-year-old girls and 15.8 per cent of 15- to 19-year-old girls were pregnant during the time of the survey (Figure 2.10). The same data also show that 0.1 per cent of boys and 0.2 per cent of girls aged 10–14 years were already married, and among those aged 15–19 years, 1.6 per cent of the boys and 11.7 per cent of the girls are also married. The 2009 SUSENAS also revealed that 0.21 per cent of children were already married (see Table 1.5 in Chapter 1, section 1.3). The SUSENAS data also show that 0.86 per cent of women aged 14–49 years married before the age of 15, and 5.91 per cent married before the age of 18, which means that 4 per cent of women aged 10–54 years married at the age of 15–17 years. The disaggregated data show a decreasing proportion of married individuals among the younger age groups. Among the various factors that may potentially be associated with (or predictive of) child marriage, it seems that household size and the education level of the girls were not significant. Meanwhile, household economic background seemed to be influential. This can be inferred from the fact that the proportions of women who married before the ages of 15 and 18 years were twice as high among the poorest quintile as compared to the richest quintile, and a larger proportion of girls married young in households with at least one working child and households with a single parent, compared to the national average (Table 2.9).

Figure 2.9: Frequency of children meeting with both parents, 2000 and 2007



Source: Estimated using data from IFLS 3 and IFLS 4

Figure 2.10: Child marriage, pregnancy and childbirth among the population aged 10–24 years, 2010



Source: RISKESDAS 2010, cited in Atmarita, 2012

Table 2.10: Child marriage and correlates, 2009

	Women aged 15–49 married before age 15 (%)	Women aged 15–49 married before age 18 (%)
Total incidence	0.86	5.91
Individual dimension		
Age		
Age group 1 (15–20)	0.29	3.79
Age group 2 (21–25)	0.75	7.56
Age group 3 (26–30)	1.3	10.52
Age group 4 (31–40)	1.9	13.34
Age group 5 (41+)	1.28	6.91
Household dimension		
Household size		
Less than 3	1	5.36
3–4 members	0.9	6.55
5–6 members	0.82	5.61
7+	0.75	4.99
Women's education		
None	1.68	11.43
Primary	1.78	12.23
Secondary+	1.74	11.99
Gender of the head of the household		
Male	0	0
Female	1.74	9.32
Wealth index quintiles		
Q1 (poorest)	1.19	7.48
Q2	1.06	7.07
Q3	0.87	6.35
Q4	0.66	5.12
Q5	0.47	3.12
Work (not mutually exclusive categories)		
Both parents working	0.91	6.33
None of the parents working	0.9	6.09
No adult in primary working age (18–54 years)	0.01	0.08
At least one child under age 15 working	1.72	7.66
Illness and disability in the household		
Child/children with disability	n/a	n/a
Family vulnerability		
Single parent	1.07	7.23
High dependency ratio (4+ children per adult)	0.8	5.27
Elder (age 70+) person in household	0.48	3.37
Residence		
Urban	0.55	4.06
Rural	1.15	7.63

Source: Estimated using data from 2009 SUSENAS

Evidence from the qualitative study[14]

Qualitative case study evidence from North Jakarta and East Sumba[15] can provide deeper insights into how children experience deprivation. Table 2.10 presents examples of non-material deprivation described by children during focus group discussions with children

[14] The qualitative study was conducted only in two precincts in North Jakarta and two villages in East Sumba. It is not meant to provide nationally representative evidence, but only a snapshot of non-material deprivation from the children's perspectives (refer to Appendices I and II).

[15] A series of discussions and interviews with children and families (in the case study locations) were arranged in order to identify and describe non-material deprivation experienced by children from their own perspective, both in urban and rural settings. Although the small qualitative study is not nationally representative, this will serve as an initial assessment of the non-material deprivation facing children and the factors contributing to it.

Table 2.11: Problems and situations that contribute to a sense of deprivation in children

Age group	Urban	Rural
Primary school aged children (SD)	**Material:** • Rainy season and *rob* (flooding because of seawater high tide) • Dry season (lack of water) • Electricity power outages (fear of dark) **Non-material:** • Difficulties in learning maths, social studies, Indonesian (Bahasa Indonesia) and English languages	**Material:** • Have to fight with classmates to get a seat • Have to do domestic chores (collect water from well, etc.) **Non-material:** • Fighting with friends • Problems with teachers (mean teacher, being asked to pluck teacher's grey hairs) • Difficulties in learning maths • Too much writing in Indonesian language *(Bahasa)* lessons
Junior secondary school aged children (SMP)	**Material:** • Parents don't give money • Have been mugged by street criminals • Parents' financial problems **Non-material:** • Problems with teachers (a teacher got angry, punishments, teaching method too textbook based) • Problems with parents (parents got angry if they play too much) • Problems with friends (fighting, slandered by a friend, no solidarity) • Problems with siblings (fighting with each other) • Have to babysit younger sibling • Siblings teased by other people • Eviction by security officers (Satpol PP) who are not friendly to street children (singing beggars, etc.) • Sexual harassment by stepfather • Feeling tired after school but still being forced to study again • Heartbroken (breakup with boy/girlfriend, rejected) • Seniority in school	**Material:** • Chairs at school broken • Water not clean • Mosquitoes because of the unclean environment • Toothache • Frequent abdominal pain, headaches and malaria • Teachers who do not attend school • Parents' financial problems • Inadequate food intake (less nutrients, no breakfast, parents do not provide pocket money) **Non-material:** • Theft at school • Difficulties in school lessons • Problems with friends (disturbed by friends)
Senior secondary school aged children (SMA)	**Material:** • Unemployed father • Flooding • Drugs • Theft in the neighbourhood • Have been mugged by street criminals **Non-material:** • A married sibling still lives at parents' house (house too crowded) • Problems with boy/girlfriend • Problems with parents • Missing mother who lives apart from them • Prohibited from playing at friend's home • Promiscuity • Pregnant outside of marriage • Brawl (mass fighting) • Unemployment among teenagers • Too much playing with friends • Domestic violence • The boss got angry • Eviction by security officers (Satpol PP) who are not friendly to street children (singing beggars, etc.)	**Material:** • No secondary school nearby, in the sub-district • Inadequate computer facilities at school; unable to practice the lesson • Inadequate health facilities (inadequate medicine supply at community health centre) • Ambulance too expensive • Environment (endemic malaria) • People usually put animal cages near the houses • Dry season (famine/hungry season) • Family financial problems • Too far to school • Live in remote location **Non-material:** • Difficulties in maths lesson • Teacher too strict • Family problems • No family/relatives live near school • Laziness of people

Source: Focus group discussions with children aged 7–18 years in North Jakarta and East Sumba

aged 7–18 years about common problems and situations that make them feel deprived in some aspects of their lives. Most of the poor children who participated perceived that non-material deprivation originated from the poor services and unfair treatment they received from their parents, peers, teachers and communities, and due to the limited availability of public facilities.

In the surveyed areas, rural poor children experience more material deprivations than urban poor children due to inadequate basic facilities (e.g., schools and health facilities) and remote location. Even so, it is important to note that some of the non-material deprivation is generated from material deprivation. For example, the lack of secondary schools in a village will make it difficult for children to attain a higher education. Some families who have relatives living in the city or in other villages closer to schools may have the option of sending their children to live with these relatives during the school term. But this is not an option for those who do not have any relatives living near a school or for those who do not have the financial resources needed to send their children to school. Not attending school makes children feel unhappy. The other material problems faced by children in rural areas include inadequate health facilities, limited access to clean water and unclean environments.

In both East Sumba and North Jakarta the prominent non-material deprivations faced by poor children were related to inadequate leisure time and their vulnerability to violent acts by parents, elder siblings, teachers or other community members. In terms of inadequate leisure time, most children in East Sumba said that they were heavily engaged in domestic chores after school including cooking, washing, taking care of their younger siblings, looking for grass to feed livestock, and working on farms, as expressed in the following quotes from study participants:

"Masih jalan jauh dari sekolah. Panas lagi, jadi saya kurang bahagia." (School is far to walk from home. It's hot also, so I'm not happy.)
"Tidak tidur siang; kerja banyak." (No time to take a midday nap; too much work.)
"Terlalu banyak kerja di rumah; cape!" (Too much work at home; I am exhausted!)
"Senang kalo tidak disuruh kerja." (I am pleased if I am not told to work.)
"Senang kalo bisa bermain." (I am happy if I have time to play.)
"Saya tidak suka timba air karena jauh dan berat." (I don't like collecting water because it is far away and too heavy.")
"Mama sering sakit jadi saya cape, kerja sendiri." (My mom often gets sick and I am tired because I have to handle all the work at home.)
"Tumbuk padi bikin cape dan tangan melepuh." (Grinding rice makes me tired and my hand gets blistered.)
"Saya tidak suka cabut rumput di kebun, banyak duri." (I don't like working in the field collecting grass; there are many thorns.)
"Senang kalau liburan." (I am happy if there is a holiday.)
"Senang kalo libur dan tinggal di rumah nenek, karena kerja sedikit." (I am happy if I have holidays and can stay at my grandmother's house because there is less work to do.)
"Sedih.Jauh dr nene.Nene suka manja." (I am sad. I live far from my grandmother. She likes to spoil me.)
"Saya pingin mendapat kasih sayang dari orangtua." (I wish I could get love and affection from my parents.)
"Saya kurang bahagia karena jauh dari orang tua." (I am not happy because I am far away from my parents.)

Meanwhile, in North Jakarta, some children had to engage in paid work and had less leisure time to spend with their friends. Some children felt happy when it was raining, because they would have time to play instead of shucking mussels. Children working in the street as singing beggars, scavengers, or bajilo, were unhappy when they were victims of violence by security officers or gangsters. Many children mentioned having to obey their parents or elder siblings and said they feared severe (physical) punishment, such as being beaten. Some of the children said that they preferred to spend holidays with other relatives because they had fewer household chores to do there. The following are selected direct quotes from children regarding these situations:

"Saya tidak suka jaga adik; adik rewel, dan ibu pergi dagang." (I don't like taking care of my younger sibling; she is difficult when my mother leaves the house to go selling.)

"Kalau hanya nyuci baju sendiri ngga apa-apa.Tapi jangan disuruh nyuci baju semua anggota keluarga. Jadi bisa nonton TV lebih lama." (Washing my own clothes is fine. But don't tell me to wash the clothes of the whole family. I can spend more time watching TV.)
"Senang kalo ngga dikasih tugas jagain adik yang masih kecil. Maunya adik cepet besar." (I would be happy not to have to take care of my younger sibling. I hope he grows up quickly.)
"Cukup dinasehatin aja.Jangan pake marah-marah." (It's enough for parents togive us advice. They shouldn't get angry and use harsh words.)
"Saya pingin membantu keluarga tanpa percecokan." (I wish I could help my family without having arguments.)
"Saya pingin bisa rekreasi di tempat wisata, jalan-jalan ke Ancol" (I wish I could have recreation time at some tourist attractions, like going to Ancol)
"Saya senang kalo liburan Lebaran; kumpul-kumpul dan main-main dengan teman-teman, pergi ke keluarga." (I am happy during the Lebaran holiday; we get together and play with friends, and visit my extended family.)
"Saya senang kalo hujan, karena tidak ikut bekerja mengupas kerang dan bisa bermain." (I am happy on rainy days because I do not have to work shucking mussels and I can play with friends.)
"Gitar saya pernah dipecahkan oleh Satpol PP gara-gara ngamen." (My guitar was once destroyed by the security officer because I was busking for money in the streets.)
"Sering dipalak sama premen; dipukul atau ditelanjangin kalo tidak dikasih uang." (We often get mugged by the gangsters; they hit us and strip our clothes off if we don't give them money.)

In East Sumba, apart from the daily chores at school, like washing and sweeping the classrooms and toilets, students were upset to be given additional chores such as providing leg massage services to male teachers or pulling out teachers' grey hairs during school breaks. Some lessons, such as mathematics and English, tended to make them feel dispirited due to the difficulty of mastering these subjects. On the other hand, some children living in dormitories or with relatives close to their schools were unhappy due to being far away from their parents. The following are examples of direct comments about their school situations obtained from children during FGDs in East Sumba:

"Pelajaran matematika susah, guru galak." (Mathematics is hard, the teacher is mean.)
"Malas ke sekolah; takut guru." (I'm reluctant to go to school; I'm scared of the teacher.)
"Pingin dapat rangking tapi tidak pernah." (I wish I could be a top student at school, but it never happens.)
"Pada jam istirahat, beberapa anak laki-laki diminta pijit kaki guru dan lainnya mencari rambut uban." (During the break time at school, some of us boys have to give leg massages to the teacher and others have to pull out his grey hairs.)
"Saya pingin dapat nilai bagus dan membuat orangtua senang." (I wish I could get good grades and make my parents happy.)
"Saya tidak suka pelajaran PPKN karena tulis terus." (I don't like PPKN - Pancasila and citizenship lessons - because we have to write constantly.)

Similarly, in North Jakarta, some children were unhappy and frustrated with teachers who punished them for not doing homework, not bringing their text books, or chatting during lesson time. Some children complained about being mugged by adults on the way to school, particularly when passing through unsafe areas. They had to pay IDR500–1,000 or all the money in their pockets. The following are examples of direct quotes on the situation in schools in North Jakarta:

"Bisa membanggakan orang tua dengan mendapat nilai bagus di sekolah." ([I wish] I could make my parents proud of me by getting good grades at school.)
"Dapat penghargaan kalau lomba atau dapat beasiswa." ([I wish] I could win a prize in a competition or obtain a scholarship.)
"Lulus sekolah."([I wish] I could pass the final exam.)
"Mendapat nilai bagus." ([I wish] I could obtain good grades.)
"Kadang bete sama pelajarannya." (I am sometimes frustrated with the lessons.)
"Kadang gurunya galak." (The teachers are sometimes mean to us.)

Most of the unpleasant feelings experienced by children are similar in both urban and rural areas. As described in Box 2.3, the list of daily activities that they do not like illustrates that many of the daily tasks, including those at home, school, and for religious activities, might be taking up too much of their time and overburdening them. Poor children from these

Box 2.3: Daily activities the children do not like

Urban	*Rural*
• *Taking a nap* • *Going to school (for school children)* • *Taking a sibling to school* • *School cleaning chores* • *Praying rituals* • *Babysitting younger siblings* • *Domestic chores (e.g., house cleaning)* • *Studying*	• *Having to provide services to teachers (e.g., plucking the teacher's grey hair, massage)* • *Walk a long distance to school* • *School cleaning chores (cleaning the toilet)* • *Praying rituals* • *Domestic chores (e.g., mopping, draw water from well, cooking, farming, wood gathering, mashing rice)* • *Studying*

areas may have little variation in their daily routine and this monotonous pattern eventually makes them dislike these activities.

Children's feelings of happiness and discontent also vary across seasons and events. Their feelings change as a result of the experiences they have had during each season. For children living in an urban environment, an unhappy feeling is often experienced during the season is caused by an environmental threat. Environmental degradation along with poor living conditions affects children in the form of skin disease, and reduced income – for children working shucking mussel shells in the wet season, and lack of water supply in the dry season. Even so, children can often still derive enjoyment out of the disruption. For example, even though water had flooded their neighbourhood in the wet season, they could still play and have an adventure making rafts, providing them with a recreation outlet, making them feel happy. For children living in rural areas, those who were obligated to help their parents in the fields during the wet and dry seasons were unhappy – some were temporarily withdrawn from school to help on the farm. Working on the farm sometimes makes them happy, especially during fruit harvest season, because then they can eat a lot of fruit and make money from selling it. In general, children in both urban and rural areas feel happy when the holidays come. Table 2.11 summarizes children's feelings about various events in their daily lives.

The secondary school-aged children, both girls and boys, consider both material and non-material dimensions important for their well-being. Being recognized for their achievements, being loved and having good relations with their parents and extended family were all identified as being important aspects of non-material well-being. The results of the discussions with children aged 15–18 years are presented in Figures 2.11and 2.12, showing that the non-material components of well-being were more varied than the material components. Among the non-material components, affection from parents and good relations with their extended families were quite dominant, both for boys and girls who participated in the case study villages and urban precincts. In addition, achievements in and outside of school – and recognition for these achievements – also contributed to their non-material well-being. As poor children in rural areas experience more material problems than those in urban areas, having new possessions, like clothes, a bicycle, a mobile phone and stationery items, contributed to their sense of well-being. On the other hand, well-being for children in urban areas is not merely about getting something but also being able to give something to other people. As revealed in a discussion with secondary school-aged girls in the sample area in North Jakarta, to give a gift or surprise to someone, and to have enough money for their parents and siblings are both contribute to a sense of well-being for them.

Table 2.12: Events during the year that affect children, and their feelings about the events

Urban	Rural
Wet season Unhappy because of flooding **Independence Day celebration** Enthusiastic to participate in Independence Day competitions **Prophet's birthday** Religious holiday **Weekend** Happy because of free time **West monsoon** Can only shuck 1–2 sacks of shellfish in 3 days, and receive less money Can play *getek* (self-made raft) Girls usually help their parents clean the water that enters the house Get skin diseases (itchy) Flood sea water at high tide (and theft) **School holidays** Happy, going on picnics **Marine festival** Happy; lots of food, playing in the water, sailing to islands Sometimes feel afraid if there are boat accidents **Dry season** Unhappy, because of limited water supplies; have to buy water from water sellers Happy because they can play in the field nearby, which is usually a water pond **Fasting month** Happy and busy with a lot of religious activities **New Year** Playing with firecrackers **Wedding season** Help to wash dishes at wedding venues, get money **Election of community leaders** Just watching many people gathering	**Wet season** Remove grass in preparation for planting corn Fix the fence (planting timber for fencing) Afraid of snakes **Harvest season** Helping parents on the farm **Hungry season** No rice **Dry season** Gathering sweet roots in the weeds **School holiday** Go home and see parents **Traditional ceremonies** Watching so many people gathering **Planting season** Sometimes cannot go to school as they must help their parents on the farm **Fruit harvest season** Eating a lot of fruit, making money from selling the fruit

Source: Case studies in North Jakarta and East Sumba, June–August 2010

Figure 2.11: Children's sources of well-being (material and non-material) revealed during FGDs with secondary school-aged boys in urban and rural areas

Urban

Material	Non-Material
Receiving money from mother (pocket money)	Being a winner in Independence Day events
Receiving a gift (stationery)	Recreation or going on a picnic (to the beach, zoo, visit relatives)
Receiving a surprise on their birthday	Playing with friends
Religious holidays (receiving money and new clothes)	Getting high grades at school
Receiving an award from the teacher (an academic certificate)	Birthday
	Receiving love and affection from parents
	Being a top student
	Making parents proud
	Visiting their hometown *(mudik)*

Rural

Material	Non-Material
Getting new clothes	Getting high grades and being a top student
Getting a new bicycle	Going to school (being a student)
Getting new shoes	Receiving love and affection from parents
Getting a scholarship	Religious holidays (a lot of treats, family gathering)
	Birthday party events (dancing)

Figure 2.12: Children's sources of well-being (material and non-material) revealed during FGDs with secondary school-aged girls in urban and rural areas

Urban

Material	Non-Material
Receiving a gift	Being a useful person in the future and helpful to other people
Getting a new mobile phone	Meeting with relatives in hometown
Being treated by someone	Living in peace and happiness with friends and family
Wanting to have a lot of money (for her parents and siblings)	Making parents happy
Giving gifts/surprises to someone	Able to read the Holy Quran
	Drawing scenery (especially the mountains)
	Gathering with family (rarely meet each other because of need to make money)
	Receiving affection from parents (sad when the parents give more affection to younger siblings)
	Making parents proud
	Seeing my grandmother smiling
	Recreation/going on a picnic with family
	Making everyone happy

Rural

Material	Non-Material
Getting new stationery	Parents being home
Getting new clothes	Being with parents
Getting a mobile phone	Passing to the next grade at school
Getting a bicycle	Not obligated to do domestic chores
	Playing

CHAPTER 3

Health and nutrition

3.1 National laws, regulations and programmes

The 1945 Constitution (UUD 1945) stipulates that all Indonesians have the right to life, the right to enjoy a healthy environment and to receive medical care (Article 28H, clause 1), and also the right to social security to support human development and dignity (Article 28H, clause 3). The state is responsible for developing a social security system for everybody (Article 34, clause 2) and for providing proper medical and public services (Articles 34, clause 3).

The provision of health services that are accessible to poor families is one of the more important efforts asserted in various laws. Law No. 23/2002 on Child Protection stipulates that the Government of Indonesia (GoI) ensure that poor families (parents and children) can receive comprehensive health services that are free of charge (Article 44, clause 4). Law No. 11/2009 on Social Welfare stipulates that one of the essential efforts towards poverty reduction is the provision of access to basic health services (Article 21). Law No. 52/2009 on the Development of the Population and Family Development stipulates that the government has a duty to guarantee the basic needs of poor people, including the need for clothing, food, housing, education, health, jobs and security (Article 41, clause 1, and Explanation of Article 5). In addition, the government must aid vulnerable people to develop their potential by providing and funding services for support, health, education and training (Article 40).

The Health Law (Law No. 36/2009) also demands that the government ensure adequate nutrition for the poor, including children (Article 142, clause 3). Nutrition improvement efforts are targeted throughout the life cycle, beginning in the womb and continuing through old age. Priority is given to vulnerable groups, namely, infants and children under the age of five ('under-fives'), adolescent girls, pregnant women and lactating mothers (Article 142, clause 1). The Law also stipulates that the government is responsible for increasing public knowledge and raising awareness about the importance and benefits of good nutrition (Article 143). In addition, the Law specifies that of the following indicators of healthy nutrition should be monitored: improved food consumption patterns towards more balanced nutrition; improved nutrition-conscious behaviour and physical activity; improved access to health and nutrition services in line with advances in nutritional science and technology; and increased reach of food and nutrition awareness-raising systems (Article 141).

The health and nutrition policy aims and objectives are set out in the National Medium-Term Development Plan (*Rencana Pembangunan Jangka Menengah Nasional*, RPJMN), and the Ministry of Health (MoH) Strategic Plan. In the RPJMN 2004–2009,[1] the general objective of health development was to increase societal health standards, which should be achieved by improving access to health services, and should be measured by the following indicators: an increase in life expectancy, a decrease in infant mortality and maternal mortality rates, and a reduction in the prevalence of underweight (low weight-for-age) in under-fives. These objectives are carried over in RPJMN 2010–2014[2] with two additional targets: decreases in the neonatal mortality rate and in the prevalence of stunting in under-fives. The standard set for lowering the prevalence of underweight in under-fives for 2014 is to decrease this to less than 15 per cent, which is lower than the Millennium Development Goals (MDG) target for 2015 (below 15.5 per cent). The RPJMN targets are shown in Table 3.1.

The National Medium-Term Development Plan (RPJMN) is translated into the Strategic Plan and the Working Plan of the Ministry of Health (MoH). To achieve the RPJMN 2004–2009 goals on health, the MoH Strategic Plan 2005–2009[3] formulated its vision of 'Self-Reliant Communities for Healthy Living'. The vision is continued in the MoH Strategic Plan 2010–2014[4] under the title 'Healthy Communities Possessing Self-Reliance and Fairness'. The main policy aim was to develop a healthy population during 2005–2009, leading to four main targets for the next period, 2010–2014, namely: (1) increase community health levels through community empowerment, including the business community and civil society; (2) protect community health through the availability of complete, evenly distributed, good quality and fair health services; (3) guarantee the availability and equal distribution of the health-care workforce; and (4) develop good governance. The strategic goals for the health improvements relating to children and mothers are shown in Table 3.2.

The MoH Strategic Plan closely follows the MDG targets, especially in the area of nutrition. Nutrition is one of the output indicators of the 'Programme for Community Nutrition Improvement' in the MoH Strategic Plan (see Table 3.3). The first MDG is to eradicate extreme poverty and hunger, with a target of reducing the proportion of people suffering from hunger by half over the years 1990–2015. To achieve this objective, the targets for Indonesia are: to reduce the prevalence of underweight children below the age of five to 15.5 per cent; to reduce the proportion of the population that is below a minimum level of dietary energy consumption (1,400 kilocalories per capita per day) to 8.5 per cent, and those consuming less than 2,000 kilocalories per capita per day to 35.32 per cent. The proportion of the population below the minimum level of dietary energy consumption is a target that requires special attention while the other targets are considered to be 'on track' for achievement by 2015.

Table 3.1: National Medium-Term Development Plan (RPJMN) health targets, 2009 and 2014

No	Indicators	RPJMN 2004–2009 (target for 2009)	RPJMN 2010–2014 (target for 2014)
1.	Life expectancy	from 66.2 (in 2003) to 70.6 years	from 70.7 (in 2008) to 72 years
2.	Infant mortality rate (per 1,000 live births)	from 35 (in 2002–2003) to 26	from 34 (in 2008) to 24
3.	Maternal mortality rate (per 100,000 live births)	from 307 (in 2002–2003) to 226	from 228 (in 2008) to 118
4.	Underweight in under-fives	from 25.8% (in 2002) to 20%	from 18.4% (in 2008) to <15%
5.	Neonatal mortality rate (per 1,000 live births)	-	from 19 (in 2007) to 15
6.	Stunting in under-fives	-	from 36.8% (in 2007) to 32%

Source: National Medium-Term Development Plans (RPJMN) 2004–2009 and 2010–2014

1 Presidential Regulation No. 7/2005 on the RPJMN 2004–2009
2 Presidential Regulation No. 5/2010 on the RPJMN 2010–2014
3 Decision of MoH No. 331/MENKES/SK/V/2006 on the MoH Strategic Plan 2005–2009
4 Decision of MoH No. HK.03.01/160/I/2010 on the MoH Strategic Plan 2010–2014

Table 3.2: MoH Strategic Plan targets for maternal and child health improvements, 2009 and 2014[5]

Strategic goals	Target for 2009	Target for 2014
Households practicing healthy and clean lifestyle behaviours (%)	60	70
Life expectancy (years)	70.6	72
Infant mortality rate (per 1,000 live births)	26	24
Maternal mortality rate (per 100,000 live births)	226	118
Neonatal mortality rate (per 100,000 live births)	-	15
Births where a skilled birth attendant was present (%)	90	90
Neonates receiving complete neonatal examination (%)	90	90
Pregnancies receiving complete antenatal care (at least four visits) (%)	90	95
Babies 0–11 months with complete immunizations (Universal Child Immunization) (%)	98	100
Doctors per 100,000 population	24	-
Midwives per 100,000 population	100	-
Nurses per 100,000 population	158	-
Districts/cities implementing the 'Minimum Service Standards on Health'* (%)	-	100

Source : Ministry of Health (MoH) Strategic Plans 2005–2009 and 2010–2014

*Note: *This refers to the stipulations in the MoH Decree No. 741/MENKES/PER/VII/2008 on Minimum Service Standards on Health for District Government and MoH Decree No. 828/MENKES/SK/IX/2008 on the Technical Guidance for the Implementation of Minimum Service Standards on Health for District Government.*

Table 3.3: MoH Strategic Plan targets for community nutrition improvement, 2009 and 2014

No.	Indicators	Target for 2009	Target for 2014
1.	Overweight under-fives (%)	5	
2.	Overweight school children and adults (%)	10	
3.	Nutritional iron deficiency anaemia in pregnant and post-partum women (%)	40	
4.	Pregnant women obtaining iron supplements (%)	80	85
5.	Exclusive breastfeeding for children aged 0–6 months (%)	80	80
6.	Vitamin A for children aged 6–59 months	80%	85%
7.	Under-fives being treated to prevent severe under nutrition (%)		100
8.	Under-fives who are weighed (%)		85
9.	Households consuming iodized salt (%)		90
10.	Districts/cities that have conducted nutritional surveillance (%)		100
11.	Complementary food buffer stocks (%)		100

Source: MoH Strategic Plans 2005–2009 and 2010–2014

Besides the high-priority programme contained in the MoH Strategic Plan regarding community nutrition improvement, the other health programmes in the MoH Strategic Plan include programmes for health promotion and community empowerment, public health provision, and health research and development, and each also includes policies and activities relating to nutrition. In the MoH Strategic Plan 2010–2014, the main programmes targeting nutrition are the programmes for community nutrition improvement and for maternal and child health. The objectives for nutrition improvements are integrated into preventative, curative and rehabilitative approaches.

However, unfortunately these programmes are not mentioned in the corresponding Government Work Plan (*Rencana Kerja Pemerintah*, RKP) 2010. The nutrition programme in the Government Work Plan does not include a focus on maternal and child nutrition.

Government policies on food and nutrition are also mentioned in the Strategic Plan of the Ministry of Agriculture. The Ministry of Agriculture Strategic Plan 2005–2009 included the aim to increase national food security, by increasing the agricultural commodity production capacity and reducing dependence on food imports. The objectives of the current

5 These targets only represent the part of the MOH Strategic Plan concerning maternal and child health.

Ministry of Agriculture Strategic Plan 2010–2014 include the development of nutrition and food security, and food diversification. Given the wide scope of the term 'food security', here the focus of the discussion in relation to nutrition is limited to the nutritional programmes implemented by the MoH.

As a guide for the direction of the development of food and nutrition to be implemented by central and local governments, the GoI issued a National Action Plan (*Rencana Aksi Nasional*, RAN) on Food and Nutrition 2006–2010. Some policies mentioned in the RAN included improvements to the quality and quantity of food consumption towards more balanced nutritional intake, and improvements in the status of community nutrition. The RAN on food and nutrition also established seven objectives to be achieved by 2010, four of which were related to nutrition (see Table 3.4). According to this document, the programmes that support the policy of improving community nutritional status are: community nutrition improvement (primary programme), public health services, early childhood education (ECE), improvement of child welfare and protection, health promotion and community empowerment, improved women's empowerment, family endurance and empowerment, and disease prevention and eradication.

The GoI has strengthened the nutrition improvement policy contained in the current National Action Plan on Food and Nutrition (RAN 2011–2015). Some policies in this RAN are an improvement on the previous RAN for 2006–2010. One of the new objectives is to reduce the prevalence of stunting to 32 per cent in 2015. Besides the national-level plan, this document also contains a local action plan aimed at reducing the disparities among provinces. Some policies in the current RAN also aim to reduce disparities among poor households. Unlike the

Table 3.4: Objectives of the National Action Plan on Food and Nutrition 2006–2010

No	Objectives
1.	Reduce the prevalence of various forms of malnutrition (i.e., moderately underweight, severely underweight, iron deficiency, vitamin A deficiency and iodine deficiency) by at least 50 per cent of the 2005 levels by 2010, and prevent an increase in the prevalence of overweight.
2.	Increase the per capita food consumption to meet balanced nutritional needs with a minimum energy intake of 2,000 kilocalories per day, 52 grams of protein and sufficient micronutrients. Increase in the diversity of food consumption to attain a 'Hope Food Pattern' (Pola Pangan Harapan, PPH) score of at least 85, such that rice consumption falls 1 per cent per year, tuber consumption increases 1–2 per cent per year, vegetable consumption rises 4.5 per cent per year, and animal food products consumption rises 2 per cent per year.
3.	Reduce the number of people who experience food insecurity by streamlining food distribution systems and increasing the ability of the community to access food, including fortified food.
4.	Maintain the availability of at least 2,200 kilocalories per capita per day and the provision of at least 57 grams of protein per capita per day, especially animal protein, and increase vegetable and fruit consumption.
5.	Increase the coverage and quality of nutrition services in the community particularly for vulnerable groups, with the following objectives: a. Increase exclusive breastfeeding for infants up to the age of six months. b. Increase the percentage of children aged 6–24 months who obtain proper complementary food (*makanan pendampingan air susu ibu*, MP-ASI) c. Reduce the prevalence of anemia in pregnant women and women of reproductive age. d. Increase the effectiveness and coverage of surveillance of women of reproductive age, pregnant women and adolescent girls at risk of chronic energy deficiency (upper arm circumference <23.5 cm) e. Lower the prevalence of xerophthalmia.
6.	Increase the knowledge and ability of families to adopt healthy lifestyles and nutrition-conscious behaviours, as indicated by increased access to nutrition services and by family food consumption.
7.	Improving food security, quality and hygiene of food consumed by people, by reducing the rate of violation of food safety regulations up to 90 per cent and increasing research on safe and affordable food preservatives.

Source: National Development Planning Board, National Action Plan on Food and Nutrition 2006–2010 [http://ntt-academia.org/Pangantt/RAN-Food-Nutrition-English.pdf]

RAN 2006–2010, the current RAN did not outline detailed objectives or policies because these were already detailed in the MoH Action Plan for 'community nutrition guidance' for the period 2010–2014.

The MoH Action Plan on 'community nutrition guidance' for 2010–2014 was issued in 2010, with a view to facilitating the achievement of the targets of the MoH Strategic Plan (see Tables 3.2 and 3.3). Therefore the objectives of this action plan match the eight objectives of the MoH Strategic Plan 2010–2014. But the action plan includes more specific activities in support of each output indicator of the MoH Strategic Plan that relates to nutrition.

The Health Law No. 36/2009 stipulates that child health care begins with maternal health care from the moment a woman becomes pregnant. The commitment to reducing infant and maternal mortality rates has been incorporated into the Health Law. The GoI policy for reducing maternal mortality is delineated under the 'Making Pregnancy Safer' (MPS) programme. Some of the essential components of the MPS programme are as follows: (1) continuation of the use of village midwives to reach all pregnant women, and supporting policies stipulating that all births should be attended by a skilled health professional; (2) renewed emphasis on antenatal care, with particular emphasis on universal coverage of the first antenatal visit during their first trimester; (3) development of both basic and comprehensive systems for emergency neonatal and obstetric services; and (4) expanding the *Desa Siaga*[6] (Alert Village) programme in all areas. Additionally, the MoH focuses on community empowerment and raising awareness with regard to birth preparedness and the prevention and management of obstetric complications, referred to as P4K or *Program Perencanaan Persalinan dan Pencegahan Komplikasi* (Birth Preparedness and Complication Prevention Programme) (Mize et al., 2010, pp. 16–17).

The RPJMN 2010–2014[7] identified that a substantial number of cases of maternal and neonatal death are caused by poor nutrition among pregnant women and low adherence to exclusive breastfeeding. Additionally, high rates of morbidity, especially from diarrhoea, asphyxia, and acute respiratory infections (ARI), are caused by poor environmental health conditions, such as inadequate access to clean water and sanitation and unhealthy housing conditions, as well as by minimum utilisation of *posyandu* (integrated health services posts), in addition to other socio-cultural determinants. The future challenges are therefore: to improve access to and quality of maternal and child health care through improved nutrition; to increase knowledge among new mothers; to make more health personnel available; to provide adequate health-care facilities; to increase immunization coverage and quality of services; and to improve the quality of environmental health.

In an effort to reduce the prevalence of malnutrition in communities, the following steps have been taken by the Ministry of Health: (1) weighing under-fives at *posyandu* for early detection; (2) maintaining the buffer stocks of complementary food; (3) treating severe under-nutrition of children in hospitals or health-care centres; (4) conducting nutrition surveillance in *puskesmas* (community health centres) at district/city levels; (5) providing Vitamin A to under-fives; (6) providing iron supplements to pregnant and post-partum women; (7) providing access to iodized salt in the community; (8) promoting exclusive breastfeeding for a baby's first six months of life (Ministry of Health, 2010).

Besides nutritional improvement, one of the major health programmes promoting

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6 *Desa Siaga* is a new approach introduced by the GoI as a part of community empowerment efforts in the health sector. In principle, it promotes the idea that village people have the resources and the ability to solve their own health problems with assistance from the sub-*puskesmas (pustu)*. It consists of approaches that are promotive (e.g., information dissemination), preventive (e.g., nutritional surveillance, antenatal care and routine visits for under-fives), and curative/rehabilitative (e.g., treatment), as well as ensuring adequate supplies of health equipment and medicines. Health-care services are provided by health cadres and *puskesmas* staff and the funding comes from the community, from businesses and from the government (BAPPENAS, 2009, p. 110).

7 RPJMN 2010–2014, Book 2, Chapter II, sections II.2–20, page 22.

child survival is the national immunization programme.[8] The purpose of the immunization programme is to reduce morbidity and mortality caused by diseases preventable by immunization. Immunization targets are based on age and include routine immunizations and recommended immunizations. Routine immunizations are given to infants, elementary school-aged children and women of reproductive age. Since 1997, the MoH has included three doses of the Hepatitis B vaccine to be given to infants as part of this programme. The routine immunizations for elementary school-aged children are scheduled as follows: Grade 1 – DT (diphtheria and tetanus) and measles; Grade 2 – TT (tetanus toxoid); and Grade 3 – TT booster. Women aged 15–39 years are given four TT immunizations with at least four weeks between doses. The additional immunizations are given based on problems identified during the monitoring and evaluation of infant and child immunization status across the country. They are administered in locations that have specific health problems, such as high infant mortality or incomplete basic immunization coverage. All villages in the country are targeted by the immunization programme. The immunizations are administered by competent immunization officers who have received training and have nursing or medical backgrounds.

The immunization programme includes mass immunization programmes. Firstly, the PIN (National Immunization Week) aims to accelerate the termination of the life cycle of the polio virus by giving polio vaccines to all infants (up to age one year), including newborns, regardless of their previous immunization status. This immunization is administered twice; two drops each time with a one month interval between doses, with the aim that each infant should receive the polio immunization twice in their first year of life. Secondly, there is what is known as the 'Sub PIN', where the same polio vaccine regimen will be implemented in response to the discovery of a case of polio in a particular district *(kabupaten)*, targeting all infants under one year old. Thirdly, the 'Measles Catch-up Campaign' is an attempt to stop the spread of measles among primary school-age children from 1st to 6th grade, as well as under-fives. Measles immunization for primary school children is administered to all, regardless of previous immunization status. One of the target's of the immunization programme in 2010 was the achievement of Universal Child Immunization (UCI), with the specific aim of full basic immunization coverage (according to WHO guidelines) of at least 80 per cent of infants (under 12 months old) in 100 per cent of villages. However, because UCI achievement in 2008 had only reached 68.2 per cent of villages, the MoH revised the national target, setting 2014 as the new target date for 100 per cent coverage.

Another child health concern in Indonesia is the growing prevalence of HIV/AIDS. In 2006, it was estimated that there were 193,000 adults living with HIV/AIDS in Indonesia, and 21 per cent were women. In 2009, the estimate of people living with HIV/AIDS rose to 333,200 people, with 25 per cent being women. People of productive age (15–49 years) are the most vulnerable to becoming infected with AIDS (NAC, 2009, p. 15). In 2004, 16 provinces reported cases of HIV infection, but by the end of 2009, AIDS cases were reported in all 33 provinces. In 1994, the GoI formed the National AIDS Commission (NAC, or *Komisi Penanggulangan* AIDS). Since 2006, there has been an intensive response to AIDS through Presidential Decree No. 75/2006, which not only expanded the participation of all government sectors and civil society in combating AIDS but also strengthened national leadership in this field (NAC, 2009, p. 27).

A specific programme was implemented with the aim of preventing mother-to-child transmission (PMTCT) of HIV/AIDS, through the provision of antiretroviral therapy (ART). According to estimates in 2006, the sub-population of HIV cases caused by mother-to-child transmission stood at 26,000, with the highest proportion of these cases (13,950) being located in Papua (NAC, 2007, pp. 17–18). Based on MoH data, there has been a decrease in the rate of HIV

[8] The immunization programme is regulated by the MoH Decree No. 1611/Menkes/SK/XI/2005. The Health Law also mandates the government to provide complete immunization for every infant and child (Article 130).

infection among infants born to HIV-infected mothers, from 23 per cent in 2008 to 20.7 per cent in 2009. The growing availability of PMTCT services is seen as a contributing factor in this decrease (NAC 2009, p. 64).

As of November 2009, there were 37 referral centres for PMTCT available in 24 provinces, although only 9 provinces had comprehensive PMTCT services including testing and counselling for pregnant women, delivery by caesarean section, provision of formula for infants, and HIV testing for the infants by Polymerase Chain Reaction (PCR) (NAC, 2009, pp. 15, 43). In 2008, there were 30 PMTCT referral centres, which conducted HIV tests on 5,167 pregnant women of whom 1,306 (25 per cent) were found to be HIV-positive. Only 165 (12.6 per cent) were known to have received Antiretroviral prophylaxis (NAC, 2009, p. 26).

The national health system in Indonesia uses a family-based approach to the protection of children's health. For children who live in poor families, the GoI pays the national insurance contribution to the health protection programme for poor and underprivileged people under the 'Community Health Insurance Programme' which is financed through the National Revenue and Expenditures Budget (*Anggaran Pendapatan dan Belanja Negara*, APBN) under the allocation for social aid expenditure (MoH, 2011, p. 7). Thus, children from poor families benefit from their parents' membership in the health protection scheme, which is a form of social security as stipulated in Law No. 40/2004 on The National Social Security System (Article 17, clauses 4 and 5). The Ministry of Health has proposed that by the end of 2014, all Indonesian citizens will be covered by the health insurance system (MoH, 2011, p. 2).

The GoI introduced the first phase of universal health insurance coverage in 2004 through 'Health Insurance for the Poor Community' (*Asuransi Kesehatan Masyarakat Miskin*, Askeskin) which was designed to increase access to and quality of health services for the poor. Askeskin included free care at *puskesmas* and government hospitals, including 3rd class rooms for inpatient treatment. In addition, it provided funds to support *posyandu* revitalization, supplementary feeding and operational funds for *puskesmas*, health services in isolated regions and additional funding for medications and vaccines (Hastuti et al., 2010, pp. 17–18).

In 2008, Askeskin evolved into the 'Community Health Insurance Scheme' (*Jaminan Kesehatan Masyarakat*, Jamkesmas). The scopes of the two programmes were essentially the same, but the priority of Jamkesmas is the provision of health services to poor pregnant women with the aim of reducing maternal and infant mortality rates. The Jamkesmas targets the poor and less affluent members of society, which includes as many as 18.9 million households or 76.4 million people (Hastuti et al., 2010, p. 18).

One improvement that began with Jamkesmas in 2008 was that the homeless, beggars and abandoned children, who did not hold identity cards, could be covered by the programme as long as they obtained a recommendation letter from local social affairs agency. In 2010, Jamkesmas has expanded the services to poor people who live in social care institutions *(panti sosial)*, in prisons, detention houses and in post-emergency response care shelter up to one year after a disaster (Ministry of Health, 2011, p. 2).

However, in order to access Jamkesmas benefits, a baby – including those born to poor parents – must fulfil certain requirements (Ministry of Health, 2011, p. 10), including having a birth certificate or a birth registration letter issued by the birth attendant. This requirement becomes a burden for poor people since around 70 per cent (in 2009) of under-fives from the poorest income quintile did not have birth certificates (see Chapter 5, section 5.2). Another requirement is that the baby should be delivered with the assistance of health-care personnel. This requirement is also often difficult to fulfil due to limited availability of health-care facilities and personnel in remote areas (see more details in section 3.4 of this chapter).

3.2 The institutional setting and provision of health services

In Indonesia, public health is managed by central, provincial and district governments as well as by communities, and the private sector is also involved in health care provision (Figure 3.1). Since the 2001 decentralization reforms, the main responsibility for managing health is officially in the hands of district/city *(kabupaten/kota)* governments. The role of central and provincial governments, through the Ministry of Health and Provincial Health Offices, is in facilitating managerial and cooperative mechanisms among district governments through the provision of technical standards, guidelines, technical assistance and training. To ensure that local governments maintain public health standards and collect measurable indicators for monitoring purposes, the MoH issued a decree outlining 26 types of minimum/essential public health services that local governments must perform and specifying 54 indicators and targets (minimum service standards, known locally as 'SPM'). Of the 26 services, 18 are related to public health, including maternal and child health, promotion and prevention of prevalent diseases, school health and disease surveillance.

At the district/city level, district heads and city mayors are responsible for managing and controlling the implementation of the minimum service standards (SPM), and the *Dinas Kesehatan Kabupaten/Kota* (District/City Health Offices) are responsible for the coordination of service provision at the district/city, sub-district and village levels.[9] The SPM are used as benchmarks for health programme achievements. However, the health sector SPM has not been implemented by all district heads and city mayors *(bupati/walikota)*.

Each district has at least one district public hospital, which is responsible for providing health services to all of the district's population, particularly the poor. In addition to public hospitals, one or more private hospitals are also available in almost every district in Indonesia. Between 2000 and 2008, the total number of hospitals increased from 1,145 to 1,372 (Table 3.5).

Figure 3.1: Health management structure

Each sub-district *(kecamatan)* should have at least one community health centre *(puskesmas)* headed by a doctor or public health specialist, usually supported by two or three sub-*puskesmas* (*puskesmas pembantu*, known as '*pustu*'), the majority of which are headed by nurses. The *puskesmas* working areas are determined by the population, geographical conditions, infrastructure and other local conditions. For large cities with dense populations, *pusksemas* working areas are located at the precinct level *(kelurahan)*. As an example, in the capital city Jakarta, 44 *puskesmas* were located at a sub-district *(kecamatan)* level and 295 at a precinct level in 2008 (*Dinas Kesehatan Provinsi DKI Jakarta*

[9] This refers to the stipulations in the MoH Decree No. 741/MENKES/PER/VII/2008 on Minimum Service Standards on Health for District Government and MoH Decree No. 828/MENKES/SK/IX/2008 on the Technical Guidance for the Implementation of Minimum Service Standards on Health for District Government.

Table 3.5: Numbers of hospitals of different types, 2004–2008

No	Management/Ownership	2004	2005	2006	2007	2008
1	MoH and provincial/district/city government	435	452	464	477	509
2	Indonesian National Army/ Indonesian Police	112	112	112	112	112
3	State-owned enterprises (BUMN)	78	78	78	78	78
4	Private	621	626	638	652	673
	Total	1,246	1,268	1,292	1,319	1,372

Source: National Development Planning Agency (BAPPENAS), Profil Kesehatan 2008 *(Health Profile 2008), 2009, p. 164*

2009, p. 37). Most *puskesmas* are equipped with four-wheel drive vehicles or motorboats to serve as mobile health centres *(puskesmas keliling)* and provide services to underserved and remote populations in urban and rural areas.

Health services available at a *puskesmas* consist of compulsory health services and community adjustment-based health services. Compulsory health services are mandatory for all *puskesmas* in Indonesia. Compulsory health services, commonly known by the term 'the six basics', cover: health promotion, environmental health, maternal and child health (including family planning), community nutrition improvement, prevention and eradication of communicable diseases, and basic medical treatment. Meanwhile, community adjustment-based health services vary by *puskesmas* and are determined by the District Health Office in accordance with the local issues and needs as well as the capabilities of the *puskesmas* facility and staff. For example, dental and oral health or elderly health services may or may not be provided. Nutrition-related activities conducted at a *puskesmas* include weighing for under-fives, tracking and treating malnutrition, monitoring children's development, and providing nutritional counselling.

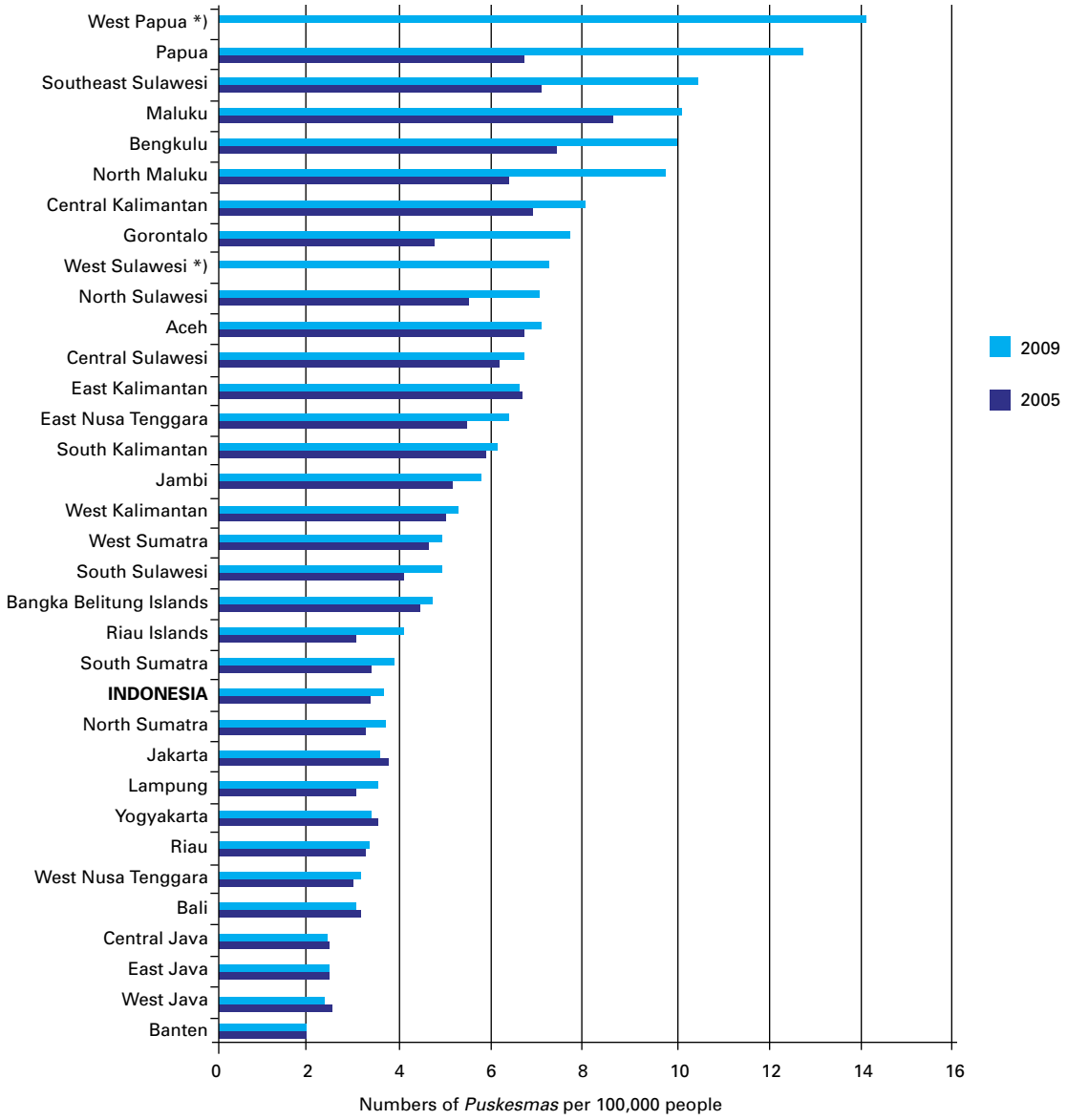
There has been an increase of more than 1,000 *puskesmas* facilities between 2005 and 2009, from 7,699 to 8,737 (BAPPENAS, 2009). This means that the number of *puskesmas* was greater than the total number of sub-districts by 6,543 units. One common indicator used to measure the coverage of *puskesmas* is the ratio of *puskesmas* per 100,000 population. Table 3.6 shows that this ratio has increased from 3.5 in 2005 to 3.78 in 2009. Nevertheless, this ratio is not always a good indicator of access to health services, particularly in remote and sparsely-populated areas, such as Papua or East Nusa Tenggara (Figure 3.2). According to the RISKESDAS 2007 (Basic Health Research survey), it took members of households more than 30 minutes to reach health service facilities (including *puskesmas*) in some provinces, namely East Nusa Tenggara (30.7 per cent), Papua (30.6 per cent), West Kalimantan (19.4 per cent), West Sulawesi (17.7 per cent) and Southeast Sulawesi (13.8 per cent). This was found to be related to per capita household expenditure: the higher the per capita expenditure levels the closer the distance and the shorter the travel time required to reach health service facilities.

Table 3.6: Number and facility-to-population ratio of community health centres *(puskesmas)* in Indonesia, 2005–2009

	2005	2006	2007	2008	2009
Number of *puskesmas*	7,699	8,015	8,234	8,548	8,737
Ratio of *puskesmas* per 100,000 population	3.50	3.61	3.65	3.74	3.78

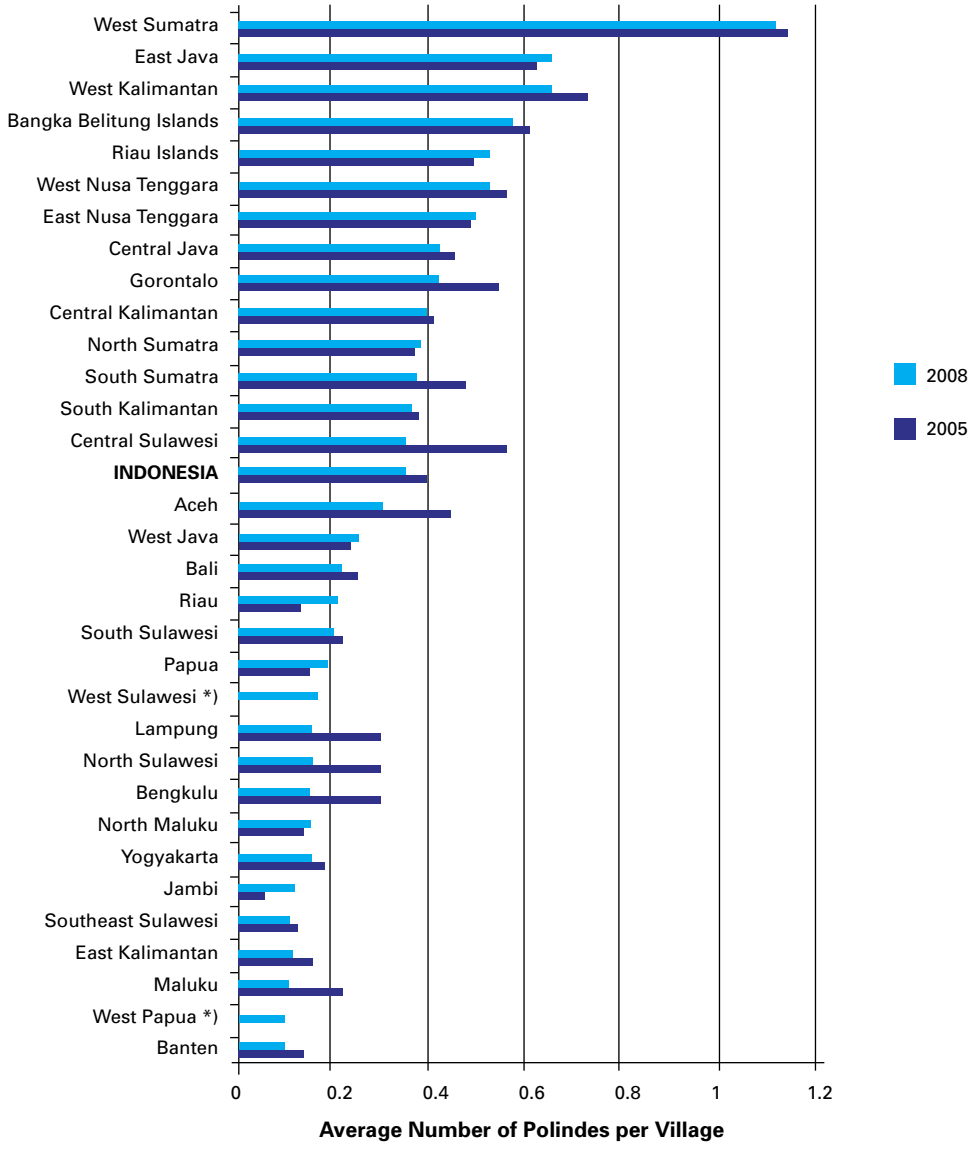
Source: BAPPENAS, 2009

Figure 3.2: Number of community health centres *(puskesmas)* per 100,000 population by province, 2005 and 2009



Source: BAPPENAS, 2009
*Note: *New provinces established after 2005*

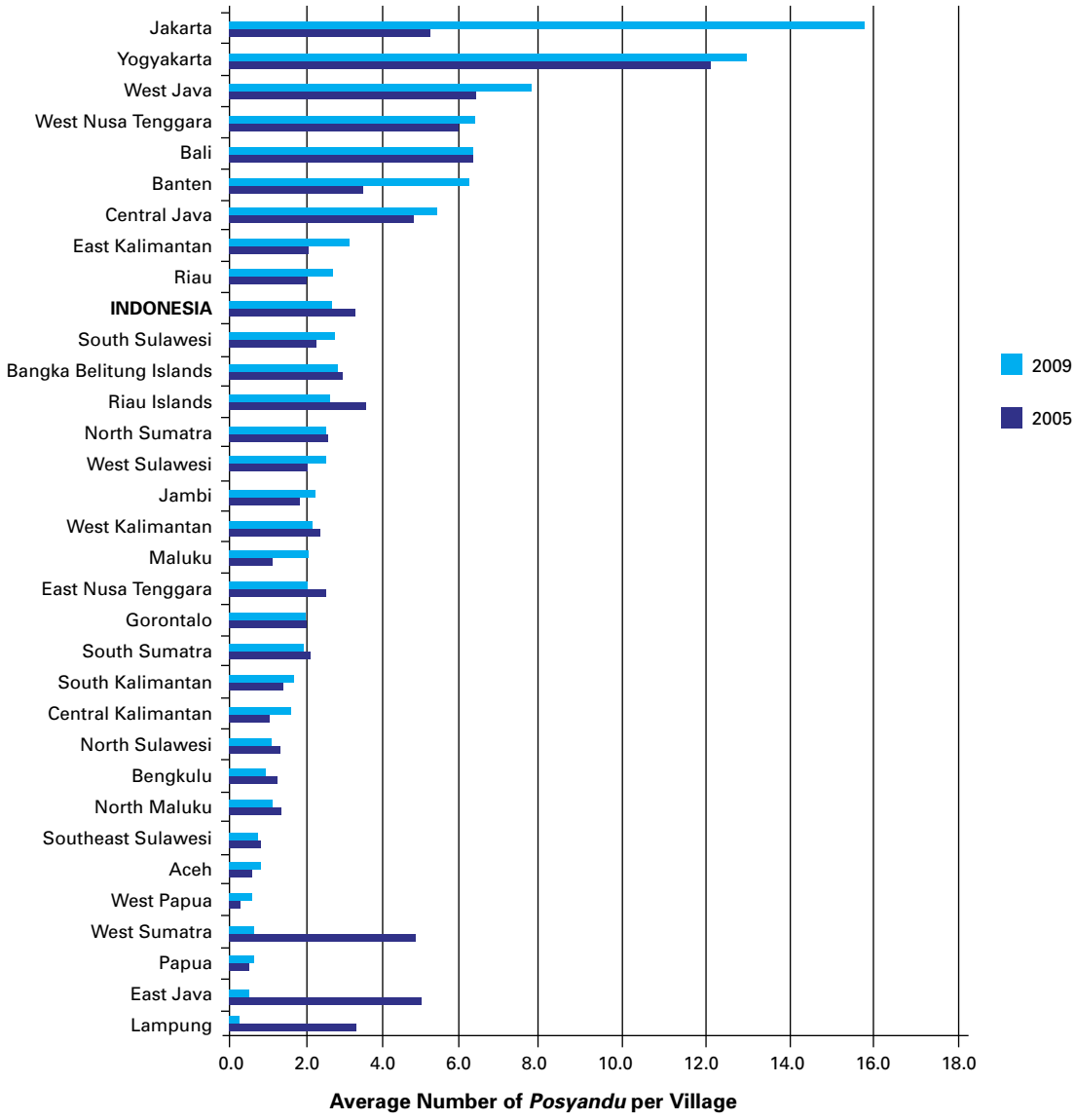
Figure 3.3: Average number of village maternity clinics *(polindes)* per village, 2005 and 2008



Source: Potensi Desa (Village Potential) 2005 and 2008
*Notes: *New provinces established after 2005;*
The absence of Jakarta is because it has no village administration level

At the community level, the integrated health post *(posyandu)* provides preventive and promotional health services. A *Posyandu* has five main activities: (1) child growth monitoring and supplementary feeding; (2) basic general health services for mothers and children; (3) family planning services; (4) immunization; and (5) prevention of diarrhoea. These health posts are established and managed by the community with the assistance of health centre staff (from the *puskesmas* or *pustu*). In 2009, the total number of villages *(desa)* in Indonesia was 76,983 and the total number of *posyandu* was 212,629, such that the ratio of *posyandu* to villages at a national level was 2.8. In the same year, almost all provinces had at least have one *posyandu* per village on average except Lampung, East Java, Papua and West Papua (Figure 3.4).

Figure 3.4: Average number of integrated health services posts *(posyandu)* per village, 2005 and 2009



Source: MoH, www.bankdata.depkes.go.id, 2005 and 2009

The utilisation of health facilities is largely determined by their physical accessibility. According to RISKESDAS 2007, 85.4 per cent of households could reach their nearest health facility in 15 minutes or less. Provinces where more than 30 minutes was often required to reach health facilities were Papua and NTT (15.3 and 11.6 per cent of households, respectively). With regard to distances, 78.9 per cent of households had distances of less than 1 kilometre to travel to their nearest health facility. Provinces where distances to the closest health facility were often greater than 5 kilometres included West Kalimantan and Riau (6.3 and 5.4 per cent of households, respectively). The proportion of households with a distance of more than 5 kilometres to a health facility was greater in rural areas than urban areas. It was also found that higher household income was associated with living closer to the nearest health facility, but the level of disparity based on income category was low (less than 5 per cent).

In order to monitor child growth and development, the government provides a 'Mother and Child Health Card' (*Kartu Ibu dan Anak*, KIA) and a 'Road to Health Card' (*Kartu Menuju Sehat*, KMS). The KIA contains information and educational materials on maternal and child health including nutrition, intended to help families, especially mothers, in maintaining their own health during pregnancy and until the child is five years old. A KIA will be given to a pregnant woman when she comes for her first antenatal care visit e.g., to a village midwife practice. A KMS is given when a child under the age of five makes his or her first visit to a health-care facility. The KMS contains important notes about the child's physical growth and immunizations, as well as information about preventing diarrhoea, supplementation with Vitamin A capsules, certain children's health conditions, exclusive breastfeeding and complementary feeding (MP-ASI), supplementary feeding for children, and referrals to health centres and hospitals. If a case of malnutrition or under nutrition is detected, the child will receive intervention, such as supplementary feeding.

Unfortunately, the percentages of under-fives and mothers who have KIA and KMS are still low. In 2010 only 25.5 per cent of mothers of under-fives had a KIA, 18.8 per cent claimed to have a KIA but could not show it or claimed it was held by someone else, and 55.8 per cent had no KIA. As for KMS, 30.5 per cent of under-fives had a KMS, 24.1 per cent claimed to have a KMS but could not show it or claimed it was held by someone else, and 45.4 per cent had no KMS (RISKESDAS 2010).

Together the KIA and KMS are used by health-care personnel as tools for monitoring the health status of pregnant and post-partum mothers and under-fives. Not having these cards implies underutilisation of health-care facilities; for example the pregnant woman may have gone instead to a traditional birth attendant or traditional healer for antenatal care and childbirth. One consequence is the lack of documentation of immunizations for under-fives, and correspondingly the data may indicate low coverage of Universal Child Immunization (UCI) (see more detail on UCI in section 3.4.3 of this chapter).

Beginning in 1997, the MoH worked with the WHO, UNICEF and the Indonesian Pediatric Association (IDAI) to adopt the Integrated Management of Childhood Illness (IMCI) module. The IMCI is an approach aimed at ensuring that illnesses in under-fives are handled by health professionals using the standard IMCI algorithm. This includes assessment of the problem based on several lists of questions for the parents as well as a direct examination of the sick child. The IMCI processes in general consist of: disease diagnosis, detection of all illnesses in under-fives, prompt referral whenever necessary, assessment of nutritional status, and provision of immunizations. Mothers are given counselling on the procedures for providing medicine to their young children at home, advice for appropriate feeding of under-fives, and confirmation regarding when to return for a check-up and when seek referral services. In monitoring and addressing child nutrition problems, the IMCI suggests that growth monitoring for infants under two months of age be done by checking the child's weight against their age and providing breastfeeding counselling in some areas. Children aged two months to five years receive nutritional monitoring. Twice a year, Vitamin

A capsules are provided to children aged 6–59 months.

By the end of 2009, the implementation of IMCI had covered all 33 provinces in Indonesia, but not all *puskesmas* were able to implement it due to a lack of health professionals who had received IMCI training, and/or a lack of appropriate facilities and infrastructure. Another factor influencing the implementation of IMCI was the level of commitment shown by the heads of the local *puskesmas* (community health centres), which was often low. Based on data from provincial health officers at the National Meeting of the Child Health Programme in 2010, only 51.55 per cent of *puskesmas* had implemented IMCI by the end of 2009.

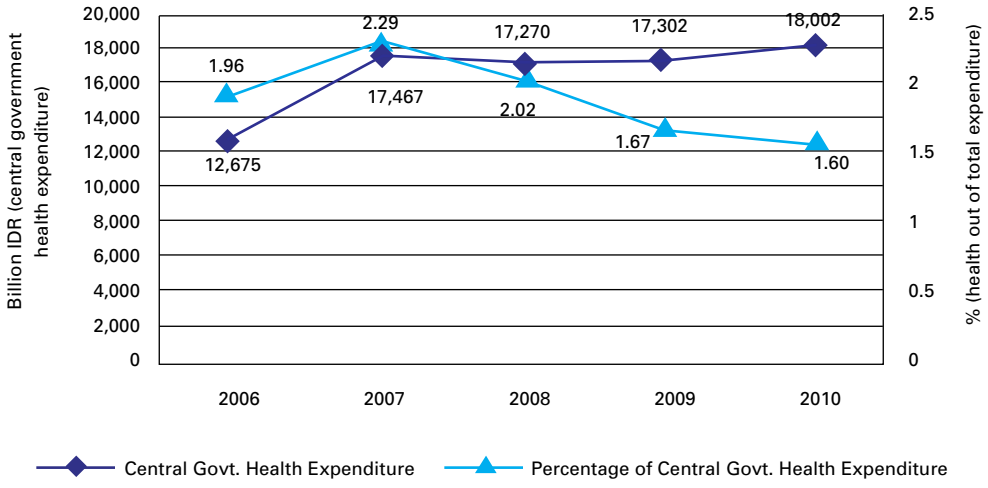
The *puskesmas* were considered to have implemented IMCI if they had conducted IMCI for at least 60 per cent of patient visits relating to illnesses in under-fives (Wijaya, 2009). In the study area in North Jakarta, the *puskesmas* in Kalibaru Precinct had been implementing IMCI for one year, and it faced the following obstacles: poor understanding of healthy behaviour and low levels of infant immunization, related to the parents' low level of education and fear of fevers associated with immunization. In the two case study areas in East Sumba, neither of the local *puskesmas* were conducting IMCI.

3.3 Health and nutrition budgets

There is still a long way to go to achieve the minimum budget allocation for health as mandated in Law No. 36/2009 on Health at either the national level (5 per cent) or the district level (10 per cent). The health budget allocation at a national level during 2006–2010 was still below 5 per cent of total central government expenditure based on the APBN (National Revenue and Expenditures Budget). A comparison of the allocated budgets between 2006 and 2010 showed that the health budget had increased in nominal terms, but as a percentage of APBN it had actually decreased (Figure 3.5). However, according to the Ministry of Health, the increase in the nominal health budget had made a positive impact towards building self-sufficiency in the health financing sector.

The Indonesian Forum for Budget Transparency (*Forum Indonesia untuk Transparansi Anggaran*, FITRA) took a sample of 39 districts and cities from across the country in order to make a comparison between health budgets and the total Regional Revenue and Expenditure Budgets (APBD) over a three-year period, 2007–2009 (Sucipto, 2010). The results showed that among the 39 districts/cities only 11 of the local governments[10] (28.21 per cent) had allocated a health budget of more than 10 per cent (Table 3.7).

Figure 3.5: Central government health expenditure as a proportion of total expenditure, 2006–2010



Source: National Revenue and Expenditures Budget (APBN) 2006–2010

[10] The 11 *kabupaten/kota* were Bondowoso, Bojonegoro, Semarang, Garut, Kota Blitar, Kota Pekalongan, Kota Padang Panjang, Polewi Mandar, Sumedang, Kota Palu and Aceh Besar.

Table 3.7: Budget allocated for health in 39 sampled districts and cities, 2007–2009

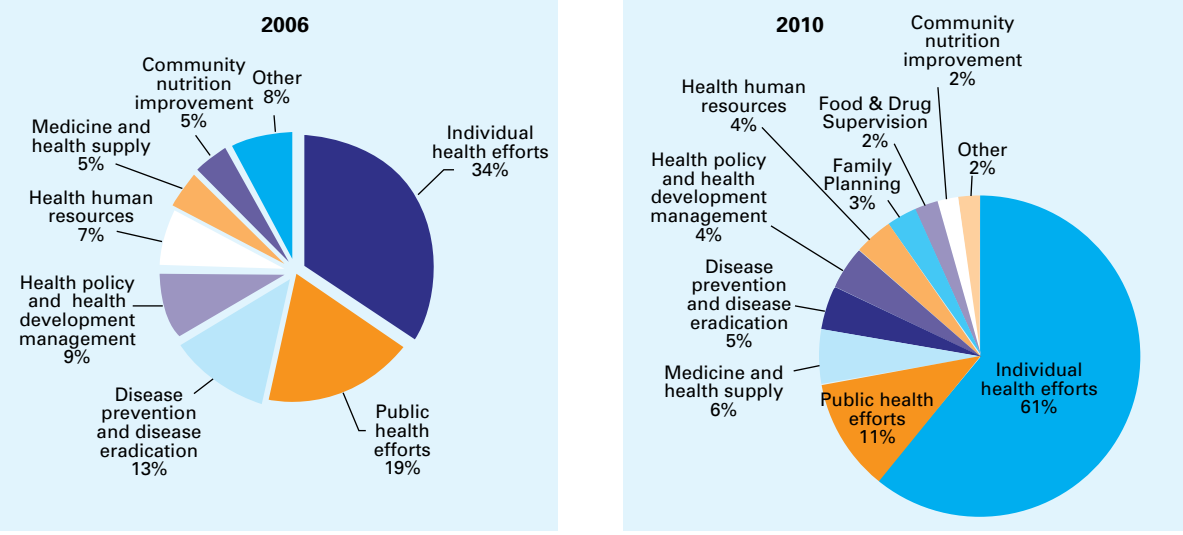
Budget allocated for health out of total local budget	Number of districts/cities	%
< 6%	7	17.9
6% ≤ health budget < 10%	21	53.8
10% ≤ health budget < 16%	11	28.2
Total	39	100

Source: Sucipto, 2010

The main reference document for health budget analysis is the Central Government Expenditure Budget (*Anggaran Belanja Pemerintah Pusat*, ABPP) which is stipulated each year by presidential regulation. The ABPP already includes monies from: the Decentralization Fund *(Dana Desentralisasi)*, the Helping Task Fund *(Dana Tugas Pembantuan)*, and loans which are indicated on an allocation from the Matching Fund *(Dana Pendamping)*.[11] According to the MoH, the amount of foreign loans used in the health sector has decreased gradually by around 10–15 per cent since 2008. In line with rises in health budget expenditure, the health fund allocation for local government also increases through the Decentralization Fund and Helping Task Fund. The role of private companies, i.e., corporate social responsibility (CSR) implementation, falls outside of the ABPP because companies conduct their own independent activities, although they coordinate with the MoH when choosing the location and the form of these activites.

The largest proportion of central government health expenditure (in 2006–2010) was allocated to provide health service protection for poor people either in hospitals or community health centres (*puskesmas*). Three health programmes received the highest percentage of the central government budget allocation, namely: (1) individual health services (medical); (2) public health services (including maternal and child health), and (3) disease prevention and eradication (Figure 3.6). In terms of individual health services, a focus on poor people was underlined with an allocation of the central government budget to district public hospitals to guarantee inpatient services for poor people in third class wards (Table 3.8). Compared to 2006, the total budget allocation for individual health services increased 153.17 per cent from IDR4,346 billion in 2006 to IDR11,003 billion in 2010. As for public health services, the central government budget for poor people was channelled through a budget allocation to all *puskesmas*.

Figure 3.6: Allocation of central government's budget for health programmes, 2006 and 2010



Source: APBN 2006 and 2010

[11] The Decentralization Fund is part of the national budget given to provincial governors, as the heads of local government, in order to implement decentralization tasks (i.e., devolution of authority from the central government to the local government). The Helping Task Fund is part of the national budget given to local governments to conduct 'helping tasks', i.e., specific assignments from the central government to the provincial government or from the provincial to the district/village government; accountability for these funds is the responsibility of each level of government and the institution which has been given the assignment. The Matching Fund is a fund which should be provided by local government to complement grants provided by the central government.

Table 3.8: Budget allocation for poor people in hospitals and community health centres *(puskesmas)*, 2006–2010

Budget allocation	2006	2007	2008	2009	2010
Health services for poor people in third class wards (billion IDR)	1,701 (13.42%)	1,708 (9.78%)	3,692 (21.38%)	4,584 (26.49%)	4,126 (22.92%)
Health services for poor people at *puskesmas* (billion IDR)	1,069 (8.43%)	1,080 (6.18%)	1,000 (5.79%)	1,694 (9.79%)	1,000 (5.55%)

Source: APBN 2006–2010
Note: Figures are amounts in billion IDR and percentages of central government's health expenditure

A high proportion of the health budget was also intended to make hospitals places of referral for health services and to address the problem of fear of seeking qualified health services that is common among poor people. According to the MoH Strategic Plan 2010–2014, by 2014 the number of poor people in hospitals could reach nine million people per year, and 95 per cent of hospitals should be providing services to poor people under the Jamkesmas community health insurance scheme. Budget analysis from FITRA indicated that these high proportions of health budget allocations still prioritize curative services rather than preventive efforts and that the budget expenditure for preventive efforts remains inadequate (*Sekretariat National* FITRA, 2009, p. 29). There is no ideal standard budget, according to the Ministry of Health, in terms of the proportions that should be allocated to promotional, preventive and curative efforts.

The budget allocation for maternal and child health, which comes under public health services, is problematic. Between 2006 and 2010, the budget allocation for maternal health decreased from 2.23 per cent to 0.56 per cent, and the allocation for child health decreased from 1.54 per cent to 0.56 per cent (Table 3.9). The percentage allocated for each was below 1 per cent for the years 2008–2010. The definition of child in this budget allocation was limited to children under the age of five. The budget for maternal and child health decreased significantly in 2008 when the GoI launched the Jamkesmas scheme which covered maternal and child health, and again in 2010 with the launch of the Jampersal cost-free childbirth programme *(Jaminan Persalinan)*. The Jampersal and Jamkesmas programmes are categorized under 'individual health services' (medical) rather than as 'public health services' or 'disease prevention and eradication'. Therefore, funding for maternal and child health is actually spread out among the three different categories.

The nutrition budget is also very difficult to classify into promotional, preventive and curative sections. The difficulty is not just due to the spread of the budget for nutrition activities over other programmes, but also the change in the organizational structure of the MoH. This can be seen in the main government programme for nutrition, namely, the Programme for Community Nutrition Improvement. The budget for this Programme increased from IDR586 billion to IDR668 billion from 2006–2007. However, from 2008 this budget was reduced each year, reaching IDR393 billion in 2010. In 2006 the budget for this programme was 4.62 per cent of the central government's health

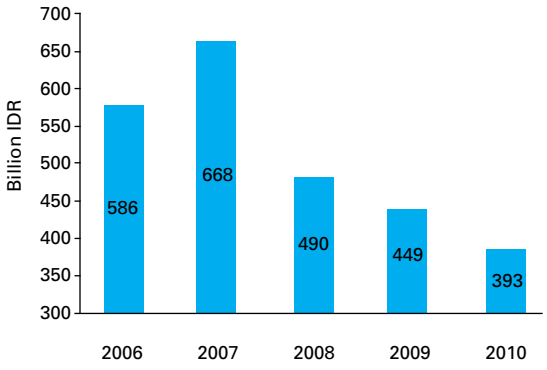
Table 3.9: Budget allocation for improving maternal and child health, 2006–2010

Programme	2006	2007	2008	2009	2010
Improving maternal health (million rupiah)	282,334 (2.23%)	318,929 (1.83%)	18,000 (0.10%)	19,000 (0.11%)	100,000 (0.56%)
Improving child health (million rupiah)	194,777 (1.54%)	313,000 (1.79%)	17,000 (0.10%)	18,000 (0.10%)	100,000 (0.56%)

Note: Figures show amounts and percentages of central government health expenditure
Source: APBN 2006–2010

budget and it continued to decline, accounting for just 2.18 per cent in 2010 (Figure 3.7). According to Figure 3.6, the budget for this programme represented only 5 per cent of the central government's health budget in 2006 and decreased further to 2 per cent in 2010.

Figure 3.7: Budget for the Community Nutrition Improvement Programme, 2006–2010



Source: APBN, 2006–2010

The decreases in the budget for nutritional programmes in 2008 were caused by an Asian Development Bank (ADB) loan for the Nutrition Improvement Community Empowerment (NICE) project. The GoI has been receiving loans for NICE projects since 2008 and will continue to receive them through 2012. On average, the annual amount of the loan received is IDR120 billion, used as the companion budget of the NICE activities in the Ministry of Health, allowing the government to reduce the national budget allocated for nutrition. Thus, in 2008 some of the nutrition budget was transferred to other programmes, including an exclusive breastfeeding campaign within the programme for 'Health Promotion and Community Empowerment', coordinated by the Secretariat-General of the MoH.

During 2006–2010, the Community Nutrition Improvement Programme was under the authority of the Directorate General of Public Health Development and it included funds for *puskesmas*. In 2011, there was a change in the organizational structure of the MoH, placing *puskesmas* under the coordination of the Directorate General of Community Health Development. Consequently, the budget for the Directorate General of Public Health Development decreased and it will also show a budget decrease for nutrition.

The main component of the budget allocation within the Community Nutrition Improvement Programme was for community nutrition improvement activities, which received 60 per cent of the programme budget per year. In 2006–2007 these activities were the main focus of the programme and were allocated IDR514 billion in 2006 and IDR537 billion in 2007. In 2008, a new activity was incorporated into the programme; the treatment of undernourished pregnant and lactating women, and children under the age of five. The budget allocated for this activity was IDR184 billion, or about 37.61 per cent of the total nutrition programme budget; in 2009 it amounted to IDR191 billion or 42.54 per cent of the total programme budget and in 2010 it had declined to IDR141 billion, or 35.87 per cent of the total programme budget (Table 3.10).

As for HIV/AIDS expenditure, the main source of funding is still from external sources, although funding from the GoI has shown an increasing trend. In 2006, the total AIDS expenditure was US$56,576,587, of which 73.42 per cent was financed by international sources and 26.58 per cent (US$15,038,484) was from central and local government funding (NAC 2008, p. 26). In 2008, the total HIV/AIDS expenditure was US$49,563,284, of which 59.96 per cent was financed by international sources and 40.04 per cent (US$19,845,267) was covered by central and local government funds (NAC 2009, p. 28). The largest spending allocation was for prevention efforts, which accounted for 49.84 per cent of the HIV/AIDS budget in 2008 and 40.97 per cent in 2006. Care and treatment spending was 14.78 per cent in 2008 and 24.88 per cent in 2006 (NAC, 2008, p. 28; NAC, 2009, p. 29). The main concern regarding HIV/AIDS funding was sustainability, which put pressure on the GoI to increase allocation from domestic sources and reduce reliance on external funding sources (NAC, 2009, p. 32).

According to RISKESDAS 2007, health financing includes medical treatment for inpatient and patient service utilisation whereas the source of

Table 3.10: Allocation of the budget for the Community Nutrition Improvement Programme, 2006–2010

Activities	2006	2007	2008	2009	2010
Community nutrition improvement	88%	80%	57%	56%	24%
Planning and design of health development and community nutrition programme	5%				
Maintenance and recovery of health	3%				
Community health improvement	3%				
Improvement of health services for poor families	1%				
Procurement of functional equipment					
Improvement of community nutrition education		20%	6%	1%	2%
Treatment of undernourished pregnant and breastfeeding women, infants and under-fives			38%	43%	36%
Nutrition improvement community empowerment (NICE)					38%
Total	100	100	100	100	100

Source: APBN, 2006–2010

financing is divided into self/family financing, insurance, Askeskin/SKTM[12], *Dana Sehat*[13], and others. The data shows that only 7 per cent of households have experienced inpatient hospitalisation and they utilize government hospitals (44 per cent) more than private hospitals (28.5 per cent). The source of financing for inpatient services was dominated by self-financed (71 per cent) or family (out of pocket), followed by various types of 'health insurance' schemes, including Askes/Jamsostek[14] (15.6 per cent), Askeskin/SKTM (14.3 per cent), *Dana Sehat* (2.9 per cent) and other sources (6.6 per cent). In terms of outpatient service utilisation, 34.4 per cent of households have experienced patient service and most of them have utilised maternity hospitals (43 per cent). In contrast with inpatient service financing, most patient service utilisation was self-financed (74.5 per cent), followed by Askeskin/SKTM (10.8 per cent), Askes/Jamsostek (9.8 per cent), *Dana Sehat* (2.5 per cent) and other sources (4.4 per cent). There were six provinces where the proportion choosing a *puskesmas* for inpatient services was higher than the national average: West Nusa Tenggara, East Nusa Tenggara, North Sulawesi, Central Sulawesi, West Papua and Papua.

3.4 Children's health and nutrition out comes

3.4.1 Child mortality in children under the age of five

The Indonesia Demographic and Health Survey (IDHS) divided early childhood mortality into several groups namely: neonatal mortality, post-neonatal mortality, infant mortality, child mortality, under-five mortality and fetal death/ miscarriage. Infant mortality refers to deaths occurring between birth and the first birthday, while child mortality refers to deaths occurring between the exact age of one and five years, and under-five mortality includes all of those combined deaths, between birth and the age of five years.

Overall, the improvements in malnutrition status have had a statistically significant effect in terms of declines in child mortality rates (Pelletier and Frongillo, 2003). But the increasing prevalence of underweight in under-fives within poor households (Q1) from 22.1 per cent to 22.7 per cent during 2007–2010 needs special attention because it might significantly contribute to under-five mortality. A child's right to survival is usually appraised in terms of the under-five

[12] Askeskin was described earlier, towards the end of section 3.1. SKTM is *Surat Keterangan Tanda Miskin*, a certificate or letter proving one's status as poor.

[13] *Dana Sehat* (Health Funds) is a community health insurance scheme under which households pay the insurance premium and the money is managed by the community themselves.

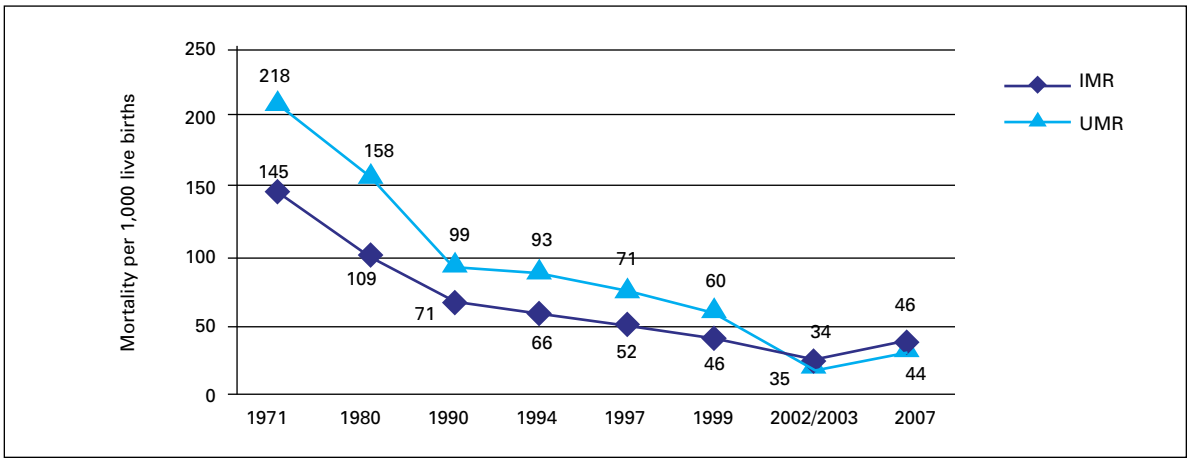
[14] Askes/Jamsostek are non-subsidized health insurance schemes under which civil servants and formal workers pay their own premiums.

mortality rate (U5MR), which is as the basis for one of the MDGs.

The mortality rates among infants and under-fives have declined considerably. The long-term picture of the progress in reducing the infant mortality rate (IMR) and the U5MR is presented in Figure 3.8. As shown, Indonesia has substantially reduced the national IMR from more than 100 per 1,000 live births in the 1970s and 1980s to 68 in 1991 and 34 in 2007. Meanwhile, the U5MR has declined from 97 per 1,000 live births in 1991 to 44 in 2007. This progress justifies optimism that the MDG target to reduce the U5MR by two thirds between 1990 and 2015 will be attained. However, it is important to be aware that the efforts to further reduce these mortality rates are likely to be much more challenging, and indeed the speed of the reduction has been slowing in recent years. During 1971–1991 the IMR declined by 2.7 per cent per year on average. The decline accelerated to 3.9 per cent per year during 1990–1999, but then significantly decelerated to an average of 0.5 per cent annually during 1999–2007. The reduction of the U5MR has followed similar patter; it was declining by 2.9 per cent per year during 1971–1990, and accelerated to 4.4 per cent during 1990–1999, but slowed down to an average of 2.8 per cent per year during 1999–2007.

In spite of the national progress, not all regions share the same level of accomplishment and provincial disparities are still clearly evident. The province of DI Yogyakarta recorded the lowest IMR and U5MR in 2007, 19 and 22 per 1,000 live births, respectively. At the other end of the scale, West Sulawesi recorded the highest IMR (74) and U5MR (96) among all 33 provinces. The majority of provinces lagged behind the national average. Only six provinces had IMR below 34 per 1,000 live births in 2007: Aceh, Jakarta, Central Java, Yogyakarta, Central Kalimantan and East Kalimantan (IDHS 2007). Important efforts to reduce the IMR include the provision of antenatal care to pregnant women and improved access to trained health-care providers to assist at childbirth.[15] Meanwhile, seven provinces achieved U5MR lower than the national average, namely: North Sulawesi, Bali, East Kalimantan, Jakarta, Central Kalimantan, Central Java and Yogyakarta (IDHS, 2007).

Figure 3.8: Infant and under-five mortality rates, 1971–2007



Source: Badan Pusat Statistik (BPS) – Statistics Indonesia 1971–1999; Indonesia Demographic and Health Survey (IDHS) 2002/2003 and 2007

[15] IMR for children whose mother received antenatal care and childbirth assisted by a trained health-care provider was 17 deaths per 1,000 live births compared with 85 deaths per 1,000 live births among children whose mothers received neither antenatal care nor assistance at delivery from a trained provider (IDHS 2007, p. 122).

More detailed data reveal greater challenges in reducing neonatal mortality, particularly among baby boys. The neonatal mortality rate, which is the number of babies under the age of 28 days who have died per 1,000 live births, among boys during 2002/2003–2007 was higher than girls and remained steady at 24, while the rate among baby girls declined from 21 to 19 in the same period. The mortality rate among boys aged 28 days to 11 months (the post-neonatal mortality rate) was also relatively higher than among girls of the same age. The under-four and under-five mortality rates (U4MR and U5MR) among boys are also slightly higher than girls (Table 3.11). These figures indicate the need to devote more attention to babies under 28 days of age and children aged 1–4 years.

Table 3.11: Neonatal, post-neonatal, under-four and under-five mortality rates by sex, 1994–2007

		1994	1997	2002/2003	2007
Neonatal mortality rate	Total	33	25	23	19
	Male			24	24
	Female			21	19
Post-neonatal mortality rate	Total	34	27	20	15
	Male			21	19
	Female			19	16
Under-four mortality rate	Total	28	19	12	10
	Male			13	13
	Female			11	12
Under-five mortality rate	Total	93	71	54	44
	Male			58	56
	Female			51	46

Source: IDHS 1994 and 1997, IDHS 2002/2003 and 2007

According to data from the 2007 RISKESDAS, the causes of post-neonatal and under-five deaths were dominated by communicable diseases, especially diarrhoea and pneumonia. These diseases were responsible for 55.2 per cent of deaths among infants aged 29 days to 11 months, and 40.5 per cent of deaths among children aged 1–4 years. The analysis using data from the IDHS 2002/2003 and IDHS 2007 on the treatment of diarrhoea (Table 3.12) shows that under-fives were generally brought to a health facility or provider if they had diarrhoea. People living in urban areas were more likely to bring their sick children to a health facility. IDHS 2007 data showed that the utilisation of health facilities for cases of children's diarrhoea was higher among the richest families (quintile 5) compared to the poorest (quintile 1) families. There was a strong correlation between both parental lack of any formal education and very low household income and higher U5MR. Access to professional medical facilities/providers was controlled for in the analysis. Table 3.13 shows that neonatal and infant mortality were higher among children whose mothers lacked any education, and received no medical care during pregnancy or delivery. Rates were also higher amongst the lower income groups and among rural children. Thus, additional support and awareness-raising, and research on child mortality issues, are required to decrease the U5MR, especially in rural areas where there is a stark difference in comparison to urban areas.

With a view to reducing child mortality, in 2007 the GoI implemented a programme called *Desa Siaga* (Alert Village) aimed at assuring that every childbirth is attended by a skilled midwife at an adequate health-care facility. Raya and Lada (2009) evaluated 34 'Alert Villages' in East Nusa Tenggara and concluded that the programme had succeeded in boosting the demand for improved maternal and neonatal health, as well as family health. However, it had failed to significantly improve the supply side, due to high staff turnover among midwives in remote villages and the absence, or inadequacy, of health facilities. One of the main barriers was the lack of effort among local governments to support the increasing awareness and demands for improved health in remote villages by providing additional funding and health extension workers.

Table 3.12: Treatment of diarrhoea, 2002 and 2007 (%)

Characteristic	Treatment									
	Taken to a health facility or provider		Oral rehydration therapy (ORT)		Increased fluids		Traditional medicine/other		No treatment	
	2002	2007	2002	2007	2002	2007	2002	2007	2002	2007
Age in months										
< 6	24	31.3	15.3	6.6	25.3	22.8	-	10.1	41.1	50.1
6–11	60	59.1	35.5	28	26.3	23	-	14	16.6	23
12–23	59.7	57.1	35.4	40.2	29.1	33.8	-	17.3	12.2	9.2
24–35	55.2	52	34.7	37.7	30.3	33.9	-	10.8	8.2	14
36–47	39.1	39.7	40.4	35.1	24.7	26	-	16.6	12.4	16.3
48–59	43.7	52.3	46.6	42.7	33.4	34.3	-	11.7	4.3	11.3
Sex										
Male	49	52.1	33	35.4	24.9	31.1	-	13.3	15.3	14.2
Female	52.7	49.7	38	33.7	32	29.4	-	14.9	12	20.4
Residence										
Urban	54.6	54.4	35	33.4	29	29	-	14.4	12.6	16.1
Rural	47.3	49.7	35.9	35.4	27.9	31.1	-	13.8	14.7	17.4
Wealth Quintile										
Quintile 1	-	37.7	-	31.6	-	27.2	-	12.3	-	20.2
Quintile 2	-	46.2	-	36.1	-	28.8	-	17	-	14.3
Quintile 3	-	61.3	-	38.4	-	34.6	-	16.5	-	13.5
Quintile 4	-	58.3	-	39.6	-	31.4	-	11.3	-	18.8
Quintile 5	-	64.3	-	27.4	-	32.4	-	13.2	-	16.1

Source: Indonesia Demographic and Health Survey 2002/2003 and 2007

Table 3.13: Child mortality rates by demographic characteristics and type of obstetric services, 2007

	Neonatal	Infant	Under-five
Mother's education			
No education	39	73	94
Complete primary	23	44	56
Secondary or higher	14	24	32
Antenatal care/delivery assistance			
Both antenatal care and delivery assistance	10	17	n/a
Antenatal care only	9	18	n/a
Delivery assistance only	35	58	n/a
No antenatal care and no delivery assistance	54	85	n/a
Household expenditure			
Quintile 1 (poorest)	27	56	77
Quintile 2	25	47	59
Quintile 3	19	33	44
Quintile 4	17	29	36
Quintile 5 (richest)	17	26	32
Urban/Rural			
Urban	18	31	38
Rural	24	45	60

Source: IDHS 2007

3.4.2 Child mortality in all children under the age of 18

Heretofore, the focus of child mortality has been on children under the age of five. But for this study on child poverty, the definition of children is all people under 18 years old. Unfortunately, there has never been a calculation of the child mortality rate for all children under the age of 18 in Indonesia. However, a picture of the health conditions of children under the age of 15 is available from RISKESDAS 2007, which contains data on the causes of mortality disaggregated by age group, including three children's age groups: 0–28 days (neonatal), 29 days to 4 years, and 5–14 years. After the age of 14, the groups are combined as follows: 15–44 years, 45–54 years, 55–64 years, and above 65 years.

Based on RISKESDAS 2007 data (Table 3.14), the major causes of neonatal mortality (0–28 days) were respiratory disorders (35.9 per cent) and premature birth (32.4 per cent). The main causes of child deaths from age 29 days to 14 years were diarrhoea and respiratory diseases, which can be further identified as respiratory disorders, respiratory distress syndrome, pneumonia and tuberculosis (TB). The problem of respiratory diseases, especially pneumonia, should be given priority in the efforts to reduce child mortality for children aged 0–14 years. The data also show that malaria tends to be more prevalent in rural areas (e.g., in Sumba), compared with dengue fever, which is more prevalent in urban areas (e.g., in Jakarta).

From a qualitative study in East Sumba, child mortality due to pneumonia was caused not only by the problem of limited medical supplies, especially respiratory aid equipment in local health facilities, but also by parents' lack of ability to differentiate between pneumonia and ordinary influenza. In one sub-district studied in East Sumba District there were 10 cases of child mortality caused by pneumonia in 2010. Both diarrhoea and pneumonia were exacerbated by poor sanitation, malnutrition, lack of clean water, unhealthy settlements, both in the urban poor areas of North Jakarta and the rural poor areas of East Sumba. In East Sumba, the improvement of healthy settlements focused not only on housing conditions but also on the arrangement of space in terms of separating livestock from children's play areas. In North Jakarta, the settlement conditions were characterized by slums and overcrowded houses, flooding with high tides, unsanitary household conditions, a lack of clean water, and problems with waste water and air pollution from industrial estates.

In East Sumba, poor parents would bring their sick children to *'dukun urut'* (traditional massage healers) as a first step in treatment-seeking, since these healers are located in the village and thus did not require money for a motorcycle taxi *(ojek)*, and the *dukun urut* never asked for payment. In North Jakarta, poor parents would buy over-the-counter drugs at their nearest *warung* (small shop) if their child was sick. In both East Sumba and North Jakarta, parents would only bring sick children to health-care providers (e.g., *puskesmas* or a doctor's private practice) when they were already severely ill. Hospitals were seen by poor parents as the last resort, only for children with critical or severe medical conditions. This was the case even among poor parents in North Jakarta who had ample access to health facilities. The poor families were very dependent on health-care personnel to access assistance, since they first have to complete administrative requirements for their SKTM (*Surat Keterangan Tanda Miskin*; a certificate proving their status as poor), then obtain referrals from the *puskesmas*, be escorted to hospital, accompanied during doctors' examinations, and assisted in clearing the inpatient fees with the hospital administrative management. Such assistance from health-care personnel was very important whenever for poor families who were afraid of the high cost or were otherwise reluctant to go to hospitals (Figure 3.9).

Residents of East Sumba faced many limitations on their access to health facilities, including long distances to a *puskesmas* in the nearest sub-district centre or village, and shortage of available and affordable public transport. Community members placed high priority on the quality of health services whenever they wanted to access a health service provider. Although their local pustu (sub-*puskesmas*) may be closer, they would go to a *puskesmas* or another pustu further away if it had a better standard of

Figure 3.9: Housing conditions of the poor in the study areas of East Sumba (left) and North Jakarta (right)

Table 3.14: Main causes of mortality by age group, 2007

Mortality rate per 1,000 live births, 2007	Neonatal (0–28 days)		Infant (0–1 year)	Under-five (0–5 years)	Children (0–17 years)		Adult	
	19		34	44	n/a		n/a	
Age group	0–6 days (n=142)	7–28 days (n=39)	29 days–11 months (n=173)	1–4 years (n=103)	5–14 years		15–44 years	
					Urban (n=23)	Rural (n=53)	Urban (n=240)	Rural (n=325)
Mortality Causes	Premature birth		Diarrhoea			Diarrhoea		
	32.40%	12.80%	31.40%	25.20%		11.30%		
		Pneumonia						
		15.40%	23.80%	15.50%	13%	11.30%		
	Respiratory disorders	Respiratory distress syndrome (RDS)	TB				TB	
	35.90%	12.80%	1.20%	3.90%			10.50%	9.00%
	Congenital malformations		Measles			Liver disease		
	1.40%	18.10%	1.20%	5.80%	4.30%	7.50%	8.80%	9.90%
	Sepsis			Dengue				
	12%	20.50%	4.10%	6.80%	30.40%			
	Bleeding disorder and yellow colouration of the skin	Yellow colouration of the skin		Malaria		Malaria		Malaria
	5.60%	2.60%		2.90%		9.40%		6.20%
		Nutrition deficiency	Malnutrition					
		2.60%	2.30%					

Source: Mortality rate from IDHS 2007; additional data from RISKESDAS 2007

service. There was also a lack of available health professionals, due to the limited number of graduates in the health sector in the district. East Sumba District still does not have a midwifery educational institution, and the current health education institutions only provide general nursing education.

In relation to HIV/AIDS, the qualitative study in North Jakarta found five children (aged 0–11 years) who had been infected with HIV/AIDS by their parents. Fathers with an HIV/AIDS positive status were often drug addicts, alcoholics and/or suffering from tuberculosis (TB) while still in their productive age. A *puskesmas* could identify children infected with HIV/AIDS from symptoms including constant diarrhoea, continuous weight loss and severe malnutrition. To help people who appeared to have HIV/AIDS, *puskesmas* staff actively assisted them through a voluntary counselling and testing (VCT) process and referring them to hospitals and NGOs providing services for people living with HIV/AIDS.

3.4.3 Child survival rates

Improved child survival rates have been supported by improvements in immunization coverage, but under-coverage is still substantial. Overall, immunizations against communicable diseases like tuberculosis, diphtheria, polio and measles improved during 2003–2007 (Table 3.15). Among all types of immunization, Polio 1 had the widest coverage at nearly 90 per cent, while Hepatitis B and DPT 3 had the smallest coverage at approximately 60 per cent and 67 per cent, respectively. Around 44 per cent of infants had not received complete immunization in 2007. More recent data regarding all types of immunizations are not yet available, but the latest RISKESDAS data (2010) showed alarming evidence of decreasing percentages of children immunized against measles. The 2010 RISKESDAS found that 74.5 per cent of children aged 12–24 months had been immunized against measles, down from 81.6 per cent recorded in the 2007 RISKESDAS. Across provinces, 2010 complete immunization

Table 3.15: Child deprivations in a variety of health dimensions, 2003–2009

Dimension of poverty	Indicators	Years/Values		Annual change (%)	Source of information
		2003	2009		
Health	Self-reported work/school disrupted by ill health	12.91	16.22	4.27	SUSENAS Panel
	Self-reported fever	11.22	14.8	5.32	SUSENAS Panel
	Self-reported cough	11.06	16	7.44	SUSENAS Panel
	Self-reported influenza	11.88	16.31	6.21	SUSENAS Panel
	Self-reported asthma	0.4	0.8	16.67	SUSENAS Panel
	Self-reported diarrhoea	1.07	1.66	9.19	SUSENAS Panel
	(12–23 months old)	**2002/2003**	**2007**		
	Immunization: complete	48.5	41.4	-2.44	IDHS
	Immunization: BCG	17.5	14.6	-2.76	IDHS
	Immunization: DPT 1	18.6	15.6	-2.69	IDHS
	Immunization: DPT 2	28.9	24.3	-2.65	IDHS
	Immunization: DPT 3	41.7	33.3	-3.36	IDHS
	Immunization: Polio 1	12.7	10.8	-2.49	IDHS
	Immunization: Polio 2	20.4	17.4	-2.45	IDHS
	Immunization: Polio 3	33.9	26.5	-3.64	IDHS
	Immunization: Measles	28.4	23.6	-2.82	IDHS
	Immunization: Hepatitis B 1	29.1	19.5	-5.50	IDHS
	Immunization: Hepatitis B 2	41.9	28.3	-5.41	IDHS
	Immunization: Hepatitis B 3	54.7	39.7	-4.57	IDHS
	Infant <6 months old exclusively breastfed	60.5	67.6	1.96%	IDHS
		2007	**2010**		
Nutrition	Stunting	38.8	35.6	-1.37	RISKESDAS
	Wasting	13.6	13.3	-0.37	RISKESDAS

Source: Estimated using data from the 2009 SUSENAS Panel, IDHS 2002/2003 and 2007, and RISKESDAS 2007 and 2010
Note: Information on complete immunization from IDHS data excludes Hepatitis B immunization

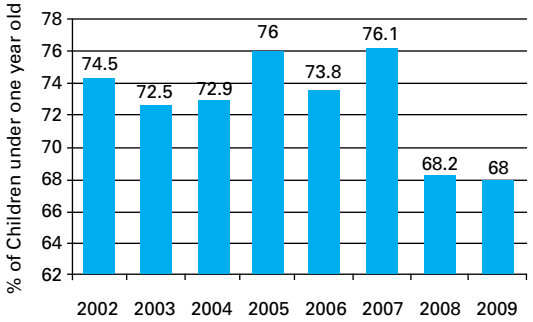
coverage ranged from a low of 47.4 per cent in Papua to a high of 96.4 per cent in Yogyakarta, with 19 provinces having coverage rates below the national level. Compared to the 2007 levels, only four provinces recorded increased coverage with improvement ranging between 2.5 and 6.8 percentage points (Ministry of Health, 2010).

The achievement of UCI coverage in Indonesia was still low at 73.8 per cent of children in 2006, 76.1 per cent in 2007, 68.2 per cent in 2008 and 68 per cent in 2007 (Figure 3.10). The GoI identified the weaknesses of the national health system and the management of immunization programmes as the causes of the low coverage achievement.

Complete immunization consists of one BCG, three DPT, three polio, three Hepatitis B and one measles immunizations. Children who receive incomplete immunizations are referred to as 'dropouts'. According to RISKESDAS 2007, the percentage of drop-outs was 45.3 per cent compared with 46.2 per cent who received complete immunization (Table 3.16). Some barriers to the supply of immunization services were: (i) changes of vaccination staff (*juru imunisasi*, JURIM) who were appointed in the mid-1980s, but then transferred to become midwives; (ii) regional proliferation, natural disasters, and violent conflicts between communities causing a weakened capacity of institutional arrangements; and (iii) poor commitment from local governments when it came to prioritizing immunization programmes, as evidenced by inadequate allocation in local budgets and unsupportive local regulations regarding immunization.

Further analysis of rates of immunization revealed the persistence of a rural/urban gap (Table 3.17). However, mixed results on other variables do not point to any particular determinants associated with incomplete childhood immunization. For complete immunization, the deprivation in urban areas is larger than rural areas whilst for immunization against measles in particular, the deprivation in rural areas is greater than in urban areas. The deprivation with regards to complete immunization was two percentage points higher in urban areas in 2009. The urban/rural gap for measles immunization was wider; around seven percentage points in 2007, increasing to nine percentage points in 2010. Regarding complete immunization, the deprivation was slightly higher among children from households headed by males than by females, which might reflect greater awareness among women regarding the importance of immunization. The size of the households, the educational background of the household head, and the socio-economic status of the households were also associated with differences in the proportions of children receiving complete immunizations and measles immunization.

Figure 3.10: Coverage of Universal Child Immunization (UCI), 2002–2009



Source: MoH Decree No. 482/2010

Table 3.16: Children aged 12- to 23-months obtaining complete immunizations by respondent characteristics, 2007 (%)

	Complete	Incomplete	None
National	46.2	45.3	8.5
Boys	46.6	45.2	8.2
Girls	45.7	45.4	8.9
Urban	54	41.5	4.5
Rural	41.3	47.7	11.1
Quintile 1 (poorest)	41.6	47.1	11.3
Quintile 2	43.4	46.9	9.7
Quintile 3	47.3	44.6	8.1
Quintile 4	49.4	44.5	6.1
Quintile 5 (wealthiest)	53.5	41	5.5

Source: Riskesdas 2007

Table 3.17: Children deprived in the health dimension, by household characteristics (%)

	Self-reported*		Incomplete immunization (2009)*	No measles immunization**	
	Diarrhoea (2009)	Asthma (2009)		2007	2010
Gender of household head					
Female	1.46	0.63	20.65		
Male	1.68	0.81	25.47		
Number of household members					
Less than 3	1.22	0.85	10.74		
3–4	1.73	0.83	27.83		
5–6	1.58	0.72	23.41		
7+	1.72	0.9	23.17		
Educational level of household head					
None/did not attend school	1.83	0.83	20.1	28.4	43.7
Finished primary school	1.65	0.82	24.25	21.8	30.3
Finished junior high school	1.77	0.95	27.95	17.7	22.5
Finished senior high school	1.55	0.68	28.57	11.4	18.7
Finished diploma/academy/university	1.24	0.64	27.53	6.9	14.5
Geographical location					
Urban	1.58	0.74	26.28	14.0	21.4
Rural	1.73	0.85	24.1	21.2	29.8
Household welfare (expenditure quintile)					
Q1	1.92	0.82	25.27	21.9	35.0
Q2	1.61	0.77	24.48	21.5	28.6
Q3	1.45	0.71	24.86	16.9	22.2
Q4	1.77	0.85	25.56	15.7	19.2
Q5	1.41	0.84	25.48	13.2	13.7

Note: The immunization data refers only to children 12–23 months old
*Source: * Estimated using data from the 2009 SUSENAS Panel and Core; ** RISKESDAS, MoH, 2010*

Other factors that might affect child survival include a lack of access to safe water and proper sanitation, breastfeeding practices and child nutritional conditions in general. As discussed in the previous section, many children still suffer from a lack of access to safe water, sanitation and healthy shelters which has potentially caused hygiene-related diseases. The 2003 and 2009 SUSENAS data indicated an increasing prevalence of diarrhoea, asthma, influenza, coughs and fevers, as well as self-reported work or school disruption due to ill health. Diarrhoea and asthma (as well as other acute respiratory infections) are among the main causes of infant and under-five mortality (see also the discussion in section 3.4.1 of this chapter). As presented in Table 3.17, the prevalence of these diseases is higher among the children of male-headed households, large households, households where the household head has a low level of education, households in rural areas, and poor households. According to SUSENAS, exclusive breastfeeding has been becoming less popular. The data in 2009 shows 67.8 per cent of infants under 6 months were not exclusively breastfed; an increase from 60.5 per cent in 2003. Regarding nutritional conditions, there have been some improvements reflected in the decreasing prevalence of stunting and wasting among children. However, according to RISKESDAS, the prevalence of wasting (13.30 per cent) and stunting (35.60 per cent) in 2010 remain too high to be ignored in the overall context of child survival (see also section 3.4.6 of this chapter).

3.4.4 Maternal mortality

The progress in reducing maternal mortality in Indonesia is still far from the MDG target for 2015 and hence requires special attention (Figure 3.11). The quality of antenatal care is not optimal; 61.4 per cent of pregnant women attend at least four antenatal care visits and only 18 per cent took at least 90 doses of iron tablets (RISKESDAS

Box 3.1: Factors influencing immunization coverage among poor children in urban and rural areas

In North Jakarta, immunization facilities are available in each posyandu *(integrated health post).* Posyandu *personnel are also active in providing information about about child health, including about immunization. However, the awareness of some poor households is still lacking. Ibu Asih (not her real name; 34 years old) works shucking oysters and has four children; three of them are already in primary and secondary school, but the youngest one (Widi) is still four years old and not yet attending school. Widi was never immunized at the* posyandu *although this service is provided for free. Ibu Asih cannot take Widi to the* posyandu *because the* posyandu *opens at the same time that the supply of oysters arrives to be shucked, and nobody else can take Widi to the* posyandu*. Similarly, Ibu Inah (46 years old), who never finished her primary school education and is now working collecting unused medicines, also never took her ten children to be immunized because she was afraid that her children would become feverish after being immunized. She did not believe that her children would be healthier after being immunized; on the contrary she believed it would make them ill, due to the high fever. Ibu Yati (54 years old), a single mother who now has five grandchildren, shared the same opinion. She never allowed her four children and five grandchildren to be immunized. She is afraid of needles and does not want her grandchildren to be injected with syringes.*

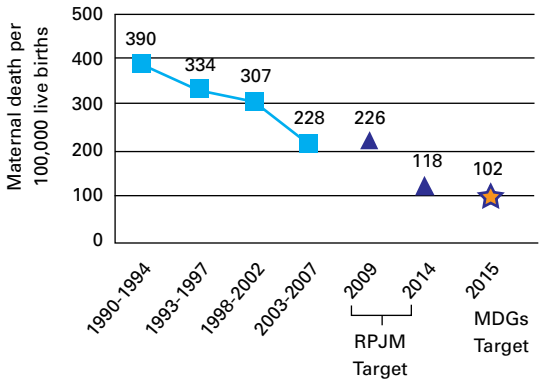
On the contrary, in many remote villages in East Sumba, a lack of access and limited health facilities are the main hindrance to the expansion of immunization coverage. To overcome this problem, the local government is conducting a mass immunization programme of all children under five years old at the posyandu *and using the PNMP GSC (National Programme for Community Empowerment – Healthy and Smart Generation) to intensify immunization activities at the* posyandu*. Parents are encouraged to take their children to the* posyandu *by way of tokens of appreciation as an incentive for parents who take their children to* posyandu *routinely, and penalties for those who never attend* posyandu *(excluding them from receiving the other benefits from the programme). Ibu Ina (36 years old) has six children and takes them to be immunized at the posyandu free of charge. She also has a Jamkesmas (community health insurance scheme) card that allows her to receive free medication at the* puskesmas*. Ibu Ana (47 years old), who has four children, had her babies delivered in the* puskesmas *and her children were immunized there as well.*

Source: Case study in North Jakarta and East Sumba, June–August 2010

2010). As part of RISKESDAS 2010 (Basic Health Research survey), two indicators regarding maternal health status were monitored: the proportion of deliveries attended by professional birth attendants and the level of contraceptive use among couples of reproductive age (15–49 years old). During 2005–2010, the national average rate of births attended by a professional birth attendant was 82.2 per cent. However, in 20 provinces (about 60 per cent of the country's 33 provinces) the rates were below this national average. The lowest proportion was found in North Maluku Province (26.6 per cent) and the highest proportion was in DI Yogyakarta Province (98.6 per cent). East Nusa Tenggara Province was the eleventh lowest ranked province (64.2 per cent), while DKI Jakarta Province was the fourth highest ranked (95.8 per cent).

Although DKI Jakarta had the fourth highest ranking, women from poor families still preferred to give birth with the assistance of a nearby traditional birth attendant. The main reasons for this were the cheaper cost (IDR400,000–700,000) for the services of a traditional birth attendant compared with a midwife (IDR800,000–900,000),

Figure 3.11: Indonesia's maternal mortality rate, 1990–2015



Source: IDHS 1994–2007

and the option to pay by installments. Women from poor families also rarely attended a *puskesmas* for routine check-ups regarding contraceptive use. They did not want to wait in queues and faced difficulty attending due to child care commitments and/or their existing workloads. Almost all poor families in North Jakarta had more than two children, with most having three to seven children.

Mothers from poor families in East Sumba experienced improving conditions between 2005 and 2010 due to the multi-stakeholder programmes implemented by the local government, e.g., the Jamkesmas programme and the Nation Programme for Community Empowerment 'PNPM Generasi', which provided: (1) tetanus toxoid immunization to pregnant women and reproductive aged women who intended to become pregnant; (2) free monthly antenatal checkups and a financial incentive of IDR 5,000 for each visit to a health facility, with the target of 3,350 pregnant women; (3) free childbirth services and the provision of up to IDR50,000 in transportation costs for both the pregnant woman and a companion (midwife/ traditional birth attendant/family member) to travel to a health-care facility for safe delivery, with a target of 2,500 births; (4) two free post-partum examinations (when the infant is aged 0–1 month and again when aged 28–40 days); (5) complete immunization free of charge; and (6) revitalization of *posyandu*. Those programmes had a positive impact on reducing maternal mortality rates in the district. The number of maternal deaths recorded was five in 2010 compared to 10 in 2009, 14 in 2008, and 30–50 cases annually in previous years.

3.4.5 Reducing child mortality and maternal mortality with nutrition supplementation for mothers and children

Government intervention for improved child nutrition begins in the womb, with nutritional supplements for pregnant women. The government programme of iron supplementation twice a year (February and August) was aimed at reducing the prevalence of pregnant women with iron deficiency to 40 per cent (2009 target), with 85 per cent of pregnant mothers receiving any iron supplementation (2014 target). Based on RISKESDAS 2010 data, the percentage of pregnant mothers aged 10–49 years old who consume iron supplements in Indonesia was 80.7 per cent, but only 18 per cent of them consumed the supplements for more than 90 days during pregnancy (Figure 3.12) – this percentage is far from the target of 85 per cent. Women in urban areas and those from wealthier households are more likely to consume iron tablets for more than 90 days during pregnancy.

Giving solid foods to infants under the age of six months also contributes to malnutrition. Exclusive and continued breastfeeding as well as optimal complementary feeding practices are among the top three most effective interventions for reducing child mortality and under-nutrition (Jones et al., 2003 and Bhutta et al., 2008). Between 2002 and 2007 exclusive breastfeeding declined from 40 to 32.4 per cent (Figure 3.13) with milk other than breast milk generally being introduced before six months. In 2007 only 41.2 per cent of children 6–23 months old are fed according to WHO recommendations (Figures 3.13 and 3.14). The data show that more children from rich households and living in urban areas are fed with the recommended complementary foods (Table 3.18).

If we compare exclusive breastfeeding practices between urban and rural areas, and by household expenditures (wealth quintile),

Table 3.18: Coverage of nutrition intervention by urban/rural location and household expenditure, 2007 and 2010 (%)

	Households having sufficient iodized salt consumption, 2007	Children aged 6–59 months received Vitamin A, 2010	Mothers received iron tablet distribution, 2010	Children aged 6–23 months with 3 IYCF* practices, 2007
Indonesia	62.3	69.8	18.0	41.2
Urban	70.4	74.0	20.3	44.7
Rural	56.3	65.3	15.6	38.7
Quintile 1	56.7	63.8	12.8	36.5
Quintile 2	59.3	69.4	16.2	40.7
Quintile 3	61.8	73.1	18.7	42.1
Quintile 4	64.1	72.3	21.0	42.5
Quintile 5	70.0	73.3	25.1	44.4

Source: RISKESDAS 2007 and 2010; IDHS 2007
*Note: *IYCF, infant and young child feeding*

the RISKESDAS 2010 data show that exclusive breastfeeding was more commonly practiced in rural areas than in urban ones, and fewer babies were exclusively breastfed in richer households than in the poorer ones (see Figure 3.15). More women working outside the home and longer women's working hours contributed to the lower prevalence of breastfeeding among the urban and richer households. As also shown in Figure 3.15, boys were more likely to be breastfed than girls.

In North Jakarta, many infants aged 0–6 months were not exclusively breastfed and many babies aged over four months received solid foods due to tradition. Mothers believe that giving solid foods, such as bananas, to their children will make them less fussy and less likely to cry. In addition to giving solid food, formula milk was commonly given to complement breast milk. Work demands on mothers were also a reason for not breastfeeding. In fact, *posyandu* personnel advised mothers to exclusively breastfeed their children and explained how important breast milk is for child development. A low level of exclusive breastfeeding was also found in East Sumba.

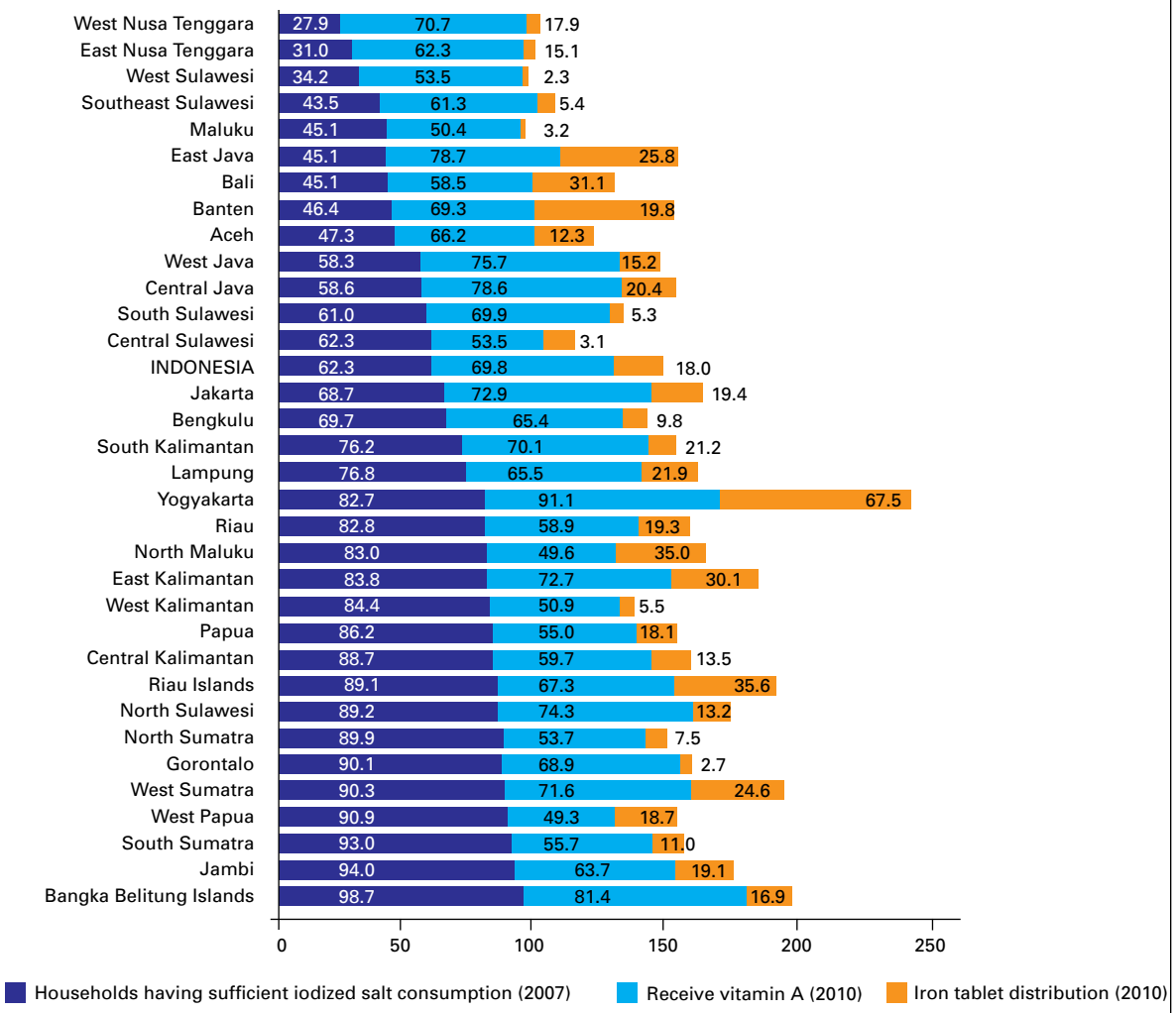
Vitamin A consumption among children aged 6–59 months is important because it prevents blindness, Vitamin A deficiency, other nutritional problems, and death. In the MoH Strategic Plan 2010–2014 the government set a target for 85 per cent of children aged 6–59 months to be taking Vitamin A capsules by 2014. Data from RISKESDAS 2007 indicated that 71.5 per cent of children aged 6–59 months received Vitamin A capsules, and this figure decreased in 2010 to 69.8 per cent (Figure 3.12). Children who live in urban areas and come from rich households consume more Vitamin A than those who live in rural areas and come from poor households.

Between the two case study areas there were obvious differences in terms of nutrition, with cases of malnutrition being more common in East Sumba than in North Jakarta. Causes of malnutrition in both regions differed, but the basic cause was poverty – the prevalence rates of all nutritional problems were higher in poor families.

In North Jakarta, household economic difficulties forced mothers to work. As a result, exclusive breastfeeding was not possible for babies and older children had to buy food outside the home, making them susceptible to illness since the purchased foods generally did not meet standards of good nutrition and hygiene. Usually such food consisted of tofu, *tempe, perkedel*, vegetables, salty fish, soy sauce and crackers. Insufficient food, since these children generally only eat once or twice a day, also contributes to child malnutrition.

In East Sumba poverty also affected the food consumption patterns of children. The limited economic resources of families made it difficult to provide nutritious food. Children usually ate twice or three times a day but they rarely ate healthy food. A typical child's breakfast consisted of rice mixed with salt (commonly called plain rice), raw chili, and sometimes sweet tea or coffee, and lunch was rice and vegetables.

Figure 3.12: Coverage of micronutrient intervention, by province (%)



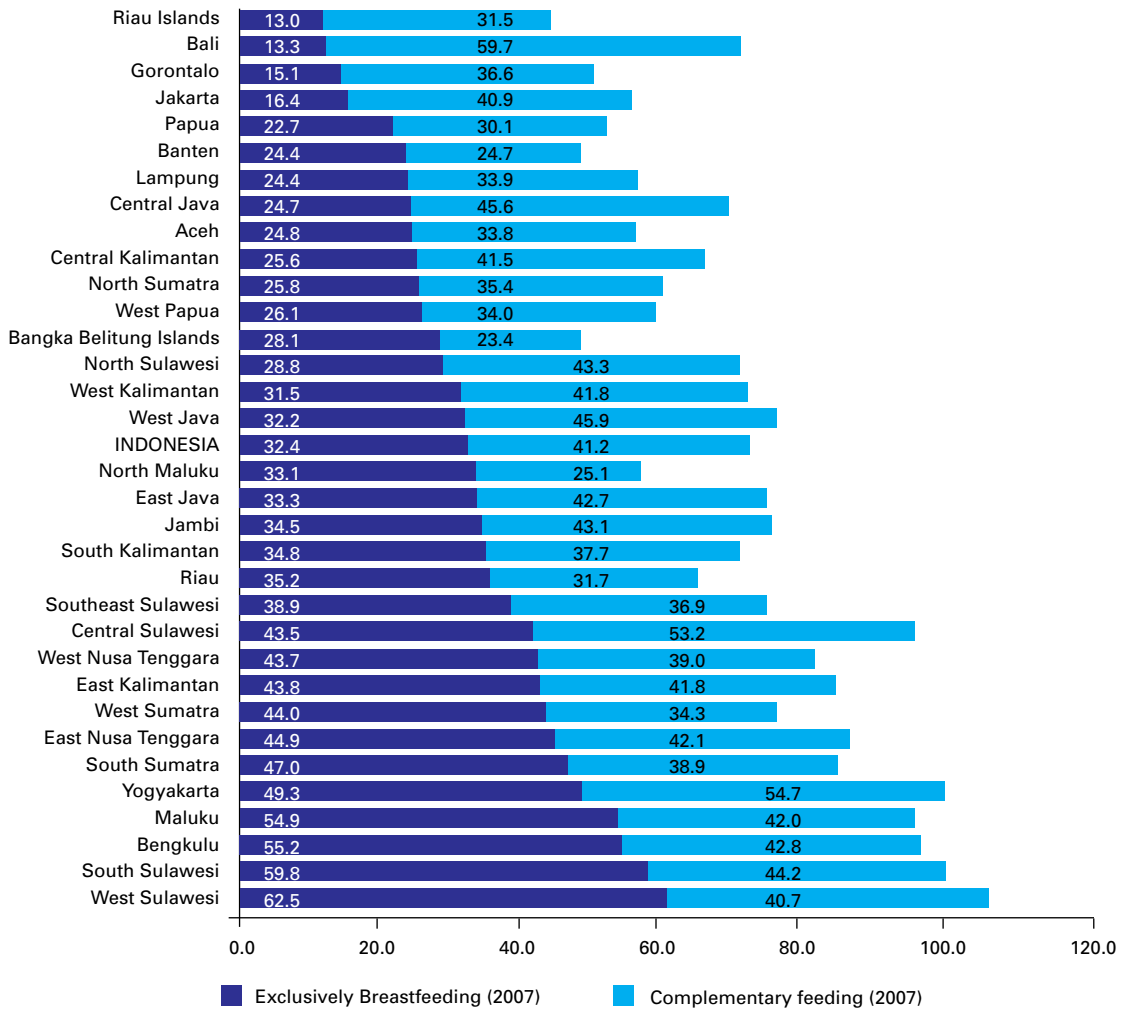
Source: RISKESDAS 2007 and 2010; IDHS 2007
Notes: - Iodized salt consumption: Numbers of households consuming iodized salt
- Vitamin A: Children aged 6–59 months receiving vitamin A for the last 6 months
- Iron tablets: Pregnant women receiving iron tablet distribution

Sometimes lunch and dinner was just rice mixed with salt. To save money, sometimes rice was mixed with or replaced by corn. If they could not afford rice or the corn supplies had run out (they called this 'the hungry season'), they sought an alternative food from the surrounding forest called *iwi* – a kind of sweet tuber that needs to be prepared carefully to remove its poison by immersing it in a river for several days.

Besides poverty, the culture in East Sumba also shapes the food consumption patterns. Most households own livestock such as pigs and chickens, but they rarely use these livestock for their own consumption. Rather, when there were ceremonies in the community, such as a funeral, they would offer their pigs to the bereaved family.

The government has already established policies for improving nutrition, including both prevention and treatment approaches. Government activities in this area range from; monitoring children's nutritional status and providing supplementary feeding, to treating cases of malnutrition,

Figure 3.13: Coverage of macronutrient intervention, by province, 2007 (%)



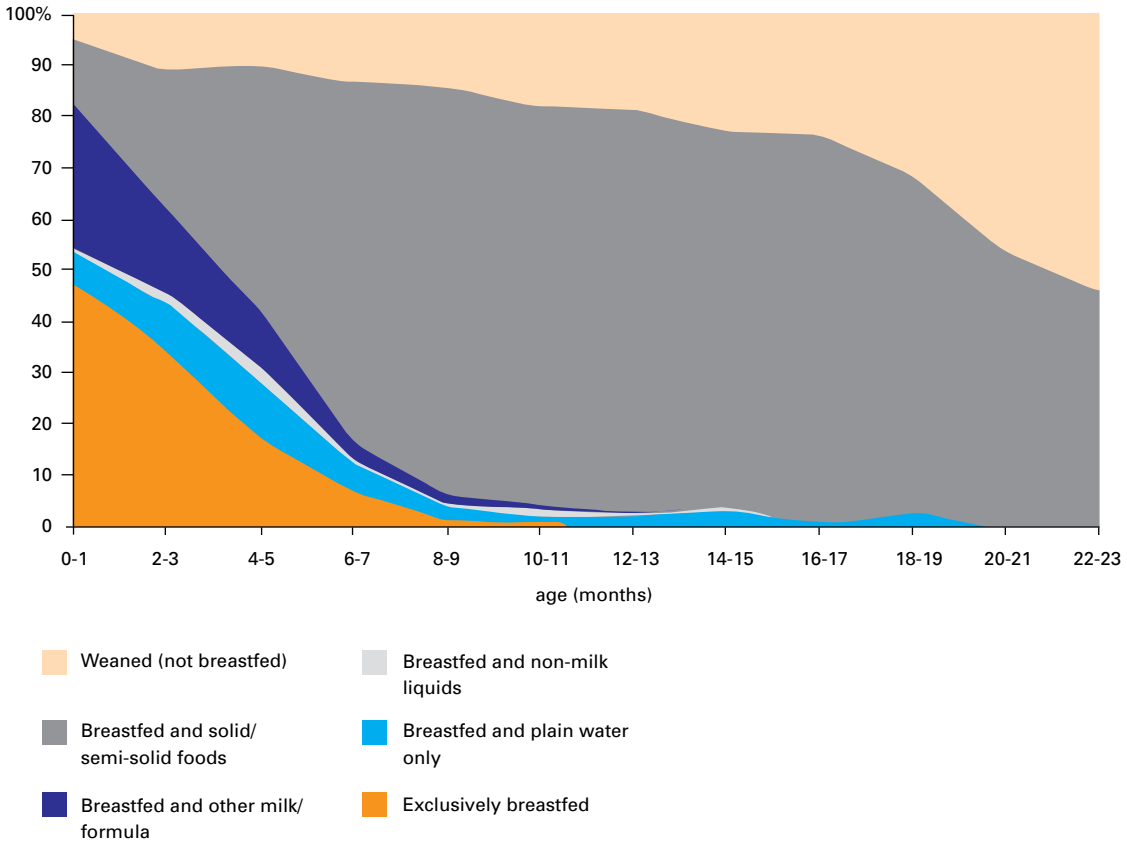
Source: IDHS 2007

Notes: Complementary feeding: Percentage of children aged 6–23 months with 3 IYCF practices

providing counselling on feeding practices, and providing micronutrient supplements to children and pregnant women. Unfortunately the government has often focused on underweight children (weight-for-age) and has given inadequate attention to the problems of stunting (height-for-age) and wasting (weight-for-height), as was evident from the nutritional targets set by the government. Furthermore, the prevalence of cases of overweight children is increasing, not only in rich households but also in the poor ones. Yet the government so far has only issued policies aimed at preventing an increase in the prevalence of overweight children, and has no policies aimed at reducing the prevalence of overweight children.

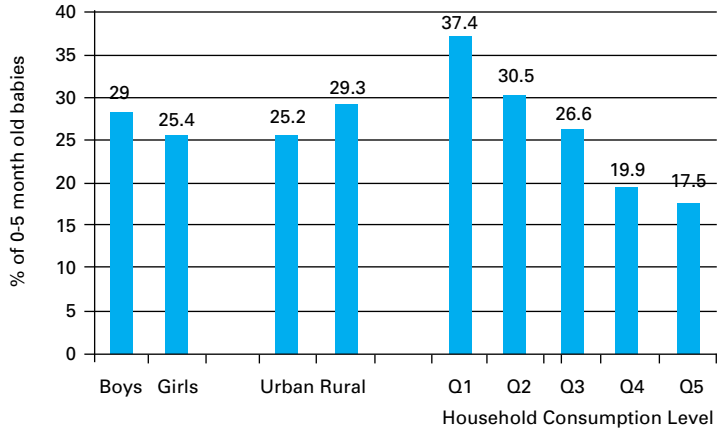
A number of government nutrition improvement activities are already easily accessible in communities, since they are channelled through the *posyandu* and *puskesmas* system. However, these programmes and activities are not specifically intended for poor households but are aimed at the general community. The increasing prevalence of malnutrition occurring in poor households from 2007–2010 is evidence that the government's nutrition interventions have been ineffective for poor households.

Figure 3.14: Infant feeding practices, 2007



Source: IDHS 2007, in UNICEF, 2009

Figure 3.15: Exclusively breastfed babies aged 0–5 months, by urban/rural location, gender and household expenditure, 2010 (%)



Source: RISKESDAS 2010

3.4.6 Child nutritional status: Underweight, wasting, stunting and overweight

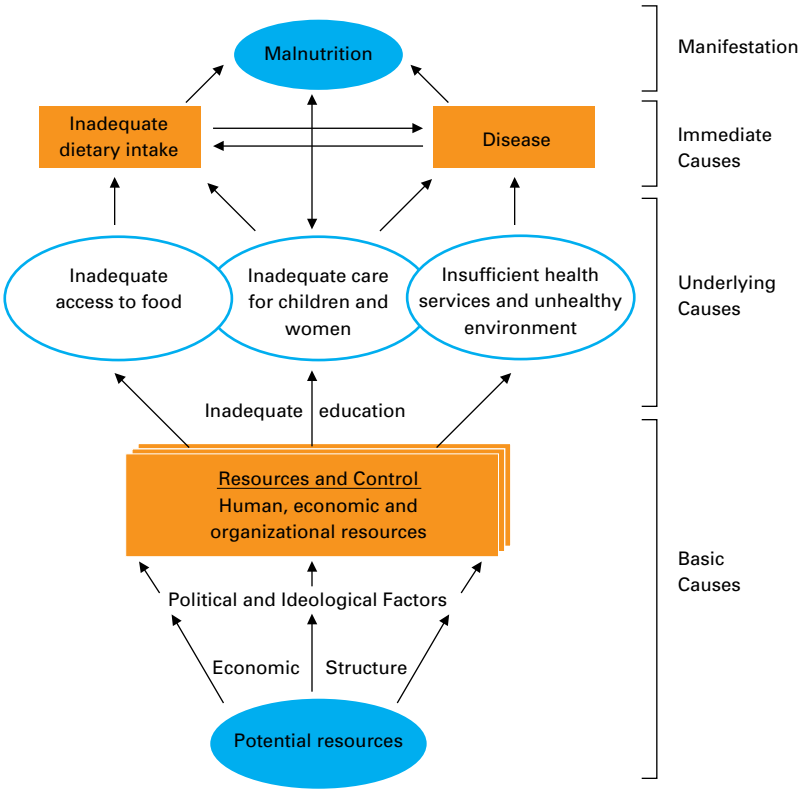
As illustrated in UNICEF's conceptual framework on the determinants of nutritional status, the causes of malnutrition are multi-sectoral. Dietary intake and health status – which act in synergy – are the immediate determinants of nutritional status (UNICEF, 1990). Dietary intake in turn will be affected by the food available and accessible to the household (or its food security) while health status will depend on the household's access to health services as well as to safe water and appropriate sanitation (or access to health). Access to food as well as access to health will both be modified by the household's capacity to fulfill the care needs of women and children. From that perspective, household food security is a necessary but insufficient condition to ensure adequate nutritional status. Food security, adequate care for children and mothers as well as access to health services are all determined by underlying factors operating in the family, community and broader society. Beaurdy (1996) found that these conditions are related to the availability and control of human, economic and organizational resources in the society, themselves the results of current and previous technical and social conditions of production together with political, economic and ideological-cultural factors (see Figure 3.16).

Anthropometry is a universal method to assess individual nutritional status, most commonly evaluated among under-fives, as their nutritional status constitutes an indicator of societal health and well-being. In a population of children, height-for-age, weight-for-height and weight-for-age indices are estimated using WHO growth standards (Multicentre growth reference study group, 2006). Weight-for-age reflects body mass relative to age. Low weight-for-age is described as 'lightness' and reflects a pathological process referred to as 'underweight'. Weight-for-age also reflects both weight-for-height and height-for-age; hence it fails to distinguish tall, thin children from those who are short with adequate weight. Height-for-age reflects the achieved linear growth that can be used as an index of past nutritional or health status. Low height-for-age is defined as 'shortness' and reflects either normal variation or a pathological process involving failure to reach linear growth potential referred to as 'stunting'. Finally, weight-for-height measures body weight relative to height. Low weight-for-height in children is described as 'thinness' and reflects a pathological process referred to as 'wasting'. This condition arises from a failure to gain sufficient weight relative to height or from losing weight (Figure 3.17).

The MDG target focuses on the prevalence of underweight children, which has been associated with an increased risk of mortality in under-fives in the 1990s. Since 1989, the number of underweight children under the age of five in Indonesia has tended to decrease each year. In 2010 the prevalence of undernourished under-fives in Indonesia was 17.9 per cent (Figure 3.18), which is a good indicator of progress towards achieving the MDG target of 15.5 per cent in 2015. In 2007, East Nusa Tenggara was the province with the largest prevalence of underweight children (33.6 per cent), while West Nusa Tenggara had the greatest prevalence of underweight children in 2010 (30.5 per cent). In 2007, Yogyakarta was the province with the lowest prevalence of underweight children at 10.9 per cent, and in 2010 North Sulawesi had the lowest prevalence, at 10.6 per cent. There was also a tendency for girls to be better off than boys with regard to all three nutritional status indicators. This is unlikely to have been caused by differential treatment of boys and girls by their parents but is most likely due to boys being more active than girls, and therefore needing a larger intake of nutritious food. This general difference between boys and girls should be understood and explained by *puskesmas* staff and *posyandu* personnel.

The disparities in nutritional status between urban and rural areas and between wealthier and poorer households are apparent. The number of children under the age of five who were underweight was higher in rural areas compared to urban areas. Moreover, from 2007 to 2010 the prevalence of underweight children in urban areas decreased by 4.4 per cent while in rural areas it increased by 1.5 per cent (Figure 3.19). The prevalence of underweight was higher among children in poor households. Although the national prevalence of underweight children decreased in 2010, the opposite was happening

Figure 3.16: Factors causing malnutrition



Source: UNICEF, 'Strategy for improved nutrition of children and women in developing countries', A Policy review, New York, 1990

Figure 3.17: Anthropometrics of nutrition

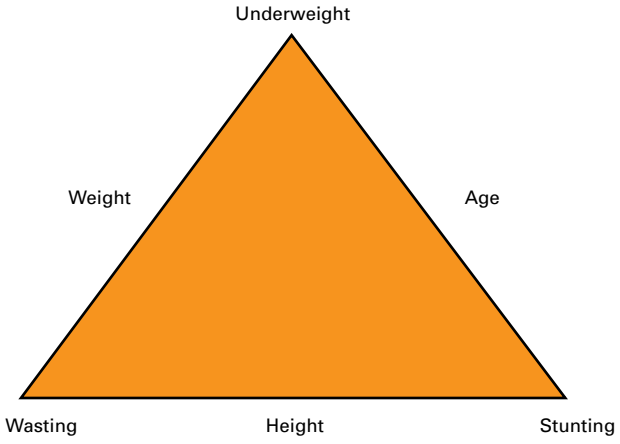
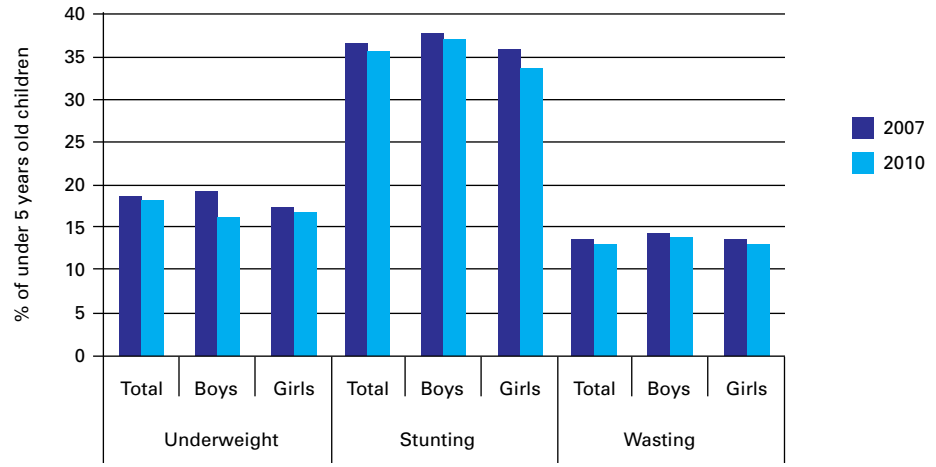


Figure 3.18: Nutritional status of children under age five years, 2007 and 2010



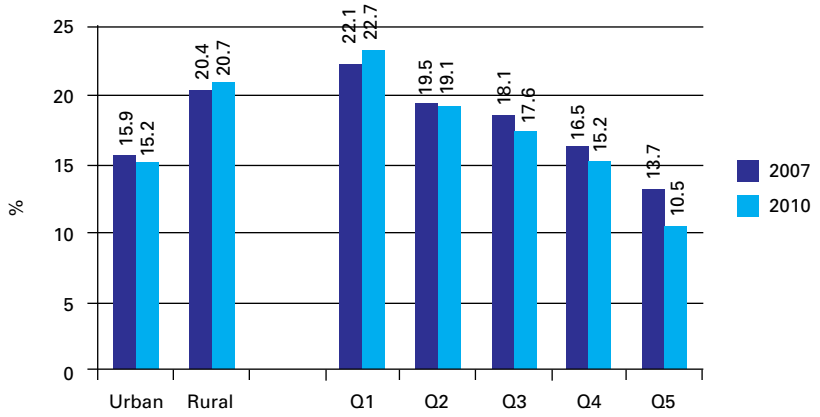
Source: RISKESDAS 2007 and 2010

within poor households. The prevalence of underweight children in quintile 1 households (the poorest) had increased from 2007 to 2010 by 2.7 per cent. As for households in quintiles 2, 3, 4 and 5, the prevalence of underweight children had decreased and continued to decrease as the level of household expenditure increased.

Besides the prevalence of underweight children, Indonesia actually faces a greater nutritional problem in stunting (low height-for-age) among under-fives. Based on RISKESDAS 2007 data, 36.8 per cent of under-fives were considered to be stunted. In 2010, this percentage had decreased slightly to 35.6 per cent but was still much higher than the prevalence of other nutritional problems (Figure 3.20). In 2007 and 2010, the province that experienced the highest prevalence of stunting of children was East Nusa Tenggara with 46.8 per cent and 58.4 per cent respectively. In this province, the prevalence of stunting among under-fives was higher in rural areas than in cities. The province with the lowest rate of stunting in 2007 was Riau (26.2 per cent) and in 2010 it was Yogyakarta (22.5 per cent). Nationally, the prevalence of stunting in Indonesia declined, but when analysed on the basis of household expenditure, the decline in stunting only occurred in (wealthier) households in quintiles 3, 4 and 5, where a greater decline was also associated with increases in household expenditure levels. In very poor households, or those in quintile 1, the prevalence of stunting among under-fives increased by 6.4 per cent between 2007 and 2010, to 43.1 per cent. In households with expenditures in quintile 2, the prevalence of stunted children was stagnant at approximately 39 per cent. In rural areas the prevalence increased by 0.25 per cent between 2007 and 2010, while in urban areas the prevalence decreased by 3.98 per cent in the same period.

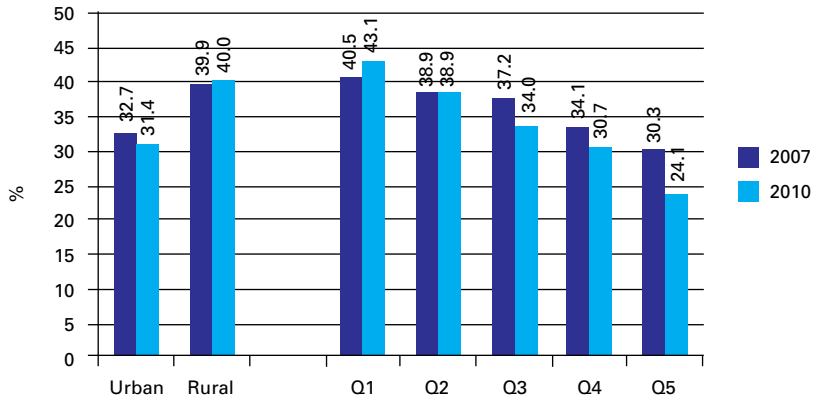
Nutritional status of under-fives can also be viewed on the basis of weight-for-height, where low weight-for-height indicates wasting. The prevalence of wasting among under-fives decreased by 2.2 per cent, from 13.6 per cent in 2007 to 13.3 per cent in 2010 (Figure 3.18). The prevalence of wasting among under-fives was higher in rural areas than in urban areas. Based on the level of household expenditure, a decline in the prevalence of wasting between 2007 and 2010 only occurred in households with middle to upper levels of expenditure, while in households with expenditure levels in quintile 1 the prevalence of wasting actually increased by 15 per cent, and in quintile 2 it remained unchanged. In the quintile 5 (wealthiest) households the prevalence of wasting decreased

Figure 3.19: Prevalence of underweight children under age five by urban/rural location and household expenditure, 2007 and 2010



Source: RISKESDAS 2007 and 2010

Figure 3.20: Prevalence of stunting among children under age five by urban/rural location and household expenditure, 2007 and 2010



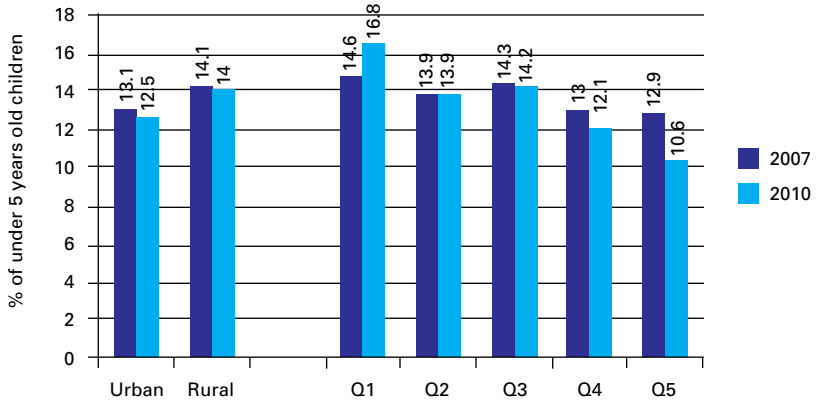
Source: RISKESDAS 2007 and 2010

by 17.8 per cent.

No less important than the problem of undernourishment is the problem of obesity in children, which often escapes the attention of the government. The average prevalence of overweight children under the age of five in Indonesia in 2007 was 12.2 per cent, increasing to 14 per cent in 2010. There were 18 provinces that recorded a prevalence of obesity above the national average in 2007, and a decrease occurred in 12 provinces in the period between 2007 and 2010. The highest prevalence of obesity in 2007 occurred in South Sumatra Province (20.9 per cent) and in 2010 it was in Jakarta (19.6 per cent). The lowest prevalence of overweight children in 2007 was in Gorontalo (6.8 per cent) and in 2010 it was in North Maluku (5 per cent).

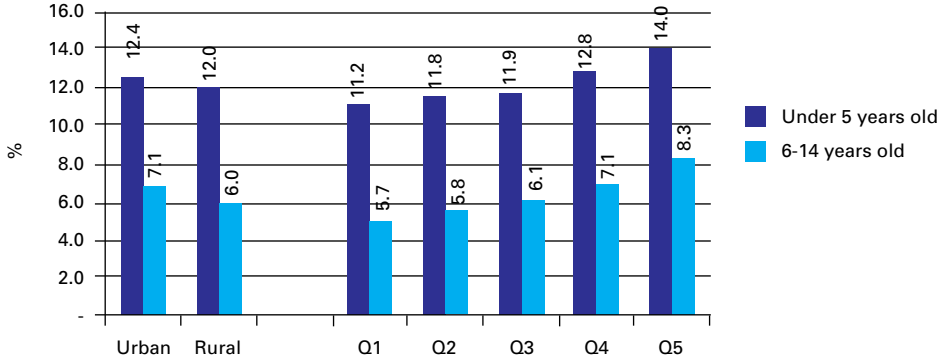
Children who suffer from being overweight, a problem that has always been associated with rich households, are also found in poor households. In 2007, 12.2 per cent of under-fives were overweight. The data showed in the

Figure 3.21: Prevalence of wasting among children under age five by urban/rural location and household expenditure, 2007 and 2010



Source: RISKESDAS 2007 and 2010

Figure 3.22: Prevalence of overweight children by urban/rural location and household expenditure, 2007

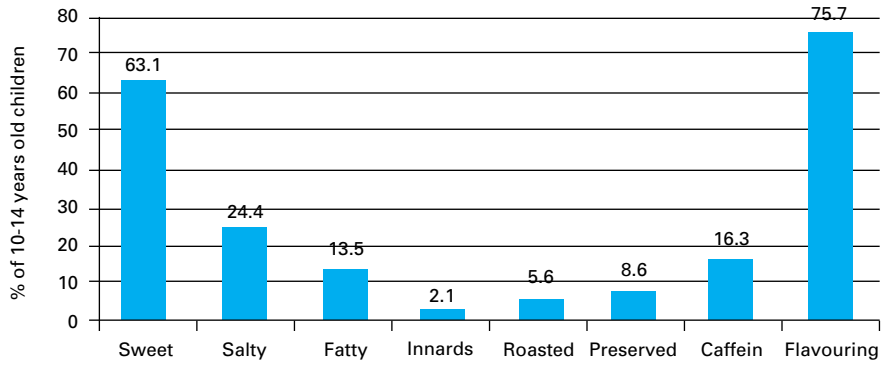


Source: RISKESDAS 2007

poorest households (quintile 1), 11.2 per cent of under-fives were overweight as were 5.7 per cent of children aged 6–14 years, and these numbers were not far below the rates in richer households (Figure 3.22). Based on the region, the prevalence of overweight children was slightly more common in urban areas than in rural areas for both under-fives and children aged 6–14 years. In 2010, the proportion of under-fives suffering from being overweight had increased to 23.2 per cent (RISKESDAS 2010).

Children may become overweight due to their individual characteristics and behaviours, including genetic factors and behaviours such as poor or inadequate dietary intake, lack of physical activity and an increase in sedentary behaviour (Davison and Birch, in Crowle and Erin, 2010). In 2007 among children aged 10–14 years as many as 63.1 per cent of children frequently ate sweet foods (Figure 3.23). Over time, excess sugar can cause children to become overweight. In childhood, being overweight can result in respiratory disorders and diabetes,

Figure 3.23: Prevalence of unhealthy food consumption in children aged 10–14 years, 2007



Source: RISKESDAS 2007

among other health problems.

According to UNICEF's nutritional framework, malnutrition is influenced by multiple factors. Malnutrition is directly caused by unhealthy food consumption patterns and ill health, and indirectly influenced by child care, food availability, genetic factors, as well as social, economic, cultural and political factors.

3.5 Recommendations

Despite the various programmes initiated to improve the survival and health of Indonesian children, and the special attention and assistance being directed to the poor, the fact remains that children living in remote areas, in income-poor households and in households with low educational achievement are still more likely to be deprived. More resources and collaborative efforts are needed to increase the effectiveness of existing health programmes. Additionally, in terms of nutrition, the government has already implemented many programmes to address with nutritional problems. It has improved the situation at the national level, but these gains are not equally distributed between urban and rural areas, or across households with different consumption levels. Thus, special attention is needed to target the children of the households in the poorest quintile, and in rural areas.
To improve the supply side, the government needs to:

1. Increase the budget allocation for health at the national, provincial and district levels to achieve the level required by the law. The budget allocation for child and maternal health should be increased and more equally allocated between curative and preventive efforts. The budget for nutrition improvement should also be increased, with a larger proportion being allocated to poor and vulnerable groups in society.
2. Develop more facilities in remote regions, distribute health personnel more equally, and increase the availability of medical equipment for respiratory aid in health centres and in every village.
3. Increase the effectiveness and reach of national and regional health insurance schemes so that all income poor households benefit. This includes increasing the role of health personnel to assist the poor in obtaining health assistance and better coordination across relevant institutions at the local level.
4. Increase the skills of village midwives to handle asphyxia in newborns.
5. Subsidize the cost of childbirth attended by a midwife, so that the cost is lower than that of a traditional birth attendant and can be paid in flexible instalments.
6. Improve the environmental conditions of housing for the poor. This will need strong cooperation between the Ministry of Public

Works, the Ministry for Public Housing and the Ministry of Health, at the national and local government levels, in order to support the improvement of clean and healthy lifestyle behaviours.

7. Expand the focus of children's health to include all children under the age of 18, not only under-fives, and focus attention on the prevention of pneumonia in addition to diarrhoea.
8. Improve monitoring and evaluation mechanisms to ensure full implementation of the minimum service standards (SPM) at the district level.
9. Adjust the current programme, which is quite general, to be more targeted towards the most deprived regions and households.
10. Increase the attention given to stunting.
11. Improve monitoring systems to allow for more frequent and inclusive monitoring of the nutritional status of children and pregnant women. Also, ensure the availability of valid and reliable data on child and maternal nutritional status.

To support the demand side, there needs to be an increase in health-related knowledge and awareness, particularly among parents with low education levels, in order to reduce child mortality. This could be supported by a local government effort to increase the number of *puskesmas* implementing Integrated Management of Childhood Illness (IMCI). In addition, there should be a mainstreaming of male roles in caring for under-fives during the period of antenatal and post-partum care. This could be achieved by expanding the coverage of *Suami Siaga* (Alert Husbands). This requires the support and involvement of community leaders in places of worship, village offices and traditional adat institutions.

In relation to nutrition, there is a lack of awareness among low income parents about the importance of nutrition, causing many children to have poor dietary habits. Parents are paying less attention to their children's nutritional requirements, although this is essential during their growth period. To overcome this problem, the government should endeavour to raise awareness among parents about the importance of nutrition, especially the nutritional content of daily meals. This can be done through counselling in *puskesmas* and *posyandu*, and mass nutrition education campaigns.

CHAPTER 4

Education

4.1 Laws and policies on education

The right to receive basic education in Indonesia is guaranteed in the nation's constitution. Chapter XIII, Article 31 in the Indonesian Constitution (UUD 1945) clearly states that every citizen has the right to receive an education, and that the government has to provide the necessary resources to operate a national education system. In addition, an amendment to the constitution mandates that the government is obliged to allocate a minimum of 20 per cent of the state and regional budgets to education.

The specific foundation for the framework of the education system in Indonesia is provided by Law No. 20/2003 on Education. It unambiguously states that education must be delivered to all citizens without any form of discrimination and that this education, at least for basic level education, shall be free from tuition fees. As education expenses do not consist solely of tuition fees, but include other related costs such as those for books, uniforms, and fares, the law also mandates that students have the right to receive an educational grant if his/her parents are not able to bear the cost of education expenses. Moreover, it emphasizes that every citizen should complete nine years of compulsory education. This goal was later reinforced by Presidential Instruction No. 5/2006, on the National Movement to Hasten Compulsory Nine-Year Basic Education Attainment and the Fight against Illiteracy.

The educational policy directions and objectives are set out in the National Medium-Term Development Plan (RPJMN) and in the Strategic Plan of the Ministry of National Education (*Kementerian Pendidikan Nasional*, MoNE). General objectives for the next five years are set out in the RPJMN 2010–2014, which states that the education development aims are to improve equal access, quality, relevance and efficiency in education management. The specific targets are: (1) to increase the net enrolment rate in primary schools from 95.14 per cent in 2008 to 96 per cent in 2014; (2) to increase the net enrolment rate in junior secondary school from 72.28 per cent in 2008 to 76 per cent in 2014; (3) to increase the gross enrolment ratio in senior secondary schools from 64.28 per cent in 2008 to 85 per cent in 2014,[1] and;(4) to reduce disparities in participation

[1] The net enrolment rate (NER) at any particular level of education (e.g., primary) is the proportion of children of official school age at that level who are enrolled in education at that level as a percentage of the total number of children of that age group. The gross enrolment ratio (GER) is the proportion of pupils enrolled in a given level of education, regardless of age, expressed as a percentage of the population in the theoretical age group for that same level of education.

and the quality of education services across regions, genders, social economic groups, and among education services that are implemented by the government and by private institutions.

In order to attain these goals, the Ministry of National Education has outlined more strategic and specific plans in their Strategic Plan 2010–2014 (Rencana Strategis, Renstra). In comparison to the previous Strategic Plan (2004–2009), the current Strategic Plan places more emphasis on increasing equitability and ensuring access to educational services (Table 4.1), whereas the 2004–2009 plan paid more attention to improving the quality of education and education management.

coverage of basic education, reducing the school participation gap between children in urban and rural areas, and improving the quality of basic education services. To this end, several important and large scale programmes have been crafted and implemented over the past several decades.

One particular programme that laid the foundation for increased equality in access to primary education was the 'Sekolah Dasar Inpres' programme. This programme was implemented between 1973 and 1978, during which time the government constructed one primary school building for every 1,000 children in each district and recruited the additional

Table 4.1: Strategic objectives of national education policy, 2010–2014

Level	Strategic objectives
Early childhood education (ECE)	- National GER ≥ 72.9% - At least 75% of provinces have GER ≥ 60% - At least 75% of cities have GER ≥ 75%; at least 75% of districts have GER ≥ 50% - Teacher qualifications: o Formal ECE: 85% have a university/diploma degree, and 85% have a certificate o Informal ECE: 55% have been trained
Primary education (SD/MI/Paket A)	- National NER ≥ 96% - At least 85% of provinces have NER ≥ 95% - At least 90% of cities have NER ≥ 96%; at least 90% of districts have NER ≥ 94% - Enrolment rate of children aged 7-12 is 99.9% - Teacher-student ratio from 1:20 to 1:28
Junior secondary (SMP/MTs/Paket B)	- National NER > 76.8% - National GER ≥ 110% - At least 90% of provinces have GER ≥ 95% - At least 80% of cities have GER ≥ 115%; at least 85% of districts have GER ≥ 90% - Enrolment rate of children aged 13-15 is 96%
Senior secondary (SMA/MA/SMK)	- Teacher-student ratio from 1:20 to 1:32 - National GER ≥ 85% - At least 60% of provinces have GER ≥ 80% - At least 65% of cities have GER ≥ 85%; at least 70% of districts have GER ≥ 65%.

Source: Ministry of National Education (Kementerian Pendidikan Nasional), Strategic Plan 2010–2014
Notes: NER=net enrolment rate; GER=gross enrolment rate

4.2 Key national education programmes

As a developing nation, Indonesia still faces challenges in achieving universal or near-universal coverage at every level of education. Hence, inarguably, the emphasis of government intervention in the education sector should primarily be focused on achieving universal

teachers needed for the new schools. With US$500 million in funding, more than 61,000 primary schools were established across districts, while the number of teachers increased by 43 per cent over the period (Duflo, 2001). This programme significantly raised enrolment rates among children aged 7–12 years, from 69 per cent in 1973 to 83 per cent in 1978. The impact of this programme on these children's futures

has been interesting. Despite the questionable quality of the education being delivered at these new schools, Duflo (2001) observed good economic returns, of approximately 6–10 per cent, implied by a 1.5–2.7 per cent increase in wages for individuals who went to primary schools established through this programme.

Various education programmes have been implemented since then, all designed to stimulate both the supply of and the demand for education, with the over-arching goal of providing equal access to education for every child. Some of the important ongoing programmes are as follows:

1. School Operational Assistance (BOS): Starting in 2005, the government launched the School Operational Assistance Programme (*Bantuan Operasional Sekolah*, BOS). The objective of this programme was to lighten the burden of education costs on communities, in order to support more children achieving the goal of at least nine years of basic education. Initially, the programme was part of a fuel subsidy removal compensation programme, but later it became part of a poverty reduction programme. In 2009, the government added an additional objective to the BOS programme: to raise the quality of education. In line with this new objective, in 2009 the allocation of funds to BOS also rose significantly (Table 4.2). Over the last five years the coverage and unit costs of BOS have improved.

According to the BOS guidelines, all state schools were obliged to accept BOS funds and any school that refused would be prohibited from levying costs from students. All private schools with operating permission, and which were not being developed as international standard schools (*sekolah bertaraf internasional*, SBI) or local superior standard schools, were obliged to accept BOS funds. Schools could only refuse BOS funds if they obtained the agreement of parents by guaranteeing to continue educating poor students.

The role of regional governments in the implementation of the BOS programme was to restrict schools from collecting tuition fees from poor students or excessive tuition fees from students who were not poor. If BOS funds were not sufficient, the local government was obliged to make up the shortfall from its own budget. Several districts provided additional 'District BOS' funds from their local budgets.

The BOS programme funds were managed autonomously by schools in consultation with school committees. The funds could be used to finance various activities and school needs within certain limitations. They could not be kept long-term to earn interest, loaned to other parties, or used for substantial or major renovations, expansion (construction), or activities that were already being funded by the central or regional government either wholly or in part, such as paying the salaries of contract

Table 4.2: School operational assistance (BOS) funding allocation and budget developments, 2005–2010

Issue		2005	2006	2007	2008	2009	2010
Funding allocation (IDR/student/year)	Primary school (rural)	235	235	254	254	397	397
	Primary school (urban)					400	400
	Junior secondary school (rural)	324.5	324.5	354	354	570	570
	Junior secondary school (urban)					575	575
Budget (IDR trillions)		5.13	10.28	9.84	11.2	16.2	16.5
Number of students (millions)	Primary school	28.9	29.1	26.4	28.7	26	27.6
	Junior secondary school	10.7	10.6	8.9	11.1	9.8	9.6

Source: Ministry of National Education, 2005–2009; National Budget 2010.
Note: The BOS budget for 2005 was only for one semester

teachers or assistant teachers *(guru bantu)*. The funds were channeled through a bank or post office to each school every quarter based on the number of enrolled students.

2. Scholarships for Poor Students (*Bantuan Siswa Miskin*, BSM): Starting in 2008, the government significantly increased its scholarship budget and reach, from a coverage of 52,121 students in 2007 to approximately 698,570 students in 2008 (Agustina et al., 2009). Beginning at the same time, the scholarships were targeted only at poor students for primary and junior secondary levels of education, instead of the former target group which consisted of students with high levels of academic achievement. The programme aimed to improve access to basic education for children from poor families. The unit cost per scholarship ranged between IDR60,000 and IDR720,000 depending on the level and type of school the student was attending. Poor students enrolled in madrasah (Islamic) schools received a higher amount than those in regular schools. In 2009 the scholarships supported 1.8 million students in primary schools or approximately 6.9 per cent of the total number of students enrolled at this level (Agustina et al., 2009).

The scholarships were managed centrally by the Ministry of National Education. Scholarship quotas were allocated for each district based on the number of students from poor families and the poverty conditions in each district. Education offices at the district level then selected the student beneficiaries. The scholarship funds were disbursed from the Ministry of National Education directly to the central post office and channeled to the district post offices annually. The scholarship funds could then be withdrawn directly by students or their parents/guardians or collectively through schools (Agustina et al., 2010).

3. The New Schools and New Classroom Construction Programme (*Program Pembangunan Unit Sekolah Baru dan Pembangunan Ruang Kelas Baru*): In remote areas, particularly in the eastern part of Indonesia, until 1999/2000 access to secondary schools (both junior and senior) was still limited, resulting in low enrolment rates at the secondary school level. Given these conditions, starting in 2000/2001, each year the central government allocated funds to build new schools as well as new classrooms. In villages where the number of primary school graduates was too small but the nearest junior secondary school was too far, the government built 'One Roof' junior secondary schools, attached to existing primary schools, in order that they could share some of the facilities and teachers belonging to the primary school. Table 4.4 provides information on the number of junior and senior secondary schools built and the allocated budgets.

Table 4.3: Coverage and cost of the scholarships for poor students programme, 2008–2009

School	Number of students covered		Unit cost IDR per year/student	% of all students		Total of scholarship budget (IDR million)	
	2008	2009	2008/2009	2008	2009	2008	2009
Primary	69,857	1,796,800	360,000	2.7	6.9	251.48	646.848
Junior secondary	27,606	710,057	531,000	3.0	7.8	146.6	377.04
Islamic primary (MI)	360	640	360,000	12.5	22.3	129.6	230.4
Islamic junior secondary (MTs)	280	540	720,000	11.9	23.0	201.6	388.8
Total	1,338,570	3,688,866				729.35	1,643.088

Source: Agustina et al., 2009

Table 4.4: New schools and classrooms built, 2006–2009

Activities	2006		2007		2008		2009	
	Target	Budget	Target	Budget	Target	Budget	Target	Budget
Junior secondary								
New schools	427	579.8	564	684.187	500	650.0	177	n/a
New classrooms	13,273	730.015	9,113	510.328	10,949	656.94	2	n/a
'One Roof' primary-junior secondary	749	255.6	983	n/a	759	309.1	-	n/a
Senior secondary								
New schools	101	86.96	28	20.475	29	25.0	10	n/a
New classrooms	2,354	174.825	1,479	111.065	803	80.325	780	n/a
Vocational senior secondary (SMK)								
New schools	66	33.0	181	126.7	214	149.8	195	n/a
New classrooms	334	45.23	972	150.15	3,289	248.09	3,656	n/a

Note: Budget is in millions of IDR
Source: Ministry of National Education, various years

4. Early Childhood Education, ECE (*Pendidikan Anak Usia Dini*, PAUD): The conclusion of many studies in a number of countries converged in agreement that early childhood education (ECE)–during the years before the start of formal schooling –provides short-term and long-term positive impacts in terms of children's cognitive and non-cognitive development. Based on data on the long-term impacts of ECE on children in poverty, Barnett (1998) found that ECE provided persistent and positive effects on achievement and academic success. Moreover, he further found that the economic returns from providing ECE to poor children far exceeded the cost. This evidence led to calls for further empirical studies on the effects of various policies and interventions to determine which forms would be most beneficial and effective. A recent study by Barnett (2010) found that children in 23 countries experienced the greatest cognitive benefits from programmes containing educational or stimulation components rather than from cash transfer or nutritional programmes.

In the case of Indonesia, the emphasis of education policies was confined to stimulating the supply side through the progressive construction of buildings across the country. Starting in 2006 the Ministry of National Education through collaboration with the World Bank and the Kingdom of the Netherlands implemented a new programme to promote ECE, specifically aimed at improving access to ECE for children from poor households. The program hopes that by 2013 it will reach approximately 738,000 children, particularly from poor households, in 3,000 villages stretched across 50 districts in 21 provinces.

The total budget for this programme was approximately US$127.74 million, made up of a government budget (central and regional) of US$34.94 million with additional funding provided by multinational donors and institution grants. The project provided block grants to communities where residents decided how best to deliver ECE services. In addition, the programme prepared 32 national trainers, 200 provincial/district trainers and around 6,000 community-based teachers to promote child development. National trainers train the provincial/district trainers, who then train the community-based teachers to implement ECE.

5. The National Examination System (*Ujian Akhir Nasional, UAN; Ujian Nasional*,UN): The ambitious goal of this system was to promote comparable levels of academic achievement among students across all provinces in the country, whether in state or private schools. Prior to this national examination system (the name of which was changed from 'UAN' to 'UN' in 2005), there was a different system called *Ebtanas*. The most significant and controversial difference between the two examination systems was in the way they determined students able to

graduate. Using *Ebtanas*, a student's graduation is determined by a combination of grades from their first semester, second semester, and their *Ebtanas* result. The UN, however, sets required score thresholds across a range of subjects in order for the student to graduate from primary school as well as from junior and senior secondary school. With the commencement of UAN in 2002, every junior and senior secondary school student had to obtain an overall average of 3.0 (out of a possible 10.0) for the three core subjects of mathematics, English and Bahasa Indonesia. The threshold was raised every year and by 2009, students could only graduate if they managed to obtain an average overall grade of 5.5.

4.3 Education system and institutional setting

The education system in Indonesia follows a 'six-three-three' framework comprising: (a) six years of primary education; (b) three years of junior secondary education; and (c) three years of senior secondary education. Senior secondary education is divided into general and vocational streams.[2] Compulsory basic education in Indonesia consists of six years of primary school and three years of junior secondary school, for a total of at least nine years of schooling. Early childhood education (ECE) and senior secondary school education are not compulsory according to national law.

The national education system applies to both state and private schools. In addition, there are also Islamic schools, called *madrasah*. While regular schools are under the supervision of the Ministry of National Education, the *madrasah* are supervised by the Ministry of Religious Affairs and Islamic teaching is the foundation of the curriculum. As with regular schools, there are also state and private *madrasah*. In addition, there are also other private religious schools. The non-Islamic religious-based private schools are under the supervision of Ministry of National Education and have to follow the national curriculum, but may include additional courses emphasizing religious studies.

In terms of the number of schools, regular (non-religious) state schools accounted for the vast majority of schools at the primary level, but less than half of those at senior secondary level. The majority of *madrasah*, at all levels of schooling, are run privately by Islamic foundations (Table 4.6). Nearly all ECE (kindergarten or preschool) institutions are operated by private foundations.

Table 4.5: Indonesia's formal education system

Level	Age (years)	Grades	Regular school	Islamic school
Pre-school (ECE)	3–6		TK/PAUD	Raudatul Atfal (RA)
Primary school	7–12	1–6	SD	Madrasah Ibtidaiah (MI)
Junior secondary	13–15	7–9	SMP	Madrasah Tsanawiah (MTs)
Senior secondary	16–18	10–12	SMA	Madrasah Aliah (MA)

Source: Calculated using data from the Ministry of National Education and Ministry of Religion Affairs

Table 4.6: Number of schools and madrasah, 2008/2009

Types of schools		State	%	Private	%	Total
Primary level	SD	131,490	91	12,738	9	144,228
	MI	1,567	7	19,621	93	21,188
Junior secondary level	SMP	16,898	59	11,879	41	28,777
	MTs	1,259	10	11,624	90	12,883
Senior secondary level	SMA	4,797	45	5,965	55	10,762
	MA	644	12	4,754	88	5,398

Source: Ministry of National Education website [www.kepmendiknas.go.id] and Ministry of Trade website [www.kemendag.go.id] (accessed 11 November 2010)

2 Higher education is beyond the scope of this analysis.

Nationally, the discrepancies in the numbers of schools available at different educational levels are very apparent (Table 4.6). In 2008, 91.9 per cent of all villages and urban precincts *(kelurahan)* had a primary school, but only 41.8 per cent had a junior secondary school and only 19.9 per cent had a senior secondary school. If we compare the availability of education facilities disaggregated by urban and rural areas and by province, there are also large disparities in terms of the availability of schools at each educational level. In 2008, 96.2 per cent of urban precincts had at least one primary school, 70.7 per cent had a junior secondary school and 55.9 per cent had one or more senior secondary school. In contrast, while 91.2 per cent of villages in rural areas had a primary school, only 37.9 per cent and 15.5 per cent had a junior and senior secondary school, respectively (see Table 4.7).

By province, Papua, West Papua, Aceh and East Nusa Tenggara (NTT) had the lowest average number of schools per village, while Jakarta and Yogyakarta provinces (major cities) have the highest average number (see Figure 4.1). In terms of average distance to schools, access problems were still apparent in rural areas. While the average distance to junior and senior secondary schools from urban areas with no local schools was 2.13 kilometres and 3.39 kilometres, respectively, in 2008, the average distance from rural areas was 8.18 kilometres and 13.1 kilometres for junior and senior schools, respectively (see Table 4.7). In some remote villages access to primary schools was also still a problem; some primary school students in the provinces of Papua, Papua Barat, or NTT had to walk more than 10 kilometres to go to school. The availability and distance to school had some influence on the students' motivation and households' decisions about attending school.

Beside the formal regular schools, there are also non-formal educational 'packages' available for those who cannot access these. Learning Package A *(Paket A)* is equivalent to primary school education, Learning Package B *(Paket B)* is equivalent to junior secondary school level, and Learning Package C *(Paket C)* is equivalent to senior secondary school. Features distinguishing non-formal from formal education include flexibility of the former in terms of schedule and time spent on studies, easier access (long-distance learning), the age of the learners, the content of the lessons (relatively easier and more practical), the way the lessons are organized, and the methods of assessment.

Table 4.7: Availability and accessibility of schools in urban and rural areas, 2005 and 2008

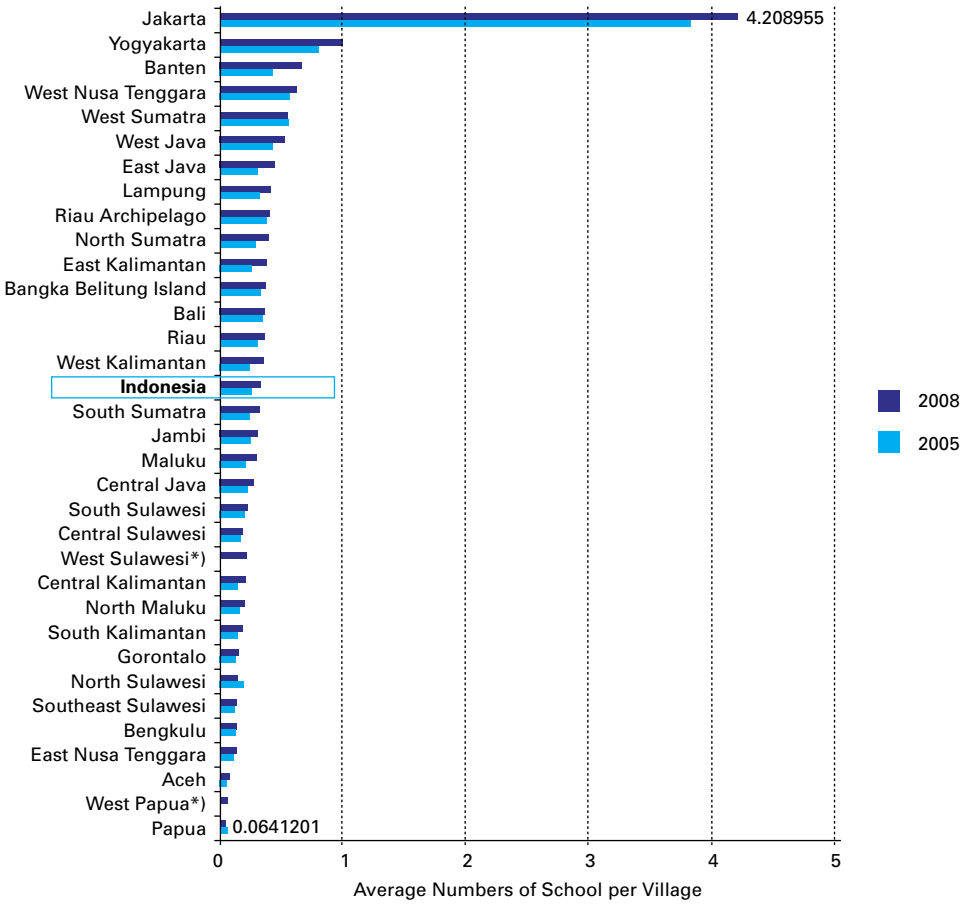
	Villages with no schools (%)		Average number of schools per village		Average distance to schools (km)*	
	2005	2008	2005	2008	2005	2008
Primary level						
Indonesia	10.43	8.14	2.36	2.65	5.99	5.92
Urban	4.21	3.76	3.92	4.57	1.09	1.13
Rural	11.76	8.77	2.03	2.39	6.36	6.12
Junior secondary level						
Indonesia	66.60	58.15	0.48	0.68	8.97	7.82
Urban	40.76	29.32	1.13	1.58	1.65	2.13
Rural	72.18	62.05	0.34	0.55	9.85	8.18
Senior secondary level						
Indonesia	83.78	80.07	0.27	0.34	14.41	12.51
Urban	54.04	44.04	0.97	1.30	2.89	3.39
Rural	90.12	84.51	0.12	0.22	16.04	13.16

Source: Podes, village-level data, 2005 and 2008
*Note: *Average distance from villages with no schools*

Since the implementation of decentralization in 2001, the provision of and control over the formal and non-formal education systems have been devolved to district governments, with the exception of *madrasah*, which are still controlled centrally by the Ministry of Religious Affairs via the branch offices at the provincial and district levels. The role of the central government is limited to defining the national educational standards and devising policies to guarantee the quality of and equal access to education. Provincial governments, on the other hand, are responsible for providing education facilities and teacher training, and for handling all educational matters that are particular to the province or districts.

Decentralization implies the delegation of authority not only from central to regional governments, but also from the government to the community. For that reason, almost every school (state and private) now has a school committee. School committee members include parents, teachers and local community representatives. The main responsibilities of school committees include contributing to the school decision-making process, controlling the school's accountability in accordance with the school budget, and providing financial support when necessary. In practice, however, the performance of each school committee varies widely depending on the agendas and personalities of the committee chairperson and the school principal.

Figure 4.1: Average number of senior secondary schools per village/precinct, 2005 and 2008



Source: Podes, 2005 and 2008
*Note : *) New province, no data for 2005*

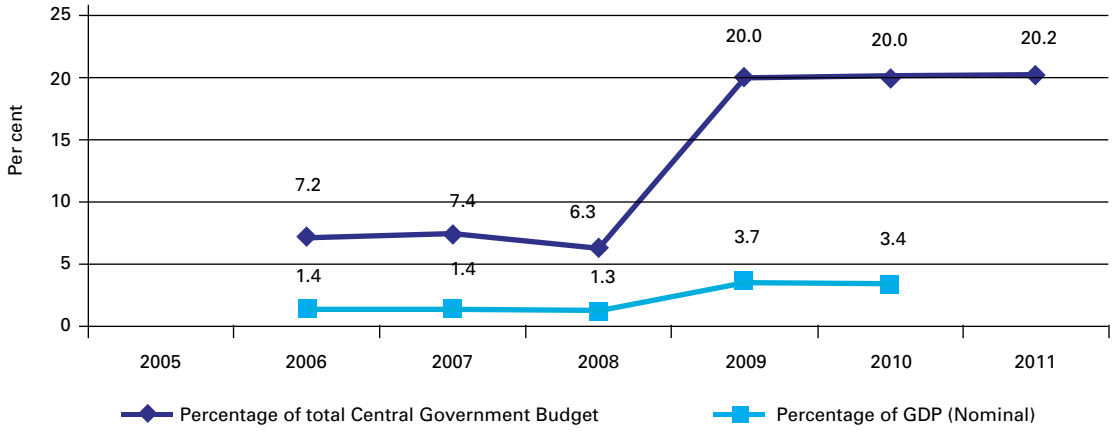
4.4 Budget for education

Education in Indonesia is financed by the central, provincial and district governments' budgets as well as parental and community contributions. As a commitment to implementing the policy on education and the constitutional stipulation to allocate 20 per cent of the budget to education, the central government has increased its education budget. The education share of national expenditure has grown by 180 per cent in five years, from 7.2 per cent in 2006 to 20.2 per cent in 2011, and the education share of GDP has increased by 142 per cent from 1.4 per cent in 2006 to 3.4 per cent in 2010 (Figure 4.2). It should be noted that 20 per cent of the allocated education budget also includes an allocation for routine administrative expenditure; mainly teacher salaries. Since higher education (university or college) is beyond the scope of this analysis, we disaggregate the total budget allocation and only analyse the budgets for ECE, and primary and secondary schools. Figure 4.3 shows that from 2006 to 2010, the overall average budget for compulsory basic education (nine years of primary and junior secondary combined) decreased even though it still consumed the largest proportion (40–50 per cent) of the education budget. The budget for senior secondary education also decreased while the ECE budget allocation has gradually increased.

Similar to other sectors, the central government spending on education is channeled through two mechanisms. Firstly, funds are allocated to the line ministries (particularly to the Ministry of National Education and the Ministry of Religious Affairs) and are mainly intended to fund routine education expenditures (especially for *madrasah* schools managed by the Ministry of Religious Affairs) and development spending (school operational costs, scholarships, textbooks, etc.). Secondly, funds are transferred directly to district governments. Since 2009, there has been a significant increase in the central government's budget allocation for education. This is because the central government has shifted some of the funds previously transferred to districts in the form of 'general allocation funds' (*dana alokasi umum*, DAU) to a fund that is specifically allocated for education (*dana alokasi khusus pendidikan*, DAK). This increase in the funds allocated specifically for education is what enabled the government to reach its goal of 20 per cent of total national expenditure for education.

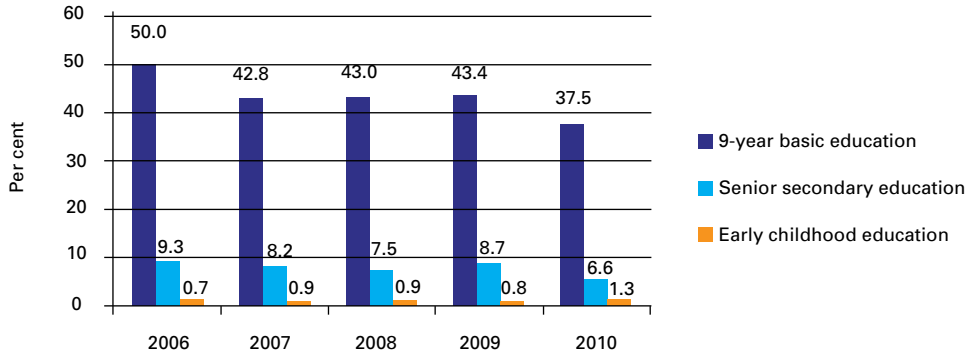
As for local governments, their spending on education, outside of the DAK-*pendidikan*, varied among districts and municipalities. Even though it is stated clearly in the constitution that the central and local governments should allocate a minimum of 20 per cent of their budgets to

Figure 4.2: Central government budget for education as a proportion of total government expenditure and of nominal GDP, 2006–2011 (%)



Source: National Revenue and Expenditure Budget (APBN) various years; Ministry of Finance.

Figure 4.3: Central government education budget allocated directly to children, 2006–2010 (%)



Source: APBN, various years; Ministry of Finance.

education, in practice the budget allocations for education were determined mostly by the commitment of local leaders to the development of education. A study on provincial and district/city budgets showed that out of 27 districts and cities studied, 24 already allocated more than 20 per cent of their 2010 budgets to education, including some which allocated more than 30 per cent.[3] Meanwhile, at the provincial level, on average in the four provinces studied the allocations for education were less than 8 per cent (The Asia Foundation, 2010)

In addition to government funding, significant funding also comes from the community, particularly from parents and students. While nine years of basic education is compulsory and free, this only applies to state schools. Most of the education expenses at private schools are paid for by parents, with the amount being determined by the school's board of trustees after consultation with the school committee.[4] In state schools, even though the government has guaranteed to cover all operational costs for basic education (primary and junior secondary), a lack of funding for necessary school activities and development initiatives make it necessary for most state schools to collect some fees from parents upon consultation with school committees. These include fees for things such as books, photocopying, extracurricular activities and school maintenance. In addition, parents still have to bear some indirect expenses related to their children's education, namely transportation costs and pocket money. A study by SMERU (Hastuti et.al., 2010), for example, revealed that many children refused to go to school if their parents did not provide them with lunch money.

4.5 Educational outcomes, disparities and gender inequality

An increasing number and proportion of Indonesian children have been enrolling at schools, from early childhood education (ECE) up to senior secondary school. As shown in Table 4.8, during 2003–2009 the increase in enrolment rates for ECE among children 3–6 years old was the highest (5.94 percentage points per year), followed by enrolment rates among children aged 16–17 in senior secondary school (3.13 percentage points per year). But despite the notable rate of increase, the proportion of children aged 16–17 years enrolled in senior secondary school in 2009 was still relatively low at around 67.2 per cent, and the proportion enrolled in ECE was even lower, at 32.25

3 This allocation included teacher salaries, which accounted for about 80 per cent of the education budget.
4 The percentages of children enrolled at private schools in 2010 were: 18 per cent at the primary level, 32 per cent at the junior secondary level, 35 per cent at senior secondary schools, and 56 per cent at vocational secondary schools.

per cent. The level of enrolment for children aged 7–12 years (primary school) was already very high (more than 95 per cent) and was continuing to increase, although at a slower rate. Meanwhile, the enrolment rate for children aged 13–15 years (junior secondary school) achieved an impressive increase of 1.57 percentage points annually to reach 86.49 per cent in 2009.

This progress has been enjoyed by approximately equivalent numbers of boys and girls. In fact, as shown in Figure 4.4, the school enrolment rates were slightly higher at each level among girls than among boys, both in 2003 and 2009. At senior secondary school, for example, the female enrolment rate in 2009 was 68.6 per cent, slightly higher than that of males at 66 per cent. Gender disparities were relatively minor compared to disparities by urban/rural residence and household wealth. Enrolment rates were consistently higher in urban areas than in rural areas, but compared to 2003 this disparity had decreased by 2009. At the senior secondary school level, for example, the enrolment rates in 2003 were 73 per cent for urban areas and 42 per cent for rural areas, while in 2009 they were 75 and 59 per cent, respectively. However, the most apparent and persistent disparities were between the richest households and the poorest ones, and the higher the level of schooling the larger the disparity. In 2009, only 41.8 per cent of children from poor households were enrolled at senior secondary schools, compared to 83.7 per cent of children from rich households.

Regarding the progress of enrolment rates among children aged 3–6 years old, the government's massive efforts, supported by donor agencies, to establish ECE in rural areas, have been reflected in the improvement in the number of children enrolled at ECE. Nationally the enrolment rate in ECE increased from 23.8 per cent in 2003 to 50 per cent in 2009,[5] with no significant percentage differences between boys and girls (49.3 and 50.8 per cent, respectively in 2009). Previously, ECE was mostly accessed by children from non-poor households, because most facilities were run privately and were too expensive for the poor. The government's ECE programme, which focused more resources on the establishment of facilities in rural areas and targeted children from poor households, resulted in a decrease in the enrolment disparities between urban and rural areas and between the richest and poorest households. In 2003 the ECE enrolment rate for children from the poorest households was only 15 per cent compared to 44 per cent of those from the richest households. This gap narrowed in 2009, as the enrolment rate among the poorest increased faster than among the richest.

Despite the progress in access to formal education, there is still inadequate access to information in the form of educational materials and communication media. Children enjoyed relatively high and increasing access to television while still lacking access to school textbooks, science books, story books, newspapers and magazines (Table 4.8). A recent study shows that there was an increase in the average amount of hours children spent in front of a television each week, from 22.5 hours in 2002 to 30–35 hours in 2008 (Hutapea, 2010). Longer hours spent in front of a television leave less time for reading story books, magazines and newspapers. Since Indonesia's television has a high proportion of non child-friendly content excessive exposure may have a negative impact on child development. The study findings also indicated that watching television could be more attractive to children than reading, and this could lead to a detrimental effect on children's long-term cognitive abilities. Although there has been solid progress during the past six years, one out of four children still has no access to school textbooks and more than half have no access to science books. In addition to this, despite some progress regarding children's access to school textbooks and science books, there have been set backs in terms of access to story books, newspapers, magazines, art materials and displays of art.

[5] It is important to note that some children aged 5–6 years old have already enrolled in primary school so that the overall school enrolment rates among children aged 3–6 years old in 2009 was higher and it stood at almost 50 percent.

Table 4.8: Progress in children's access to formal education, 2003 and 2009 (%)

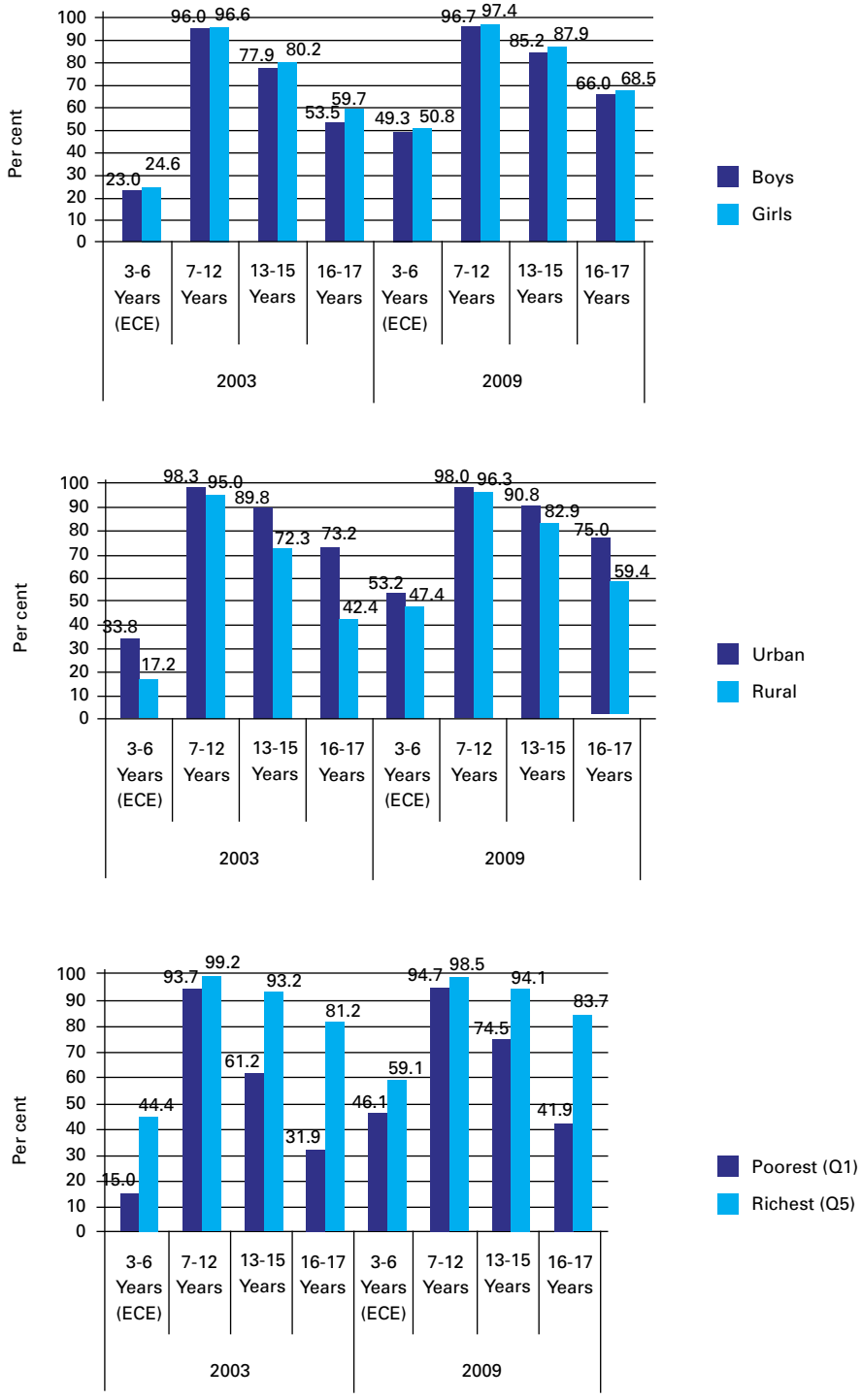
Dimension of child poverty	Indicators	2003	2009	Average annual change (%)
Education	Early Childhood Education (ECE) enrolment rate among children 3–6 years	23.78	32.25	5.94
	School enrolment rate among children 7–12 years	96.25	97.05	0.14
	School enrolment rate among children 13–15 years	79.04	86.49	1.57
	School enrolment rate among children 16–17 years	56.59	67.21	3.13
	School enrolment rate among children 7–17 years	84.44	89.21	0.94
	% of children 3–6 years who never attended ECE	76.22	67.75	-1.85
	% of children 7–12 years who never enrolled in school	2.15	1.9	-1.94
	% of children 13–15 years who never enrolled in school	0.82	0.84	0.41
	% of children 16–17 years who never enrolled in school	0.59	0.7	3.11
	% of children 7–17 years who never enrolled in school	1.53	1.42	-1.20
	% of children 7–12 years who dropped out or discontinued (DOD) school	1.6	1.05	-5.73
	% of children 13–15 years who DOD school	20.14	12.67	-6.18
	% of children 16–17 years who DOD school	42.82	32.09	-4.18
	% of children 7–17 years who DOD school	13.63	9.37	-5.21
Educational materials and media (5–17 years)	% of children with no access to school text books	40.12	25.06	-6.26
	% of children with no access to science books	81.88	66.45	-3.14
	% of children with no access to story books	82.15	84.91	0.56
	% of children with no access to newspapers	90.54	95	0.82
	% of children with no access to magazines/tabloids	90.72	95.19	0.82
	% of children with no access to television	9.51	6.23	-5.75
	% of children with no access to radio	51.92	83.42	10.11
	% of children with no access to art materials or art shows	88.53	92.4	0.73

Source: Estimated using data from the 2003 and 2009 SUSENAS (Panel), except for deprivation information from 2003 and 2009 SUSENAS.

The school dropout and discontinuation (DOD) rates for children aged 16–17 years are still at alarming levels. During 2003–2009, the DOD rate among children aged 7–12 years was decreasing and it achieved a very low level of 1.05 per cent in 2009. The DOD rate for children aged 13–15years was also declining at an even faster rate, dropping from 20 per cent in 2003 to 12.67 per cent in 2009. However, among children aged 16–17 years, despite the significant rate of decrease of around 1.78 percentage points per year, the DOD rate was still quite high at 32 per cent in 2009, meaning that approximately one out of three children in this age group dropped out of school that year. As depicted in Figure 4.5, in 2009, among children of all ages, the DOD rate started to increase among children around 12 years of age – the age that most graduate from primary school – and further steeply increased between the ages of 16 and 19 years – the senior secondary school age, after which the rate of increase declined but the rate of DOD remained high during the university years. The figure also reveals that quite a large proportion of children that dropout or discontinue schooling, especially males, engage in paid employment instead. From around the age of 15, it's clear that an increasing number of girls choose work instead of school, probably as domestic workers. This data also reflects the relatively low rates of child labour, as discussed further in Chapter 5, section 5.4.2.

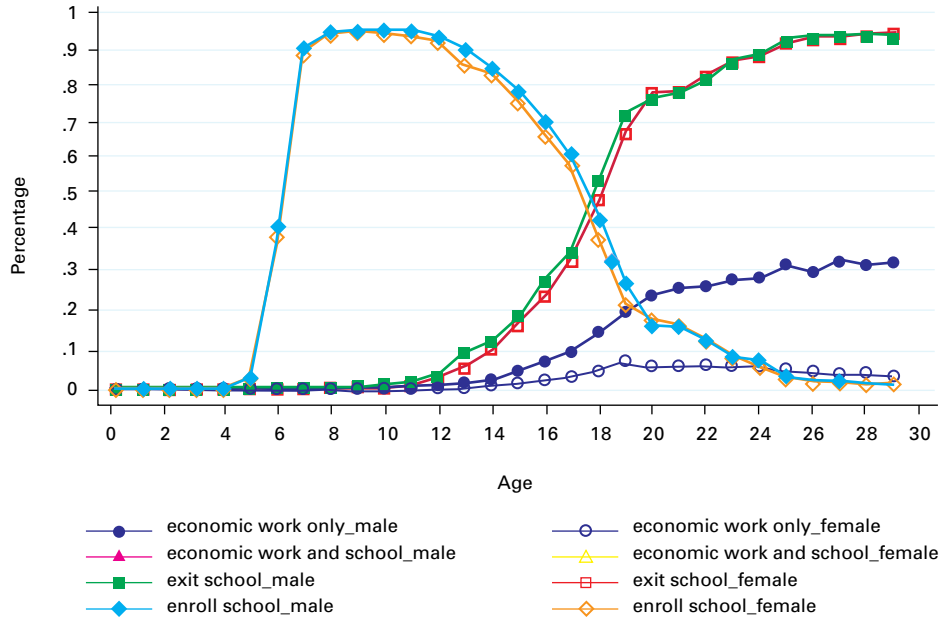
There are many contributing factors, but overwhelmingly the main reason given for children dropping out or discontinuing school is an inability to afford the cost, or poverty. Figure 4.6 presents the reasons for discontinuation after completing junior secondary school instead of continuing to senior secondary school. More than 60 per cent of male and females aged 16–18 years who had not enrolled in senior secondary school in both rural and urban areas confessed that financial difficulty was the main reason. It is not surprising that many students are forced to drop out of school after junior secondary school,

Figure 4.4: Progress of school enrolment rates among girls and boys, in urban and rural areas, and from the poorest and richest household quintiles, 2003 and 2009



Source: Estimated using data from the 2003 and 2009 SUSENAS (Panel)

Figure 4.5: Participation in school and work of the population under the age of 30 years, 2009



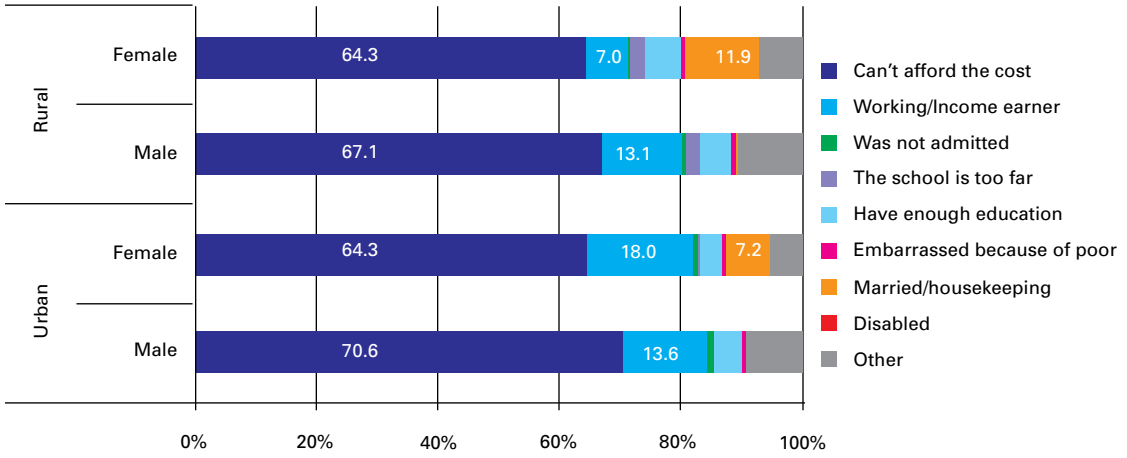
Source: Estimated using data from the 2009 SUSENAS (Panel)

since most of the major government subsidy schemes, particularly BOS and the scholarship programme, only contribute to educational costs during the compulsory nine years of basic education (primary and junior secondary school). In addition, at the senior secondary school level, the school entry and tuition fees are much more expensive, and the school facilities are often further away, pushing up the costs of transport (see Table 4.7).

More than 18 per cent of female students in urban areas admitted that the reason for discontinuation was because they had to find work after graduation from junior secondary school, as did 13.6 per cent of male students. In rural areas, the situation was slightly different. While the proportion of girls graduating from junior secondary school who had to work to earn an income was lower than boys, far more of the girls had to do household chores or get married. Working immediately after graduating from junior secondary school is a risky choice. A study by the World Bank (2010) found that only 60 per cent of young senior secondary school graduates could secure paid employment, and there was a decreasing trend with age, meaning that only 30 per cent of junior secondary school graduates managed to obtain paid employment. In the long run, higher education meant higher salaries which arguably meant greater prosperity.

There were similar findings from the qualitative field research, which provided vignettes illustrating the situation experienced by the poor in urban North Jakarta and rural East Sumba (see also Box 4.1). In North Jakarta, it was observed that the most common time for children to drop out or discontinue schooling was either just before or just after junior secondary school. In terms of gender disparity, female students were better off at the time the study was conducted than they were five years ago. Five years ago, more female than male students dropped out before senior secondary school. The main reason was that female students were perceived to have a better chance of obtaining work, whereas male students were kept in school because they would become the head of their own families in the future. At the time of the study, this inequality had somewhat diminished, and the problem of discontinuing school affected girls and boys approximately equally.

Figure 4.6: Reasons for discontinuation by junior secondary school graduates aged 16–18 who did not enroll in senior secondary school, 2009 (%)



Source: Suharti, 2009, quoted in Jalal, 2010 (original source is 2009 SUSENAS)

This qualitative study also revealed that the main cause of children dropping out or discontinuing school in North Jakarta was due to poverty within their families. In general, parents' monthly incomes were only enough to cover daily needs; sometimes, their income was not enough to cover daily needs, let alone the cost of sending their children to school, especially a private school. Moreover, the apathy of children in regard to studying or going to school, and with their preference for playing video games or browsing the Internet, were mentioned as other significant problems. Additionally, parents' lack of interest in their children's education meant that many children were not motivated to study harder. This problem was found to be related to parental education levels. Parents with low levels of education would prefer to see their children working and earning an income rather than going to school.

Another obstacle to school enrolment was the absence of birth certificates. Most of the residents were migrants from other provinces, which made it difficult for them to obtain birth certificates if they did not already have them. Consequently, this made it difficult to enrol their children in school, especially at state schools, which were cheaper than good quality private schools, as possession of a birth certificate was a prerequisite for admission.

Parents in the study area in North Jakarta were fortunate to receive some generous assistance from private foundations, in addition to government scholarships, which enabled their children to attend school. The construction of school buildings by foundations helped to curb the increasing incidence of school discontinuation among students. The foundations also applied free tuition policies for students living in the child care institutions that the foundations managed, whereas students that came from outside of the child care institutions were required to pay small tuition fees or just IDR6,000 per month. Programmes run by the government also worked very well in combating high dropout rates. The BOS programme, conditional cash transfer program (*Program Keluarga Harapan*/PKH), ECE and other government programmes managed to keep children in, or attract them to attend, school.

In East Sumba, the dropout rates at all levels of formal schooling were fairly high. However, the trend showed general decline in these rates, except for senior secondary school level which remained high, and there was still a fairly high dropout rate at the primary school level. The distance of schools from children's houses appeared to be a major problem affecting school attendance in East Sumba, especially for those living in remote areas. Some primary

school students often needed to walk as far as 6 kilometres to reach schools. Worse yet, those who wanted to continue their education to senior secondary school had to travel up to 36 kilometres to other villages or towns due to lack of a local senior secondary school. It was normal for parents to only send their children to school when they were perceived to be old enough to walk the long distance to school with their friends, so it is not surprising that data showed that 9.26 per cent of primary school students were as old as 13 years – when they should be in junior secondary school. Alternately, many parents sent their children to live with relatives located closer to the schools, but there were also additional costs associated with this option. In the most recent last academic year at the time of the study, three children dropped out of the 4th grade of primary school simply because according to their age they were supposed to be in 9th grade (the last year of junior secondary school).

Apparently, a lack of parent knowledge and awareness regarding the importance of education was another factor. Most parents who did not finish primary school or never went to school themselves did not believe that education was really the key to a better life. Parents who worked as farmers tended to restrict their children's education as they viewed children as additional labourers who could assist in the family business. Moreover, many children were not disciplined and could be found outside of school grounds during lesson time.

The central government's 'BOS' programme to support primary and junior secondary school students, combined with other funding from the Regional Revenue and Expenditure Budget (APBD) which provided scholarships for students from kindergarten up to senior secondary school level, relieved many parents from the high financial burden associated with education. These programmes helped to significantly increase the school enrolment rates in East Sumba, but there were still other school expenses for parents to pay, such as uniforms, admission fees, shoes, bags and stationery. Financial difficulties in some families resulted in some children going to school wearing slippers or even barefoot.

Box 4.1: The causes of drop out and school discontinuation among poor children aged 13 and above

Being faced with economic hardship has made poor households take a pragmatic approach to education: they take the view that it is not necessary to achieve a high level of education as long as their children can read and write and make money. Ipung (not his real name; a 17-year-old boy living in North Jakarta) dropped out from the 2nd year of senior secondary school (11th grade) and is now working as a bajilo (a thief who jumps on to moving trucks to steal goods from the load and then runs away) because he thought that his family needed money. His grandmother is very old and his father, who no longer lives with him, hardly earns any money. Soni (not his real name; a 16-year-old boy living in North Jakarta) also dropped out from the 1st year of vocational senior secondary school (10th grade) because he could not stand the tight discipline. He was willing to continue if he was transferred to another school, but his mother did not have money to support the transfer. In this case his mother wanted to send him along with her other children to senior secondary school to receive a good education, but because her income as a single mother was not sufficient she could only afford to send her children to school until they completed junior secondary school. After dropping out of school, Soni worked as a labourer at the port and then moved to a printing company, but he is now unemployed. Sita (not her real name; a 13-year-old girl living in North Jakarta) lives not far from Tri's house but she has had better luck. She is the only child in the family.

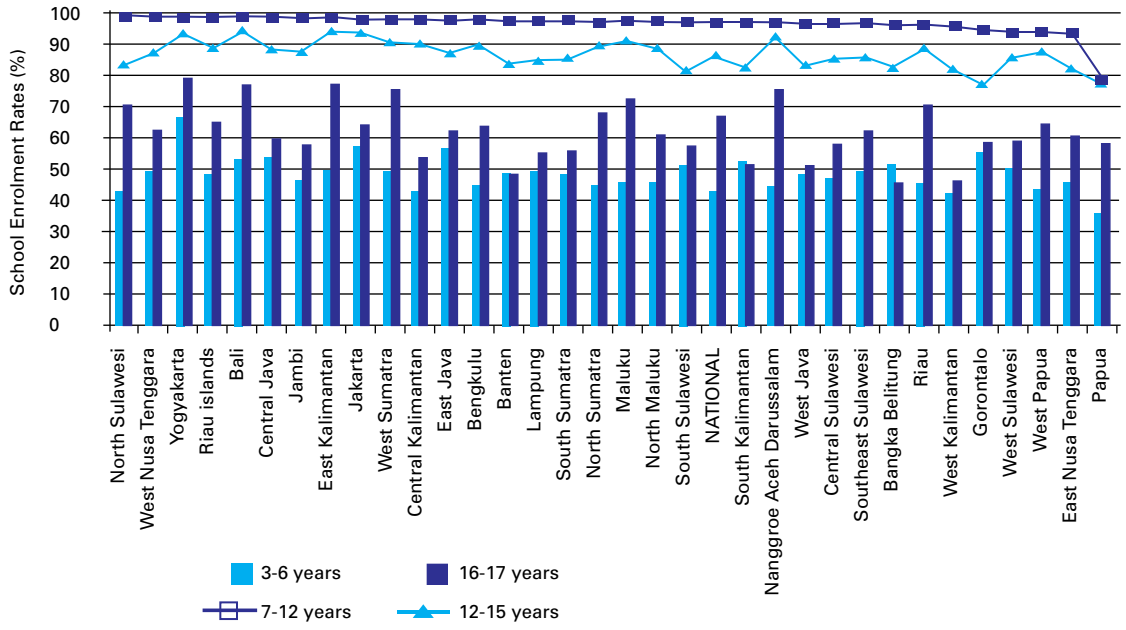
Unlike the cases in North Jakarta, in addition to a lack of income and a low level of motivation, most children of poor families in East Sumba could not afford junior and senior secondary school due to long distances to school and the high cost travel to get there. Some are not able to access higher education because they do not have relatives in town, where the schools are. In one of the hamlets that is largely inhabited

by poor households, the elementary students would walk more than 30 minutes to the nearest elementary school that is located more than 7 kilometres away. In the same hamlet, none of the children aged 13–15 years are attending secondary school because the closest secondary schools are more than 20 kilometres away. Ani (not her real name; a girl living in a remote village in East Sumba) just graduated from junior secondary school but did not continue to senior secondary school because she could not afford to pay the costs for transport, school entry fees and dormitory accommodation. There is no senior secondary school in the sub-district where she lives and the nearest one is in another sub-district located 15 kilometres away. She does not have family or relatives in that sub-district. Thus, distance is often the main obstacle to sending children to school, particularly senior secondary school.

Source: Case study in North Jakarta and East Sumba, June–August 2010

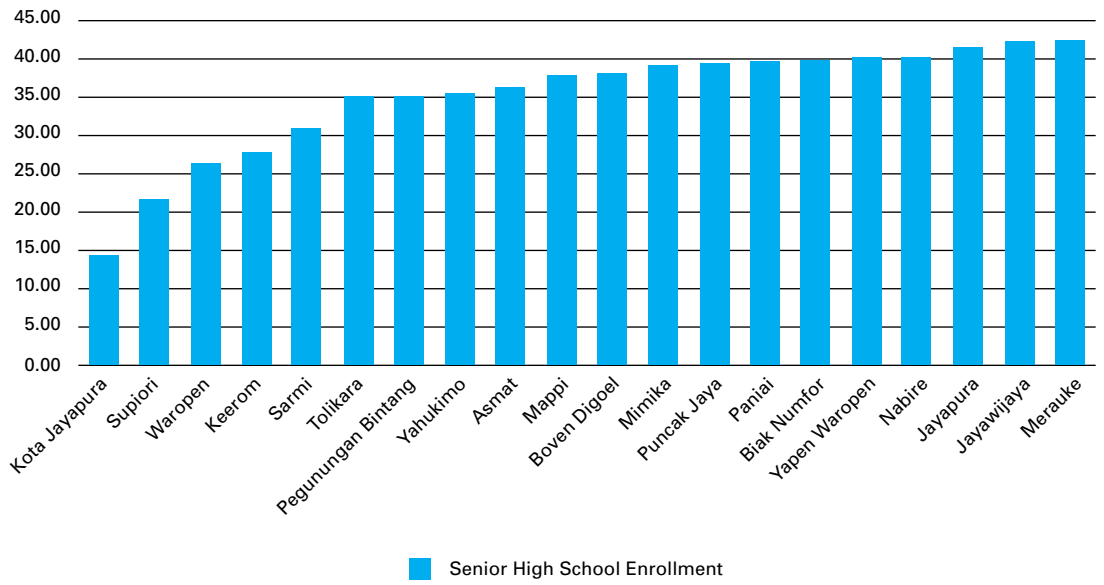
The different educational challenges revealed by the qualitative study and the regional disparity in terms of education facilities presented in the previous section (Section 4.3) might explain the pervasive regional inequality problem, particularly the relatively low rates of enrolment in junior and senior secondary school. Papua in particular lags behind other provinces. The enrolment levels in early childhood education ranged from 33.1 per cent (Papua) to 66.7 per cent (Yogyakarta). At the primary school level, Papua was the only province recording a rate as low as 78.5 per cent (Figure 4.7), While in other provinces primary enrolment reached more than 90 per cent and North Sulawesi had one of the highest rates, at 99.1 per cent. The province with the lowest enrolment rate for junior secondary school aged children was Gorontalo (77.2 per cent), while the highest was East Kalimantan (94.7 per cent). For senior secondary school aged children, the lowest enrolment rate was 46 per cent in Bangka Belitung, and the highest rate was 79.1 per cent in the city of Yogyakarta.

Figure 4.7: School enrolment rates by province, 2009 (%)



Source: Estimated using data from the 2009 SUSENAS (Panel)

Figure 4.8: Twenty districts and cities with the lowest senior secondary school enrolment rates, 2009



Source: Estimated using data from the 2009 SUSENAS (Panel)

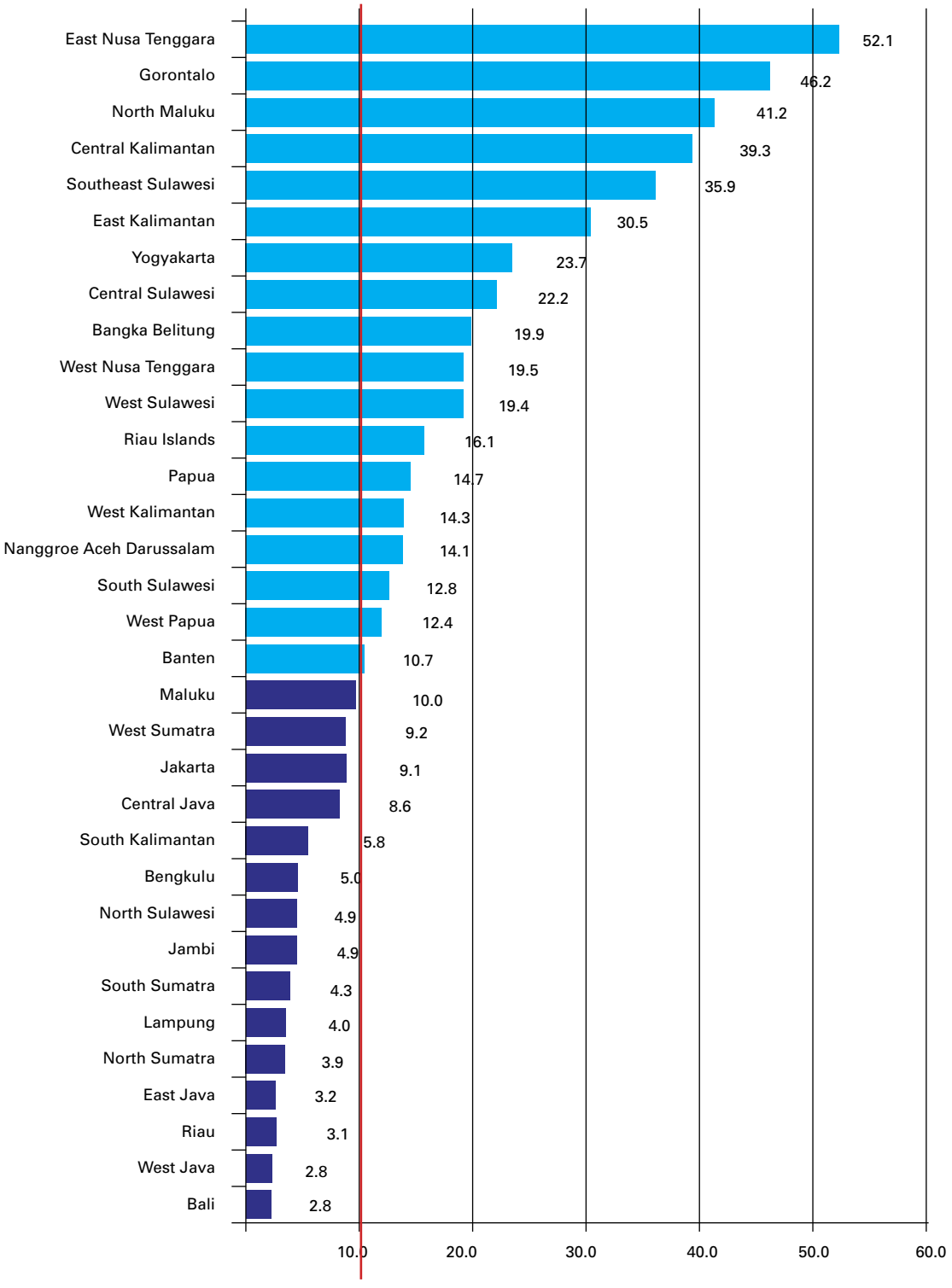
The disparities in senior secondary school enrolment across districts were particularly intriguing. Figure 4.8 shows a depressing picture of the districts with the lowest level of senior secondary school enrolment. The average across the twenty worst performers was only 35 per cent enrolment, compared with 85 per cent among the twenty best performers. All of the worst performing districts were located in the province of Papua (see Figure 4.8)

Besides school enrolment rates, the quality of education also varies greatly across regions. The disparities are evident from the scores on the national exam (UN) among senior secondary schools by province. As shown in Figure 4.9, the differences among provinces in the failure rates were substantial. The range between the lowest and highest proportion of students failing to graduate was around 50 percentage points. Bali and West Java were the best performers, with only 2.8 per cent failing to graduate, while East Nusa Tenggara (NTT) had the highest failure rate at 52.1 per cent, whereas the national average stood at 10 per cent.

Notwithstanding the controversy surrounding the national examination system (UN),[6] basic indicators regarding the distribution of teachers in urban and rural areas could be seen as one explanatory factor for the varying levels of academic achievement. As can be seen from Figure 4.10, teachers were unequally distributed, especially in rural areas. About 52 per cent of schools in rural areas were oversupplied with teachers, while at the same time 37 per cent were undersupplied, which indicates massively uneven distribution. The qualitative study also found evidence of this problem. For instance, in East Sumba, there were limited supplies of both qualified teachers (who held bachelor's or higher degrees in education) and teachers who

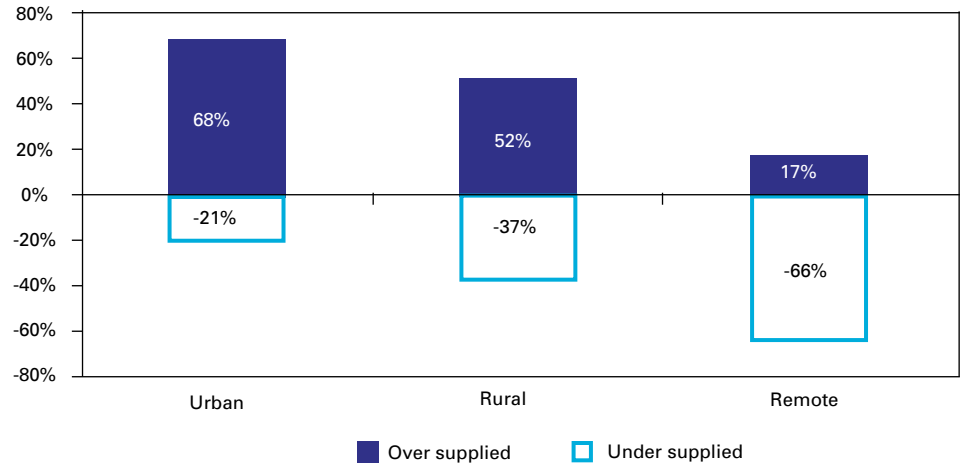
6 The identified negative effects included; teachers 'teaching to the test', encouragement of some students and teachers to cheat, and considered too extravagant for the national budget.

Figure 4.9: Percentage of senior secondary school students failing to pass the national exam threshold by province, 2009/2010



Source: Jalal, 2010

Figure 4.10: Distribution of teachers by region, 2009 (%)



Source: Jalal, 2010

were highly committed. Some teachers failed to arrive on time and stay in the classrooms for the duration of lessons. This resulted in the low achievement of students in terms of reading, writing and arithmetic. There were cases of 3rd graders who were still unable to read.

In many ways, the UN is a sound approach to make students study more vigorously. However there has been a perceived downside of the UN among education experts. It is reported that the UN results have now become the top priority at every school and that the most fatal consequence of this is schools neglecting the process of learning and creative thinking. Using the mathematics score of an international survey as an indirect measurement does not reflect a positive impact from the UN. Using data collected by the Trends in International Mathematics and Science study (TIMMS) in 2007, Indonesia's average score in mathematics fell to 397 from 411 in 2003. In addition, internationally, Indonesia was inferior when compared to its fellow ASEAN countries; its test score was lower than the scores from Malaysia, Singapore and Thailand, both in 2003 and 2007.

Besides regional disparities, there are also disparities in school participation rates among children from families with different socio-economic backgrounds and living in urban versus rural locations. Among the various factors linked to school participation, the economic background of the household appears to exert the strongest influence (Table 4.9). The likelihood of being enrolled in primary, junior secondary and senior secondary schools was approximately five times lower among children in the poorest economic quintile than those in the richest quintile; whereas their chance of becoming a child labourer was three times higher. The only exception to this was among the very young, aged 3–6 years old. For this particular age group, the proportion of children that did not enroll was even larger in the richest quintile than in the poorest quintile. It seems that all households shared approximately the same level of deprivation regarding early childhood education, although the households with fewer members, those headed by someone with a higher educational level, and those located in urban areas performed relatively better. Although early educational stimulation of children is actually very pivotal to their future development, it seems that many parents, regardless of their backgrounds, are not yet aware or concerned about this.

Besides the household economic level, the gender of the head of the household seemed to be associated with enrolment in junior and senior secondary school. The proportion of children aged 13–17 years that were not enrolled from female-headed households was around

Table 4.9: Children deprived of education, by household characteristics, 2009 (%)

	Percentage of children not enrolled in schools											
	Early childhood education (3–6 years)			Primary school age			Junior secondary school age (13–15)			Senior secondary school		
Gender of the household head												
Female	50.32			2.78			16.20			38.45		
Male	49.97			2.97			13.22			32.05		
Number of household members												
Less than 3	36.00			3.22			16.78			37.13		
3–4 members	49.40			2.17			11.13			29.81		
5–6 members	49.88			3.02			14.02			32.24		
7+ members	51.94			4.76			17.06			39.12		
Educational background of the household head												
Never attended/did not finish primary school	47.00			5.12			23.42			51.90		
Finished primary school	47.41			3.21			14.85			37.42		
Finished junior secondary school	50.26			2.18			7.39			19.71		
Finished senior secondary school	53.89			1.18			4.31			11.20		
Finished diploma/academy/university	59.38			1.21			3.78			14.53		
Welfare level of the household (by quintile, and urban/rural locations)	Total	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural
All	51.12	53.23	47.42	2.95	1.98	3.74	13.51	9.25	17.13	32.79	25.00	40.62
Q1	46.14	46.45	46.04	5.32	3.41	5.92	25.48	21.39	26.88	58.15	52.75	63.55
Q2	48.10	49.26	47.43	2.96	3.03	2.92	14.65	12.36	16.01	41.97	37.36	46.58
Q3	49.76	52.30	47.48	1.89	1.57	2.18	10.22	7.61	12.42	27.33	24.52	30.14
Q4	52.73	55.30	48.59	1.66	1.53	1.87	6.04	5.25	7.16	18.76	14.18	23.34
Q5	59.13	60.30	55.23	1.46	1.20	2.33	5.88	5.56	6.89	16.30	11.50	21.10

Source: Estimated using data from the 2009 SUSENAS (Panel)

backgrounds. This situation is rather worrying as it could lead to the formation of a vicious cycle of poverty as explained by Basu (1999). Basu explained that those who receive less education during childhood tend to be poorer as adults. As a consequence, these people will send their children to work resulting in the children receiving less education, and this self-perpetuating cycle will likely continue: they become stuck in a situation called a 'dynastic trap' or a 'child labour trap'.

Finally, it is also important to note the persistence of urban/rural gaps in terms of school enrolment rates. Rural households only outperformed urban households in terms of enrolment of children aged 3–6 years, which was around six percentage points higher. The enrolment rates of other age groups in rural areas were lower than in urban areas. Although in general the school enrolment among those aged 7–12 years (primary school) was already high, the proportion of rural children not enrolled was still three times higher than urban children. Meanwhile the proportion of children aged 13–17 years (secondary school) who are not enrolled in rural areas was approximately twice as high as those in urban areas. The persistent problem

Box 4.2: Education of poor children living in female-headed households and with parents with low education levels

Tri (not his real name), is a 16-year-old boy living in North Jakarta. He is the third of four siblings in the family. He dropped out of the 5th grade of primary school five years ago when his father died and his mother, a primary school graduate who makes a living by selling snacks at schools, decided to move to a new house far away from Tri's former school. Tri was a good student and he often achieved first rank in his class and won various inter-school sporting events. But now his daily activity is ngamen (singing in the streets for money). Sita (not her real name) is a 13-year-old girl who lives in North Jakarta, not far from Tri's house. She has had better luck. She is the only child in the family. Sita always achieved good marks in her classes and once won a dancing competition. Her father works as a driver for a garment factory with a monthly wage of IDR900,000 (US$100) and her mother sometimes obtains work shucking oysters. Although the family income is quite low by Jakarta's standards (the poverty line for Jakarta in 2009 was IDR316,936 per capita per month), her mother who graduated from junior secondary school and her father who graduated from senior secondary school are determined to support Sita's education as much as possible.

In East Sumba, a lot of villages are located far from school so that in addition to economic capability, parents' attention and awareness is very crucial in supporting children's education. Meli (female, 16 years old), discontinued her education in the 6th grade of primary school for no clear reason. Her parents only graduated from primary school and did not make any effort to persuade her to return to school. They also never paid any attention to the school records of their children and usually just returned them to the school without looking at the marks their children obtained. Oki (male, 14 years old) is Meli's brother and is still in his 1st year of junior secondary school (7th grade) because he has been held back due to poor grades on several occasions. Budi (male, 11 years old), is another brother of Meli's who is in the 5th grade of primary school and is considered to be a good academic achiever by their parents because he always passes to the next grade. Disability can also be a cause of school discontinuation. Andi and Angga were unable to speak clearly and so were forced to discontinue attending primary school by their parents, who considered it hopeless to continue their schooling. Their younger sister could not afford to go to secondary school because of the cost and distance. She is forced to work helping her parents in the fields. Their two younger brothers are still in elementary school and their parents are not really sure whether they will be able to afford for them to attend secondary school.

Source: Case study in North Jakarta and East Sumba, June–August 2010

of unequal distribution of education facilities and teachers contributes to this disparity in enrolment, as previously discussed.

Although children in urban areas are generally better off then children in rural areas, children in urban area are not homogeneous. As presented in Table 4.9 above, the disparities among children in urban areas were more pervasive than the urban/rural gap. The rate of school participation among urban children aged 7–12 years old from the richest quintile was almost three times higher than those from the poorest quintile households. The disparities also widen with increasing age group, and the participation rate among children aged 16–17 years from the richest household quintile was almost five times those from the poorest quintile. This represents a clear call for the government and other stakeholders to improve education access for income-poor children in urban areas, who – as evidenced by the qualitative findings from North Jakarta presented earlier – are facing non-physical challenges to accessing formal education.

4.6 Recommendations

So far considerable progress has been achieved in terms of the rate of enrolments and gender equality in schools. The provincial disparity in primary school enrolment rates is also relatively low, with the exception of Papua, which is still left far behind. However, a small portion of primary school-aged children are still not enrolled in school and they are mostly from the poorest households. The school enrolment rates among junior secondary school-aged children is also progressing quite impressively although the levels are still too low and the urban/rural, as well as regional disparities are still far too wide. Similarly, the enrolment in ECE is also improving, although the level needs to be further increased. The more pressing problem, particularly for the children of the poorest households, is access to senior secondary school. In addition, the quality of education also needs to be improved.

Thus, on the supply side, the following needs are clear:

1. The availability of ECE should be greatly expanded. ECE facilities should be located closer to residential areas and the cost should be affordable; the government and civil society need to collaborate closely.
2. At the primary school level, attention should be devoted specifically to Papua, and especially the children of the poorest households who cannot easily reach formal schools due to their remote locations. Special efforts by both the government and civil society need to be devoted to reaching this group of children, whose education has been left behind, in the spirit of guaranteeing their right to education.
3. For junior secondary school, the problem of physical distance should be overcome. Building one regular junior and senior secondary school in each village may not be the most efficient or effective solution. More innovative solutions may be necessary, such as establishing a 'one roof school' (primary and junior secondary school in one building) and/or providing a dormitory or a free school bus for distant students – these or similar solutions should be considered by governments and non-government organizations in order to improve access to secondary schools.
4. For senior secondary school, in addition to physical infrastructure needs similar to those of junior secondary schools, the government should also consider more progressive efforts to significantly reduce the school fees, either by providing a subsidy like BOS or by providing a major scholarship programme.
5. Overall, improving the quality of schools and teaching is very critical, as well as ensuring this is done in an equitable way across locations and communities. This can be done by closely monitoring students' performance (through a national examination) as well as improving the quality and distribution of teachers.

On the demand side, a lack of awareness among parents about the importance of education is still a major problem, especially for education continuation from junior to senior secondary school. Therefore, the Government of Indonesia should conduct a broad awareness-raising campaign among parents and children.

CHAPTER 5

Child Protection

5.1 General policies and approaches to child protection

The interpretation of the term 'child protection' has been evolving from one that was issues-based towards a more systemic approach. Traditionally, child protection had been seen as any effort to protect children who need special protection, such as victims of violence, exploitation, abuse and neglect. Mostly, these issues were handled separately through remedial interventions. This approach to child protection has undergone critical assessment leading to a common agreement that, while it has been successful in tackling the problems of a specific group of children, it is less effective when it comes to addressing long-term development challenges that require a more preventive approach. This process of deliberation led to the emergence of a holistic and systemic approach to child protection, which broadened the scope of child protection to provide a guarantee for the rights of the child, according to the United Nations Convention on the Rights of the Child (CRC). Consequently, intervention could be shifted from charity and remedial approaches to one that promotes the establishment of a system of intervention – consisting of formal and informal institutions and provision of child-sensitive social protection programmes – that protects all children from any form of risk that makes them vulnerable to poverty or deprivation.

Since the aftermath of the 1997–1998 Asian financial crisis, Indonesia has increasingly used this more holistic definition of child protection. The original version of Indonesia's 1945 Constitution (Article 34) and the 1979 Law on Child Welfare adopted a narrow definition of child protection that covered only protection for materially deprived or income-poor children. The change in approach came about due to raised awareness about the psychological and physical vulnerability of children in families, schools, playgrounds and in the labour market, in particular children affected by socio-economic crises, and those in communities affected by conflict or natural disasters. A Constitutional amendment in 2002[1] established the foundation for a holistic definition of child protection to cover the fulfillment of all child rights – to have identity, to survive and to grow – as stipulated

[1] The first amendment was on 19 October 1999, the second was on 18 August 2000, the third was on 9 November 2001, and the fourth amendment was on the 10 August 2002.

in Articles 20, 20A, 21, 28B, 28G, 28I and 34.[2] This was then elaborated in Law No. 23/2002 on Child Protection, which defines child protection as:

> *"[A]ll activities directed to guarantee and protect children's rights to grow up, develop and participate optimally, in accordance with human dignity and pride, as well as to be protected from violence and discrimination."* (Article 4)

The adoption of this holistic definition has expanded the coverage of child protection in Indonesia to all aspects of development, including health and education. Child protection is also incorporated into other related laws, including the 2009 Health Law, which guarantees the fulfillment of children's rights to live healthily through the provision of health services and sufficient nutrition with assistance programmes for the poor, the 2003 National Education Law, which guarantees the right of children to have nine years of basic education, and also the 2003 Labour Law, which asserts government responsibility for the protection of children below 15 years of age from having to earn their own living.

The current development planning documents have already adopted a more integrated approach to child protection. This is reflected in the 2010–2014 National Medium-Term Development Plan (RPJMN), which states:

> *"[D]eveloping integrated and comprehensive child protection will produce public policy that is more effective in realizing a world fit for all Indonesian children, both male and female."*

The document affirms three main development objectives with regards to child protection. The first of these objectives is to increase access to services aimed at fulfilling the rights of children to grow up and develop optimally, including integrated and holistic early childhood development. The second is to increase the protection of children against all forms of discrimination and violence. The third is to increase institutional capacity for child protection.

To achieve the first objective, policies and programmes of the Government of Indonesia (GoI) together with all development partners are directed towards: (i) improving the quality and accessibility to early childhood development programmes; (ii) improving the quality of child health; and (iii) improving reproductive health among teenagers. The second objective is to be accomplished through: (i) increasing child protection and social rehabilitation; (ii) increasing prevention of child labour and eliminating the worst forms of child labour; and (iii) increasing protection for children in contact or conflict with the law. Finally, to achieve the third objective, a variety of activities are directed towards: (i) developing and coordinating regulations related to child protection; (ii) improving the management of child protection information and data; and (iii) improving partnership and coordination among stakeholders working on children's rights at the local, national and international levels.

As a consequence of the adoption of a holistic approach, responsibility for the provision of child protection services rests with various ministries. In the past, the Ministry of Social Affairs (MoSA) has held the main responsibility for providing services to children. But in 2003, the GoI established the Indonesian Commission for Child Protection (*Komisi Perlindungan Anak Indonesia*, KPAI) as stipulated by the 2002 Child Protection Law. Furthermore, the position of child protection within the national development agenda has been further enhanced by creating a unit responsible for child protection within the State Ministry for Women's Empowerment, which in 2009 formally became the Ministry for Women's Empowerment and Child Protection (MoWE&CP). One of the mandates of this ministry is to ensure that development in Indonesia is child-friendly. Recently, a study listed that there were 14 ministries/agencies that allocated a certain portion of their 2010 budgets to child protection programmes.[3] On average, 33.5 per cent of these 14 ministries' budgets, or a

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2 Previously, in the second amendment of the 1945 Constitution (UUD), child protection was included in articles related to human rights that protected children and people of all age groups from acts of violence, as stipulated in Chapter X on Human Rights.

3 Among others are: Ministry of Social Affairs (MoSA), Ministry for Women's Empowerment and Child Protection (MoWE&CP), Ministry of Manpower and Transmigration, Ministry of National Education (MoNE), Ministry of Health (MoH), Ministry of Religious Affairs, National Development Planning Agency (BAPPENAS), Indonesian Commission for Child Protection (KPAI), the Police, Ministry of Information and Communication, and Ministry of Home Affairs (MoHA)

total of about IDR 44,234.7 billion, was allocated to support child protection programmes. Among these 14 ministries, the 3 ministries that are the most dominant are the MoSA, MoWE&CP and the Ministry of Labour and Transmigration (Table 5.1).

As can be seen in Table 5.1, MoSA allocated more than half of its budget (62.4 per cent) to child protection programmes. The implementation and improvement of the Conditional Cash Transfer, known as *Program Keluarga Harapan* (PKH), contributed to almost half of MoSA budget for children, reaching as much as 49.5 per cent (see further discussion of this programme in Chapter 4). In addition, MoSA has also just implemented the Social Welfare Programmes for Children (*Program Kesejahteraan Sosial Anak*, PKSA), which has adopted a new holistic approach with the aim of reduce the numbers of children living or working on the street and child labourers. This programme will be further described in section 5.5 of this chapter.

The rest of this chapter covers only four specific issues in child protection, namely: (1) birth registration; (2) violence against children; (3) working children and child labour; and (4) children outside parental care. Other issues within the holistic definition of child protection are discussed in other chapters of this report. The selection of issues being covered in this section is based merely on the availability of data and information and not the degree of importance of these issues. Some other child protection issues that are not covered in this section, but which are no less important, include early marriage and children with special needs.

The four selected issues will be discussed in the next four sections of this chapter, which follow the structure of the previous chapters on health and education. Each section is organized to cover: regulatory framework and key policies and programmes; institutional settings and budgets; outcomes; and recommendations. Although each issue is discussed separately, interconnection across issues will be evident, including cross referencing to other chapters of this report where relevant.

The four selected issues – birth registration, violence against children, working children and child labour, and children outside parental care – are covered in the Child Protection Law (Law No. 23/2002). Regarding birth registration, the law stipulates that a birth certificate is the identity document of every child and must be provided after birth (Article 27). The GoI manages the provision of birth certificates extending to the village level (Article 28). In regard to violence against children, the law requires integrated efforts to combat violence against children under the framework of child protection as defined in the law (Article 3). Efforts to prevent violence against children are mentioned in Articles 69, 13, 15 and 54 of the Law. Moreover, the Law also stipulates special protection services for child survivors of violence and sanctions for acts of violence and abuse against children, in Articles 59, 77, 78, 80, 81, 82 and 87. Concerning child labour, the Law stipulates that children should be protected from economic or sexual exploitation (Article 13), from involvement in the usage, production or distribution of addictive substances (Article 67), and it is stated that the GoI or an institution authorized by the state should be responsible and accountable for

Table 5.1: Budget for child protection in ministries responsible for major child protection issues, 2010

Observed ministries & agencies	2010 ministry total budget (billion IDR)	Budget related to children (billion IDR)	% of each ministry's total budget	% of GDP
14 ministries & agencies	132,232.5	44,234.7	33.5	0.7
Three main ministries:				
Social Affairs	3,427.7	2,140.4	62.4	0.04
Women's Empowerment & Child Protection	132.9	52.5	39.5	0.001
Manpower & Transmigration	2,680.3	54.2	1.9	0.001

Source: Johanna, Diponegoro University

providing special protection to children who are exploited economically or sexually, as well as children who are the victims of kidnapping, trafficking and trading (Articles 59 and 66). With regard to children outside of parental care, the Law stipulates that the government is responsible for providing special protection to neglected and abandoned children (Articles 59 and 68), and alternative care can be provided by institutions that have the authority, both inside and outside of residential care (childcare institutions) (Article 37).

5.2 Birth registration

5.2.1 Regulatory framework, policies and programmes

One of the rights affirmed in the Convention on the Rights of the Child is the right to identity, and the GoI has pledged its responsibility for administering and regulating birth under the Child Protection and Population Administration Laws. Law No. 23/2006 on Population Administration is the legal basis for the provision of birth registration services, as part of civil registration services and also one source of demographic data. Article 27 of this Law requires all residents to report all births to local government services (office of population and civil registration) no later than 60 days following the birth. The law stipulates that the registration service is free of charge, but for late registration (more than 60 days after the child birth) will subject to penalty fee and for those above 1 year (from the birth) have to register to the sub-district level court. Furthermore, the GoI issued Government Regulation No. 37/2007 on the Implementation of Law No. 23/2006 on Population Administration, in an effort to raise awareness about the implementation of population registration and civil registration among relevant government agencies and residents. This matter is further regulated under Presidential Regulation No. 25/2008 on Requirements and Procedures of Population and Civil Registration. According to this regulation, issuing birth certificates requires a birth report provided by the doctor/midwife/birthing assistant, the name and identity of the birth witnesses, the family identification card (*Kartu Keluarga*), and the parents' identity cards (KTP) and marriage certificate.

At the operational level, in 2008 the MoHA, as the ministry responsible for birth registration, issued a Strategic Plan with the target of achieving universal birth registration of all children in Indonesia without exception by 2011. Possession of a birth certificate is intended for children aged 0–18 years with priority given to under-fives (children under the age of five years). The plan contains 16 strategic programmes comprising 11 main programmes and 5 support programmes. The main programmes are to: (1) establish and strengthen institutions; (2) issue implementing regulations to ensure universal birth registration by 2011; (3) establish birth registration units at local levels; (4) specify the procedures for birth registration services; (5) build capacity of birth registration administrative staff; (6) generate a birth database; (7) raise public awareness regarding the importance of birth certificates; (8) hold mass birth registration events in each district; (9) waive the costs of marriage administration for Muslim residents; (10) waive the cost of marriage certificate (for both Muslims and non-Muslims) at religious or district courts; and (11) monitor, evaluate and report on the birth registration and birth certificate programme. The five supporting programmes are: (1) provide orientation about support for the birth registration system for members of parliament; (2) develop birth statistics at district level; (3) utilise birth statistics; (4) issue identity cards for children as a requirement for admittance to incentive systems; and (5) accelerate the selection of a location for a birth registration system pilot project.
In addition to the central government policy, provincial and district governments may determine their own supporting policies regarding birth certificates, usually stipulated in the form of regional government regulations. According to UNICEF (2009), the number of district governments that have already introduced a free birth certificate policy increased from only 16 districts in 2005 to more than 200 districts in 2007. Since 2006 the central government has provided blank register books and birth certificate forms to facilitate free provision of birth certificates for babies from birth to 60 days in all districts in

Indonesia (UNICEF, 2011). The programme was implemented in stages, with the objective of encouraging the implementation of regional regulations on free birth certificates.

5.2.2 Institutional setting and budget

At the national level, the MoHA – in particular the Directorate of Civil Registration of the Directorate General of Population and Civil Registration – is the primary institution designated to manage the provision of birth certificates. Based on the MoHA Strategic Plan for 2011 concerning universal birth registration, the implementation of birth certificate programmes also involves the Ministry of Religious Affairs, which is specifically tasked with the implementation of the programme to provide special dispensation for Muslim residents for the costs of marriage. Meanwhile, the general implementation of a birth registration service is also assisted by the provincial governor and the district chief executive *(bupati/walikota)* in accordance with their duties and functions.

District governments are the main institutions that provide birth certificate services to the public, administered by the Population and Civil Registration Offices at the district level. Birth certificates are issued to families by the Regional Technical Implementing Units (UPTD), which are local units responsible for administering civil registration services and issuing birth certificates. Each of these units covers one or more neighbouring sub-districts.
In regard to budgetary issues, it is not possible to track the precise budget allocated for birth registration in Indonesia from the available published details of the national budget. The budget for birth registration is part of the 'demographic budget' *(anggaran kependudukan)* and could only be identified if there were funds earmarked for the implementation of the Strategic Plan for universal birth registration by 2011. UNICEF (2010) estimates that the GoI has allocated IDR 12 billion annually to cover all of the costs associated with the provision of birth certificates for all children aged 0–60 days in 100 districts in Indonesia.[4]

One method of tracking budgetary trends birth registration is by monitoring the budgets for the population administration system and for the institution responsible for administering birth registration. In the 2006–2010 national budget there was no budget line that specifically mentioned the implementation of the birth registration system under the population administration programmes; instead, the programme's budget consisted of the 'programme for consistency in population policies' *(Program Keserasian Kebijakan Kependudukan)* and the 'programme for demographic data collection' *(Program Pendataan Administrasi Kependudukan)*. As presented in Table 5.2, the budget for the programme for consistency in population policies declined during the 2006–2010 period. On the other hand, the budget for the programme of demographic data collection in 2010 increased by almost 18 times the level in the 2006 budget. Meanwhile, the budget of the Directorate General of Population and Civil Registration fluctuated but tended to increase during this period. The increases of the budget for demographic data collection and for the Directorate General of Population and Civil Registration in general might be a good indicator of the GoI's commitment to improve population administration services in Indonesia.

The budget allocation of the district governments, which are at the forefront of the birth certificates service, varied. Qualitative data from the case study in East Sumba provides a positive view. The government in East Sumba has implemented a free birth certificate programme. The budget for the local birth registration system was covered by the budget of the Population and Civil Registration Office *(Dinas Kependudukan dan Catatan Sipil)*. Based on the East Sumba local budget documents, in 2008 the budget for this particular office was IDR 5 billion and it declined to IDR 4.1 billion (0.8 per cent of total local government expenditure) in 2010. Although the available data do not allow for identification of the precise budgetary allocations for birth certificates, there were signs that the birth certificate programme

[4] As mentioned in Chapter 1, Indonesia has almost 500 districts in total.

Table 5.2: Budget for population related programmes and departments, 2006–2010 (in million IDR)

Programme and Department	2006	2007	2008	2009	2010
Programme for consistency in population policies	10,000	9,545	9,111	6,752	6,752
Programme for demographic data collection	27,771	235,520	255,955	124,134	494,134
Directorate General of Population and Civil Registration	61,213	290,035	301,065	168,686	541,033

Source: Details of National Revenue and Expenditure Budgets (APBN), 2006–2010

had been prioritized. Despite a decline in the overall budget of the Population and Civil Registration Office, the budget of the population administration management programme *(Program Penataan Administrasi Kependudukan)* – which covered birth certificates – had increased. In 2008 the budget of this programme was IDR 643 million and in 2010 it increased to IDR 793 million, of which 3 per cent was used for the dissemination of the programme's strategic plan at the district and village level and 4 per cent was used to make an inventory of all children aged five years who possessed birth certificates, which was done by distributing birth reporting forms (F2-01).[5]

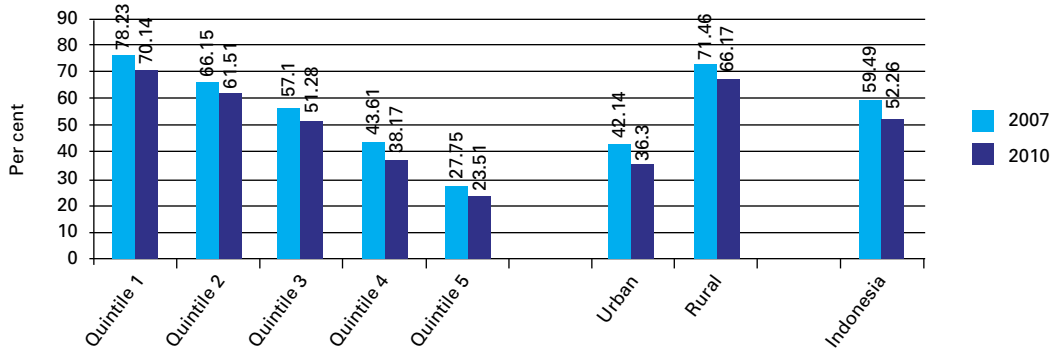
5.2.3 Outcomes regarding birth registration

Data from the National Socio-Economic Survey (SUSENAS) revealed an increasing trend in birth registration among under-fives, but the current growth and achievement rates remain too low to achieve universal coverage by 2011. In 2000, it was estimated that around 40 per cent of under-fives already had birth certificates, and the proportion had increased to 48.8 per cent in 2009; thus it had increased on average by 2.75 per cent annually. The estimates derived from the 2007 and 2009 SUSENAS (see Figure 5.1) show an acceleration of birth certificate possession so that deprivation of the right to have a birth certificates had declined by an annual average of around 6 per cent. Still, around 52.3 per cent of under-fives did not have birth certificates in 2009. Using a different definition of birth registration, an estimate based on the 2007 IDHS (Indonesia Demographic and Health Survey) showed that around 53.4 per cent of under-fives were already registered. The IDHS definition of registration includes not only the official birth certificate but also a letter from the hospital and a birth report letter from the village administration (UNICEF, 2011).

In spite of the good progress, there were significant disparities in the proportions of under-fives possessing birth certificates depending on rural/urban location, household wealth quintile and province. The proportion of children in rural areas who did not have birth certificates was higher than those in urban areas. In 2009, 36.3 per cent of children in urban areas had no birth certificate whereas in rural areas that proportion was almost double. Based on household wealth quintile, the under-fives from the poorest quintile had the lowest proportion of birth certificate ownership (highest rate of deprivation). In 2009, 70.1 per cent of the poorest children had no birth certificate compared to just 23.5 per cent of the richest under-fives. This indicates that lack of a birth certificate was still a significant problem among poor children.
The performance across provinces also varies greatly. In 2009, the under-fives, both girls and boys, in the province of North Sumatra were the most deprived with around 80 per cent lacking birth certificates, compared to just 12 per cent of girls and 11 per cent of boys of this age group in Yogyakarta (Figure 5.2).
Economic factors represent the main hindrance to progress in the provision of birth certificates. According to IDHS data (Figure 5.3), the main reason for not registering a child's birth is because it is considered too expensive. The free birth registration promoted by the central government has not entirely addressed the issue of cost. In fact, some districts still charge for birth

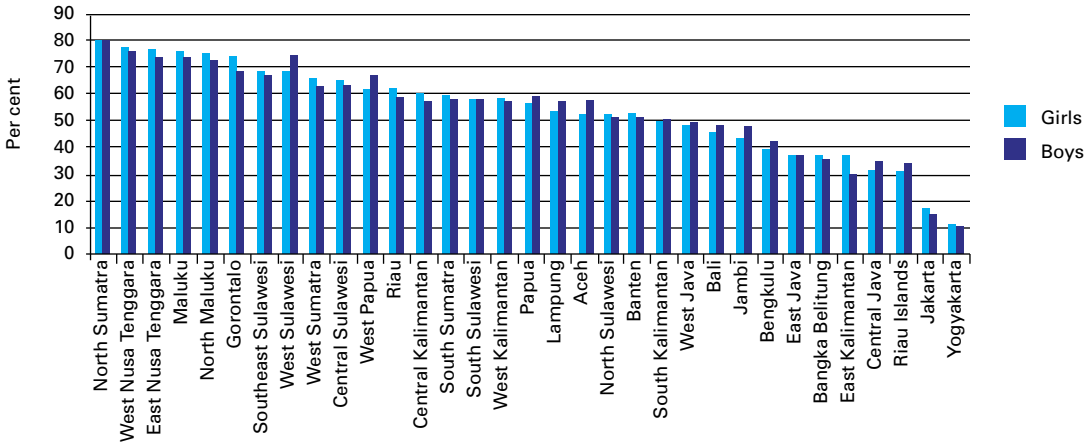
[5] Birth reporting forms (Form F2-01) are provided in villages for reporting the births of citizens of Indonesia.

Figure 5.1: Children under age five deprived of the right to have a birth certificate, by wealth quintile and urban/rural location, 2007 and 2010 (%)



Source: 2007 and 2009 National Socio-Economic Survey (SUSENAS) Core and Panel

Figure 5.2: Children under age five without birth certificates by province, 2009 (%)

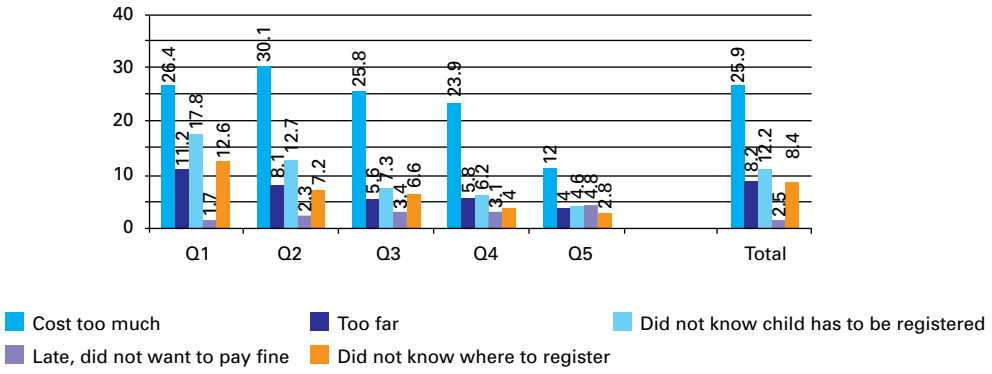


Source: Estimated using data from the 2009 SUSENAS

registration. Besides the fee for birth registration and birth certificates, parents also face indirect costs, including transportation to a registration office. The issue of cost is the most commonly mentioned problem at all levels of household wealth. The second and third most common reasons are related to a lack of information, as many parents reported not knowing that they had to register the birth or where they should go to register.

Similarly, the qualitative case studies also revealed that low birth registration is related to economic issues. In North Jakarta, most of the poor could not afford the cost of a birth certificate. In both study precincts, parents still incurred some cost when applying for a birth certificate. In East Sumba, since 2006 there have been regulations to ensure that birth certificates for all children up to age 17 years were free of charge until the end of 2010. However, the high cost of transport to the sub-district capital to apply for the certificate was still prohibitive for many. In addition, many also faced the cost of obtaining other documents required for the application, including copies of the parents'

Figure 5.3: Reasons for not registering birth by wealth quintile and total, 2007



Source: Indonesia Demographic and Health Survey (IDHS), 2007

marriage certificate and identity cards, a certificate from the hospital or birthing facility, and the family card. Most poor families do not have a complete set of identification and other documentation, as these documents must be paid for and they may have not previously been viewed as necessary. As a final cost, applicants often have to pay a fee to people who assist them in the registration process.

In addition to economic barriers, a lack of public awareness about the importance of birth registration is another cause for the low proportion of children possessing birth certificates in some regions. Most people in North Jakarta only realize the importance of a birth certificate when enrolling their children in school, since this is a registration requirement, especially at state schools. In East Sumba, there were obvious differences in the rates of birth certificate possession between the regions that had been targeted by awareness-raising campaigns on this subject and those that had not. This also demonstrates the effectiveness of awareness-raising campaigns. Similar to North Jakarta, people in East Sumba also realized the importance of possessing a birth certificate in relation to enrolling their children at school, especially at the senior secondary level.[6]

Being born outside of marriage, or outside of a legally registered marriage, also results in children being deprived of a birth certificate, since possession of a marriage certificate is generally required for birth registration. Based on the study results in North Jakarta, a child who was born outside of marriage could have a birth certificate that did not include the name of the father, but unfortunately, this policy is not widely known by the people. Generally only civil registration personnel (at the district level) know about this policy, while most community and precinct *(kelurahan)* officials do not. Meanwhile in East Sumba, in the case of children born outside of marriage, people are generally ashamed to apply for a 'single parent' birth certificate, although in East Sumba people were generally aware of the policy allowing a birth certificate without the father's name. Moreover, in East Sumba, marriage ceremonies are often carried out according to custom only, without any official registration procedure. Nevertheless, the culture allows a man to have two or three wives and usually the second and third marriages are only done according to customs thus many marriages lack an official certificate which in turn has an implication on to the children's legal status.

These issues indicate that the system of decentralization in Indonesia is fraught with

6 In the study area of East Sumba, many schools do not require a birth certificate as a requirement for school enrolment, especially at the elementary and junior secondary school levels.

challenges for the strategic plan for all births to be registered by 2011. The MoHA extended the birth registration service dispensation policy aimed at accelerating the achievement of the national strategic plan's target (i.e., all children in Indonesia are to be registered by 2011).[7] With reference to the Letter of the Minister of Home Affairs No. 472.11/2945/SJ, the dispensation period which expired in December 2010 was extended until the end of December 2011. However, the implementation of this policy is fully assigned to the Offices of Population and Civil Registration at the district level, such that every district might implement the policy using different procedures. Indeed, not all local governments have implemented free birth registration since some still regard it as a source of income.

5.2.4 Recommendations

Although access to birth registration has increased, many children in Indonesia still do not have birth certificates resulting in a high degree of disparity across regions and across different levels of household wealth. The government has issued many regulations and programmes to address this but problems related to supply and access continues to arise.

On the supply side, the government should:

1. Bring the service closer to those who are not accessing registration by:
   a. Moving the service point to the closest possible location, or subsidizing the transport and administrative costs of accessing birth registration;
   b. Ensuring that birth attendants and midwives register the births they attend, including home deliveries (the government should also allocate some funds for operational costs, so that birth attendants will not be burdened by the cost or pass these costs on to the parents); and/or
   c. Ensuring that civil registration agencies collect birth registration forms from hospitals on a daily basis.
2. Empower midwives and traditional birth attendants to help parents with the birth registration process by filling in the registration forms and delivering them to the closest civil registration office.
3. Subsidize the cost of birth registration and issue birth certificates free of charge.
4. Review the law and regulations to remove discriminatory practices against children born outside of marriage (and outside of legal marriage).
5. Extend the time requirement of 60 days post-birth to register the child's birth.

On the demand side, the government needs to disseminate information to the public, especially to poor communities, about the importance of birth registration.

5.3 Working children and child labour[8]

5.3.1 Regulatory framework, policies and programmes

After ratifying ILO Convention No. 138 on the minimum age for admission to employment through Law No. 20/1999 and ILO Convention No. 182 on the worst forms of child labour (WFCL) through Law No. 1/2000, the GoI has continuously made efforts to reduce child labour, especially the WFCL and child trafficking. Several laws have been issued to provide a legal basis for this endeavour, including: Law No. 23/2002 regarding Child Protection, Law No. 23/2004 regarding Domestic Violence, and Law No. 21/2007 regarding the Eradication of Criminal Acts of Trafficking. In addition, in 2006, ILO's Global Report on Child Labour called for a global united effort to eradicate the WFCL by 2016. A consensus was reached among ASEAN governments in mid-2009 to support this agenda, which was linked to achieving the main MDG target of reducing extreme poverty.

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7 During the dispensation time, children exceed the age limit are still allowed to be registered (their birth) through office of population and civil registration with free of charge

8 Although trafficking and some activities of children living or working on the street can be considered as among the worst forms of child labour, these issues are not discussed in this section but later in the chapter. Child trafficking will be discussed in section 5.4 and children living or working on the street in section 5.5.

In spite of the progress, Irwanto (2011) points out that Law No. 13/2003 on Labour does not fully incorporate ILO Conventions Nos. 138 and 182.[9] He explained that while the Law stipulates that it is prohibited to employ children (Article 68), it makes an exception for children aged 13–15 years to perform light work (Article 69), defined as activities "that will not negatively affect a child's development and physical, mental and social health" and states that the work should not exceed a maximum of three hours per day and should be performed during the day time but not during school hours. Another exception extends to children who work within their own family business. This stipulation is not in line with Article 2 (clauses 3 and 4) of the ILO Convention No. 138, which states that the minimum age for work in developing countries is 14 or 15 years. Another criticism of this Law is that it fails to address the lack of any regulations on work for 16- to 17-year-old children.

Presidential Decree No. 12/2001 established a National Action Committee (NAC) for the Elimination of the WFCL, and subsequently Presidential Decree No. 59/2002 set out the National Action Plan for the Elimination of the WFCL (NAP–WFCL). The NAP–WFCL provides a guideline for all stakeholders – government institutions, non-government organizations, the private sector, academics and the mass media – for joint efforts to prevent and eliminate the WFCL. This programme targets all children employed in the WFCL and all parties who make use of, supply, or offer children (aged under 18 years) for employment in the WFCL. The NAP–WFCL defines the WFCL as including:

1. Children trafficked for prostitution
2. Children engaged in the production, trade and distribution of explosive and chemical substances
3. Children engaged in the production processes of mining
4. Children engaged in the process of footwear production in the informal sector
5. Children engaged in the offshore fishery sector
6. Children employed as domestic workers
7. Children employed in the plantation sector, particularly in oil palm plantations
8. Children working in the streets

The NAP–WFCL is being implemented in three stages, each with specified targets and of which takes a certain period of time. Stage I takes 5 years, stage II takes 10 years, and stage III takes 20 years. The objectives, strategies and programmes for stage I and II are listed in Table 5.3.

The evaluation of stage I of this programme (2002–2007) concluded that it had run relatively well. During these first five years, the programme managed to deliver direct assistance to 45,111 children, of whom 3,656 were withdrawn from and 41,453 were prevented from entering the WFCL through the provision of non-formal and vocational education programmes and rehabilitation. In an effort to raise awareness and increase knowledge about this programme in the larger community, the government conducted several intensive campaigns through various media. In addition, the government also increased the involvement of key stakeholders by providing capacity building opportunities at institutions at the central and local levels. They succeeded in establishing Provincial WFCL Action Committees in 21 provinces and 72 districts/cities, and issued Provincial Regulations on WFCL in 2 provinces.

In addition to these achievements, the evaluation of the first stage of this programme also revealed a number of major challenges. These included a lack of updated data on child labour, a lack of efficient coordination and cooperation at national and local levels, and a lack of optimal budget allocation for programme implementation. To enhance the impact of the programme, this evaluation also acknowledged the importance of developing integrated and sustainable programmes by mainstreaming child labour issues in education programmes and national poverty alleviation efforts across the country.

Currently, stage II of this programme focuses on: (i) educating children who have been withdrawn from or prevented from entering

[9] This law was also criticized by Indonesia's National NGO Coalition for Child Rights Monitoring for failing to give consideration to the minimum age of employment and the nature of work (Irwanto, 2011).

the WFCL; (ii) strengthening the framework of the programmes, policies and legislation on child labour; (iii) strengthening the capacity of stakeholders to implement action programmes on the elimination of child labour; and (iv) increasing people's awareness about the WFCL and the importance of education for all children (Table 5.3).

In addition to the specific programmes designed for the elimination of the WFCL, the NAP–WFCL also acknowledges the contribution of other government programmes that, although they do not directly address the issue of child labour and the WFCL, have the potential to address some of the causes. These programmes include non-formal education for school dropouts, 'one-roof' schools (to assist children to attend secondary school locally), BOS programmes, the student scholarships programme, Unconditional Cash Transfers (*Bantuan Langsung Tunai*, BLT), Conditional Cash Transfers (*Program Keluarga Harapan*, PKH), and health insurance for the poor.[10]

Table 5.3: Objectives, strategies and programmes of the National Action Plan for the Elimination of the Worst Forms of Child Labour (NAP–WFCL), Stages I and II

Stage I (2002–2007)	Stage II (2008–2018)
Objectives	
1. Increased public awareness that the worst forms of child labour (WFCL) must be eliminated. 2. Mapping problems concerning the WFCL as well as mapping efforts that have been made to eliminate them. 3. Realization of the goals for the elimination of the WFCL by giving priority to the elimination of the use of children for: a. offshore fishing and deep-water diving; b. trafficking for prostitution; c. working in mines; d. working in the footwear industry; and e. working in the drug industry and trafficking drugs (i.e., narcotics, psychotropic, and other addictive substances).	1. Replicating successful models for the elimination of the WFCL implemented in the stage I. 2. Developing programmes to eliminate other WFCL. 3. Developing the policies and instruments needed to implement the elimination of the WFCL.
Strategies	
1. Determining priorities for elimination of the WFCL as part of a gradual process. 2. Involving all stakeholders at every level. 3. Developing and making use of domestic potential. 4. Developing and maintaining collaboration and technical assistance relationships with various international governments and organizations.	1. Building the commitment of all stakeholders to prohibit and take immediate action to eliminate the WFCL. 2. Integrating cross-sectoral programmes to eliminate the WFCL. 3. Strengthening coordination and cooperation among all stakeholders at every level to encourage participation in efforts to prevent and withdraw children from the WFCL. 4. Mainstreaming the elimination of WFCL in related policies and programmes, such as compulsory basic education, poverty alleviation, health-care for poor families, community empowerment programme (i.e., PNPM Mandiri), etc. 5. Strengthening the capacity of human resources of the 'action committees' at national, provincial and district/city levels. 6. Optimizing the potential of each region in the elimination of the WFCL.

[10] Most of these programmes are discussed in various chapter of this report. See Chapter 3 for programmes related to education, Chapter 4 for programmes on health and Chapter 6 for cash transfer programmes.

Programmes	
1. Mainstreaming (and awareness-raising) of the issue of child labour: This programme is aimed at increasing public awareness of the prohibition of employing children in the WFCL and the adverse consequences to children engaged in the WFCL. 2. Cooperation and coordination: This programme is aimed at building commitment of government agencies and the public to the elimination of the WFCL. 3. The development of modules for tackling child labour: The modules were guidelines for strengthening the capacity of labour inspectors and other stakeholders in tackling child labour issues. 4. Development of guidelines for collecting data and mapping child labour: The guidelines were intended to encourage each area to obtain accurate data on child labour, the number of children engaged in it, and the types of work. 5. Facilitating the establishment of 'action committees' and the development of action plans in the provinces, districts and cities, in order to coordinate and integrate all activities to prevent and retrieve children from the WFCL. 6. Programme to withdraw children from child labour through direct interventions by the Ministry of Manpower and Transmigration: This programme was intended to withdraw and prevent children from entering the WFCL by providing school dropouts aged 15–17 years with skills training, their parents with entrepreneurship education, as well as working capital to empower their economy. 7. Preventing and withdrawing children from child labour through the 'Child Labour Free Zone' in the district of Kutai Kartanegara, in the province of East Kalimantan: The objective of this programme is to prevent children from entering the WFCL, and to withdraw those who were already involved in the WFCL, by providing them with better access to education facilities so that they could complete nine years of compulsory basic education, and involving their parents in a microcredit scheme to enable them to start a small business of their own. 8. Programmes supported by ILO-IPEC* to prevent and withdraw children from child labour: These programmes were intended to prevent children from entering the WFCL and withdraw those who were already involved, by giving them life skills training in the following provinces: North Sumatra, West Java, DKI Jakarta, East Java and East Kalimantan. 9. Programmes to reduce the number of children engaged in child labour through 'Program Keluarga Harapan' (Conditional Cash Transfer): The objective of the programmes was to withdraw children from work, provide them with assistance in shelters and motivate and prepare them to get back into the education system.	1. Development of institutions for the elimination of the WFCL: The objective is to encourage provinces and districts/cities to establish 'action committees' and develop action plans for the elimination of the WFCL. The target is the establishment of 'action committees' in 8 provinces and 358 districts/cities. 2. Replication of models: The objective is to replicate and implement models of programmes for the elimination of the WFCL implemented during stage I in other regions during stage II. 3. Programme development: The objective is to develop programmes to eliminate the WFCL in other sectors (beyond the five that were initially prioritized). The target is for such programmes to be implemented in all sectors where the WFCL are found. 4. Policies and instruments of implementation: The objective is to develop the policies and instruments to support implementation of the programme to eliminate the WFCL.

Source: Secretariat of the National Action Committee on the Elimination of the Worst Forms of Child Labour, 2010
*Note: *ILO-IPEC is the International Labour Organization's International Programme on the Elimination of Child Labour*

5.3.2 Institutional setting and budget

At the central level, the issues of child labour and child trafficking are handled by several committees or task forces involving multiple stakeholders. The most relevant institutions are the National Action Committee for the Elimination of the Worst Forms of Child Labour (NAC–WFCL), Indonesian National Commission on Human Rights *(Komnas HAM),* the Indonesian Commission for Child Protection (KPAI), and the Task Force for the Prevention and Law Enforcement of Trafficking.

As previously mentioned, the NAC–WFCL was established by Presidential Decree No. 12/2001. The Committee consists of representatives from various government institutions, non-government organizations, business representatives, labour unions, employers associations and academics. Among the government institutions involved are the Ministry of Manpower and Transmigration (in the role of coordinator and supporting secretariat), the MoHA, the MoNE, the MoH, the MoWE&CP, the MoSA and the Indonesian National Police Force. The Committee, with all these stakeholders as its members, performed the following tasks: (1) identified child labour issues; (2) formulated a National Action Plan for the Elimination of the Worst Forms of Child Labour (NAP–WFCL); and (3) monitored and evaluated the implementation of programmes. By August 2007, 15 provinces and 60 districts had established regional/local action committees reflecting the structure and composition of the national committee (NAC-WFCL).

The Indonesian National Commission on Human Rights is an independent state institution. It was formed based on Law No. 39/1999 with a mandate to carry out research and studies, education, monitoring, and mediation of human rights, including children's rights. This commission has wide-ranging legal powers and can send recommendations directly to the President, the Parliament, the House of Representatives and other parties for investigation and dialogue. However, the Commission's recommendations are not legally binding. The Commission also lacks power to enforce the recommendations put forward to companies and enforcement agencies, including to the Attorney General's office.

Another independent state institution responsible for child protection is the Indonesian Commission for Child Protection (*Komisi Perlindungan Anak Indonesia*, KPAI), established based on Presidential Decree No. 77/2003 to facilitate the implementation of the articles of Law 23/2002 on Child Protection. The mandate of this Commission is to conduct dissemination of all the laws and regulations relating to child protection. Responsibilities include: collecting data and information, receiving community complaints, conducting studies, monitoring, evaluation and supervision of programmes and activities relating to the protection of children's rights. The Commission is required to submit reports, advice, input and suggestions to the President. The members of this Commission include representatives of the government, religious figures, community leaders, charitable organizations, community organizations, professional associations, non-government organizations, businesses, and community groups that are concerned with the protection of children. They are appointed and removed by the President, based upon the advice of the Republic of Indonesia's House of Representatives (*Dewan Perwakilan Rakyat*, DPR), for individual terms of three years, and may be reappointed for one additional term (Articles 75 and 75, Law No. 23/2002).

Besides these various government institutions, there are several CSO coalitions, such as JARAK (the network of Indonesian child labour NGOs), the National Coalition against Trafficking of People, and the National Coalition against Sexual Exploitation of Children, that have been actively engaged in the prevention, rescue, care and treatment of victims or survivors, as well as in providing input for national and sectoral policies. During the first and second CRC periodic reporting period, for example, they were actively engaged in writing shadow reports to the UNCRC Committee. The members of these coalitions have also contributed to the development of pilot projects for the elimination of the WFCL. Some of the projects that have been developed are: (1) removing children from work and sending them back to school; (2)

moving children from hazardous work places to safer ones; and (3) providing apprenticeships for certain kinds of work. However, there have always been challenges when it came to replicating the pilot projects on a larger scale.

Given the multi-stakeholder nature of institutions assigned to tackle child labour and child trafficking, including involvement of multiple national ministries, it is not possible to track the trends of budgetary allocations for these efforts. In order to provide a very rough picture of the resources allocated for the 2010–2014 period, Table 5.4 presents the budget for the cross-sectoral action plan on child protection contained in the RPJMN 2010–2014.

5.3.3 Outcomes regarding working children and child labour

One serious obstacle to monitoring the situation of child labour in Indonesia is the lack of standard definitions used across agencies and data sources, including the national data sets. Discussion of child labour issues involves making a distinction between economically

Table 5.4: Cross–sectoral action plan on child protection, National Medium-Term Development Plan 2010–2014

Priority focus/ activities	Indicators	Ministry/ agency	Budget allocation 2010–2014 (billion IDR)
Formulation and harmonization of the policy on protecting women from violence	Percentage of violence victims children being served	Women's Empowerment & Child Protection	50.1
Strengthening relations and foreign policy with countries in East Asia and Pacific	Number of illegal migrants and human trafficking cases being handled	Foreign Affairs	27.8
Strengthening relations and foreign policy with countries in South and Central Asia	Number of illegal migrants and human trafficking cases being handled	Foreign Affairs	18.8
Enhancing efforts for the protection of female labour and the eradication of child labour	Number of children rescued from the worst forms of child labour (WFCL) % of children rescued from the WFCL returned to their education or sent to vocational training % of employees fulfilling working norms for women and children Availability of policy on protection of women and children Number of supervisors responsible for monitoring the working norms for women and children, having capacity building (training)	Manpower & Transmigration	212 58.8
Rehabilitation and social protection for children	Number of neglected children, children living/working on the street, children with disabilities, and children in conflict with the law	Social Affairs	1,717.1
Monitoring and implementation of child protection	Monitoring data on the implementation of child protection at province, district and sub-district levels Number of recommendations on the child protection implementation results	Indonesian Commission for Child Protection (KPAI)	43

Source: Nina Sardjunani, 'Child Protection Policy in the National Medium-Term Development Plan 2010–2014', 2010[11]

[11] As presented at the launching of Centre for Child Protection Studies (Puska PA), 15 December 2010

active or working children or children in the labour market versus those cases that can be categorized as 'child labour'. However, the national data published by BPS – Statistics Indonesia have generally not separated the two categories. Recently, the Indonesian Child Labour Survey or ICLS (BPS – *Statistics Indonesia*, 2009) defined 'working children' as 'children in employment', engaged in any activity falling within the production section in the System of National Accounts (SNA) for at least one hour during the reference time period (usually one week), thus including all children (i.e., under 18 years) in employment regardless of legality, whether paid or unpaid. But in addition, those working children who met the following specific criteria with regard to age and work hours were categorized as 'child labourers':

(i) A working child aged 5–12 years regardless of working hours
(ii) A working child aged 13–14 years who works more than 15 hours per week
(iii) A working child aged 15–17 years who works more than 40 hours per week

The 2009 ICLS found a modest number of working children in Indonesia. The data from this survey, which was conducted by the ILO and BPS – Statistics Indonesia as a sub-sample of the 2009 National Labour Force Survey (SAKERNAS), revealed that out of the total number of children aged 5–17 years, 81.8 per cent (48.1 million) were attending school, 41.2 per cent (24.3 million) were involved in household chores, 11.4 per cent (6.7 million) were considered idle (neither attending school nor involved in paid work or household chores), and 6.9 per cent (4.05 million) were working children. Around 43 per cent of the working children (or around 1.76 million) are categorized as child labour. More than half of those categorized as child labour (57 per cent) worked in the agricultural sector, while 10.4 per cent worked in industry, 19 per cent in trade, and the remaining 5.4 per cent worked in the service sector.

Out of 1.76 million child labourers, the proportion of boys was higher than girls with a ratio of 126:100 (or 61 per cent boys). More than 43 per cent of child labourers worked in hazardous situations, since they had to work for more than 40 hours per week. This figure is worrying since they worked longer than most adults in full-time work, indicating a high prevalence of the worst forms of child labour (WFCL). The average number of child labour working hours was also alarming, at approximately 35.1 hours per week. The sex and age profiles of the child labourers reported by the 2009 ICLS are presented in Table 5.5.

Table 5.5 illustrates that the most common form of child labour is 15- to 17-year-olds who work more than 40 hours a week; this group accounted for 43 per cent of all child labourers (47 per cent of male child labourers and 38 per cent of female child labourers). Children of this age may be physically stronger and more stable mentality than younger children, but the excessive work hours qualify this as 'child labour'. Among female child labourers, the most common form of child labour was between the young ages of 5 and 12 years (46 per cent of female child labourers).

The available time series data revealed mixed trends for working children during the period from 2003/2004 to 2009. Due to the ICLS being conducted only one time (in 2009), it could not be used for a time series analysis. Other national data sets – SUSENAS and SAKERNAS – contain questions regarding the activities, including economic activities, of children aged 10 years old and above, so they can be used to estimate trends in the incidence of working children.[12] However, it should be noted that in SUSENAS, child labour[13] is defined as children aged 10–17 years who participate in:

(i) economic work only
(ii) economic work and household chores
(iii) economic work and school
(iv) economic work, school and household chores

[12] Each data set has different strength and weaknesses. SUSENAS data contains comprehensive sets of information regarding the household attributes so that it can be used to analyze the factors that correlate with the incidence of working children; but it does not have information on the length (working hours) that the children performed. On the other hand, SAKERNAS data has very limited information regarding the household attributes but has information on the working hours of the children so that the child labour definition in ICLS can be applied.

[13] For this chapter, and to avoid confusion, the data estimates from SUSENAS and SAKERNAS is using the term 'working children' to refer to children involved in paid and unpaid economic work. Whilst, child labour cannot be estimated from the SUSENAS since there were no data on working hours.

Table 5.5: Estimated number of child labourers by category and gender, 2009 (in thousands)

Category of child labour based on age and work hours	Boys	Girls	Total
All working children aged 5–12 years (any hours)	320.1 33%	354.2 46%	674.3 38%
Working children aged 13–14 years who work > 15 hours per week	193.4 20%	127.8 16%	321.2 18%
Working children aged 15–17 years who work > 40 hours per week	463.6 47%	296.3 38%	759.8 43%
Total child labour	977.1 100%	778.2 100%	1,775.30 100%

Source: Indonesia Child Labour Survey (ICLS), 2009

The analyses using data from the SUSENAS and SAKERNAS revealed different trends for working children (Table 5.6). The SAKERNAS data uncovers a slight but increasing trend in the combined rates of working children between the years 2004 and 2009, with an average annual growth rate of 3.78 per cent (and also a slight increase in child labour). Meanwhile, the SUSENAS data for 2003 and 2009 indicate a declining trend, with an average annual decline of 2.37 per cent. Further examination of the data shows that the difference is due to the variation in the change over time of children's involvement in multiple activities (economic work plus school and/or domestic chores), which showed greater increases according to the SAKERNAS data, while there was not such a great difference between the datasets in terms of the declining trends of children involved purely in economic work (no school or domestic chores). Taken together, these datasets underline the importance of addressing the increasing trend for children who are still attending school to be involved in economic and domestic work also, making them more vulnerable to dropping out of school.

Although the SUSENAS data could not provide answers as to why children went to work, the characteristics associated with child labour as presented in Table 5.7 indicate several issues. Among the various potential determinants of working children, level of household wealth clearly has the strongest correlation. The likelihood of children in the poorest economic quintiles being involved in economic work outside of the household was three times higher than among children in the richest quintile.

Male gender of the head of the household is also associated with a prevalence of working children; the proportion of working children in female-headed households was six times lower than in male-headed households. However, household

Table 5.6: Work activities of children aged 10–17 years, 2003 and 2009 (%)

Activity	Based on SUSENAS			Based on SAKERNAS		
	2003	2009	Average annual change (%)	2004	2009	Average annual change (%)
Economic work only	6.98	4.58	-5.7	4.44	2.18	-10.2
Economic work and household chores	2.27	2.25	-0.1	1.97	3.38	14.3
Economic work and schooling	2.08	2.09	0.1	1.81	3.52	18.9
Economic work, household chores and schooling	0.92	1.59	12.1	0.49	1.29	32.7
Working children (total)	12.25	10.51	-2.4	8.72	10.37	3.8
Child labour *	n/a	n/a	n/a	4.23	4.71	2.3

Source: Estimated using data from the 2003 and 2009 SUSENAS (National Socio-Economic Survey), and the 2004 and 2009 SAKERNAS (National Labour Force Survey)

*Note: * based on the ILO definition used in the 2009 ICLS; child labour cannot be estimated from the SUSENAS since there were no data on working hours.*

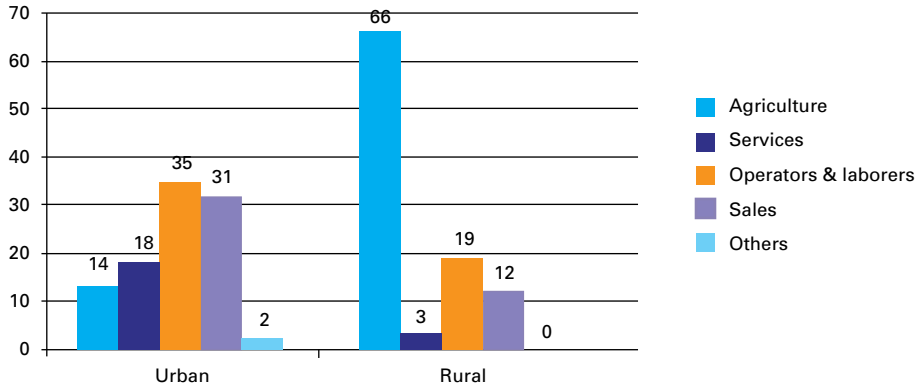
size and education level of household head also played a role. The prevalence of child poverty decreased with higher education level of the household head (Table 5.7). It is also important to note the remaining urban/rural gaps in the incidence of working children. The proportion of working children in rural areas was twice as high as in urban areas. With regard to the different types or sectors of labour that children are involved in, as depicted in Figure 5.4, most working children in rural areas are working in the agricultural sector, while those in urban areas are mostly working as labourers or as sales persons.

Comparing rates of working children among provinces in Indonesia reveals severe disparities, as shown by Figure 5.5. The province of Papua had the highest rate by far with around 16.12 per cent of children aged 10–17 years engaged in economic work. Meanwhile, at the other end of the scale, only 0.94 per cent of children of the same age in the province of North Sulawesi are working children. The ILO-EAST[14] rapid assessment in 2009 (ILO, 2011) uncovered a strong association between being poor and being a member of an indigenous ethnic group. Indigenous peoples suffer from a lack of physical and non-physical access to education, have inadequate awareness of the impacts of child labour, and limited knowledge of children's rights. These are identified as the main reasons for the high rates of working children in Papua.

In addition, the qualitative case study in East Sumba indicated the possible influence of local customs as a factor related to work among children. In East Sumba, a set of values in society supports the local belief among parents that work is not harmful for children and that children should contribute to family income by working. The proportion of children working in unpaid and paid jobs was approximately equal, since most children in East Sumba were involved in family businesses or domestic chores. Most children who performed economic work received only negligible pay since not many jobs were available to them. Most of them obtained jobs as shop assistants or domestic workers.

It is interesting to compare the burden of unpaid work or domestic chores performed by boys and girls. Girls in East Sumba carried out several chores in their family households and gardens. On the other hand, boys were only ordered to take care of the family animals, if they possessed any. Furthermore, the study revealed that local cultural norms dictated that girls should do this type of work to help their mothers and,

Figure 5.4: Type of work among all working children in urban and rural areas, 2009 (%)



Source: BPS – Statistics Indonesia and ILO, 2009 (based on SAKERNAS data)

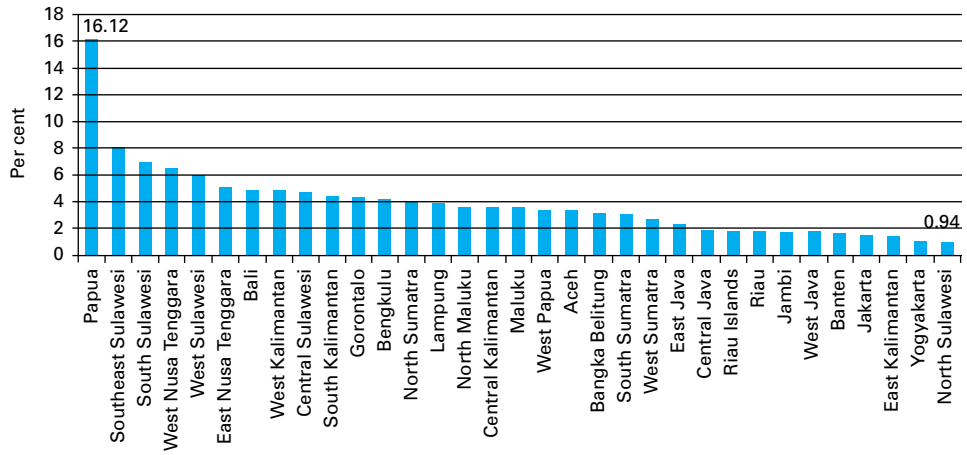
[14] ILO – EAST (Education and Skills Training for Youth Employment in Indonesia) is an ILO project aiming at improving employability and entrepreneurship of young people, as well as contributing to the elimination of child labour.

Table 5.7: Working children by characteristics, 2009 (%)

Characteristics	Age 9–14 years*				Age 10–17 years
	Total		Economic work outside household (% of total)		
Total incidence	3.2		46.36		6.67
Individual dimension					
Sex and age*	**Male**	**Female**	**Male**	**Female**	
Age 9–14	3.13	3.27	72.1	25.2	
Age group 3 (9–10)	0.62	0.58	48.16	43.4	
Age group 4 (11–12)	1.63	1.81	72.34	16.52	
Age group 5 (13–14)	5.99	6.06	73.44	26.59	
Household dimension					
Household size					
Less than 3	4.55		40.43		17.57
3–4 members	2.71		49.07		9.04
5–6 members	3.11		44.68		10.37
7+	4.53		45.86		13.38
Gender of the head of household					
Male	3.1		45.77		34.78
Female	4.27		51.24		5.04
Wealth index quintiles					
Q1 (poorest)	6.17		46.38		15.16
Q2	3.52		48.6		11.02
Q3	2.36		43.57		9.35
Q4	1.77		42.32		7.18
Q5	1.08		51.74		8.3
Residence					
Urban	1.95		37.86		6.89
Rural	4.22		49.57		13.72
Work (not mutually exclusive categories)					
Both parents working	3.4		50.38		
Neither parent working	1.9		27.19		
No adult in primary working age (18–54 years)	4.89		59.61		
At least one child under 15 working	99.77		90.1		
Illness and disability in the household					
Child/children with disability	1.52		39.01		
High dependency ratio (4+ children per adult)	3.94		45.58		
Elder (70+) person in household	7.6		48.27		
Mother's education					
None	6.77		17.9		
Primary	3.15		19.69		
Secondary+	1.42		25.31		
Education level of the household head					
Never attended/did not finish primary school					16.5
Finished primary school					10.89
Finished junior secondary school					8.1
Finished senior secondary school					5.08
Finished diploma/academy/university					6.02

*Note: * The SUSENAS only documented the working activity of children aged 10 years and above*
Source: Estimated using data from the 2009 SUSENAS (Panel)

Figure 5.5: Proportion of children aged 10–17 years who are working, by province, 2009



Source: Estimated using data from the 2009 SUSENAS

moreover, that girls did not mind doing it. This child labour situation in East Sumba may be found elsewhere in Indonesia.

5.3.4 Recommendations

The GoI has implemented various programmes to address child labour including many within the framework of the National Action Plan for the elimination of the worst forms of child labour (WFCL). Despite some challenges in terms of the availability of data and non-standard definition of terms, there are some indications of a decrease in the number of child labourers. The number of working children who perform economic work only is decreasing but unfortunately the number of children who perform multiple activities (economic work in addition to school and/or domestic chores) is increasing. The implementation of all programmes on child labour still faces the problem of inadequate support from other stakeholders in society.

To overcome this situation, on the supply side, the government should conduct the following activities:

1. Pay more attention to the issue of children who perform multiple activities: This phenomenon requires holistic, multi–pronged interventions focusing on efforts to keep children at school (prevent them dropping out) while also providing household assistance to families to help reduce the 'push factor' of poverty which forces many children to engage in paid and unpaid work.
2. Improve data collection: Data collected should be more specific, including data on child labor and the worst form of child labor, and should accommodate the ILO definition of child labour.
3. Increase efforts to strengthen the resilience and economic foundation of families.
4. Increase enforcement of the current and future legal framework to protect children from involvement in child labour, especially the WFCL.
5. Increase coordination among government institutions as well as with non-government organizations and informal leaders to prevent children from engaging in hazardous work.

On the demand side, the phenomenon of working children involves both push and pull factors. Children living in unpleasant family conditions, such as when there is domestic violence, divorce, poverty, unemployment and/or lack of parental supervision, may be seeking a way to remove themselves from the household into a different environment, and thus these family problems act as push factors, pushing the children out to seek other activities and a source of income. Meanwhile, the existence

of opportunities and the supply of jobs for children act as pull factors, luring them in. Children who succumb to these push and pull factors, who enter the world of work at a young age, will tend not to continue their education to a higher level (junior to senior secondary school). One alternative solution is to provide an unconditional cash transfer programme directed at preventing children from engaging in child labour. Bazzi, Sumarto and Suryahadi (2010), for example, found that the number of child labourers decreased in the households that received unconditional cash transfers (see Chapter 6, section 6.4).

5.4 Violence against children

5.4.1 Regulatory framework, policies and programmes

The GoI has issued several laws and regulations to protect children from violent acts. Among the first laws to stipulate a child's right to such protection was Law No. 39/1999 on Human Rights. Article 58 of this Law states, "Every child is entitled to receive legal protection from every form of physical and mental abuse, neglect, and sexual violence while under the care of their biological parents or caregivers who are responsible for the child's well-being." Article 65 of the Law also stipulates that every child is entitled to receive protection from exploitative acts and sexual abuse, kidnapping, child trafficking, and from the misuse of narcotics, as well as psychotropic and other destructive drugs. Then, in 2004, the GoI issued Law No. 23/2004 on the Elimination of Domestic Violence *(Penghapusan Kekerasan dalam Rumah Tangga)*, aimed at eliminating acts of violence within the household, includes husbands, wives, children, and people possessing a work or family relationship to the household (Article 2). Preventative aspects of the Law include the prohibition of physical violence, psychological violence, sexual violence and neglect (Article 5), but this Law also indicates sanctions for the perpetrators of each specified form of violence (Articles 44–49).

In 2007, Law No. 21/2007 on Anti-Trafficking *(Pemberantasan Tindak Pidana Perdagangan Orang)* was issued. This law is directed at preventing people, especially women and children, from becoming trapped in various forms of modern slavery. The use of violence and threats of violence have been identified as common elements of trafficking techniques, causing the loss or restriction of individual freedoms and creating fear (Article 1). In addition, the provision of protection for children who are victims of violence is also included in Law No. 44/2008 on Pornography, which obliged the government, social agencies, educational institutions, religious institutions, families and/or communities to conduct coaching, mentoring and social rehabilitation for the physical and mental health of every child victim and pornography perpetrator, under Article 16, clause 1.

Another relevant law is Law No. 11/2009 on Social Welfare, which requires social rehabilitation for victims of violence to be conducted, in the forms of motivation and psycho-social diagnostics, caring and nurturing, vocational training and entrepreneurship development, mental/spiritual guidance, physical guidance, social guidance and psycho-social counseling, accessibility services, social assistance, re-socialization guidance, further guidance and referral, as needed (Article 7, clause 3). Consequently, the GoI revised the Health Law (Law No. 39/2009), which now guarantees the provision of protection for every infant and child from all forms of discrimination and violence that could be detrimental to their health (Article 133, clauses 1 and 2).

To guide programme development and implementation, the 2015 National Programme for Indonesian Children (*Program Nasional Bagi Anak Indonesia*, PNBAI) set four general targets for combating violence against children, namely: (1) prevention of abuse and exploitation of children; (2) establishment and enforcement of legal protection for children; (3) recovery and social reintegration for child survivors; (4) strengthened coordination and cooperation; and, (5) enhanced child participation. In addition, the

document highlights some methods that have been used to monitor and assess the trends, including: a 2006 national survey on violence against women and children; documentation of cases of violence managed at public hospitals; establishment of 'Comprehensive Service Centres for Women's and Children's Empowerment'[15] in every province of Indonesia and special units within police departments in all municipalities and cities in Indonesia; establishment of a children's hotline called Telepon Sahabat Anak 129 (Friend of Children Telephone 129, known as 'TESA 129'), which is being tested in the four major cities of Banda Aceh, Jakarta, Surabaya and Makassar.

In strengthening the provision of services to the survivors of violence against women and children, in October 2002 the MoWE&CP, the MoSA, the MoH and the Head of the Indonesian National Police announced a joint decree for the provision of such services (Peddle and Suharto, 2009, p. 9).[16] To respond to the needs of victims of violence, in 2006, the GoI also released Government Regulation No. 4/2006 on the Partnership for Rehabilitation of Victims of Domestic Violence *(Penyelenggaraan dan Kerjasama Pemulihan Korban Kekerasan Dalam Rumah Tangga)*, which involved health-care providers, social workers, volunteer assistants and spiritual advisers. The regulation also formalizes cooperation arrangements between the relevant central and local government institutions - including: the MoSA, the MoH, the MoWE&CP, the Indonesian National Police, governors, lawyers, the National Commission on Violence Against Women *(Komnas Perempuan)*, the Indonesian Commission for Child Protection (KPAI), and other law enforcement personnel - in order to assist victims during legal trials,. In this regard, the Indonesian police is mandated to provide special service rooms for witnesses and survivors of human trafficking at the provincial level (by regional police station - POLDA) and at district/city levels (by greater urban city/city police station, or by district police station) as emphasized in Article 45 of the Anti-Trafficking Law (Law No. 21/2007).

In order to strengthen the support from provincial and district governments, the MoWE&CP issued minimum service standards for women and children as victims of violence in January 2010 through Ministerial Regulation No. 1/2010.[17] This regulation was the implementation of Article 3 of Government Regulation No. 4/2006, and it aimed to guide the central and local governments in organizing integrated services for women and children victims of violence (Article 2). Those integrated services included service complaints/reports, health care, social rehabilitation, law enforcement and legal assistance, and repatriation and social reintegration (Article 5).

In regard to human trafficking, the GoI issued Presidential Decree No. 88/2002 on the Elimination of Trafficking of Children and Women, which outlined an ambitious set of programmes in the form of the National Plan of Action for the Elimination of Trafficking of Children and Women (known as 'RAN P3A'). In addition, Presidential Decree No. 87/2002 on the Elimination of Sexual Exploitation of Children set out the National Plan of Action for the Elimination of Sexual Exploitation of Children (known as 'RAN PESKA'). These decrees were then replaced by the Decree of the Coordinating Ministry for Community Welfare No. 25/KEP/MENKO/KESRA/IX/2009 on the National Action Plan for Combating the Crimes of Human Trafficking and Sexual Exploitation of Children.

Additionally, in order to maximize and enhance the coordination among ministries in tackling human trafficking, the GoI has issued Presidential Decree No. 69/2008, which stipulates the establishment of a Task Force of Prevention and Law Enforcement regarding Trafficking. The Coordinating Minister of Social Welfare was

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15 *Pusat Pemberdayaan Perempuan dan Anak*, P2TP2A

16 Joint Decree among: Ministry of Women's Empowerment, Ministry of Social Affairs, Ministry of Health and the Head of the Indonesian National Police (No. 14/Men.PP/Dep.V/X/2002, No. 1329/MENKES/SKB/X/2002, No.75/Huk/2002, No. Pol B/3048/X/2002) on Integrated Services for Victims of Violence against Women and Children.

17 Ministry of Women's Empowerment and Child Protection Regulation No. 1/2010 on the Minimum Service Standards in the Integrated Services Sector for Women and Children Victims of Violence *(Standard Pelayanan Minimal Bidang Layanan Terpadu Bagi Perempuan dan Anak Korban Kekerasan)*.

appointed as the chairperson and the Minister for Women's Empowerment and Child Protection was appointed as the deputy chairperson for the Task Force. At the central level, the Task Force consists of 14 ministers, the National Police Chief, the Head of the Supreme Court, the Head of the National Agency for the Placement and Protection of Indonesian Migrant Workers (BNP2TKI), the Head of the National Intelligence Board (BIN), and the Head of BPS – Statistics Indonesia.

5.4.2 Institutional setting and budget

Services that address violence against children are delivered by a variety of ministries, the National Police Force, local government agencies, and also non government parties. Until 2009, there was no single government agency which had overall authority to coordinate and implement services directed prevention and care for children victims of violence, abuse and exploitation. The responsibility to provide these services was spread among various institutions at the national, provincial, district and sub-district levels (*Kementrian Sosial* and UNICEF 2010, p. 30). Decentralization has caused the MoSA to have limited influence in implementing child protection mechanisms at the provincial level. Furthermore, MoSA has low capacity in monitoring and supervising child and family welfare services at the local level (*Kementrian Sosial* and UNICEF, 2010, p. 33).

In general, services for children victims of violence were conducted through integrated services unit both at the central and local levels, located in various places such as at the Integrated Services Centres or Integrated Crisis Centres (*Pusat Pelayanan Terpadu*, PPT or *Pusat Krisis Terpadu*, PKT), at the Integrated Service Centres for the Empowerment of Women and Children (*Pusat Pemberdayaan Perempuan dan Anak*, P2TP2A), at the Women's and Children's Service Unit (*Unit Pelayanan Perempuan dan Anak*, UPPA), at the Trauma and Healing Centres (*Rumah Perlindungan Trauma Centre*, RPTC), or at Social Protection Homes for Children (*Rumah Perlindungan Sosial Anak*, RPSA).

The establishment of the Pusat Pelayanan Terpadu (PPT or Integrated Service Centres) for witnesses and victims of human trafficking was regulated in Government Regulation No. 9/2008.[18] The PPT was designed to provide convenient, comfortable, safe and cost-free services to witnesses and victims of human trafficking in every district/city (*kabupaten/kota*). However, establishment of the PPT needed supportive local regulations in order to fulfil the mandate (Articles 2 and 6). To guarantee the service quality of the PPT, the MoWE&CP was responsible for creating appropriate minimum service standards and standard operational procedures. In 2009, the Ministry supplied these through Ministerial Regulation No. 1/2009.

The PPT are generally located at police hospitals, although there were some at public hospitals (known as PKT, Integrated Crisis Centres). Prior to 2009, there were 38 PPT at police hospitals and 20 PKT at public hospitals in Indonesia. The PPT/PKT are the main service delivery points providing protection and support for children victims of violence, abuse and exploitation. The types of services provided there include: medical care, legal aid, temporary shelter and counseling for children and adults who are victims of violence and exploitation (*Kementrian Sosial* and UNICEF, 2010, pp. 39–40). The Ministry of Health also intends to install at least two *puskesmas* (community health centres) at *kabupaten/kota* level capable of managing cases of violence against children, with the target of covering at least 90 per cent of *kabupaten/kota* by 2014 (*Rencana Strategis Kementerian Kesehatan* 2010–2014, 2010, p. 65).

The Social Protection Homes for Children (RPSA) are social welfare centres for children deprived of caring and nurturing within their families.

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[18] Government Regulation No. 9/2008 on the Mechanisms and Procedures for the Provision of Integrated Services to Witnesses and Victims of Human Trafficking *(Tata Cara dan Mekanisme Pelayanan Terpadu Bagi Saksi dan/atau Korban Tindak Pidana Perdagangan Orang)* is the implementing regulation in support of Article 46 of the Anti-Trafficking Law No. 21/2007.

Prior to 2009, there were 15 RPSA units spread over 13 provinces,[19] consisting of of 7 managed by the Provincial Social Service, 1 managed by the community (RPSA Muhammadiyah Bandung), and 7 managed by the Ministry of Social Affairs (*Kementrian Sosial, 'Rencana Strategis Kementerian Sosial* 2010–2014', 2010, pp. 8–9). Based on the Guidelines for Child Nurturing, which were released by the Ministry of Home Affairs in 2004, the protection houses (RPSA) were divided into temporary stay (maximum 30-day stay) and long-term stay (maximum 6-month stay), with a capacity of 30–100 children per RPSA. The guidelines were not explicitly designed to handle reunification of children and their families or to support and further supervise children once they had left the RPSA. But the guidelines did require each RPSA to have a referral unit responsible for the identification and preparation of the child's own family or a foster family to receive the child, and to monitor children following their departure from the RPSA (Kementrian Sosial and UNICEF, 2010, p. 21–22).

Women's empowerment offices in each province were established and authorized to provide protection for the rights of children, but the role of these institutions was generally to focus on the coordination functions and they did not have the staff or structure to implement service provision or programme execution. However, the initiative at the national level had encouraged women's empowerment offices at the provincial level to take responsibility for funding and supervising PPT/PKT (Integrated Service/Crisis Centres) for women and children as victims of violence (*Kementrian Sosial* and UNICEF, 2010, p. 39). Until June 2009, there were 92 Integrated Service Centres for the Empowerment of Women and Children (P2TP2A) located at both the provincial and *kabupaten/kota* levels (*Kementrian Negara Pemberdayaan Perempuan*, 2009). P2TP2A are located at offices of the bureau of community empowerment, women's empowerment, and family planning or other similar programme units at provincial and *kabupaten/kota* level.

Special Services Rooms (RPK) have been established at police stations since 1999 to handle cases of violence against women and children. On 6 July 2007, the name RPK was changed to Women and Children's Service Unit (*Unit Pelayanan Perempuan dan Anak*, UPPA) based on Police Regulation No. Pol.: 10, 2007. Prior to 2010, there were 300 UPPA at the provincial level (POLDA or Regional Police Station) and *kabupaten/kota* level (POLRES). The service procedures at the UPPA begin with the receipt of a report either on site or by a call system, the provision of counseling, the referral of the victim to the PPT, case investigation, guarantee of security and safety for those who make reports and for victims, referral of victims to legal aid institutes or safe houses if necessary, and follow-up of the case by coordination with prosecutors and courts (UPPA, 2010).

The government also initiated a nationwide hotline for children called 'Telepon Sahabat Anak 129' or 'TESA 129', on 21 July 2006. This was an office-hours hotline available with a toll-free number (129) from anywhere in the country, for children who needed protection, were in emergency situations, or were seeking consultation. TESA 129 was an adaptation of the international project called Child Helpline that has operated in more than 77 countries around the world. TESA 129 was a joint effort involving the government, the private sector and NGOs. It ran based on a Memorandum of Understanding signed by the Ministry of Social Affairs, the Ministry of Women's Empowerment and Child Protection, the Ministry of Communication and Information, P.T. Telkom Indonesia Ltd. and Plan Indonesia. Prior to 2009, TESA 129 operated only in major capital cities across Indonesia, including national capital, Jakarta, Banda Aceh (Aceh Province), Makassar (South Sulawesi), Surabaya

[19] West Java Province (RPSA Muhammadiyah Bandung), Central Java Province (RPSA Antasena Mangelang, RPSA Ungaran, and RPSA Baturaden), East Java Province (RPSA Batu), DI Yogyakarta Province (RPSA Yogyakarta), Nanggroe Aceh Darussalam Province (RPSA Aceh), Lampung Province (RPSA Lampung), Jambi Province (RPSA Jambi), DKI Jakarta Province (RPSA Bampu Apus), West Nusa Tenggara Province (RPSA Paramitha NTB), East Nusa Tenggara Province (RPSA Naibonat NTT), West Kalimantan Province (RPSA Kalimantan Barat), East Kalimantan Province (RPSA Samarinda Kaltim) and South Sulawesi Province (RPSA Turikale Kota Makassar).

(East Java) and Pontianak (West Kalimantan) (*Layanan Telepon Sahabat Anak*/TESA 129, 2009). Indeed, critics of this facility have pointed out that it is not connected to the institutions responsible for conducting follow-up action, thus limiting its effectiveness.[20]

Allocations of funding for protection of children from violence for 2006–2009 are documented in the Government Work-Plan (*Rencana Strategis Pemerintah*, RKP) and the annual national revenue and expenditure budget (APBN). The RKP document identifies the ministries or institutions responsible for programme implementation and outlines the activities and their targets. The national budget explains the final allocation of funds for programmes. Analysis of RKP documents for the years 2006–2009 shows that there were two major institutions charged with the protection of children from acts of violence: the Ministry for Women's Empowerment and Child Protection and the Ministry of Social Affairs.

The ministry charged with implementation of the Social Welfare Rehabilitation and Services Programme was the Ministry of Social Affairs (see No. 1 in Table 5.8), while the three other programmes listed in Table 5.8 were implemented by the Ministry for Women's Empowerment and Child Protection.

One of the activities of the Social Welfare Rehabilitation and Services programme was to develop and provide social and legal protection for victims of exploitation, trafficking of women and children, and violence. One of the target indicators was the financing of Technical Implementation Units (*Unit Pelaksana Teknis*, UPT) of the Ministry of Social Affairs. The RPSA (social protection homes for children, discussed earlier in this section) are one type of UPT related to the handling of child victims of violence.

In 2006, one of the activities financed by the Child Protection and Child Welfare Improvement programme was strengthening institutions and networks in order to abolish violence against children (RKP 2006). In subsequent years (2007–2009), this programme focused on strengthening child-friendly aspects of policy and legal systems so that children would have protection from various forms of violence (*Rencana Strategis Kementerian Pemberdayaan Perempuan* 2007–2009, p. 17), and on institutional strengthening for regional offices of the Indonesian Child Protection Commission at the provincial or *kabupaten/kota* level (RKP 2007, 2008 and 2009).

One focus of the Strengthening of Gender and Children's Mainstreaming Institutions programme during the years 2006–2009 was the establishment of P2TP2A (Integrated Service Centres for Women's and Children's Empowerment) at the provincial and *kabupaten/kota* levels (RKP 2006–2009).

One of the activities of the Improving Women's Protection and Quality of Life programme was financing RPK (Special Services Rooms) at police stations, and PPT (Integrated Service Centres) at hospitals or other community-based locations.

Table 5.8: Budget for protection of children from acts of violence, 2006–2009

		Allocation (IDR millions)			
No	**Name of programmes**	**2006**	**2007**	**2008**	**2009**
1	Social Welfare Rehabilitation and Services	593,587	528,913	528,098	533,444
2	Child Protection and Child Welfare Improvement	5,750	8,500	12,440	13,079
3	Strengthening of Gender and Children's Mainstreaming Institutions	89,320	110,910	104,041	76,493
4	Improving Women's Protection and Quality of Life	14,319	16,315	n/a	11,212

Source: Government Work-Plan (RKP), 2006–2009

[20] This critic was raised by one of the participants of an FGD conducted in 29 September 2010

Moreover, the development of community-based and hospital-based PPT continued at the provincial and *kabupaten/kota* levels in accordance with the Ministry for Women's Empowerment and Child Protection's Strategic Plan 2007–2009.

5.4.3 Outcomes regarding protecting children from violence

The major challenge in assessing the progress of efforts to protect children from violent acts lies in the lack of data. National statistics on this topic simply do not exist and most available data are based on case reports and small studies with limited scope. The only national database that contains relevant indicators is the SUSENAS, since the survey asks questions about child exposure to criminal acts; but this only represents a small fraction of the violent acts involving children. According to reports received in 2008 and 2009 by the National Commission for Child Protection, perpetrators of violence against children derived from all social strata, religions, ethnicities and races. Violence against children typically occurred in everyday children's environments including households, schools, other educational institutions, and children's social environments (*Komisi Nasional Perlindungan Anak*, 2009, p. 2).

Based on the 2007 and 2009 SUSENAS, the number of children who were victims of criminal acts decreased from 2,226,021 cases in 2007 to 424,348 cases in 2009 (Table 5.9). However, in 2009 only 14.9 per cent of these cases were reported to the police, which explains the under-reporting of cases in police records. The most commonly reported criminal acts against children were cases of robbery, experienced by 2.32 per cent of SUSENAS respondents in 2007, and 0.27 per cent in 2009.

Meanwhile, data from the National Commission for Child Protection *(Komisi Nasional Perlindungan Anak)* showed that in 2008 there were 1,736 reported cases of violence against children, and 1,998 cases in 2009 (*Komisi Nasional Perlindungan Anak*, 2009, p. 2). During January–June 2010, the total number of reported cases was 1,649, including 453 cases of physical violence, 646 cases of sexual violence and 550 cases of psychological violence. The increased number of reports of violence against children is believed to be a sign of increased community awareness in reporting local cases of violence against children (*Komisi Nasional Perlindungan Anak*, 2009, p. 2). However, it is widely recognized that these figures do not depict the true magnitude of cases of violence against children, most of which still presumably go unreported.

Violence against children living or working on the street is likely to be statistically invisible because it is not being covered in any national surveys and censuses. Children living or working on the street are highly vulnerable to becoming victims of extortion by thugs *(preman)* who take advantage of the physical weakness of these

Table 5.9: Child victims of criminal acts, 2007 and 2009

Criminal acts against children	2007			2009		
	Number of children	% of children	% of victims	Number of children	% of children	% of victims
Theft	241,374	0.31	10.84	147,043	0.18	34.65
Robbery	1,830,723	2.32	82.24	217,344	0.27	51.22
Murder	64,009	0.08	2.88	1,114	-	0.26
Fraud	17,333	0.02	0.78	13,373	0.02	3.15
Rape	n/a	n/a	n/a	773	-	0.18
Others	72,582	0.09	3.26	44,701	0.06	10.53
No criminal acts	76,656,633	97.18		79,305,476	99.47	
Reported to the Police	-	-	-	63,592	14.90	14.99
Did not report to the Police	-	-	-	360,756	85.01	85.01

Source: 2007 and 2009 SUSENAS

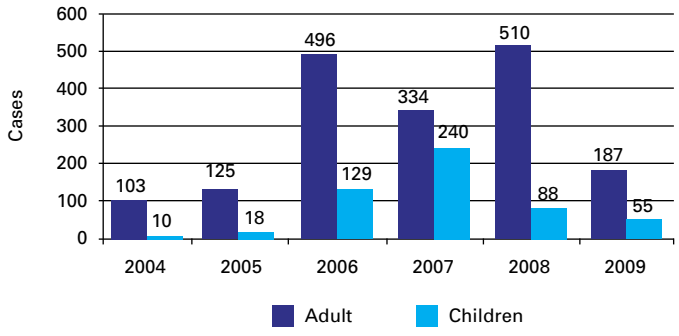
children. This situation is generally accepted as the rule of streets for these children. As the children living or working on the street become older and stronger, they begin to extort the younger children in the same way that they themselves had been victimized in the past. This vicious cycle could be stopped if the children were kept off the streets and provided with a safe place to stay in a *panti* (childcare institution).

Domestic violence against children is also often described as being related to disobedience. Based on a qualitative study in North Jakarta, parents usually punished children by pinching, flicking or hitting them on a non-vital part of their body. The parents considered these acts to be a normal way of dealing with mischief. This was a punishment more commonly experienced by boys. In East Sumba, parents gave so-called 'loving punishment' in the form of slaps, threats, twisting children's ears, or pinching their hands or feet, in order to discipline their children. Some parents also admitted that they often hit their children's legs using a hose or a small tree branch. Some participants at the children's focus group discussions in East Sumba mentioned that they were often beaten or pinched by their older siblings if they were lazy in doing their daily chores. They also acknowledged often hitting or pinching their younger sisters siblings if they were naughty or refused to do chores.

The experience of being victims of violence caused the children to tend to replicate the same violent behaviour as a way of responding to a similar situation at another time. The consequence was that the victims and perpetrators were the same people. As revealed during the qualitative study in North Jakarta, a boy was sexually victimized by another boy who had previously been sexually abused by his neighbour. The data from North Jakarta also confirmed that perpetrators of criminal acts against children are sometimes close to the victim and well-known to them. In the precinct of Kalibaru, there was a father who forced his daughter to become a commercial sex worker because of the financial crisis. In the precinct of Rawa Badak Selatan, a father tried to sexually assault his own stepdaughter. The victim managed to escape the attempted rape by hiding in her uncle's house. These examples indicate that a comprehensive approach is needed to address violence against children.

Tracking the performance of efforts to eliminate child trafficking faces problems similar to monitoring violence against children in general, since reliable data on trafficked children are lacking. The only estimates that are available are compiled by the Indonesian National Police and the International Organization of Migration (IOM). Data from the National Police indicate an upward trend in reported child trafficking cases across the country between 2004 and 2009. In 2004, there were only 10 reported cases of child trafficking; the following year this figure reached 18 and in 2006 and 2007, the numbers rose

Figure 5.6: Reported human trafficking cases in Indonesia, 2004–2009



Source: Indonesia Police Force in MoWE&CP's Kertas Kebijakan *[Policy Paper] 8, 2011*

significantly, reaching 129 and 240, respectively, before declining again in 2008 and 2009, but remaining well above the 2004 level (Figure 5.6). The Police believed that there were more cases that were not reported for various reasons.

Data from the Indonesian National Police are corroborated by data from IOM Indonesia, which showed even higher numbers of child trafficking cases across the country. From March 2005 to June 2010 there were alarming signs of an increasing number of cases of victims of child trafficking in Indonesia. This was highlighted by the fact that out of 3,785 victims of trafficking, 890 or almost 25 per cent of them were children, and 88 per cent of these children were girls. Around 40 per cent of trafficked children originate from West Java and West Kalimantan; relatively poor provinces. The main domestic destinations were Riau and Jakarta. The reason behind 88 per cent of all trafficking cases was to resolve economic problems and seek employment. A desire to avoid the poverty trap by seeking employment and a better life outside their provinces, combined with low levels of education (only 64 per cent possessed elementary to junior secondary school levels of education), meant that victims were often taken advantage of and manipulated. This was highlighted by the fact that around 17 per cent of all trafficked victims were initially promised decent jobs but ended up as sex workers (IOM, 2010).

The many negative effects of child trafficking are evident, particularly in relation to physical and psychological damage. Many children contracted sexually transmitted infections, ranging from syphilis to HIV. Around 3 per cent of the trafficked children acquired HIV, while more than 50 per cent of them tested positive for chlamydia. While some infections were treatable, psychological damage was harder to cure. The IOM reports that 75 per cent of trafficked children showed symptoms of depression, while 58 per cent of them showed symptoms of anxiety. Moreover, 11 per cent of them had tried to commit suicide (IOM, 2010). These symptoms are likely to impair a child's mental and cognitive functions due to difficulties in concentrating, which will have a negative impact on their future ability to successfully participate in society.

5.4.4 Recommendations

The GoI has initiated various policies and programmes to reduce violence against children, mostly based on strategies to reduce domestic violence. The available data, however, rely on reported cases, such that they are subject to vast under-reporting and of limited use for assessing or monitoring the true situation. The following further efforts are needed:

1 Increase the number of institutions that manage cases of violence against children at the provincial and district level, namely RPSA (social protection houses for children), PPT/PKT (integrated services/crisis centres), P2TP2A (integrated service centres for the empowerment of women and children), Unit PPA (women's and children's service units at police stations), and TESA 129 (child-friendly hotline).

2 Enhance the capacity of the relevant institutions, not only for reporting and for service provision but also for preventative action, including monitoring and educating populations of vulnerable children who are at risk of becoming victims of violence acts.

3 Use proven methods to gather reliable information on the scope and magnitude of violence against children (including children living or working on the street) and child trafficking, to establish prevalence of the problem, and identify factors associated with increases or reduced risk.

4 Use the data on risk and protective factors to develop effective social awareness-raising and behaviour changing interventions.

5 Review the role of social workers within the social welfare system as part of a broader 'child protection system' to provide primary and secondary prevention services through partnerships and tertiary services for prevention and care services.

5.5 Children outside of parental care

5.5.1 Regulatory framework, policies and programmes

Children, because of their physical and mental immaturity, require care from adults. Consequently, parents and families have a role that is central to fulfilling children's rights, as stated in the Convention on the Rights of the Child (CRC).[21] However, sometimes, for various reasons, parents and families are unable to fulfill this function of care, such that children are neglected, unprotected or even exploited. In such cases, the state's obligation to provide alternative childcare is stipulated in Article 20 of the CRC. The article states that a child who is temporarily or permanently deprived of his or her family environment, or in whose own best interests cannot be allowed to remain in that environment, shall be entitled to special protection and assistance provided by the state. The article also mentions various forms of alternative care including, inter alia, foster placement (known as kafalah under Islamic law), adoption, or if necessary placement in suitable childcare institutions. Childcare institutions, commonly referred to as *'panti* social *asuhan anak'* or *'panti asuhan'* or simply '*panti*' in Indonesia, have a broad role, not only accommodating orphaned children, but also other children who have been deprived of their family environment for some reason. The importance of childcare institutions as one form of alternative care was reinforced in Article 35 of Law No. 11/2009 on Social Welfare, which states that childcare institutions are one type of facility for the provision of social welfare services.[22]

With reference to the Minister of Social Affairs Decree No. 15 A/HUK/2010, the Ministry of Social Affairs has recently implemented the Social Welfare Programme for Children (PKSA), applying a new paradigm for childcare policies that emphasizes the roles and responsibilities of the family and community. In line with the new paradigm for childcare policies, and as part of efforts to encourage the transformation of the role of the *panti asuhan* to become a service centre for children and families, with the term officially changed by the Ministry to 'children's social welfare institution' (*Lembaga Kesejahteraan Sosial Anak*, LKSA). The new paradigm focuses efforts on providing support and social assistance as needed to families to help them care adequately for their children, to fulfil the basic rights their children may have been deprived of. However, if these efforts are unsuccessful, out-of-home family-based care was the next alternative considered before removing children to a childcare institution. The Social Welfare Programme for Children (PKSA) was also referred to in Presidential Instruction No. 1/2010 on Accelerating the Implementation of the 2010 National Development Priorities, which stated that child protection was one of the priorities of the national development agenda. This was also reinforced by Presidential Instruction No. 3/2010 on Sustainable Development Programmes, which included the PKSA as one of the programmes for accelerating the achievement of 'justice for all'.

Economic difficulties and poverty should not be the main reasons for separating children from their families and placing them into childcare institutions. To prevent this, as stipulated in the Ministry of Social Affairs Decree No. 30/HUK/2011 on the National Standard of Childcare for Children's Social Welfare Institutions, institutions that organize social services for children should provide assistance with regard to childcare needs that may exist in these families. The decree was released to emphasize the role of childcare institutions as the last resort in the childcare continuum. Regarding the role of childcare institutions in social services provision, Presidential Instruction No. 3/2010 mandated improvements to the database systems of childcare institutions, the distribution of basic needs assistance to families directly or through social care institutions, and improvements in access to basic health services for neglected children living in childcare institutions.

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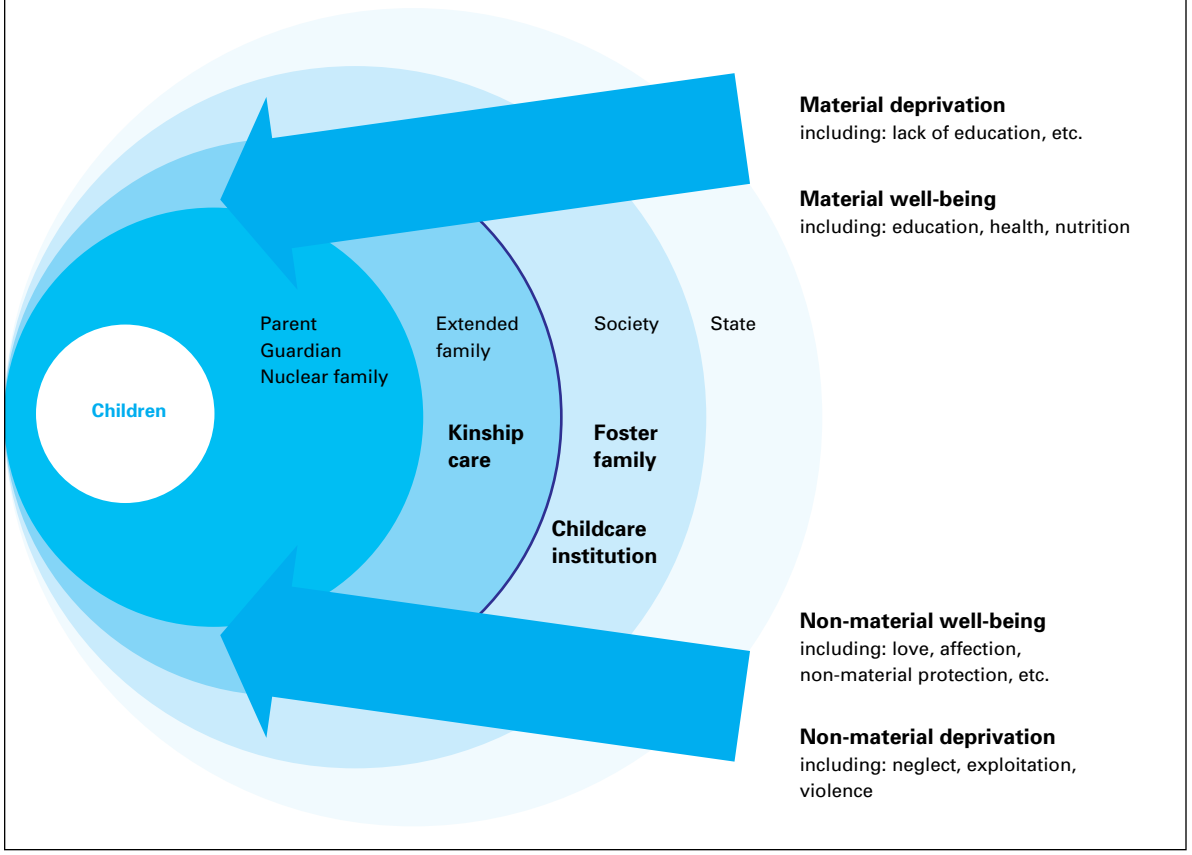
21 Family here refers to the nuclear family consisting of parents and children.

22 Besides childcare institutions, other infrastructure defined in Act No. 11/2009 includes social rehabilitation centres, centres of education and training, social welfare centres, shelters and social protection houses (RPSA) which are run based on the minimum standards established under government regulations.

Figure 5.7: The childcare system in Indonesia



The framework for efforts to deliver child rights through childcare institutions is contained in the Action Plan of Cross-Sectoral Priorities for Poverty Reduction of the National Medium-Term Development Plan (RPJMN) 2010–2014, as a priority activity of the Rehabilitation and Social Protection of Children. However, the issue of childcare institutions in the RPJMN is still very limited and unspecific. Most childcare institutions are under the same area as non-childcare institutions (such as residential care for neglected elderly people, drug addicts, etc.). As a priority activity, the aim is to achieve the implementation of social services, protection, and rehabilitation for neglected children and infants, children living or working on the street, juvenile delinquents, and children with special protection needs, delivered through the Social Rehabilitation Programme implemented by the MoSA. Furthermore, the Ministry translated this priority activity from the RPJMN into their 2010–2014 Ministerial Strategic Plan.

In the MoSA Strategic Plan 2010–2014, some of the strategic goals related to the implementation plan for childcare institutions are:

- Increasing and maintaining the facilities and technical support of the Ministry of Social Affairs both at the national and sub-national levels through the Technical Implementation Units (*Unit Pelaksana Teknis*, UPT) indicated by the percentage of facilities (residential and non-residential care) operating in accordance with minimum standards of social welfare services, with a target of 80 per cent of the facilities in 2014.
- Good availability of services and protection for neglected children, indicated by the number of neglected children served and rehabilitated successfully, with a target of 165,105 children in 2014.
- Provision of social protection services for neglected children and infants, children living or working on the street, juvenile delinquents, and children who need special protection,

in addition to coaching, training and rehabilitation for neglected children, children living or working on the street, children with disabilities, and juvenile delinquents, indicated by the number and the capacity of government and non-government institutions providing these services.
- The implementation of capacity building (training) for childcare institution staff and companions, as well as renovation of children's social welfare rehabilitation facilities, indicated by the quantity and quality of services and activities provided by staff of these facilities.
- The implementation of psychological social services for children.

The strategies, processes and performance indicators employed by the Ministry refer to the Minister of Social Affairs Regulation No. 111/HUK/2009 on Social Welfare Development Performance Indicators. Performance indicators for the services of childcare institutions are summarized in Table 5.10.

To support the efforts of social services provision delivered by social care institutions (for children and other population groups), the Ministry of Social Affairs implemented the Subsidy Programme for Social Care Institutions *(Program Subsidi Panti)* established by private institutions and communities that actively provided social services to disadvantaged people (including children). The subsidy programme was a continuation of the same programme that had been conducted in the previous five years. Under the same initiative, the Ministry of Social Affairs aimed to revitalize the social care institutions that were operating under its authority prior to regional autonomy (decentralization).

As part of the social rehabilitation programme, the Ministry of Social Affairs conducted social service activities for children and was essentially tasked with restoring the main function of childcare to families. Through childcare institutions founded by the Ministry, childcare institutions for children's protection *(panti sosial perlindungan anak)*, Social Development Centres (SDC), and Social Protection Homes for Children (*Rumah Perlindungan Sosial Anak*, RPSA[23]), the government provided temporary institutional care and protection to children who had been abandoned to live on the streets while attempting to return them to the care of their families. These activities were conducted by both central and local governments.

Another important programme that reflects the new approach adopted by the Ministry of Social Affairs is the Social Welfare Programme for Children (*Program Kesejahteraan Sosial Anak*, PKSA). The implementation of the PKSA programme was based on Presidential Instructions Nos. 1/2010 and 3/2010 on the Acceleration of Implementation of the National Development Priorities, which stated that it is necessary to improve social assistance programmes for abandoned children, children living or working on the street, disabled children, children facing criminal charges, and children with special needs for protection. The PKSA is intended to cover these vulnerable children whether they remain with their families or not. The programme implementation general guidelines are detailed in the Ministry of Social Affairs Decree No. 15A/2010, which defined the PKSA programme as "intensive, comprehensive and sustainable efforts by central and local governments and the community in the form of social services to fulfill children's essential needs, which include their basic needs, access to basic services, and access to empowering child welfare institutions."

The PKSA has five objectives: (1) increasing the responsibility of parents, families and the community; (2) improving the services coverage and quality; (3) increasing the role of child welfare institutions; (4) improving the performance of social workers; and (5) improving the regulations on child social welfare (BAPPENAS, 2010). The programme has three forms of assistance, as follows:
1. A cash transfer of IDR6,000 per day. The money may be used for nutritional support (purchasing staple foods, milk, vitamins and side dishes) and paying for school needs (text

[23] The role of the RPSAs was more closely focused on neglected children who had experienced violence.

Table 5.10: Performance indicators for childcare institutions

Strategy	Process	Indicators
Expanding and improving the quality of institutional management to support the implementation of qualified, transparent, and accountable social welfare services	• To improve the quality of institutional management to support the implementation of transparent and accountable social welfare services • To improve facilities and infrastructure to support social welfare services	• 20% of professional social workers employed at the institution serve directly in the field or as social assistants inside or outside of care institutions • 60% of districts have comprehensive operational guidelines for social welfare • 10% of social institutions implement standard operational procedures (SOP) for social welfare services • 10% of social institutions employ social welfare professionals • 10% of social institutions provide adequate social services infrastructure and facilities • 10% of social institutions manage adequate administration services • 10% of social institutions able to raise funds independently
Expansion and improvement of competence and professionalism of human resources in social welfare institutions and monitoring and evaluation of the implementation of social welfare services	• Expansion and improvement of competence and professionalism of human resources in social welfare • Monitoring and evaluation of the implementation of social welfare services	• 5 social workers for every 100 clients of social institutions

Source: Ministry of Social Affairs Strategic Plan 2010–2014.

books, school bag, stationary, shoes, uniform and school transport cost). The total amount of the transfer is IDR6,000 x 30 days x 10 months = IDR1,800,000, in a one-time transfer.

2. A remedial course for children with special educational needs who have a high risk of dropping out of school due to academic issues. The source of funding for this remedial course is from the cash transfer or from institutional operational costs.
3. A pre-remedial course mostly targeted at overweight children living in an institution or children living or working on the street. The main objective of this activity is to help children to pass their final primary school examinations *(ujian kesetaraan)*, since most of them are not primary school graduates.

The programme, however, did not cover tuition or registration fees as these costs were covered under the BOS programme (see Chapter 4)

Table 5.11: Budget for social welfare programmes for children, 2010–2011

Target	Target (children)		Budget (IDR billion)
	2010	2011	2011
Children under age 5 years	520	6,725	12.8
Abandoned children	135,014	135,685	148.5
Children living/working on the street	1,140	4,800	8.64
Child in conflict with the law	430	460	1.02
Children with disabilities	873	1,720	3.34
Children in special protection	380	1,150	1.05
Total	138,357	150,540	175.35

Source: Ministry of Social Affairs, 2011

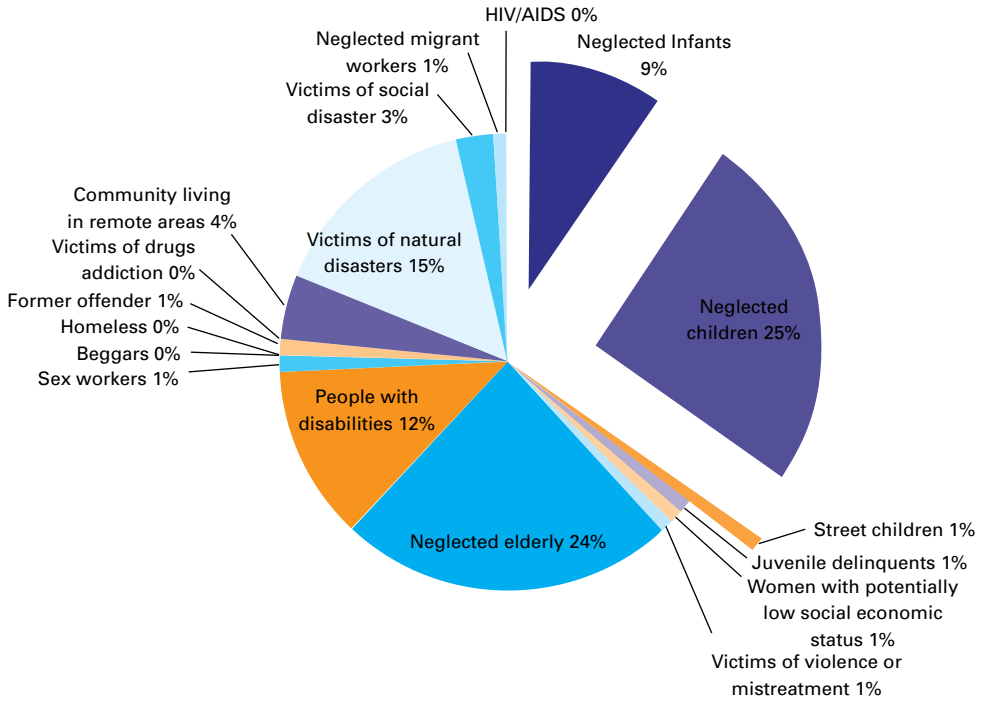
In 2010–2011 the programme has been implemented in 20 provinces (North Sumatra, West Sumatra, South Sumatra, Bengkulu, Riau, Bangka Belitung, Lampung, Jakarta, West Java, Banten, Central Java, Yogyakarta, East Java, Bali, West Nusa Tenggara, East Nusa Tenggara, West Kalimantan, East Kalimantan, South Kalimantan and South Sulawesi). The total budget allocated for this programme in 2011 was IDR175.35 billion (Ministry of Social Affairs, 2011) (Table 5.11).

5.5.2 Institutional setting and budget

Responsibility for the provision of institutional social care is divided between the provincial and district governments according to the Minister of Social Affairs Regulation No. 129/2008 on the Minimum Service Standards (SPM) for Social Affairs of provinces and districts. According to this regulation, provincial and district governments are obligated to provide appropriate facilities at each level. The regulation also detailed performance indicators for the implementation of government social services. As many as 80 per cent of social institutions, at both provincial and district level, should be able to provide social welfare services. This target is to be achieved gradually over seven years between 2008 and 2015, financed from local government revenue and expenditure budgets (APBD).

Within the Ministry of Social Affairs' budget plan, most of the funds for social care institutions were allocated as part of the budget for the Social Rehabilitation Programme in the Directorate General for Social and Rehabilitation Services. In 2010 the budget allocation for the Social Rehabilitation Programme was IDR 0.625 trillion, with a planned increase to IDR 1.55 trillion in 2014. The budget for social rehabilitation was intended to serve 37,459,992 disadvantaged people, approximately 36 per cent of whom were disadvantaged children (i.e., approximately 4,603,860 children), as indicated by combining the four segments on the right of Figure 5.8 (infants, children and juveniles).

Figure 5.8: Budget allocations for social rehabilitation, 2009



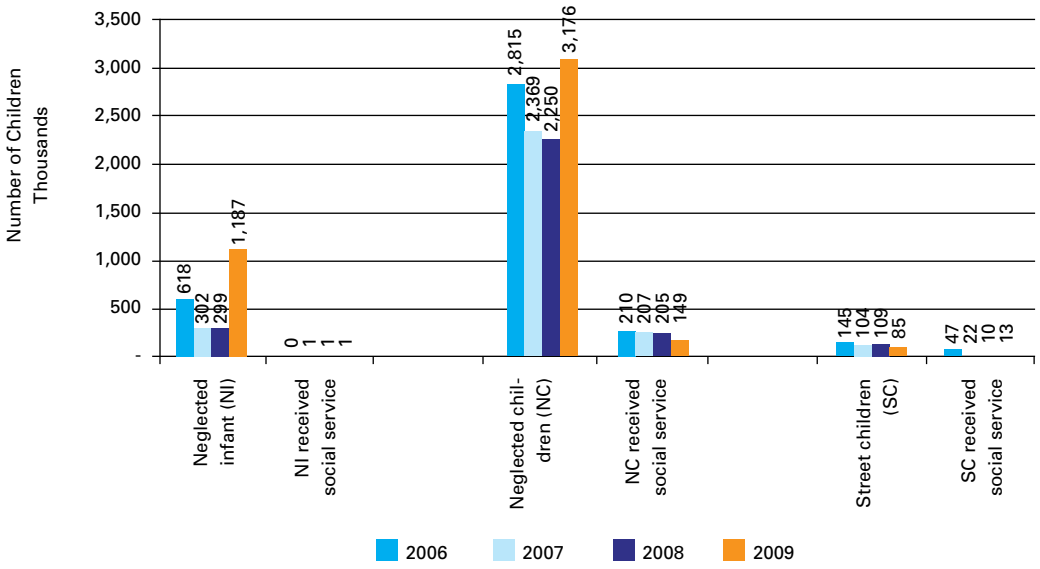
Source: Centre for Data and Information, Ministry of Social Affairs, 2009

Table 5.12: Social and rehabilitation budget allocations for children, 2009 and 2010

Year	Ministry of Social Affairs (trillion IDR)	Directorate General for Social and Rehabilitation Service (billion IDR)	Directorate for Children's Service (billion IDR)
2009	3.4	0.698	0.286 (0.158 allocated for childcare institutions—*Subsidi Panti*)
2010	3.6	0.697	0.271

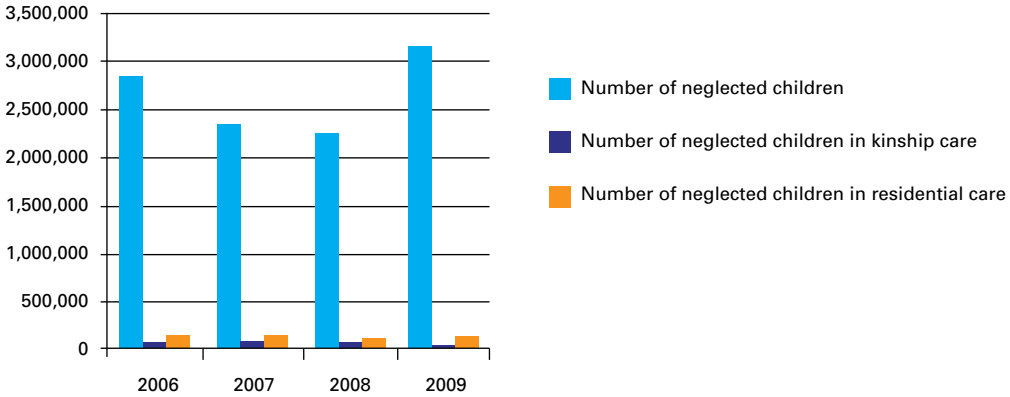
Source: Preliminary findings, study on the children's social welfare programme (PSKA), Centre for Child Protection Studies (Puska PA) in collaboration with BAPPENAS and the World Bank (as presented at the launching of Puska PA, 15 December 2010)

Figure 5.9: Disadvantaged children receiving social assistance, 2006–2009



Source: Centre for Data and Information, Ministry of Social Affairs, 2009

Figure 5.10: Disadvantaged children served by residential social care, 2006–2009



Source: Centre for Data and Information, Ministry of Social Affairs, 2009

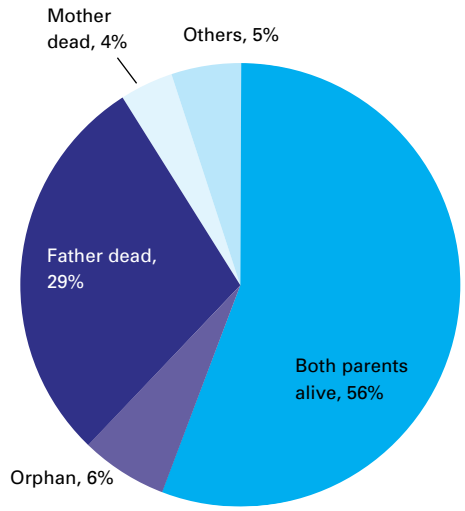
However, only a small part of the budget for the Social Rehabilitation Programme was allocated to childcare institutions, as illustrated in Table 5.12. As a consequence, only a small number of disadvantaged children received social services from the Ministry of Social Affairs (Figure 5.9). The coverage rate of disadvantaged children served by residential social care institutions was much smaller (Figure 5.10).

5.5.3 Outcomes in the provision of institutional childcare

There are limitations to the capacity of the state to provide social welfare services, so community participation is necessary for the achievement of directed, integrated, and sustainable social welfare for disadvantaged people, as mandated in Law No. 11/2009 on Social Welfare. Alternative childcare through childcare institutions is widely available in Indonesia as well as kinship care through extended families. As one of the countries with the highest per capita rate of institutionalized children in the world, Indonesia has an estimated 8,000 childcare institutions across the country.[24] An estimated 99 per cent of these institutions were established through private community initiatives while just 1 per cent were set up by the government. This estimated number of institutions may be low, as many have been established informally.

The large number of institutionalized children is directly linked to a widespread belief in Indonesian society that the solution for disadvantaged children is to place them in institutional care. Studies on children outside parental care in Indonesia are few, but the international literature has long established that children raised in institutions often face various learning disabilities and social adjustment challenges. One of the few studies on this in Indonesia was conducted by the MoSA in collaboration with Save the Children and UNICEF (2007).The study, which samples childcare institutions in six provinces, found that almost 90 per cent of children resident at the institutions still had at least one living parent and more than 56 per cent had two living parents (Figure 5.11).

Figure 5.11: Parental status of children living in childcare institutions, 2007



Source: Save the Children, Ministry of Social Affairs, UNICEF, 2007

Similar conditions were revealed during the qualitative assessment in North Jakarta.[25] Most of the children living in a *panti* (orphanages or childcare institutions) established in the case study area still had either one or both of their parents living. Some children were taken to the *panti* by their parents, while others were invited by a friend or sibling who had been living there. Some of the residents had both parents living in slums near the *panti*. These children were entrusted to live at the *panti* so that they would be enrolled in school and have a better place to live. The *panti* specialized in accommodating children that used to living or working on the street and keeping them from returning to the

24 Tata Sudrajat/Save the Children, 'Deinstitutionalization of Children', paper presented at the launching of the Centre for Child Protection Studies (Puska PA), on 15 December 2010.

25 The qualitative assessment as part of this study of child poverty and disparities was carried out in two case study locations: North Jakarta and East Sumba. There is a childcare institution established in one of the sample precincts (kelurahan) in North Jakarta, which specializes in accommodating children used to living or working on the street and keeping them from returning to the streets. It provides shelter and a community learning centre (PKBM), and also allows children to return to their families and meet with their relatives regularly.

Box 5.1: Cases of children living at a childcare institution in North Jakarta

N (11 years) is a girl whose parents divorced when she was eight years old. Her father is now living in Cakung and works as a tailor. Her mother is living in Surabaya and works as a cook. N previously lived in Pemalang until the 3rd grade of elementary school, then moved to Jakarta with her father and did not attend school for a year. After this her neighbours took her into the panti *where she has been living for a year.*
F (15 years) is a boy whose father has died but his mother is still alive. Before living in the panti *F worked on the road as a '*bajilo*' (a thief who steals iron or brass from the loads of trucks passing by). Since living in the* panti *F has experienced better living conditions; he has access to adequate shelter, food, health and education. In addition, he receives 2,000 rupiah pocket money every day without working. He ran away from the* panti *after four months, and then come back again two months later. During those two months he went to the Pulogadung terminal and become a busker.*
H (15 years), is the eldest of five siblings. His step father works as an angkot (minibus) *driver and his mother works as a busker. Even though H lives in the* panti*, he often goes home to visit his sisters and asks for money from his mother, which he uses to buy food or cigarettes. Before entering the* panti*, H had dropped out of school and become a busker. In 2006 H was invited to visit the* panti *by a friend, and since then H has lived in the* panti *and returned to enrolled education beginning from the 5th grade of elementary school, in a '*kejar paket*' (fast track) system.*

Source: Case studies in North Jakarta, June–August 2012

streets. The children were taught skills to enable them to get jobs in the future. In addition to providing shelter, the institution also organized a community learning centre (PKBM) where the children could attend school.

As indicated by the cases in Box 5.1, circumstances have generally improved for the children living in these childcare institutions. Poor and neglected children living in the *panti* were not required to work as they were supported by the institution. While some poor children living with their parents, relatives or foster families did not have to work to contribute to the household economy, other children had to work to meet their needs. This was often the case even if they lived with parents or other guardians, who may be too poor or neglect their children, or if they lived with relatives who were unable to work, such as elderly grandparents. The assessment also found that children living without appropriate care, whether from family or other sources, tended to be deprived of basic needs, including education. One case from the qualitative assessment in North Jakarta describes such a situation:

> *I (17 years) is the son of divorced parents. He is living with his grandmother and two sisters in a two-storey house made of wood and corrugated iron walls in a slum area. He works as a 'bajilo' to fulfil their needs. "I feel very insecure with the job, which is too risky." His work friend had just died after an accident while doing the job. "I had to drop out of school and did not intend to go back to school again." What he really wants right now is to get an ID card (KTP) so that he can get a driver's licence, then work more safely as a driver, like his father.*

However, *panti asuhan* (childcare institutions) should be viewed as a last resort if efforts to support the family still cannot restore the function of the family as the primary caretakers for children. Poverty is often the main factor behind the inability of the parents to take care of children and fulfil their rights. In ideal conditions, the family, especially parents, are closest to the child and play an important role in fulfilling the child's rights, including both the material and non-material needs, to support the child's well-being. These needs and rights cannot necessarily be fulfilled by other parties.

Children living in care institutions tended to lack emotional fulfillment and often received inadequate attention from the staff. The 2007 study of childcare institutions found that almost all of the sampled institutions had very low ratios of staff to child, at best reaching 1:10; but the majority of institutions had much worse ratios (Save the Children, Ministry of Social Affairs, UNICEF, 2007). Findings of the same study indicated that the children also tended to be deprived in terms of non-material needs, as their development was considered primarily in terms of physical health and education rather than in terms of personal well-being. In addition, many of the childcare institutions did not support a role for families, generally discouraging contact between residents and their families.

Children living or working on the street are among the vulnerable groups of children who need special attention. At a national level, it is estimated that the number of children living or working on the street was increasing from around 50,000 in the late 1990s to 60,000-75,000 in 2004, and further increased to 230,000 in 2008 (UNICEF, 2011). A situational analysis conducted by UNICEF (2011) found that children living or working on the street have limited access to essential basic needs such as health and education, and bore the burden of being breadwinners within their families. Risks of psychological and physical damage as a result of working to earn family income included succumbing to physical and sexual exploitation by adults and peers and exposure to sexually transmitted diseases, including AIDS. Furthermore, children living on the streets generally have no adult protection and are therefore more vulnerable to further violations, such as trafficking. It was also reported that children living or working on the street were often the victim of violations by law enforcement officials and security guards.

Many factors are involved in the problem of children living or working on the street. Several essential causes were identified. Firstly, they were a product of family poverty, unemployment, domestic violence and divorce. Second, there was a gap between opportunities for employment in rural and urban areas, leading to migration. Finally, there was a shortage of safety net programmes targeted at troubled children and families. These causes were relevant and meaningful when applied to the North Jakarta case study, where field research was conducted for this report.

The qualitative study identified that children living or working on the street in North Jakarta were involved in a range of jobs, including busking, scavenging, *bajilo,*[26] *penirisminyak*[27] and many more. These jobs were dominated by boys. This range of jobs indicates how dangerous being a street child in North Jakarta, and perhaps in other cities in Indonesia, can be. Many of the aforementioned jobs are high risk, threatening both children's health and lives. There have been cases where children working as bajilo have been crushed by trucks as they have slipped while trying to climb into the trucks to steal goods. Many boys choose to become bajilo despite the risks because of the promise of very good money – up to IDR800,000 a day – compared to the low income from the other jobs available to children living or working on the street.

Assisting their family financially was the main reason that children risked their lives and education by working on the street. Some of them were forced by extreme poverty, while others made a conscious choice to work on the street to earn additional money. But in addition to economic reasons, there were other factors. Lack of attention from their parents at home encouraged children to search for parental figures on the street. A 'boss' could provide a sense of safety and comfort – two essential things that they could not obtain from their own parents.

The Social Welfare Programmes for Children (PKSA) mentioned above have shown some

[26] Bajilo is short for bajing loncat, a kind of thief who steals goods from passing trucks by jumping on to the trucks and stealing some of the loaded goods before running away.

[27] Stealing petrol from trucks at petrol stations or while the trucks are still moving on the streets.

promise for reining in the recent increases in the numbers of children living or working on the street in Jakarta. It should be noted that the Ministry of Social Affairs set a target for Jakarta to be free of children living or working on the street by 2011. The pivotal features of the PKSA were the strategies to fulfill the basic needs of children (including subsidies for basic needs), to enhance the accessibility of social services, and to strengthen and support families and parents.

5.5.4 Recommendations

> *"Recognizing that the child, for the full and harmonious development of his or her personality, should grow up in a family environment, in an atmosphere of happiness, love and understanding…"*
> —Preamble, the United Nations Convention on the Rights of the Child

It is in every child's best interest to remain with their parents or other close family members. But there are some children who do not have this opportunity due to the death of one or both parents, family conflict, external disaster, or due to the threat of violence, abuse, neglect or exploitation at home. Poverty often leads parents to be violent, abusive, neglectful or exploitative towards their children. On the other hand, poor parents who care for their children's rights might decide that it is in the child's best interests to live separately from them, whether with another family or in an institution.

The Government of Indonesia, through the Ministry of Social Affairs, has embraced a new paradigm by focusing efforts on providing support to families to fulfill their children's basic rights. With reference to the Minister of Social Affairs Decree No. 15 A/HUK/2010, the Ministry of Social Affairs implemented the Social Welfare Programmes for Children (PKSA), applying the new paradigm for childcare policies that emphasized the role and responsibilities of the family and community. For families experiencing social problems that cause children to be deprived of their rights, support and social assistance can be delivered to allow them to adequately take care of their children. However, if these efforts are unsuccessful, out-of-home family-based care is the alternative, before placement in a childcare institution is considered. There were efforts to support provision of social services for disadvantaged children, including childcare institutions for children's protection *(panti sosial perlindungan anak)*, Social Development Centres (SDC), Social Protection Homes for Children *(Rumah Perlindungan Sosial Anak)*, Subsidy Programme for Social Care Institutions *(Program Subsidi Panti)*, and some social rehabilitation programmes.

With regard to the obligation of the state to ensure child protection and the fulfillment of children's rights, some improvements are needed to enhance the efforts for the provision of social services to children, including the following:

- Maintenance and improvement of existing childcare facilities.
- Improvement in the availability of comprehensive and accurate data on disadvantaged children and children outside parental care. This is very important for the formulation of well-targeted efforts to increase the number of neglected children who are assisted and rehabilitated.
- Improved capacity building activities, not only for the social workers but also for the children, to help prepare them to re-enter society.
- Improvement and support of the capacity of private and informal childcare institution, since Indonesia has a large number of such institutions.

Nevertheless, it is important to emphasise that the focus must continue to be on the restoration of the main function of childcare to the family, because childcare institutions should be intended only to provide a last resort. Enhancing the personal and economic capacity of the parents or other caregivers is also important for the neglected children who still have a family.

CHAPTER 6

Social Protection

6.1 National laws and policies

While previous chapters in this report have explored various policies and programmes targeted directly at children, this chapter focuses on social protection programmes that are specifically targeted towards poor households. Social protection is defined as the set of policies and programmes designed to reduce poverty and vulnerability by; promoting efficient labour markets, diminishing people's exposure to risks, and enhancing their capacity to protect themselves against hazards and disruption/ loss of income (www.adb.or.id). Child welfare has been increasingly integrated into the general discourse on social protection as the well-being of a child is inseparable from the well-being of the household they live in and a policy that provides social assistance to a parent is likely to bring benefits to that child. Indeed, children's right to social security (including social insurance) is highlighted in the United Nations Convention on the Rights of the Child (CRC). Article 26 of the CRC specifically says "States Parties shall recognize for every child the right to benefit from social security, including social insurance." Furthermore, there has been a worldwide effort to advocate child-sensitive social protection[1] as the strategic means to breaking inter-generational poverty traps and advancing investment in human capital.

In principle, the legal basis for the implementation of poverty reduction and social protection programmes in Indonesia consists of the *Pancasila* (the five principles of the Indonesian state philosophy) and the 1945 Constitution *(UUD 1945)*, which declares that the state is responsible for advancing general prosperity and developing the nation's intellectual capacity in an effort to implement social justice for all people. The 1945 Constitution stipulates that each citizen shall be entitled to an occupation and an existence suitable for a human being (Article 27, clause 2). In addition, Article 34, clause 2, stipulates that the state shall develop a social security system for all citizens and empower the weak and underprivileged in society in accordance with their dignity as human beings. These issues are further regulated by Law No. 40/2004 on the National Social Security System and Law No. 11/2009 on Social Welfare.

[1] For example, see the joint statement of various international organizations on advancing child-sensitive social protection (available at: www.unicef.org/socialpolicy/index_socialprotection.html, accessed 5 July 2012)

Poverty reduction efforts in Indonesia cannot be separated from efforts to achieve the Millennium Development Goals (MDGs). The eradication of poverty is the first MDG. The indicators for this are: (1) the proportion of people whose income is less than $1 (PPP) a day with an aim of reducing this proportion by 30 per cent by 2015 (from 20.6 per cent in 1990); and (2) reducing the poverty gap index.[2]

As a commitment to achieving the MDGs, the Government of Indonesia (GoI) has mainstreamed the MDGs in development planning and implementation, including the relevant goals and indicators in the National Medium-Term Development Plans (RPJMN), which run for five years each. According to the RPJMN 2010–2014, sustainable economic development requires a solid and equal distribution of national governance. The process of economic growth, which incorporates all layers of society, can only be realized if the government's budget allocation is truly designed to assist people in their efforts to get out of the poverty trap. Social security must be provided not only as a constitutional obligation but as a strategic consideration to enhance the quality of Indonesia's human resources; making workers more educated, skilled and healthy making them potentially more productive.

According to the current RPJMN, the priority for poverty reduction is to reduce absolute poverty from 14.1 per cent in 2009 to between 8 and 10 per cent in 2014, and to improve income distribution through household-based social protection, community development, and expansion of economic opportunities for members of society with low-incomes.

The implementation of targeted poverty reduction programmes in Indonesia has significantly improved since 1997–1998 after Indonesia was hit by the Asian financial crisis. At that time, poverty reduction was conducted through Social Safety Net programmes (SSN). The SSN programmes were intended to reduce the impact of the crisis on target communities through the provision of food, health services, education, revolving funds *(dana bergulir)* and intensive labour. All of these poverty reduction programmes were still being implemented at the time this report was written, but the names of the programmes and their implementation approaches have changed.

Since 2009,poverty reduction programmes have been classified into three clusters (Figure 6.1). The first cluster, 'Social Assistance', aims to reduce cost burdens through the programmes known as Rice for the Poor *(Raskin)*, Direct/ Unconditional Cash Transfers (BLT), Family Hope Programme (PKH), School Operational Assistance (BOS) and Community Health Insurance *(Jamkesmas)*. The second cluster is 'Community Empowerment' which aims to improve the income and buying power of communities and is conducted through the National Programme for Community Empowerment, known as 'PNPM Mandiri'. PNPM Mandiri is divided into two main categories, PNPM-Inti ('core') and PNPM-Penguatan ('strengthening'). PNPM-Inti includes the PNPM Rural (PNPM *Perdesaan*), the PNPM Urban (PNPM *Perkotaan*), the Rural Infrastructure Development Programme (PPIP), the Regional Socio-economic Infrastructure Development Programme (PISEW) and the Development Acceleration Programme for Disadvantaged and Special Regions (P2DTK). PNPM-*Penguatan* consists of PNPM Healthy and Smart Generation (PNPM *Generasi*), PNPM Green (PNPM *Hijau*), Development of Rural Agribusiness (PUAP), Community-based Sanitation and Drinking Water Provision (PAMSIMAS) and Direct Community Financial Assistance for Agricultural Investment (BLM-KIP). The third cluster, 'Micro-Enterprise Empowerment' aims to aid micro and small and enterprises through the provision of loans (*Kredit Usaha Rakyat*, KUR). In 2011, the GoI added a new fourth cluster, namely, 'Pro-Poor Programmes for Accelerating Poverty Reduction'. This new cluster consists of six programmes including: (1) low-priced housing; (2) low-priced public transportation; (3) clean water; (4) economical and low-priced

[2] The poverty gap index measures how far the income or consumption of an individual is from the poverty line. It represents the financial amount needed to bring all poor individuals up to the poverty line.

Figure 6.1: Clusters of poverty reduction programmes

*Source: *Badan Pusat Statistik (BPS) – Statistics Indonesia, 2010; ** PNPM Mandiri (National Programme for Community Empowerment), www.pnpm-mandiri.org, accessed 13 December 2010; ***Kementerian Koperasi dan Usaha Kecil dan Menengah (Ministry of Cooperatives and Small and Medium-sized Businesses), www.depkop.go.id, accessed 14 December 2011*

electricity; (5) fisheries improved livelihood; and (6) urban community livelihood improvement. It also added three others programmes in Jakarta, including job creation, rice surplus and transportation. Up to the time of the writing of this paper (late 2011), the programmes in cluster IV had not yet been implemented at the national level. However, the Jakarta Provincial Government has started to implement the programmes on job creation and transportation.[3]

The budgets for all three main clusters of poverty reduction programmes decreased in 2010 compared to 2008. The budget allocation for the first cluster was IDR43 trillion in 2008, but declined to IDR39 and 37 trillion in 2009 and 2010, respectively, mostly due to a reduction in the BLT programme, followed by its elimination. The second cluster's budget allocation in 2008 was IDR6 trillion, which increased by 57 per cent in 2009 and decreased in 2010 by 7 per cent to almost IDR13 trillion. The third cluster received the smallest budget allocation,but it increased significantly in 2010 (Table 6.1).

Government poverty alleviation programmes provided various types of basic household income support. The targeted households or beneficiaries received assistance in the form of cash or goods either directly or indirectly. Some programmes directly addressed the needs of children and others were aimed at households more broadly to enable them to meet the needs of their children. Programmes that directly targeted children include BOS and scholarships for poor students (see Chapter 4, section 4.2).

The implementation of all poverty reduction programmes and policies was coordinated by just one institution. Previously, based on Presidential Regulation No. 13/2009 on Poverty Reduction Coordination, policy coordination and implementation of poverty reduction programmes was implemented by the

[3] Communication from Jakarta Provincial Board for Development Planning in a consultative meeting for poverty reduction (30 November 2011)

Table 6.1: Budget allocation for clusters I, II and III of the poverty reduction programmes, 2008–2010

	Budget (IDR billion)		
	2008	2009	2010
Cluster I	**43,446**	**39,146**	**37,019**
• Raskin (Rice for the poor)	11,660	12,980	12,620
• BLT (direct cash transfers)	14,000	3,800	
• Jamkesmas (health insurance scheme)	4,686	7,224	5,584
• Scholarships	1,900	2,942	2,315
• BOS (School operational assistance)	11,200	12,200	16,500
Cluster II	**6,688**	**10,355**	**12,921**
• PNPM-Mandiri (community empowerment)*	6,688	10,355	12,921
Cluster III	**1,450**	**2,000**	**20,000**
• Loans for the people (KUR)	1,450	2,000	20,000

Source: Hastuti et al., 2010; Government Work-Plan (RKP) 2008–2010
*Note: *PNPM-rural, PNPM-urban, PPIP, PISEW, P2DTK*

Coordinating Team for Poverty Reduction (TKPK), which was chaired by the Coordinating Minister for People's Welfare. Other team members included representatives from government, communities, businesses and other stakeholders in poverty reduction. In order to intensify the coordination of poverty eradication, Presidential Regulation No. 15/2010 on Accelerated Poverty Reduction was released and since 2010 the coordination and implementation of poverty reduction programmes has been conducted by the National Team for Accelerating Poverty Reduction (TNP2K),chaired by the Vice President with similar membership to that of the TKPK.

6.2 Major household income support programmes[4]

Some of the household income support programmes in nutrition, health and education were already discussed in chapters 3 and 4. In this chapter the discussion of household income support will be limited to those few given directly to the target households, namely; Rice for Poor Households (Raskin), the Family Hope Programme (conditional cash transfers, known as PKH), and Direct/Unconditional Cash Transfers (BLT).

6.2.1 Rice for Poor Households (Raskin)

The Raskin programme *(Beras untuk Rumah Tangga Miskin)*, formerly known as the Special Market Operation (*Operasi Pasar Khusus*, OPK), is a poverty reduction programme initiated by the GoI in June 1998 and is a part of the JPS (Jaring Pengaman Sosial or Social Safety Nets) programme. Raskin aims to reduce the burden of food costs on poor households through the provision of rice as a basic food staple. Through this programme, the government provides a certain amount of rice at a subsidized price every month to targeted households. Until 2007 every household received between 10 and 20 kilograms of rice at a subsidized rate of IDR1,000 per kilogram at the distribution point; usually at the village or precinct *(kelurahan)* office. Since 2008 the rice quota per household has been increased to 15 kilograms with a target price at the distribution point of IDR1,600 per kilogram.

The implementation of Raskin involves several ministries and institutions. The Coordinating Ministry for People's Welfare acts as the coordinator for the programme's implementation, the National Food Logistics Agency (BULOG) is responsible for the distribution of rice to distribution points at

[4] This part was mostly taken from Hastuti et al.,'The role of social protection programmes in reducing the impact of the global financial crisis 2008/2009', SMERU Research Institute, 2010.

the sub-district or village level, and local governments are responsible for distributing the rice to the local distribution points for collection by members of the target households.

Raskin is for poor households. Until 2005, identification of the programme beneficiariesrelied on the data on 'Pre-Prosperous Families' and 'Prosperous Families 1' *(Keluarga Prasejahtera; Keluarga Sejahtera 1)* from the National Family Planning Coordination Board (BKKBN). Since 2006, determining the target households has been based on BPS – Statistics Indonesia data identifying the 'very poor', 'poor' and 'nearly poor' households as beneficiaries. The number of Raskin targeted households increased up to2008 and declined in 2009, corresponding to the number of poor households in Indonesia. Meanwhile, the Raskin budget continued to increase in accordance with the increase in the price of rice (Table 6.2).

from BPS – Statistics Indonesia. The number of target households decreased slightly from 19.1 million in BLT 2005 to 19.02 million in BLT 2008, and to 18.5 million in BLT 2009. The reduction occurred because some previous beneficiaries had passed away, changed address or improved their welfare status, while the number of new beneficiaries was lower. Through BLT programmes, each targeted household received IDR100,000 per month every two to four months through the post office. In accordance with the implementation period and the number of target households, the budget allocation for BLT decreased. The budget allocations for BLT 2005 (four periods of disbursement), BLT 2008 (two periods of disbursement), and 2009 (one period of disbursement) were IDR23 trillion, IDR14.1 trillion and IDR3.7 trillion, respectively.

The BLT programme was implemented with cross-sectoral coordination at all levels of

Table 6.2: Rice for Poor Households; numbers of households, rice ceiling and budgets, 2005–2010

Information	2005	2006	2007	2008	2009	2010
Poor households	15,791,884	15,503,295	19,100,905	19,100,905	18,497,302	17,484,009
Target households	8,300,000	10,830,000	15,800,000	19,100,000	18,497,302	17,484,007
Recipient households	11,109,274	13,882,731	16,736,411	19,131,185		
Rice ceiling (tons)	1,991,897	1,624,500	1,736,007	3,342,500	3,329,514	2,972,945
Budget (IDR trillion)	4.97	5.32	6.47	11.66	12.98	12.62

Source: National Food Logistics Agency (BULOG), 2007–2010; Coordinating Ministry for People's Welfare, 2007–2010

6.2.2 Unconditional (or direct) cash transfers

This programme, known as BLT, was first initiated in October 2005 for 12 months to alleviate the impact on poor households of an increase in fuel prices (BLT 2005/2006). The BLT programme aimed to help the poor continue to meet their basic needs in the face of the fuel price increase, thus preventing a welfare crisis. The GoI has implemented a BLT programme on three occasions. The next instance was BLT 2008, implemented over seven months, from June to December 2008. Finally, during BLT 2009, cash was only disbursed for two months in January and February 2009, again to reduce the impact of rising fuel prices.

The target households for BLT were 'poor' and 'nearly poor' households, based on data

government, working cooperatively based on the main functions and duties of the respective institutions. At the central level, the agency responsible for the programme was the Ministry of Social Affairs, which appointed PT Pos Indonesia (the national postal service) and Bank Rakyat Indonesia to undertake the task of disbursing funds to target households. Meanwhile, BPS – Statistics Indonesia was responsible for providing the necessary data.

6.2.3 Conditional cash transfers

Known as PKH, the Family Hope Programme is a conditional cash transfer programme that was started in 2007. The programme is designed to support increased demand for education and health services in poor households, assisting the children to escape the inter-generational poverty

trap. The PKH's implementation involves various agencies including the Coordinating Ministry for People's Welfare, the Ministry of Social Affairs, the National Development Planning Agency (BAPPENAS), the Ministry of Education, the Ministry of Health and local governments. The PKH also involves the national postal service in distribution of the funds to targeted households.

The target of the PKH is 'very poor households' (known as RTSM)[5] with one of the following criteria: children aged 0–6 years, children of primary or junior secondary school age, children under 18 years old who have not yet completed the nine years of compulsory schooling, and pregnant or lactating women. The PKH provides assistance in the form of cash, ranging from IDR600,000–2,200,000 per targeted household per year, with the amount depending on the composition of the household. Funds are received three times a year through the post office. Households in receipt of PKH funds must then meet certain requirements, namely sending children aged 7–18 years to school to achieve at least the compulsory nine years of schooling, taking children aged 0–6 years to health facilities, and the examination of pregnant and post-natal women and babies at health-care facilities. If RTSM participants do not meet these requirements, the amount of the transfer will gradually be reduced or even terminated.

In 2007 the PKH was piloted in seven provinces, including West Sumatra, Jakarta, West Java, East Java, North Sulawesi, Gorontalo and East Nusa Tenggara (NTT), covering a total of 49 districts and 348 sub-districts. In 2008 the programme expanded to cover 13 provinces by including Aceh, North Sumatra, Yogyakarta, Banten, West Nusa Tenggara (NTB) and South Kalimantan. In 2010 the PKH programme was extended to include 20 provinces, 90 districts and around 800,000 households. Coverage will be increased gradually until 2013, with a target of2 million RTSM, after which the numbers will be decreased due to the anticipated improved welfare of the beneficiaries. In accordance with the increasing number of beneficiaries, the PKH budget allocation will be increased toIDR3.17trillion in 2013 and then reduced until the programme's planned completion in 2018 (see Table 6.3).

6.2.4 Overall programme performance

The coverage of target households for the three poverty reduction programmes –Raskin, PKH and BLT – increased from year to year (see Table 6.4). Raskin targets until 2007 only covered a proportion of poor households, however, since 2008 the programme aimed to reach all poor households. In terms of realization, the number of recipient households has always exceeded the number of target beneficiary households because non-targeted households also receive the subsidy.

Since its initial implementation, the BLT programme has always targeted the total number of poor households, based on the collection and updating of data on poor households. For the same reason, the number of households receiving BLT was almost equal to the number of target households and the number of poor households. There were slight variations between the number of poor households, targeted households, and recipient households due to the lag in availability of updated data.

Unlike the BLT and Raskin programmes that cover all regions in Indonesia, to date the conditional cash transfers, PKH, only cover 10 of Indonesia's 33 provinces. The program's coverage will be improved gradually each year. A different set of households were also targeted or this programme. Raskin and BLT cover all categories of poor households (very poor, poor and near poor) whereas PKH only covers very poor households. Therefore, the number of households receiving the PKH is very small compared to the overall number of poor households. In fact, because the programme does not cover even a third of Indonesia's provinces and because there are specific eligibility criteria and conditions for the PKH (as

5 Very poor households were identified through proxy means testing conducted by BPS – *Statistics Indonesia*

Table 6.3: Targeted households for conditional cash transfer programme (PKH), 2010–2018

Year	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
1	392,000	392,000	392,000	392,000	392,000	392,000	Exit	Exit	Exit	Exit	Exit	Exit
2		224,000	224,000	224,000	224,000	224,000	224,000	Exit	Exit	Exit	Exit	Exit
3			120,000	120,000	120,000	120,000	120,000	120,000	Exit	Exit	Exit	Exit
4				90,000	90,000	90,000	90,000	90,000	90,000	Exit	Exit	Exit
5					500,000	500,000	500,000	500,000	500,000	500,000	Exit	Exit
6						500,000	500,000	500,000	500,000	500,000	500,000	Exit
7							600,000	600,000	600,000	600,000	600,000	600,000
Total	392,000	616,000	736,000	826,000	1,326,000	1,826,000	2,034,000	1,810,000	1,690,000	1,600,000	1,100,000	600,000
Budget (IDR trillion)	1	1.1	1.1	1.3	2	2.79	3.17	2.82	2.68	2.53	1.74	0.95

Source: Ministry of Social Affairs, Program Keluarga Harapan (PKH), www.pkh.depsos.go.id, accessed15 December 2010

described in section 6.2.3), compared to the total number of very poor households or RTSM, only a small percentage have benefited from the PKH programme. However, the program cover rate has increased over time (Table 6.4).

The number of households receiving assistance from these programmes does not automatically indicate the intended scope of the programme for poor households due to inaccuracies in targeting. Of the three programmes, the Raskin programme was the one that received the most criticism for mis-targeting beneficiaries. Several studies, by the SMERU Research Institute and others, have shown that the Raskin programme mis-targeted beneficiaries because targets tended to be spread evenly among households at all levels of wealth. This can be seen by analyzing Raskin recipients based on SUSENAS data allowing for categorization of households

Table 6.4: Number of poor households and number of target and recipient households for Rice for Poor Households (Raskin), unconditional and conditional cash transfers (BLT and PKH), 2005–2010

		2005	2006	2007	2008	2009	2010
Poor households*		15,791,884	15,503,295	19,100,905	19,100,905	18,497,302	17,484,009
Raskin	Target	8,300,000 (52.56)	10,830,000 (69.86)	15,800,000 (82.72)	19,100,000 (100.00)	18,497,302 (100.00)	17,484,007 (100.00)
	Recipient	11,109,274 (70.35)	13,882,731 (89.55)	16,736,411 (87.62)	19,131,185 (100.16)	n/a	n/a
PKH	Target			392,000 (2.05) ((10.07))	626,000 (3.22) ((15.82))	726,000 (3.98) n/a	816,000 (4.72) ((27.60))
	Recipient			388,000 (2.03) ((9.96))	700,000 (3.66) ((17.97))	720,000 (3.89) n/a	816,000 (4.67) ((27.27))
BLT	Target	15,503,295 (100.00)	19,100,905 (100.00)		19,020,763 (99.58)	18,832,053 (101.81)	
	Recipient	n/a	n/a		18,768,777 (98.26)	18,497,302 (100.00)	

Source: BAPPENAS, 2010; BULOG, 2007–2010; BPS – Statistics Indonesia, 2010

Notes : • Figures in () percentage of poor households; in (()) percentage of very poor households (RTSM)

• Cell shaded = programme not yet / not implemented

• The first BLT lasted 12 months (2005/2006); for the first phase (2005) data from PSE (Social Economic Registration) 2005 were used, while for the next phase (2006) the update was based on data for poor households in 2006 and 2007

**includes very poor, poor and near poor*

by their expenditure quintile (see Table 6.5). As shown, the number of Raskin programme recipients in quintiles 1 and 2 – the groups with the lowest welfare level – accounted for only about 53 per cent of all Raskin recipients in 2002 and 58 per cent in 2009, while more than 11 per cent of the richest (quintile 5) households also received Raskin in 2002, declining to 5 per cent in 2009. While the mis-targeting has apparently persisted over the eight years as documented in Table 6.5, nevertheless, it appears that there has been some improvement as the percentage of recipients who were from quintiles1 and 2 tended to increase, while the percentage of recipients from quintiles 4 and 5 tended to decrease, especially after 2006.

The findings of the qualitative study in North Jakarta indicate that Raskin (Rice for Poor Households, sold at a low subsidized price) is channeled by the heads of the local neighbourhood associations (known as RT and RW) to all local households who are interested in buying it. Due to the limited rations of rice compared to the number of potential buyers, these local leaders are responsible for fair distribution of the rice among households every two months. Each household can buy 5–15 kilograms of rice at a price of IDR2,000–2,400 per kilogram. As documented by the qualitative study in East Sumba, Raskin was distributed every two months and the rice could be delivered to all households except those of civil servants. Every household received 12 kilograms of rice at IDR1,600 per kilogram and was also required to cover the delivery cost of IDR800.

Meanwhile, some research results show that targeting of beneficiaries for the BLT and PKH cash transfer programmes was better than that of the Raskin programme. Both programmes use more specific methods of selecting target households. Target households cannot be replaced by others because each household is listed in data at the central level and when the funds are distributed via the post office they can only be collected by thespecified households. However, based on several studies there were still some instances of mis-targeting. For example, there were reports of some households that were categorized as more wealthy but received BLT and other households who did not qualify for PKH but still received the cash. However, the most prominent issue for both of these programmes was under-coverage. There were many poor households, with similar socio-economic conditions to transfer recipients, but which did not receive either BLT or PKH payments.

Based on SUSENAS data on wealth quintiles, the target accuracy of BLT 2005/2006 tended to be better than the Raskin programme, although this assistance was also received by households in all wealth quintiles. The BLT programme recipients from the lowest welfare group (quintiles 1 and 2) accounted for 65.82 per cent of all BLT recipients, while households in the highest welfare groups (quintiles 4 and 5) made up 13.86 per cent of beneficiaries (Table 6.6). On comparison with the results of several studies, these differences appear to be the result of data limitations. The SUSENAS data, which is intended to represent

Table 6.5: Distribution of Rice for Poor Households (Raskin) recipients by household wealth quintile, 2002–2009 (%)

Quintile	2002	2003	2004	2005	2006	2007	2008	2009
Q1 – poorest	29.11	28.19	28.47	29.19	29.04	31.92	30.62	30.89
Q 2	23.66	23.38	23.37	24.01	23.48	27.66	27.20	27.24
Q 3	19.63	19.88	20.03	19.84	19.83	21.89	22.03	21.89
Q 4	16.37	16.74	16.60	16.06	16.36	13.79	14.80	14.89
Q 5 – richest	11.22	11.81	11.53	10.90	11.29	4.74	5.36	5.09
Total	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00

Source: 2002–2009 SUSENAS

Indonesia as a whole, covered all provinces and districts but only sampled a total of 64,800 households in 2009. On the other hand, other more in-depth research efforts only covered a limited number of areas.

In North Jakarta, as documented by the qualitative study conducted for this report, the BLT unconditional cash transfers were only enjoyed by households who had identification cards (KTP) and family cards (KK) identifying them as residents of Jakarta. Many households were thus ineligible, despite socio-economic conditions that met the requirements. Meanwhile in East Sumba, BLT was received by more than 70 per cent of households in both village studies.

Just like the BLT programme, the PKH programme recipients in North Jakarta were also required to have KTP and KK showing official residence status in Jakarta. The study respondents felt that the number of PKH recipient households was very limited because the programme only accepted RTSM (very poor households) that met the requirements of the programme. The PKH programme was not implemented in East Sumba as this district had not been selected for the pilot programme.

Table 6.6: Distribution of recipients of unconditional cash transfers (BLT) 2005/2006 based on 2007 data on household wealth quintile (%)

Quintile	2007
Q1 – poorest	37.79
Q 2	28.03
Q 3	19.51
Q 4	10.09
Q 5 – richest	3.77
Total	100.00

Source: SUSENAS 2007

6.3 Benefits of social protection programmes for households and children

In 2009, more than half (58.23 per cent) of households throughout Indonesia received some form of social assistance from either government or non-government institutions, and 26.66 per cent of women aged 15 years and above were covered by health insurance (see Table 6.7). The coverage of the programmes was quite good from the perspective that they reached a significant proportion of older people, households with large numbers of members and high dependency ratios, women with lower educational backgrounds, female-headed households, women and households in the lower welfare quintiles, households with children working, households without adults of prime working age, and households caring for a child/children with a disability. As discussed in Chapter 3 of this report, these programmes have helped to improve children's well-being but there is still room for improvement, particularly in some aspects of implementation.

However, the proportion of children covered by the three major government programmes – health insurance for the poor, rice for the poor, and scholarships – have been declining from 2003 to 2009. The decline in the coverage of children under the health insurance for the poor (Jamkesmas) and rice for the poor (Raskin) programmes (which target households rather than individuals) could be due to the decreasing quota of beneficiaries corresponding to the declining national levels of poverty. Meanwhile the proportion of children receiving assistance from the scholarship programme declined significantly because in 2005 the central government replaced the scholarship programme for primary and junior secondary students with BOS, a general subsidy provided to schools rather than to students (see also Chapter 4).

The Raskin, PKH, and BLT programmes are income support programmes targeted at poor households. Through the Raskin programme, recipient households who received a full 15 kilogram ration of rice per month at IDR1,600 per kilogram (while the market price of rice was IDR6,000 per kilogram) are thus saving IDR66,000 per month. In reality, some recipient households only receive 5 kilograms because the Raskin rice was shared equally to all households in the village/precinct, rather than reserved for the targeted households as intended, and also the sale price is actually IDR2,000 per kilogram

due to additional transportation costs from distribution points, in which case they are saving just IDR20,000 per month off the market price. Through the BLT and PKH programmes, targeted households received additional income directly, consisting of IDR100,000 per month from the BLT programme and IDR600,000–IDR2,200,000 per year from the PKH programme.

If the recipient households were targeted correctly, the three programmes should be received by the same groups of households. Households with the lowest welfare levels or very poor households who meet the requirements of the PKH programme will receive assistance from the PKH, BLT and Raskin

Table 6.7: Coverage by any form of social protection programme by household characteristics, 2009 (%)

Indonesia	% of Households covered by any form of social protection (social insurance and/or cash transfers, in-kind transfers from public authorities, employers or charities)	
Total incidence	**58.23**	
Individual dimension		
Sex and Age	**Male**	**Female**
Age group 1 (0–14)	60.04	60.26
Age group 2 (15–24)	55.34	58
Age group 3 (25–44)	55.42	55.53
Age group 4 (45–64)	60.03	57.14
Age group 5 (65+)	68.72	64.68
Household dimension		
Household Size		
Less than 3	58.2	
3–4 members	57.66	
5–6 members	57.99	
7+	61	
Women's Education		
None	79.07	
Primary	70.45	
Secondary+	36.54	
Gender of the Head of the Household		
Male	57.46	
Female	65.37	
Wealth Index Quintiles		
Q1 (poorest)	87.25	
Q2	76.81	
Q3	64.19	
Q4	44.41	
Q5 (richest)	18.49	
Work (not mutually exclusive categories)		
Both parents working	60.3	
None of the parents working	45.13	
No adult in primary working age (18–54)	70.11	
At least one child under 15 working	66.74	
Illness and Disability in the Household		
Child/children with disability	69.36	
High dependency ratio (4+ children per adult)	62.9	
Elder (70+) person in household	66.22	
Residence		
Urban	43.06	
Rural	72.43	

Source: Estimated using data from the 2009 SUSENAS

Table 6.8: Children living in households that received various forms of government assistance (%)

Indicators	% Children of all the children in Indonesia		
	2003	2009	Annual Changes
Households that receive health insurance (Jamkesmas)	15.52	9.34	-1.03
Households that receive subsidized rice (Raskin)	46.1	41.22	-0.81
Households that receive anti-poverty credit (KUR)	2.11	5.99	0.65
Households whose children receive scholarships	7.49	3.65	-0.64

Source: Estimated using data from 2003 and 2009 SUSENAS (Panel), except scholarship from SUSENAS MSBP (data are weighted by population).

programmes. Meanwhile, other households including the very poor households that are not eligible for the PKH will still receive BLT cash payments and Raskin rice. When BLT programmes have been implemented in the past, poor households received assistance of IDR120,000–IDR350,000 per month. At the time of writing this report, when the BLT programme had ceased to be implemented, eligible households should have been able to receive assistance in the range of IDR20,000–250,000 per year.

The findings of various studies have indicated that much of the assistance received by households benefitted children. Rice from the Raskin programme was used to feed children, while the savings due to the subsidized cost of the Raskin rice could be used to supplement their nutritional needs with vegetables and sources of protein, as well as other needs. The number of children who benefitted from the Raskin programme was significant – according to 2009 SUSENAS data, the percentage of children from households who were recipients of the Raskin programme was 41.22 per cent of all Indonesian children (see Table 6.8).

During the qualitative studies in North Jakarta and East Sumba, a few respondents stated that the Raskin programme was very helpful in ensuring adequate food consumption for the family, and reducing the cost of rice. Although the quality of the rice was often poor, this was accepted by households as the price was far below the market price.

Assistance from the BLT programme was partially used by recipient households to meet the needs of children. Data from the SUSENAS surveys and analysis by the SMERU Research Institute (2008) based on data from BPS – Statistics Indonesia showed that recipient households used BLT funds to meet various needs. Types of uses that could benefit children directly included food purchases, medical expenses and school fees. A substantial proportion of recipient households used the BLT funds to meet these basic needs; 15–42 per cent used the funds for medical expenses, and 11–27 per cent used the funds for school fees (Table 6.9).

Table 6.9: Use of unconditional cash transfer (BLT) funds, 2005 and 2008 (%)

Type	BLT 2005		BLT 2005	BLT 2008
	Phase I	Phase II	Phase I	Phase I
Consumption	99	96	90	80
Medical expenses	42	41	15	32
School fees	27	27	11	13
Number of households (n)	2,685	1,968	89	90

Source: Data processed from SUSENAS (first two columns) and SMERU Research Institute (next two columns)

A study conducted by Bazzi, Sumarto and Suryahadi (2010) has examined the impact of the unconditional cash transfer (BLT) programme on education, health and the students' working hours. The study found that:(1) The BLT funds enabled households to increase their use of outpatient health services, particularly at relatively higher quality private institutions; (2) BLT reduced the number of hours worked per student per day by about 0.2–0.5 hours and the number of days worked per week by 0.05–0.2 days, lesser working hours can be associated with increasing study hours for students; (3) for working age adults, however, receipt of BLT programme assistance appears to precipitate a small decline in the labour supply in the order of one hour per week. Respondents of the qualitative study in North Jakarta and East Sumba also stated that they used the BLT programme funds to meet daily consumption needs; for example, to pay for electricity, school fees and other expenses. They considered the cash from the BLT programme very useful as it could be used to pay for various daily needs. Therefore, they regretted the discontinuation of this programme.

The PKH conditional cash transfer programme was partly intended to support the health and education of children. According to the SMERU Research Institute (2010), PKH recipients generally used the funds to meet the health and educational needs of their children, such as buying milk, extra food, shoes, uniforms, school supplies and snacks at school. According to the qualitative study in North Jakarta, the funds from the PKH programme were mainly used to finance children's school needs as well as milk and food for children under the age of five years and pregnant women. This programme was also associated with a reduction in the school dropout rates at elementary and junior secondary school levels.

6.4 Recommendations

As the number and proportion of children in poor households was disproportionately higher than in wealthier households, efforts to improve the welfare of poor households will significantly improve the welfare of children in these households. The Government of Indonesia has made considerable progress in establishing poverty reduction programmes. Targeted household income support programmes have grown, particularly since the Asian financial crisis in 1997/1998, both in terms of the scope, budget allocations and coverage of recipients.

Of the three clusters of poverty reduction programmes, social assistance programmes received the greatest attention from the government in terms of budget allocation. Most of these programmes are in the form of family or household-based income support, which has directly and indirectly benefited children as household members. In the short term, these social assistance programmes help poor, very poor and near-poor households by, at the very least, supporting minimum levels of daily food consumption. Social assistance programmes are designed to support poor and near-poor households that are vulnerable to external shocks. Studies have proved that the Raskin and BLT programmes benefited the targeted households by offsetting the impact of the rising fuel and rice prices in Indonesia. Considering the long-term impact of the social assistance programmes, some are designed to help the development of human capital by supporting improved health and education for children, such as the PKH programme, which specifically addressed the basic health, nutrition and education needs of the children of very poor families who met the eligibility criteria.

Against all the successes, the effectiveness of these programmes in reducing poverty levels in poor households is still unclear, due to the implementation challenges, such as overlapping programmes, mis-targeting of beneficiaries, as well as under-coverage, due to a lack of up-to-date data, poor coordination and problems with distribution mechanisms. There was some criticism that the design of the programmes was not practical given the real conditions in Indonesian society.

On the supply side, some improvements needed in government poverty reduction efforts are:

- Targeting of households should be improved and tightened in order to reduce errors and increase the coverage of poor households.

This can be achieved through improving data quality and by implementing adequate verification before distribution.

- Poverty reduction efforts should address multi-dimensional poverty rather than focusing merely on income poverty.
- The distribution process should be coordinated more efficiently. To this end, the government should minimize the number of intermediary parties involved in the distribution channels; for example, in the case of the Raskin programme.
- The government should give more attention to long-term social protection programmes, and strategies aimed at breaking the intergenerational cycle of poverty. Poverty reduction programmes need to focus on investment in human capital, beginning with direct support for the health, nutrition and education of children in poor households, in combination with economic assistance to these households that will allow them to help themselves out of poverty.
- Monitoring and evaluation mechanisms must be strengthened to ensure that the maximum benefit goes to the poorest in society.

On the demand side, several studies have shown that most of the assistance received by households was used to meet the needs of children, whether directly or indirectly. However, some issues concerning the use of the assistance within the recipient households have also come to light. A lack of knowledge and awareness among parents about the importance of investment in their children's health and education often caused mismanagement in the allocation of household income and social assistance funding received by the household. Indeed, a lack of awareness might have created a disincentive for parents to invest the money in their children's future success by paying for school-related expenses, creating instead a dependence on government hand-outs. In this case, training or education about household management is needed to build awareness and accountability among the adults (parents) about the importance of investment in their children's future.

In terms of programme coverage, there are still many poor households not reached by the poverty reduction programmes because they do not have an identity card or are living in illegal areas and/or in remote location. Remote locations also cause the programme's assistance to be underutilised because of the difficulty in accessing the services that the funding is meant to help pay for (i.e., schools and health centres). The high burden of transportation costs are another disincentive for the targeted households when it comes to spending the provided assistance funds.

Another crucial issue is that targeted households often fail to receive the government assistance they are entitled to due to limited access to information. More involvement of local leaders is needed to ensure that eligible poor households are informed and included in poverty reduction programmes.

CHAPTER 7

Addressing child poverty and disparities

7.1 Introduction

Children represent the future of a country and Indonesia's future will be determined by the quality of its children. Indonesia's children are shaped by the hard work and persistence of the Government of Indonesia (GoI) and also civil society groups as they work to fulfill the rights of all children, regardless of their sex, ethnicity, geographical location, family background or disability. As provided in the Constitution, every child in Indonesia has the right to survive, grow and develop to realize their full potential, as well as to be protected from discrimination and violence. This lays the foundation for the responsibility of the state to eliminate child poverty and disparities, and continuously work to improve the well-being of all Indonesian children.

The urgency of improving the well-being of Indonesian children is also linked to the economic, political and demographic stability of the country. Firstly, as Indonesia's economy progresses and becomes further integrated into the volatile world market, Indonesian children need to be made capable of withstanding the impact and potential shocks of global competition. As shown in Table 7.1, Indonesian children generally lag behind neighbouring countries in terms of school enrolment, under-five mortality rates (U5MR), and nutritional status. In the future, they will need to catch up with children from developing countries in other regions, like Brazil. Secondly, as Indonesia has already embarked on a democratic transition and decentralization process, the effectiveness of the state will not only depend on a few elites but also increasingly on a wider resource base of highly-qualified community members. Children across the country need support to develop their intellect, integrity and leadership qualities, such that leaders with strong aptitude will be available to carry on the future political transformation in order to achieve a better functioning state that not only provides equal access to welfare but also respects human rights. Finally, the demographic data show a continuous decline in the proportion of children in the national population over the last three decades, implying that in the short term the dependency ratio will increase as a result of a higher proportion of older and elderly people. Thus, the children of today will most likely shoulder a greater economic burden in the future, and without good education and healthy bodies and minds, they will be highly vulnerable to poverty.

Improving the well-being of children should be viewed as a multidimensional task. While adequate household income is a necessary component in supporting the fulfillment of child

rights, it is not sufficient on its own, and other deprivations must be addressed. Also, increasing children's welfare at an aggregate level will not be sufficient without ensuring equal access and opportunity for all children regardless of their location, gender and socio-economic background. It has been widely acknowledged that a country's capability to develop and reach its full potential cannot be judged only by the quantity of growth but also by the quality of growth. All parts of the community, including all groups of children, should have equal access to participate in and to enjoy the benefits of growth. Consequently, the GoI should ensure that development processes and outcomes will increase the well-being of all children equally.

Indeed realizing children's rights and increasing their welfare without discrimination in a large and diverse country like Indonesia entails many challenges. Essentially, the well-being of children is determined by the collective efforts of parents and extended families, the community, the local, provincial, and national government, as well as the global community. Therefore, household poverty and differences in economic development across communities and regions potentially influence the variation in children's well-being. In addition to the regional disparity in economic and physical infrastructure developments, the progress in realizing children's rights is also affected by the new decentralized decision-making process. This involves not only the central and regional government executive institutions but also the political parties sitting in the legislative, as well as the media, various non-government organizations (NGOs), and the communities themselves to provide the necessary checks and balances. The volatility of the global economy also affects the domestic economy and indirectly impacts on child well-being. In addition to this, the government's capacity to fund programmes related to the improvement of child well-being is limited by the fact that a large proportion of the central and local government budgets are allocated to the maintenance of the government administrative apparatus and fuel subsidies.

With poverty and children's welfare at the top of the GoI's agenda, this analysis of child poverty and disparity seeks to increase awareness about neglected and deprived children and to support strengthened policies and interventions to benefit these children. The intention is to specifically explore the multiple dimensions of poverty and deprivation facing children in Indonesia. The following passages draw major conclusions from the gathered quantitative and qualitative data presented in the preceding chapters and link these conclusions with relevant policies in order to develop practical and effective recommendations for the reduction of child poverty and disparities in Indonesia.

Table 7.1: Indicators of economic strength and children's well-being in Indonesia compared with selected developing countries

Country	Gross national income (GNI)	Combined gross enrolment rates in school	Expected years of schooling of children under 7	Under-5 mortality rate	Under-5 suffering moderate & high malnutrition	Child labour (5–14 years)
Indonesia	3,956.8	68.2	12.7	41	18	7
Malaysia	1,326.9	71.5	12.5	6	n/a	n/a
Vietnam	2,994.8	62.3	10.4	14	n/a	16
Philippines	4,992.1	79.6	11.5	32	22	12
Thailand	8,000.6	78.0	13.5	14	7	8
China	7,258.5	68.7	11.4	21	6	n/a
India	3,337.4	61.0	10.3	69	43	12
Brazil	10,607.0	87.2	13.8	22	2	4

Source: UNDP, International Human Development Indicators, available at: http:/hdrstats.undp.org/en/indicators; UNICEF, Childinfo, available at: http://www.childinfo.org/undernutrition_nutritional_status.php

7.2 The extent and state of child poverty in Indonesia

This study has assessed the situation of multidimensional deprivation facing children in Indonesia and the country's progress towards reducing both the deprivations and the disparities. The findings have revealed the considerable progresses in many dimensions of children's well-being. At the national level, over the past few years leading up to 2009, the proportion of children in income poverty declined significantly, enrolment rates at all levels of education increased, child mortality rates declined, children's nutritional status improved, and the proportion of children living in unhealthy settlements and without proper sanitation declined.

Despite these successes, unfortunately the level of achievement in several other dimensions is still very low and will require major efforts. As presented in Table 7.2, a high proportion of children still live below the decent living standard ($2 PPP per capita per day), there is a low level of enrolment in ECE, a low level of access to various sources of information (except television), a low proportion of babies exclusively breast fed, and a low level of possessing birth certificates. These are important issues that need special attention as more than half of Indonesian children are deprived. Meanwhile, more than a quarter of children still suffer from deprivation in regard to other dimensions such as income poverty, secondary school enrolment rates, healthy settlements and sanitation and under-five mortality. These issues also need to be addressed. More importantly, special attention should be devoted to some indicators that have experienced setbacks, including access to safe water,[1] exclusive breastfeeding, measles immunization, cases of diarrhea and asthma, access to story books, magazines and newspapers, access to artistic performance and practice, as well as child labour and children with multiple activities (school, work and chores).

Poverty is a dynamic phenomenon. Going forward, it is important that the dimensions where good progress has been achieved should not be taken for granted, but that progress must be maintained. Moreover, as will be discussed in the following passage, the national figures often hide the inequality of progress and achievements across groups of children from different backgrounds and locations. Thus, a deeper disaggregated analysis is always necessary to ensure that no particular group of children is being neglected and left behind the others.

Table 7.2. Summary of progress in reducing various dimensions of child poverty in Indonesia, 2002–2010 (%)

		2003	2009	Average annual change (%)	Data sources
Income poverty	Live below $1 PPP/capita/day	12.8	10.6	-2.9	SUSENAS
	Live below national poverty line	23.4	17.4	-4.3	SUSENAS
	Live below $2 PPP/capita/day*	63.5	55.8	-2.0	SUSENAS
Shelter	Area < 8m2/person	26.2	23.9	-1.5	SUSENAS
	Earth floor	15.1	10.8	-4.7	SUSENAS
	No electricity for lighting	15.5	7.5	-8.6	SUSENAS
Sanitation	No proper toilet	53.7	35.6	-5.6	SUSENAS
Water	No access to clean water	29.3	35.1	3.3	SUSENAS
Health condition	Self-reported asthma	0.4	0.8	16.7	SUSENAS
	Self-reported diarrhoea	1.1	1.7	9.1	SUSENAS
Immunization and breastfeeding		2002/2003	2007		
	Incomplete immunizations	48.5	41.4	-2.4	IDHS
	Not immunized: Hepatitis B1	29.1	19.5	-5.5	IDHS
	Not immunized: Hepatitis B2	41.9	28.3	-5.4	IDHS
	Not immunized: Hepatitis B3	54.7	39.7	-4.6	IDHS
	Not exclusively breastfed (<6 months)	60.5	67.6	2.0	IDHS
		2007	2010		
	Not immunized: measles	18.4	25.5	6.4	RISKESDAS

[1] This definition does not include packaged/bottled water (see Chapter 2)

				Average Annual change (%)	Data sources
Nutritional status	Underweight	18.4	17.9	-0.5	RISKESDAS
	Stunting	38.8	35.6	-1.4	RISKESDAS
	Wasting	13.6	13.3	-0.4	RISKESDAS
	Overweight	12.2	14.0	2.5	RISKESDAS
Mortality rate		2003	2009		
	Neonatal	23.0	19.0	-2.9	IDHS
	Post-neonatal	20.0	15.0	-4.2	IDHS
	Under 5 years old	54.0	44.0	-3.1	IDHS
Not enrolled in school		2003	2009		
	Age 3–6 years (ECE**)	76.2	67.8	-1.8	SUSENAS
	Age 7–12 years (primary)	3.8	3.0	-3.5	SUSENAS
	Age 13–15 years (junior)	21.0	13.5	-6.0	SUSENAS
	Age 16–17 years (senior)	43.4	32.8	-4.1	SUSENAS
Dropout and discontinued	Age 7–12 years	1.6	1.1	-5.2	SUSENAS
	Age 13–15 years	20.1	12.7	-6.1	SUSENAS
	Age 16–17 years	42.8	32.1	-4.2	SUSENAS
Schooling children without access to certain sources of information (5–17 years)	School text books	40.1	25.1	-6.2	SUSENAS
	Science books	81.9	66.5	-3.1	SUSENAS
	Story books	82.2	84.9	0.5	SUSENAS
	Newspapers	90.5	95.0	0.8	SUSENAS
	Magazines/tabloids	90.7	95.2	0.8	SUSENAS
	Television	9.5	6.2	-5.8	SUSENAS
	Radio	51.9	83.4	10.1	SUSENAS
	Art practice or display	88.5	92.4	0.7	SUSENAS
Working children (10–17 years)	Total	12.3	10.5	-2.4	SUSENAS
	Economic work only	7.0	4.6	-5.7	SUSENAS
	Economic work and household chores	2.3	2.3	0.0	SUSENAS
	Economic work and schooling	2.1	2.1	0.0	SUSENAS
	Economic work, household chores and schooling	0.9	1.6	13.0	SUSENAS
		2004	2009		
Working children (10–17 years)	Total	8.7	10.4	3.9	SAKERNAS
	Economic work only	4.4	2.2	-10.0	SAKERNAS
	Economic work and household chores	2.0	3.4	14.0	SAKERNAS
	Economic work and schooling	1.8	3.5	18.9	SAKERNAS
	Economic work, household chores and schooling	0.5	1.3	32.0	SAKERNAS
	Child Labour	4.2	4.7	2.4	SAKERNAS
		2007	2009		
Lack of birth certificate	< 5 years old	59.4	52.3	-6.0	SUSENAS

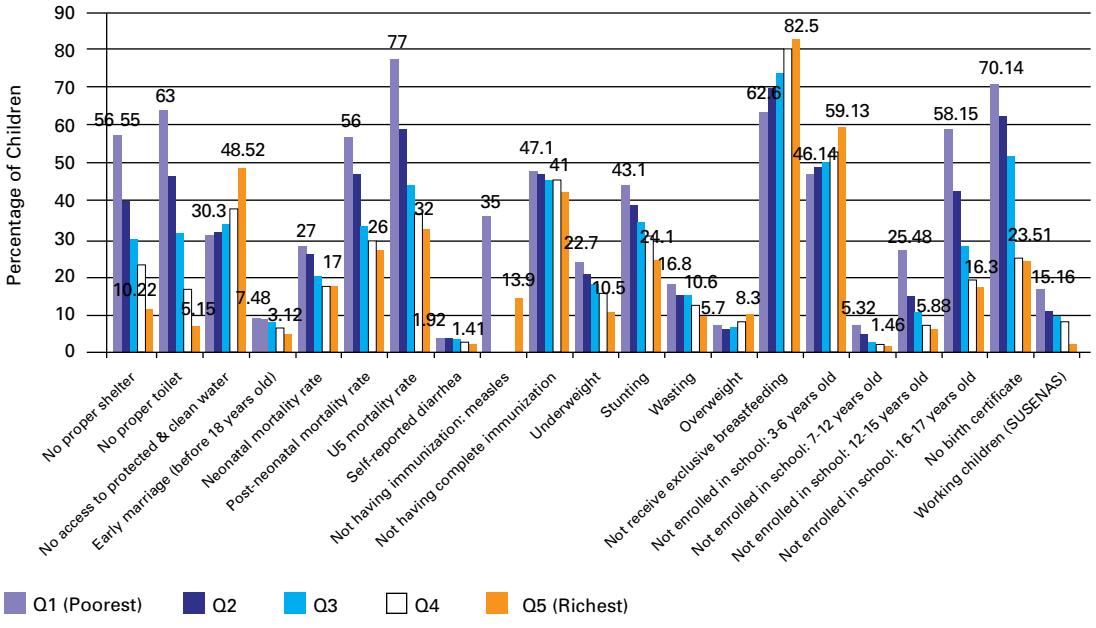
Source: National Socio-Economic Survey (SUSENAS); Indonesia Demographic and Health Survey (IDHS); Basic Health Research (RISKESDAS); National Labour Force Survey (SAKERNAS)

*Notes : *PPP=Purchasing power parity; **ECE=early childhood education*

In spite of the progress already made, a substantial number and proportion of children in Indonesia suffer from multiple deprivations. The estimates presented in Chapter 2 indicate that only around 15 per cent of children in Indonesia are completely free from all seven dimensions of deprivation – education, child labour, health, shelter, water, sanitation and income. Around a quarter of all children suffer from one dimension of deprivation, and another quarter suffers from two dimensions. In total, almost 70 per cent of all children in Indonesia suffer from one to three dimensions of deprivation. Since the proportion of children that live on less than $2 PPP per capita per day accounted for around 55 per cent (in 2009), the multiple deprivation figure indicates that even children from non-poor households by income measures, suffer from other forms of deprivation (non-income). Further analysis shows even among the top three income[2] quintiles (i.e., the three wealthiest) a significant proportion of children (more than 30 per cent) do not have access to safe water and are not enrolled in early childhood education (ECE).

Indeed, the correlation analysis indicates a strong correlation between the various deprivation dimensions, and that household income remains the most significant determining factor for other types of deprivation. Household attributes – such as female-headed household, large number of household members, and low educational background of the household head – were found to be strongly correlated with income poverty. Female-headed households, however, performed better than male-headed households in terms of nutrition and education-related dimensions. There was a higher prevalence of various types of deprivation among children from poorer households, with the exception of access to clean water, prevalence of overweight children, exclusive breastfeeding, and enrolment in early childhood education. It is important to note, however, that even in the dimensions that have been progressing well nationally, such as the U5MR, the ownership of birth certificates, and school enrolment rates among children aged 12–15 years, the gaps between children from the poorest and the richest quintiles are substantial

Figure 7.1: Selected indicators of child deprivation showing disparities among households by wealth quintiles, 2009



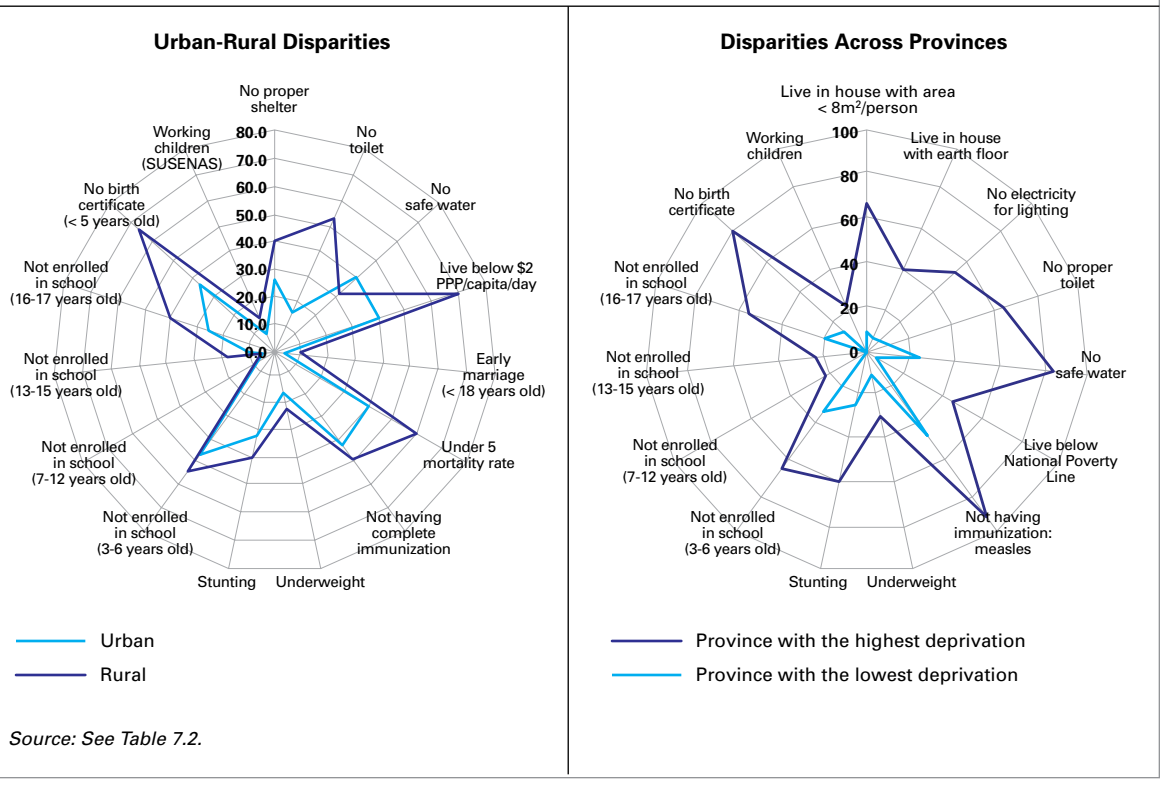
Source: See Table 7.2.

2 The term 'income' in this chapter refers to an estimate using expenditure as a proxy

(Figure 7.1). In the case of nutritional status, in particular, despite the overall good progress, the prevalence of malnutrition and stunting among children from the poorest quintile households is actually increasing. These disappointing results call for special efforts to be specifically directed at reaching children in the poorest households, through the provision of child-sensitive social protection programmes and other efforts.

In addition to the disparities across different levels of household income, there are two other important disparities affecting Indonesian children: disparities across regions (provinces and districts) and disparities between children in urban and rural areas. The east–west disparities in economic and infrastructure developments combined with the difference in population density have translated to huge gaps in children's well-being. The situation of various dimensions of child deprivation in provinces in the eastern part of Indonesia is generally worse than in the western part of the country. The number of children and the density of the living conditions in the western part of Indonesia, especially in Java and Bali, are significantly higher than those in the eastern part of Indonesia. The gaps between the best and the worst performing provinces are substantially larger than the urban–rural gaps on many key indicators (Figure 7.2). Furthermore, as presented in the previous chapters, the gaps between the districts with the lowest and the highest levels of deprivation are even larger. The narrative evidence gathered during the qualitative study shows that local social and cultural norms as well as local government policies are also affecting the child well-being. These certainly pose big challenges for regional governments – at the provincial and district levels – as they strive to continuously improve coordination in service delivery under the decentralized system.

Figure 7.2: Disparities in various dimensions of child deprivation across provinces and between children in urban and rural areas, 2009



Source: See Table 7.2.

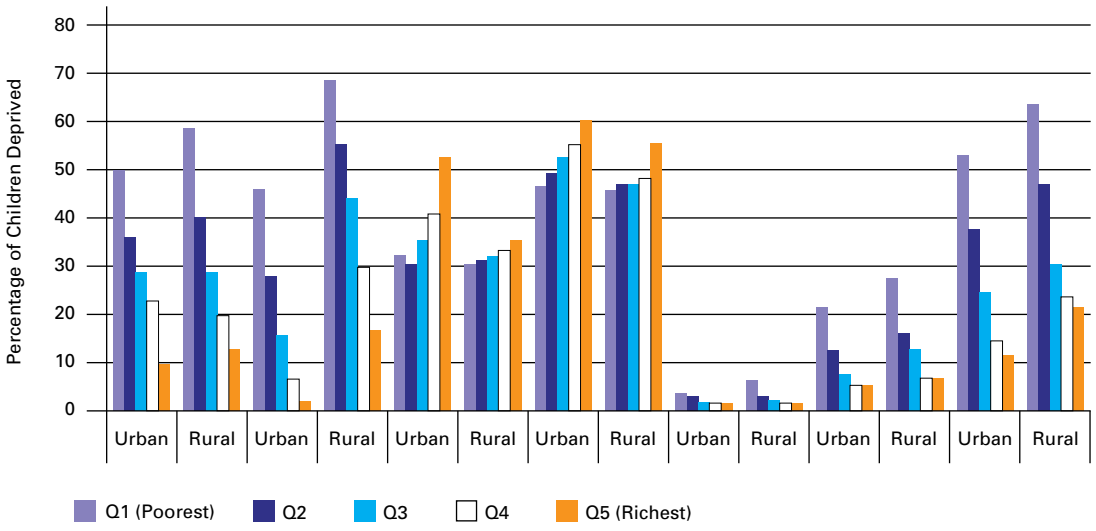
It is important, however, to note that although the deprivations of children in rural areas are more severe than those in urban areas, the poverty and deprivation among some urban children demand urgent attention. Indonesia is increasingly more urbanized, and urban poverty is also increasing. Urban children are also increasing in number, and they are not an homogeneous population. If the deprivation data for children in urban (and also in rural) areas are further disaggregated by household income quintile, it is evident that the conditions for children from poor urban households are not much different from those experienced by children from poor rural households (Figure 7.3). While available statistics point to more severe income and physical deprivations for rural children, the narrative evidence from children reveals the greater severity of non-material deprivations among urban poor children (see Chapter 2). In addition, as discussed in Chapter 2, there is a high likelihood that data on urban poor children are significantly limited by the fact that the National Socio-Economic Survey (SUSENAS) does not include children in special living situations (dormitories, childcare institutions, etc.) or children living on the streets.[3] These facts call for the same attention to be devoted to deprived children, especially children in income poor households, in both urban and in rural areas. The approaches applied to the urban and rural problems, however, should be distinct. While rural children, obviously, suffer more from difficulties of physical access to service delivery points, poor children in urban areas suffer more from various non-physical barriers that prevent their access to basic services and social assistance.

Taking in consideration all the progress and all the persistent gaps, it is important from the policy point of view to identify which policies and programmes have contributed to the progress, which have not worked well, and what policy gaps remain. Previous chapters have presented various policies and programmes directed at supporting the pillars of children's well-being. Among the government programmes that have made significant contributions to the well-being of Indonesian children are the poverty reduction and social protection programmes, which are interconnected. Although most poverty reduction programmes are not directly delivered to children, the household welfare interventions are improving the capability of households to care for their children. Before the 1997/1998 Asian financial crisis and the fall of the New Order Government, massive support for agricultural development and labour-intensive industrial and infrastructure developments had increased the welfare of Indonesians in general. These economic transformations combined with substantial investment in developing physical infrastructure for health and education, such as the construction of community health centres (*puskesmas*) in almost all sub-districts, and primary school buildings in almost all villages and urban precincts, had improved children's access to health-care facilities and schools. The sudden increase in poverty levels caused by the Asian financial crisis posed different types of problems, and government responses in the form of social safety net (SSN) programmes have been widely appreciated as successfully cushioning the adverse impacts of the crisis on children. The SSN programmes consisted of labour-intensive infrastructure projects, subsidized rice for the poor, health insurance for the poor and massive scholarship programmes, which were considered successful at keeping many children in school and safe-guarding children's health from the impact of the income shocks.

The success of the SSN programmes inspired the government to continue with most of them and further develop them as social protection programmes, which have provided direct and indirect benefits to children. The labour-intensive development programmes were modified and expanded as the kecamatan (sub-district) development programme, which then became the National Community Empowerment Programme (Program Nasional

[3] Based on a quick and dirty calculation of the difference between the number of children estimated from the SUSENAS and those counted in the national census, it is estimated that approximately two million children lived in special living circumstances (e.g., institutions) and on the streets. A more precise estimation can be calculated when the 2010 census data is formally released.

Figure 7.3: Deprivations in shelter, sanitation, water, and school enrolment among children by urban and rural location and household wealth quintiles, 2009



Source: See Table 7.2.

Pemberdayaan Masyarakat, PNPM). The PNPM is now an umbrella programme for various other programmes that involve community participation in the planning and implementation stages, and it includes, among others, PNPM urban, PNPM rural, PNPM Generasi and PNPM Green. The PNPM Generasi, in particular, is also known as the 'community conditional cash transfer' programme, and is designed to improve children's health and education conditions by providing funding for the community to be spent on any investment considered necessary by the community to improve the health and education of local children. Children also benefit from PNPM rural, since most communities decide to use the grants to build roads that improve physical access to health and education services or to improve access to water by drilling wells or constructing pipelines.

The subsidized rice for poor households programme has been slightly modified and is nowadays known as the Raskin programme (formerly known as OPK). Most of the programme beneficiaries use the savings from buying the cheaper rice for other household expenses, especially side dishes and educational expenses (see Chapter 4). The health insurance for the poor programme is also maintained as a nationwide programme that provides free basic health care services for the poor, and improves access for poor mothers and children to medical care (see Chapter 4). In 2005, the scholarship programme for primary and junior secondary school students was transformed into a general subsidy for all primary and junior secondary schools, known as BOS (School Operational Assistance). Aiming to support the policy of nine years compulsory education and education for all, the BOS programme has significantly increased budgets for private and public schools and significantly reduced the school fees paid by parents. As a result of this, enrolment in primary and junior secondary schools has significantly increased (see Chapter 4). In addition to these programmes, the government has also initiated unconditional and conditional cash transfer programmes (known as BLT and PKH, respectively) that have been very beneficial for children (see Chapter 6). Although previous chapters have highlighted some implementation problems that reduced the programmes' effectiveness in reaching poor children, these social protection programmes have made significant contributions to the improvement of child well-being as well as providing protection

in times of crisis, such as during the 2008/2009 global financial crisis (Hastuti et al., 2010).

Some of the credit for the improvement in child well-being can also be attributed to a decade of dedicated and continual advocacy for the rights of children and to the devoted efforts by both government and non-government actors in developing, implementing and overseeing various programmes aimed at fulfilling those rights. In addition to strengthening national legal foundations by stipulating various laws pertaining to children, improvement of child well-being has been incorporated into the National Medium-Term Development Plans (RPJMN) and various National Action Plans. The efforts have also been enhanced by coordination across central government agencies as well as among various levels of governments, and complemented by the establishment and development of various child protection institutions at the central and sub-national levels.

All of these efforts have provided the necessary foundation for fulfilling the rights of the child, but they are not sufficient to ensure the implementation at the local, grassroots level. Only limited numbers of provincial and district governments have participated in various child protection programmes; thus, even if the programmes are successfully implemented in the participating regions, the national impacts will be limited. Given the decentralized nature of most public service delivery in Indonesia, it will take persistent efforts and a very long time to increase the awareness and political will of all provincial and district governments to comply with and participate in various national policies and programmes related to the fulfillment of children's rights. In addition, children are generally in the care of their parents, families and communities, and in many cases there are local customs or habits that conflict with efforts to realize children's rights, such as in the cases of child labour, early marriage and violence against children. These problems cannot be easily overcome merely by issuing laws and regulations; they require sufficient advocacy and social transformation efforts that are usually best performed by civil society organizations (CSOs) that are familiar with the local context and customs. Consequently, the rather limited involvement and participation of regional governments and the limited efforts devoted to addressing unsupportive local customs could explain some of the remaining disparity problems.

Some of the overall achievements are impressive. However, considering that disparities still persist – such as in school enrolment of primary and junior secondary school-aged children (7–15 years), electricity connection, cases of underweight children under age five, and neonatal and post-neonatal mortality – further improvement to achieve universal targets is likely to be much more challenging. The same challenges apply in the case of reducing the proportion of children living in chronic poverty (less than IPL $1 PPP per capita per day), which has been declining at a much slower rate than the reduction of chronic poverty in the overall population (see Chapter 2). In many cases, existing programmes that have been successful in reducing deprivation to the current low levels are unlikely to work well in reaching those living in absolute poverty, since they are probably facing distinct problems beyond the reach of these programmes. Recently, several programmes have been developed to address the problem of children in chronically poor households or the previously untouched groups. These programmes include alternative education for street children and the expansion of non-formal education directly targeted to these children, as well as the PKSA (Social Welfare Programme for Children) and PKH (conditional cash transfers), which try to address the problem of inadequate household income. However, most programmes are either limited in coverage or are still facing implementation problems due to lack of competent human resources (such as qualified social workers) and a distinct lack of infrastructure (such as an online information system). The development of innovative new programmes based on a rigorous understanding of the problems faced by the children in extreme poverty is needed to reach these groups.

Other deprivations where relatively little progress has been made are those that have not attracted much attention or are overlooked because of monitoring difficulties. The ECE enrolment of 3- to 6-year-olds, exclusive

breastfeeding for babies up to six months old, and stunting, for example, have only recently been intensively advocated for and placed amongst the government's priorities. Thus, the efforts and resources that have been allocated for these problems are still limited. The problem of school enrolment and dropout rates among 16- to 17-year-olds has not been considered a high priority because most resources are still devoted to supporting the compulsory nine years of basic education. Meanwhile, regarding the issues of violence against children, child labour and children engaged in the worst forms of child labour, as well as trafficking, which have been addressed during the last decade, these programmes are now somewhat constrained by the lack of data to effectively guide programme planning and evaluate progress.

7.3 Reducing child poverty and disparities: How can we achieve this?

Further reducing child poverty and disparities in the current context of Indonesia will require collaborative and persistent efforts from all levels of government and non-government stakeholders. In many respects, the democratic decentralized setting has provided both challenges and opportunities to improve children's well-being, reduce poverty and deprivation, and realize the rights of the child. On the other hand, coherence and coordination of policies is becoming more difficult to achieve as the decision-making and implementation processes are complex. This fact potentially weakens national policies and associated programmes. However, some local government policies have strengthened and complemented national policies and programmes. A growing number of provincial and district governments have initiated their own social protection programmes, such as health subsidies for the poor (or even for all residents), free education, school subsidies and scholarships. Regional (provincial and district) governments, as well as non-government actors at the regional level, should be at the forefront of any efforts to reduce child poverty and disparities.

So far the GoI as well as various NGOs and donor agencies have initiated and advanced various child protection and poverty reduction policies and programmes. Thus, it would be better if further efforts to reduce child poverty and disparities build on these existing initiatives. Several important national policies have the potential to support the reduction of child poverty and disparities, including: (1) the establishment of various legal foundations to support the realization of the rights of the child; (2) the adoption of a holistic and structural approach to child protection in the government work-plan; (3) the development of a poverty reduction framework that has been recently expanded from three clusters – social assistance, community empowerment, and microenterprise empowerment – to four clusters by adding a new cluster comprising a low-priced housing programme, a low-priced public transportation vehicle programme, a clean water programme, an economical and low-priced electricity programme, a fishing folk livelihood improvement programme, and an urban community livelihood improvement programme; and (4) development of a unified data set for the targeting of social protection programmes.

The following passages will put forward some general recommendations based on the findings of the study presented in the previous chapters. Detailed recommendations for specific dimensions of deprivation have been presented in each chapter. The following recommendations are not mutually exclusive, and are often interrelated:

1. Continue strengthening the legal foundations for ensuring the fulfillment of children's rights without discrimination at all levels of governments and strengthening the monitoring of progress in this area. Strong and consistent laws and regulations are the foremost critical factor in realizing children's rights since without these it will be difficult to advocate and demand their realization. In the current context, while the central government has issued many laws and regulations, not all regional governments have responded with supporting policies, and it is difficult to track whether regional governments have issued relevant regulations and whether

they have been well implemented. Several recommended alternative actions includes: (i) continue with efforts to synchronize laws and regulations related to the realization of children's rights at the national level; (ii) assist and advocate regional governments in developing regional regulations pertaining to the fulfillment of the rights of children; (iii) develop a database and/or monitoring system to track the issuance of regional regulations and their implementation; (iv) further improve the reward system for regional (provincial and district) governments based on their progress in the provision of a strong legal basis for realizing children's rights in addition to rewarding them for their specific programmes and achievements. This could be expanded from an existing programme, such as in the case of 'Child Friendly Cities/Districts' initiated by the Ministry for Women's Empowerment and Child Protection.

2. Enhance the focus of poverty reduction programmes by mainstreaming children's issues into policy/programme development and implementation, both at the national and regional levels. It is widely acknowledged, and also falls in line with the adoption of a holistic approach to child protection, that reducing child poverty and disparities requires taking a direct approach by targeting the children concerned and an indirect approach by also targeting the families, households and communities that care for children. The latter indirect approach is a higher priority in the efforts to strengthen family and community capacity and capability to protect their own children. Since the number of children in poorer households is disproportionately higher than in richer households, the effectiveness of poverty reduction policies and programmes in assisting the poorest families will highly influence the poverty and multiple-deprivation faced by many children. The mainstreaming of children's issues should be done by: (i) increasing the profile of children in the planning, implementation, monitoring and evaluation of all poverty reduction programmes by taking into account the number of children that will benefit from the programme and the expected impacts of the programme on children's well-being; and (ii) ensuring that policies/programmes will not harm children but rather provide the maximum benefit to affected children, particularly children from income poor families.

3. Expand and improve social protection programmes to be more child-sensitive. As presented in this report, Indonesia has been advancing various social protection programmes initiated by the central as well as regional governments. Thus, in addition to the second recommendation stated above, the most strategic approach would be to build on these existing programmes and to increase the child-sensitivity of the programmes. Some programmes that produce the maximum benefit for children such as PNPM Generasi (National Programme for Community Empowerment – Health and Smart Generation), PKH (conditional cash transfers) and PKSA (Social Welfare Programme for Children), should be expanded. However, the imposition of conditions should be carefully planned to avoid any systematic exclusion of some of the poorest children, especially if they live in regions where the supply side of services is lacking. Meanwhile, other social protection programmes, such as Jamkesmas (community health insurance scheme) and Raskin (Rice for Poor Households), should be made more child-sensitive. In addition to the central government programmes, regional government social protection programmes should also be made more child-sensitive. Such programmes should assure the maximum benefit for children, should not violate children's rights, and should take into account children's needs and perspectives. For example, the local health insurance and services for the poor can be tailored to address specific risks faced by local children and to intervene as early as possible to prevent irreversible harm.

4. Focus on efforts to reduce regional disparities by devoting more effort and resources to strengthening the regional governments' awareness and capacity to reduce child poverty and disparities in their own regions, and adopt policies and programmes appropriate to the local context where

possible. These efforts will entail intensive capacity building intervention to develop the capacity of regional stakeholders, to enable them to assess the multidimensional deprivation experienced by children in their own regions. Intergovernmental transfer of funds should also be improved to support appropriate financial capacity at the provincial and district government levels for use in addressing the multidimensional child poverty problems. Since the disparities across provinces and districts are the most significant (as compared to urban/rural or household wealth-based disparities), programmes to address child poverty are ideally conducted through specific geographical targeting. This can be done by: (i) paying more attention to the regions in Indonesia with the poorest achievement on child poverty and deprivation indicators (such as Papua, West Papua and East Nusa Tenggara), and concentrating efforts to understand and overcome location-specific challenges to reduce the multidimensional poverty problems facing children in these regions; and (ii) adopt different targeting approaches in different regions. While deprivation is most severe in many regions located in the eastern part of Indonesia and in Aceh, the absolute numbers of children deprived in many dimensions are higher in the western part of Indonesia, especially in Java, due to the high population density in Java. This phenomenon leads to the classic geographical targeting dilemma. One way to address this is to implement a targeted programme in the regions where the prevalence of child poverty/deprivation is quite low, but the absolute number of poor/deprived children is high, while taking a universal approach (non-targeted) in the regions where the prevalence of child poverty is high despite smaller numbers of children affected.

5. Improve utilisation of the existing data and increase the availability and the quality of data, particularly regarding child protection and non-material deprivation. All of the aforementioned recommendations depend on the availability of reliable data and supporting facts. Some national data sets contain data on children, but these data are not yet optimally structured or utilised. The analyses on child poverty and disparities presented in this study, for example, need to be continuously recalculated using up-to-date data in order to provide the necessary evidence base for developing child-sensitive programmes. In addition, major improvements are needed in the collection of data required for various indicators pertaining to child protection – including child trafficking, child labour, violence against children, street children and children not in parental care, and non-material dimensions of child poverty – particularly regarding child-parent relationships. A series of workshops, for example, could be organized with relevant data collection groups and data users to seek ways of improving the availability and quality of data necessary for effectively monitoring multidimensional child poverty.

This very first child poverty study conducted in Indonesia has provided a unique and new assessment of the quality and progress of development across the country, from the perspective of children's rights and well-being. The study has made a critical assessment of the equality of benefits enjoyed by children, and the effectiveness of development in facilitating the fulfillment of children's rights without discrimination. The process of analyzing and interpreting the preliminary findings of this study stimulated important discourse on a range of issues, some of which are beyond the scope of this report. This has also triggered a call to conduct further research, which would, among other aims, seek to provide a deeper analysis of the effectiveness of specific policies and programmes (including budget analysis), produce analyses that look more deeply into the disparities within regions, and also analyze the correlations between various dimensions of deprivation using data other than the SUSENAS data set.

Appendices

Appendix 1

Study methods

Following the UNICEF Global Study on Child Poverty and Disparity Guide, this study on child poverty and disparities in Indonesia serves as an initial effort to provide a holistic assessment of children living in poverty in this country.

This study has the following specific objectives:
(1) To present evidence-based analysis of the condition of 'children living in poverty', based on available statistics and narrative evidence from the perspective of children and other stakeholders; and
(2) To examine gaps and opportunities in the national and regional institutional settings and policies with a view to identifying effective approaches to fulfilling the rights of children.

By analyzing outcomes and policies together, and particularly the links between them, the study aims to generate knowledge on what policies and programmes most effectively support the rights of all Indonesian girls and boys in different contexts. At the same time, by exploring different dimensions of poverty, the study aims to contribute to the understanding of how progress in relation to one aspect of poverty could promote progress in other areas.

The definition of children used in this study is people under the age of 18 years. This is the definition according to the United Nations Convention on the Rights of the Child (CRC) and also generally corresponds to the available national data. Furthermore, to assess child poverty, deprivation indicators were used instead of well-being indicators, in consideration for data availability. The link between child poverty and deprivation is interpreted according to the working definition of poor children proposed in UNICEF's *State of the World's Children 2005* (p. 18): "Children living in poverty experience deprivation of the material, spiritual and emotional resources needed to survive, develop and thrive, leaving them unable to enjoy their rights, achieve their full potential or participate as full and equal members of society." Aspects of deprivation experienced by poor children were also clearly highlighted in the UN General Assembly's 2007 annual resolution on the rights of the child, in which a powerful new definition of child poverty was adopted: "Children living in poverty are deprived of nutrition, water and sanitation facilities, access to basic health-care services, shelter, education, participation and protection, and while a severe lack of goods and

services hurts every human being, it is most threatening and harmful to children, leaving them unable to enjoy their rights, to reach their full potential and to participate as full members of the society" (January 2007).[1]

To obtain a comprehensive picture of children living in poverty, four research approaches were used, including: quantitative analysis, qualitative assessment, institutional analysis and budget analysis. The methodology for each approach will be described in the following passages.

Quantitative approach

The quantitative analysis aims to determine the national and regional prevalence of various forms of deprivation experienced by children, their determinants, correlations among them, and trends over time between 2003 and 2009. This analysis also measures the disparities among children in different regions in Indonesia. Furthermore, after stratification by age group, a pair-wise correlation analysis was performed to determine the correlation between dimensions of poverty in children.

The 'Bristol Approach' can be used to classify children living in poverty based on specified thresholds, if the child meets at least two of eight deprivation dimensions. In this study, the level of child multidimensional poverty was determined using six dimensions:
1. Education
2. Working children
3. Health
4. Shelter
5. Sanitation
6. Water

Deprivations experienced by children in these different dimensions of child poverty were calculated for all children and children in each household's expenditure quintile. Further analysis is also performed to see correlation within household characteristics that might explain the variation in the prevalence of children poverty and deprivation, including: sex of the head of household, household size, education level of the household head, and geographic location (rural versus urban).

Some indicators of deprivation used in the quantitative analysis are listed in Table A.

[1] UNICEF Press Centre, 'UN General Assembly adopts powerful definition of child poverty', New York, 10 January 2007 [available at: http://www.unicef.org/media/media_38003.html, accessed 11 July 2012]

Table A: Quantitative indicators

Approach	Domain	Indicator	Unit of analysis	Data sources
Non-monetary approach	Education	Early childhood education (ECE) enrolment rate among children aged 3–6 years	Individual, children aged 3–6 years	SUSENAS 2003 and 2009 Panel
		School enrolment rate among children aged 7–12 years	Individual, children aged 7–12 years	SUSENAS 2003 and 2009 Panel
		School enrolment rate among children aged 13–15 years	Individual, children aged 13–15 years	SUSENAS 2003 and 2009 Panel
		School enrolment rate among children aged 16–17 years	Individual, children aged 16–17 years	SUSENAS 2003 and 2009 Panel
		School enrolment rate among children aged 7–17 years	Individual, children aged 7–17 years	SUSENAS 2003 and 2009 Panel
		% of children aged 3–6 years who never attended ECE	Individual, children aged 3–6 years	SUSENAS 2003 and 2009 Panel
		% of children aged 7–12 years who never enrolled in school	Individual, children aged 7–12 years	SUSENAS 2003 and 2009 Panel
		% of children aged 13–15 years who never enrolled in school	Individual, children aged 13–15 years	SUSENAS 2003 and 2009 Panel
		% of children aged 16–17 years who never enrolled in school	Individual, children aged 16–17 years	SUSENAS 2003 and 2009 Panel
		% of children aged 7–17 years who never enrolled in school	Individual, children aged 7–17 years	SUSENAS 2003 and 2009 Panel
		% of children aged 7–12 years who dropped out or discontinued school (DOD)	Individual, children aged 7–12 years	SUSENAS 2003 and 2009 Panel
		% of children aged 13–15 years who DOD	Individual, children aged 13–15 years	SUSENAS 2003 and 2009 Panel
		% of children aged 16–17 years who DOD	Individual, children aged 16–17 years	SUSENAS 2003 and 2009 Panel
		% of children aged 7–17 years who DOD	Individual, children aged 7–17 years	SUSENAS 2003 and 2009 Panel
	Information	% of children with no access to school text books	Individual, children aged 5 –17 years	SUSENAS 2003 and 2009 MSBP
		% of children with no access to science books	Individual, children aged 5 –17 years	SUSENAS 2003 and 2009 MSBP
		% of children with no access to story books	Individual, children aged 5 –17 years	SUSENAS 2003 and 2009 MSBP
		% of children with no access to newspapers	Individual, children aged 5 –17 years	SUSENAS 2003 and 2009 MSBP
		% of children with no access to magazines/tabloids	Individual, children aged 5 –17 years	SUSENAS 2003 and 2009 MSBP
		% of children with no access to television	Individual, children aged 5 –17 years	SUSENAS 2003 and 2009 MSBP
		% of children with no access to radio	Individual, children aged 5 –17 years	SUSENAS 2003 and 2009 MSBP
	Child worker	% of children with no access to art materials or art shows	Individual, children aged 11 –17 years	SUSENAS 2003 and 2009 Panel
		% of children who perform economic work only	Individual, children aged 11 –17 years	SUSENAS 2003 and 2009 Panel
		% of children who perform economic work and household chores	Individual, children aged 11 –17 years	SUSENAS 2003 and 2009 Panel
		% of children who perform economic work and schooling	Individual, children aged 11 –17 years	SUSENAS 2003 and 2009 Panel
		% of children who perform economic work, schooling and household chores	Individual, children aged 11 –17 years	SUSENAS 2003 and 2009 Panel

Approach	Domain	Indicator	Unit of analysis	Data sources
	Health	Self-reported disruption of school/work by ill health	Individual	SUSENAS 2009 Panel
		Self-reported fever	Individual	SUSENAS 2009 Panel
		Self-reported cough	Individual	SUSENAS 2009 Panel
		Self-reported influenza	Individual	SUSENAS 2009 Panel
		Self-reported asthma	Individual	SUSENAS 2009 Panel
		Self-reported diarrhoea	Individual	SUSENAS 2009 Panel
		Immunization: complete	Individual	IDHS 2002/03 and 2007
		Immunization: BCG	Individual	IDHS 2002/03 and 2007
		Immunization: DPT 1	Individual	IDHS 2002/03 and 2007
		Immunization: DPT 2	Individual	IDHS 2002/03 and 2007
		Immunization: DPT 3	Individual	IDHS 2002/03 and 2007
		Immunization: Polio 1	Individual	IDHS 2002/03 and 2007
		Immunization: Polio 2	Individual	IDHS 2002/03 and 2007
		Immunization: Polio 3	Individual	IDHS 2002/03 and 2007
		Immunization: Measles	Individual	IDHS 2002/03 and 2007
		Immunization: Hepatitis B 1	Individual	IDHS 2002/03 and 2007
		Immunization: Hepatitis B 2	Individual	IDHS 2002/03 and 2007
		Immunization: Hepatitis B 3	Individual	IDHS 2002/03 and 2007
		Infants <6 months old exclusively breastfed	Individual	IDHS 2002/03 and 2007
		Neonatal mortality rate	Individual	IDHS 2002/03 and 2007
		Post-neonatal mortality rate	Individual	IDHS 2002/03 and 2007
		Under-four mortality rate	Individual	IDHS 2002/03 and 2007
		Under-five mortality rate	Individual	IDHS 2002/03 and 2007
	Nutrition	Stunting	Individual	RISKESDAS 2007 and 2010
		Wasting	Individual	RISKESDAS 2007 and 2010
	Shelter	Area <8m^2/person	Household	SUSENAS 2009 Panel
		Has earth floor	Household	SUSENAS 2009 Panel
		No electricity for lighting	Household	SUSENAS 2009 Panel
	Sanitation	No proper toilet	Household	SUSENAS 2009 Panel
	Water	No access to clean water	Household	SUSENAS 2009 Panel
Monetary approach	Household income	% of people living in extreme poverty (international poverty line -IPL $1 PPP/capita/day)	Household	SUSENAS 2003 and 2009 Panel
		% of people living below national poverty line	Household	SUSENAS 2003 and 2009 Panel
		% of people living under a 'decent' income standard (IPL $2 PPP/capita/day)	Household	SUSENAS 2003 and 2009 Panel

Notes: National Socio-Economic Survey, SUSENAS; Indonesia Demographic and Health Survey, IDHS

The definitions of some terms used in this analysis are as follows:

Shelter deprivation: A child is said to be deprived in the shelter dimension if s/he lives in a dwelling that is no larger than 8 square metres per person, with an earth floor and/or no electricity for lighting. This report uses electricity from the official Indonesian national electricity company (PLN) and disregards electricity from other sources. In addition, it is important to note that this report does not consider wall and roofing material since these present ambiguities in poverty assessment. For example, in some areas in Indonesia, people who live in a dwelling with walls made of bamboo might be considered rich, while in other parts of the country, they are considered poor. The same ambiguity applies to roofing material.

Sanitation facilities: A child should have access to a toilet in his/her own dwelling. Access to a communal toilet is unacceptable. The toilet should at least be squat-type with at least a metal roof.

Water deprivation: A child should have access to clean water. In Indonesia, the official sources of clean water (often officially referred to as a safe and improved water sources) include piped water, rain water, artesian and dug wells, and protected wells and springs. In addition, the water sources must be located further than 10 metres from any septic tank.

Health deprivation: A child is said to be deprived of health if s/he has not received complete immunization or has reported work or school disruptions due to ill health, or has reported diarrhoea or asthma. However, due to data limitations, the immunization information cannot be processed into detailed and disaggregated tables.

Education deprivation: A child is said to be deprived in the education dimension if s/he has never been to school and/or is not currently attending school.

Income deprivation: A child is said to be deprived in the dimension of income if s/he lives below the national poverty line. In some cases, this report also utilizes provincial poverty lines to get a more proximate and pertinent measurement. The data on income is in fact data on household expenditure or consumption. Since the National Socio-Economic Survey (SUSENAS) does not have information on income, we make the assumption that expenditure approximates income. The expenditure data is composed of food and non-food expenditure. In addition, for international comparability purposes, some analyses also use the international poverty line (IPL) of $1 PPP per capita per day (extreme poverty), and IPL $2 PPP per capita per day (decent living standard). These poverty lines were applied using the standard of purchasing power parity determined at the national level, without adjustment to provincial prices.

For this report, data were sourced from several data sets, including the 2003 and 2009 SUSENAS as the main data sources, in addition to the 2002 and 2007 Indonesia Demographic and Health Survey (IDHS), the 2007 Indonesia Family Life Survey (IFLS), and the 2007 and 2010 Basic Health Research surveys (RISKESDAS). Since the Demographic and Health Surveys are an internationally known survey format, there is no need for further explanation.

The SUSENAS is a nationally representative household survey covering all provinces and districts in the country and is conducted annually. It is composed of 'panel' and cross-section ('core') data. The SUSENAS Panel survey, which is conducted in February, collects more detailed information on specific modules of interest, namely consumption and social, cultural and educational variables. The sample consists of around 65,000 households. The consumption module of the SUSENAS is the main data source for the poverty analysis. On the other hand, SUSENAS Core survey, which takes place in July, collects information on the basic socio-demographic characteristics of over 200,000 households, and over 800,000 individuals.

The RISKESDAS was formerly the health module of the SUSENAS, but it has been conducted independently since 2007. Like the SUSENAS, the RISKESDAS is a nationally representative household survey covering the whole of Indonesia. It is a cross-sectional survey that

collects very detailed information on health issues, conducted every three years. The 2007 RISKESDAS covered around 250,000 households, and over 980,000 individuals. The 2010 RISKESDAS covered around 70,000 households, and 315,000 individuals.

The other data source used in this report is the IFLS, which is a longitudinal household survey that began in 1993. There have been four waves so far; in 1993, 1997, 2000 and 2007. Unlike the SUSENAS and RISKESDAS, the IFLS only covers 13 of the 33 provinces in Indonesia. Despite this, the sample is representative of more than 80 percent of the nation's population. The number of households covered in the latest wave was 13,000.

Institutional and budget analysis

Institutional analysis was conducted to identify and examine the government efforts to enhance the fulfilment of children's rights that have been translated into national policy, national development priorities, and programmes which have been implemented at the ministry/ institutional level. Correspondingly, budget analysis was conducted to assess government efforts in fulfilling children's rights through provision of budget allocation.

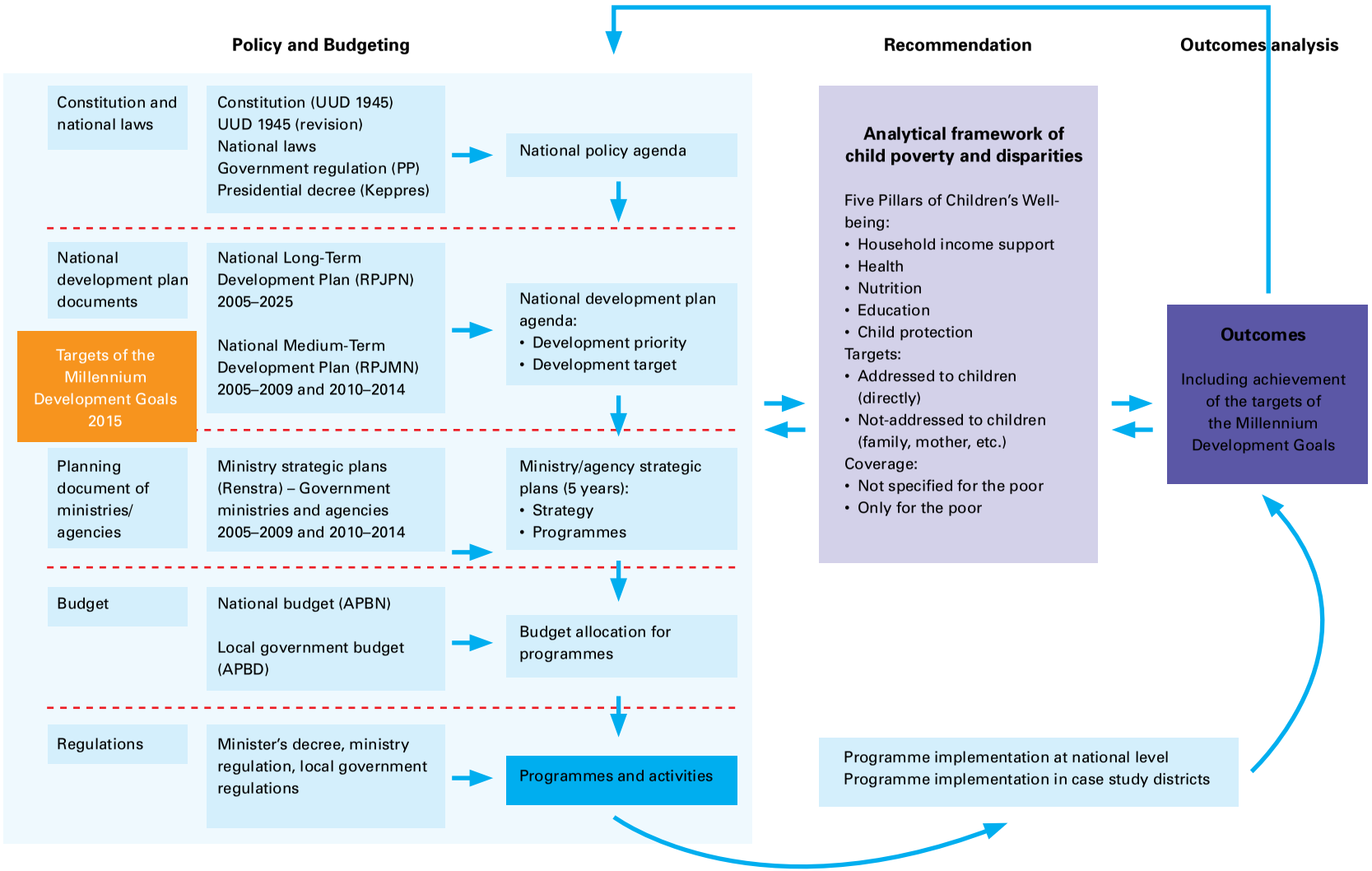
Following the analytical framework of the child poverty and disparity study, the institutional and the budget analyses were aimed at answering the following questions: (1) Is the existing policy and budget addressed directly or indirectly at children? and (2) Do the existing policies and budget allocations specifically address poor children or all children, based on the five pillars of children's well-being (family income support, health, nutrition, education and protection of children).

Applying the same framework, outcomes of the implementation of programmes and activities were also analyzed according to effectiveness in improving child well-being. In this study, institutional and budget analyses were carried out for each of the five child well-being pillars. Results of the analysis for each pillar were presented in Chapter III.

The budget analysis was conducted by grouping government programmes and activities based on budget line in the central government's national revenue and expenditure budget (ABPN). This approach limits the analysis to the use of those programme objectives and activities which are detailed in the budget document. More detailed budget investigations were beyond the scope of this study.

The analytical framework for the institutional and budget analyses conducted for this study is shown in Figure A.

Figure A : Logical framework of the institutional and budget analysis



Qualitative case studies

The case studies for qualitative assessment were conducted in two provinces in Indonesia with very different characteristics. The first province was the nation's capital, Jakarta.[2] Jakarta represents the urban context and this case study provided a general picture of children living in poverty in urban areas. As sample areas, the research was conducted in two *kelurahan* (urban precincts, equivalent to villages in rural areas) located in the district of North Jakarta (Jakarta Utara). The second selected province was East Nusa Tenggara (Nusa Tenggara Timur, NTT), representing the rural context and providing a general picture of life experienced by children living in poverty in rural areas. Research was conducted in two sample villages located in the district of East Sumba (Sumba Timur).

Data and information were collected using participatory assessment through focus group discussions (FGDs), in-depth interviews (IDIs) and observation, at national, district and *kelurahan* (precinct/village) levels (see Table B). Information acquired from the field research was analyzed through a process of triangulation by consolidating and comparing all the findings to get a complete and consistent picture of material and non-material aspects of poverty from the perspectives of children and other stakeholders, providing valuable contextual information that could not be gained using other research methods.

Although the findings from the case studies in North Jakarta and East Sumba provide valuable input for policy formulation, it should be highlighted that these results do not represent the conditions in all regions in Indonesia. The two areas represent only the living conditions of the poor in Indonesian society in two extremely different contexts (urban and rural); conditions in other areas may have some similarities but are also likely to have many differences compared to these case study areas.

The qualitative analysis presented in the report aimed to complement the results of the quantitative analysis and the institutional and budget analysis. Table B lists the activities and types of participants included in the qualitative case studies, while Tables C and D provide the full lists of the FGDs conducted in East Sumba and North Jakarta, respectively.

Table B: Qualitative research activities and participants

Activity	Information
	National level (preparation and background)
Focus group discussions (FGDs) with NGO staff members	Participants: NGOs working on children's issues To Identify issues and problems faced by children in Indonesia To Identify efforts and programmes for children conducted by NGOs
In-depth interviews (IDIs) with national-level officials	Interviewees: Government officials (from ministries/agencies) and staff of NGOs working on children's issues To get further information about issues and problems faced by children in Indonesia To identify and to explore further the efforts and programmes aimed at the fulfilment of children's rights in Indonesia To identify laws and regulations related to children
District level (before field research in case study areas)	
Observation	Collection of statistical data, area profiles, and discussion with local government officials and local NGO representatives Selection of villages as case study areas
IDIs with district-level officials and stakeholders	Interviewees: Leadership at the district level (including government officials, NGOs, programme implementers, and other stakeholders) To identify issues and problems faced by children in the case study areas

2 Officially 'Daerah Khusus Ibukota Jakarta', or DKI Jakarta, but referred to generally, and throughout this report, simply as 'Jakarta'

Activity	Information
	To identify and explore further information on the efforts and programmes related to children in the case study areas (conducted by local government or local NGOs) To explore further information about the implementation and sustainability of the efforts and programmes that were conducted, along with the opportunities and constraints faced (In general and related to the scope of work of the interviewees)
Village/Precinct level (case study areas)	
FGD with village/precinct officials and stakeholders	Participants: Mixed groups of men and women, including village/precinct officials, local leaders, health-care workers (including doctors, midwives, community health centre staff and health cadres), teachers, programme implementers, and other stakeholders Mapping the conditions of community livelihood and socio-economic stratification in the village/precinct society To identify issues/problems faced by children, as well as efforts/programmes conducted To identify the most vulnerable children in the society, especially those living in poor households
FGD with parents representing households with children	Participants: Mixed groups of mothers and fathers of poor families To describe poor families' livelihoods, including problems experienced in the efforts to meet their children's needs To identify common problems experienced by children of poor families To identify the survival and coping strategies used by poor families
FGD with primary school-age children (7–12 years)	Participants: Mixed groups of girls and boys from poor families To obtain descriptions of children's daily activities To map a seasonal calendar over a one year period To understand their feelings about events experienced in daily life To gain understanding about welfare policies from their perspective
FGD with junior secondary school-age children (13–15 years)	Participants: Mixed groups of girls and boys from poor families To obtain descriptions of children's daily activities To map a seasonal calendar over a one year period To understand their feelings about events experienced in daily life To gain understanding about welfare policies from their perspective
FGD with senior secondary school-age children (16–18 years)	Participants: Mixed groups of girls and boys from poor families To obtain descriptions of children's daily activities To map a seasonal calendar over a one year period To understand their feelings about events experienced in daily life To gain understanding about welfare policies from their perspective
IDIs with village/precinct officials and stakeholders	Interviewees: Village officials, community leaders, health-care workers (as above), teachers, programme implementers, and other stakeholders To identify and explore in greater depth the issues/problems of children and the existing efforts/programmes to address them
IDIs with parents from poor families	Interviewees: (1) Mothers and fathers from poor families with children (conducted separately for families with boys and girls); (2) Mothers and fathers of children with special circumstances (disabled children, juvenile delinquents, and others) To further describe poor families' livelihoods, including problems experienced in their efforts to meet their children's needs To identify further the survival and coping strategies used by poor families, including use of government and NGO programmes/assistance
IDIs with children	Interviewees: (1) Boys and girls of school age (7–18 years); (2) Children with special circumstances (disabled children, children from broken homes, not in schools, and others) To identify and to explore further the common problems faced by children from poor families, including their survival and coping strategies To understand their feelings about events experienced in daily life To gain understanding about welfare policies from their perspective

Activity	Information
District level (after field research in case study areas)	
FGD with district-level officials and stakeholders	Participants: Government officials, NGOs, programme implementers, and other stakeholders To verify the findings from the case study areas (North Jakarta and East Sumba) including the implementation of efforts and programmes conducted by the local government and/or local NGOs To identify and to explore further information on the efforts and programmes related to children in the case study areas (conducted by the local government and/or local NGOs) (FGDs were conducted after field research in the case study areas to confirm the findings at the precinct/village level as well as to see the interaction-coordination among government agencies, NGOs, and other stakeholders)
IDIs with district-level officials and stakeholders	Interviewees: Government officials, NGOs, programme implementers, and other stakeholders To further verify findings from the case study areas (North Jakarta and East Sumba) including implementation of efforts and programmes conducted by the local government and/or local NGOs To identify any other issues/problems as well as efforts/programmes mentioned during the field research

Table C: List of focus group discussions (FGDs) conducted in East Sumba

No	Type of participants	Number of participants		Recruitment procedures	Place and date		Number of sessions
		Male	Female				
1	District-level officials (of BAPPEDA, Office of Social Affairs, Education Office, local and international NGOs, Health Office, Civil Affairs, etc.)	7	4	Related institutions, particularly those which participated in interviews, were invited to attend the FGD. Most of the IDI interviewees attended the FGD.	BAPPEDA meeting room	7 October 2010	1
2	Lailanjang Village officials and stakeholders	13	3	IDI participants, including village head, village officials, community figures, religious leaders, cadres of *posyandu* (integrated health services post), head teacher, and other figures considered important and well-informed as recommended by the village head, were invited.	Villager's house	3 October 2010	1
3	Tanaraing Village officials and stakeholders	3	9	Same recruitment as that for Lailanjang Village above. In this village, the women were the most active.	Village office	3 October 2010	1
4	Tanaraing Village members of poor households	4	3	Most participants chosen and designated by the village head based on the criteria proposed by the team. Since most of poor households in the selected hamlet live scattered over a very wide area and were working in their fields, only some of them were available when the team came.	Village office	4 October 2010	1

No	Type of participants	Number of participants		Recruitment procedures	Place and date		Number of sessions
		Male	Female				
5	Lailanjang Village members of poor households	3	5	Since most of poor households in the selected hamlet were in their fields, only some of them were available when the team came; they were invited to the FGD and they attended it.	Villager's house	6 October 2010	1
6	Lailanjang Village primary school students	8	8	Selected based on recommendation by the head teacher and the village head based on the criteria proposed by the research team. Participants were from the 4th, 5th and 6th classes and were distributed evenly.	School room	2 October 2010	1
7	Tanaraing Village primary school students	10	9	Selected based on recommendation by the head teacher and the village head based on the criteria proposed by the research team. Participants were from the 4th, 5th and 6th classes and were distributed evenly.	Village office	5 October 2010	1
8	Lailanjang Village male junior secondary school students	15		Selected based on recommendation by the head teacher and the village head based on the criteria proposed by the research team. Most were 1st and 2nd year students. In this village, the students were easy to find as most of them lived in the dormitory near the school.	Prai Polu Hamu Junior Secondary School	2 October 2010	1
9	Lailanjang Village female junior secondary school students		14	Same recruitment as that for male students	Prai Polu Hamu Junior Secondary School	2 October 2010	1
10	Tanaraing Village male junior secondary school students	15		Selected based on recommendation by the head teacher and the village head based on the criteria proposed by the research team. The 1st, 2nd and 3rd grade students were distributed evenly.	Village office	5 October 2010	1
11	Tanaraing Village female junior secondary school students		15	Same recruitment as that for male students	Village office	5 October 2010	1
12	Lailanjang Village senior secondary school-age youths (males and females combined due to small numbers)	5	2	Selected based on recommendation by the head teacher and the village head based on the criteria proposed by the research team. Unfortunately, both male and female students were very rare, as most had dropped out of school. All participants in this village were school dropouts (due to lack of money and/or distance) aged 16–18 years.	Pari Pulu Hamu Junior Secondary School	2 October 2010	1

No	Type of participants	Number of participants		Recruitment procedures	Place and date		Number of sessions
		Male	Female				
13	Tanaraing Village senior secondary school-age youth (males and females combined due to small numbers)	3	4	Selected based on recommendation by the head teacher and the village head based on the criteria proposed by the research team. Some were still students and some were dropouts (aged 16–18 years). It was hard to get the students in this village because some live apart from their parents because the school is far from their house or village.	At the village office	4 October 2010	1

Table D: List of focus group discussions (FGDs) conducted in North Jakarta

No	Type of participants	Number of participants		Recruitment procedures	Place and date	Number of sessions
		Male	Female			
1	District level (BAPPEDA, Office of Social Affairs, Education Office, local and international NGOs, Health Office, Civil Affairs, etc.)	6	13	Relevant institutions, particularly those which participated in interviews, were invited to attend the FGD.	District Office meeting room 4 November 2010	1
2	Rawa Badak Selatan Precinct officials and stakeholders	5	10	IDI participants, including village head, village officials, community figures, religious leaders, cadres of *posyandu*, teachers, and other figures, were invited.	Village office 1 October 2010	1
3	Kalibaru Precinct officials and stakeholders	11	10	Same recruitment as that for Rawa Badak Selatan Precinct above.	Village office 1 October 2010	1
4	Rawa Badak Selatan Precinct members of poor households	5	7	Most participants were chosen and designated by the village officials based on the criteria proposed by the team, especially those living in the poor hamlets.	Classroom at community learning centre 3 October 2010	1
5	Kalibaru Precinct members of poor households	2	12	Same as for Rawa Badak Selatan Precinct above.	Community centre 2 October 2010	1
6	Rawa Badak Selatan Precinct primary school students	9	5	Selected based on recommendation by the local leader in the poorest hamlet based on the criteria proposed by the research team.	Classroom at community learning centre 2 October 2010	1
7	Kalibaru Precinct primary school students	9	9	Same recruitment as that for Rawa Badak Selatan Precinct above	Community centre. 3 October 2010	1
8	Rawa Badak Selatan Precinct male junior secondary school students	11		Selected based on recommendation by the local leader in the poorest hamlet based on the criteria proposed by the research team.	Classroom at community learning centre 2 October 2010	1
9	Rawa Badak Selatan Precinct female junior secondary school students		11	Same recruitment as that for male students	Classroom at community learning centre 2 October 2010	1
10	Kalibaru Precinct male junior secondary school students	15		Same recruitment as the one in Rawa Badak Selatan Precinct	Villager's house 3 October 2010	1
11	Kalibaru Precinct female junior secondary school students		15	Same recruitment as that for male students	Villager's house 3 October 2010	1
12	Rawa Badak Selatan Precinct male senior secondary school students	11		Same recruitment as that for junior secondary level	Classroom at community learning centre 2 October 2010	1
13	Rawa Badak Selatan Precinct female senior secondary school students		10	Same recruitment as that for junior secondary level	Classroom at community learning centre 2 October 2010	1
14	Kalibaru Precinct male senior secondary school students	15		Same recruitment as that for junior secondary level	Villager's house 4 October 2010	1
15	Kalibaru Precinct female senior secondary school students		15	Same recruitment as that for junior secondary level	Villager's house 4 October 2010	1

Limitations of the study

Despite efforts to providing a comprehensive assessment of children living in poverty by using a variety of research and analysis methods, this study of child poverty and disparities in Indonesia is not perfect. From the ouset, limited availability of study data on children in Indonesia was an obstacle in the background literature search. Furthermore, the available documents, including statistical data sets and budget documents, required much time and effort to search for the relevant data and information relating to children. Since issues of child poverty have not so far been mainstreamed, most of the child related data and information were generally combined with other issues. Another obstacle was the wide variation in definitions of terms relating to children's issues, limiting the comparability of different data sources. Another shortcoming was the limited coverage of the qualitative research that was aimed to complement the quantitative data. Due to time constraints, qualitative studies could only be conducted in two districts in Indonesia representing extreme urban and rural poverty. Nevertheless, this study is an initial effort to provide an holistic assessment of children living in poverty in Indonesia.

Appendix 2

Profiles of case study locations

As part of this study of child poverty and disparities in Indonesia, qualitative assessments were conducted in two case study areas in two provinces in Indonesia with very different characteristics. Selecting two extreme environments within Indonesia, the first district selected was North Jakarta (Jakarta Utara) in the capital city, Jakarta, and the second was East Sumba (Sumba Timur), in the province of East Nusa Tenggara (Nusa Tenggara Timur, NTT).

Jakarta was selected to represent the urban context, while NTT represents the rural context. Two precincts/villages in each area were selected as the specific case study locations.

With regard to children's rights to basic services, the information in this appendix describes the living conditions in each case study area, with an emphasis on the availability of basic public services.

North Jakarta District, in Jakarta

As the capital city, Jakarta is one of the richest provinces in Indonesia. Its gross regional domestic product (GRDP) has contributed as much as IDR 317.4 trillion to the total national GDP, accounting for 17.8 per cent.[3] This is because many Indonesian economic activities remain concentrated in Jakarta. In 2009, the per capita income of Jakarta residents was estimated at IDR 42.14 million, far above the national average, estimated at just IDR 24.3 million per capita. In general, Jakarta is characterized as the largest metropolitan city in Indonesia, divided into six administrative districts (kabupaten) including the Thousand Islands, South Jakarta, East Jakarta, Central Jakarta, West Jakarta and North Jakarta.

Figure B: Map of North Jakarta

Source: http://utara-jakarta.go.id

In this study on child poverty and disparities, North Jakarta was selected for a case study because it is home to the largest number of poor people among all of Jakarta's districts. In 2008, there were around 85,200 poor people residing in North Jakarta.[4] With a total population of

3 Trend of Selected Socio-Economic Indicators, BPS – Statistics Indonesia, August 2010
4 Jakarta in Figures 2009, BPS – Statistics Indonesia, Jakarta Province.

1,459,360 people, poor people in North Jakarta accounted for 5.8 per cent of the population. As the name implies, North Jakarta is located in the northern part of the city, spread along the Java Sea coast line. Life in North Jakarta is generally characterized by coastal livelihoods. Focused at the precinct level, the study incorporated two *kelurahan* (precincts) located in North Jakarta as study case locations. The precinct of Kalibaru is an urban area characterized by coastal livelihoods, while the precinct of Rawa Badak Selatan represents the characteristics of urban areas located in commercial centres. Another reason for the selection is that, according to the latest statistics, Kalibaru is the *kelurahan* with the largest number of poor people in Jakarta. The selection of Rawa Badak Selatan, meanwhile, was based on discussions with a number of government officials and local non-government organizations (NGOs) that referred to the existence of a slum area in the precinct. The slum neighbourhood is known locally as the 'RT 0 / RW 0', with the 'zero' figure making reference to the illegality of the settlement, which is not officially recognized (official neighbourhoods within precincts are assigned numbers within the Rukun Tetangga/Rukun Warga neighbourhood association system). People call it the 'Tanah Merah' (red earth) area and according to locals, children there face many problems. Thus, an extensive assessment was required to determine the conditions of those living there who were not covered by public services.

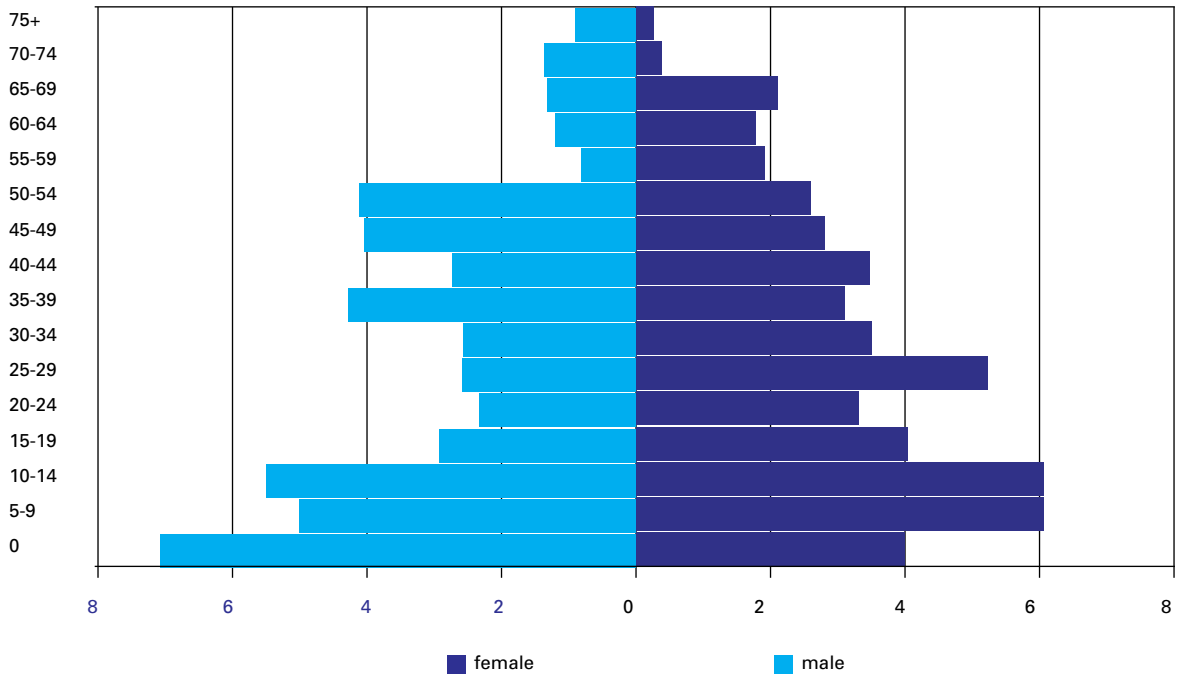
Kalibaru Precinct

Kalibaru Precinct *(kelurahan)* is located in the sub-district of Cilincing in the district of North Jakarta. With an area covering 2,467 hectares, it is divided into 14 Rukun Warga (RW) and 172 Rukun Tetangga (RT). In 2009, the estimated population was 45,103 people and a total of 10,177 households, of which 583 were female-headed. The precinct population density was 21,377 inhabitants per square kilometre. Most households in this precinct live below the provincial poverty line. There were about 8,443 households targeted as Raskin (Rice for the Poor) beneficiaries; the largest number in any precinct in North Jakarta.

Based on the official *kelurahan* data, there were 6,104 people listed as unemployed and 5,551 listed as beggars in Kalibaru. The data also show that most people in Kalibaru work as fishermen (8,703 men and 8,871 women) or conduct other work related to fisheries, including working as labourers or traders. Only a small number of residents work as professionals, civil servants, or in the military. Many people living and working in Kalibaru are not permanent residents. They are seasonal migrants mainly from the other areas along Java's north coast, such as Indramayu, Cirebon and Tegal. Many of these seasonal fishermen live in RW 01 and RW 013, which are the slum areas of the precinct. They came alone or with their families (wives and children). Many of these migrants choose to settle down in Kalibaru with their families. According to information from a local community leader in RW 01, for those who arrive with children, some of the children continue school but others do not.

Children are the largest group in Kalibaru as illustrated by the population pyramid (see Figure A). The population group aged 0–19 years accounted for 40.8 per cent of the total population of the precinct, with the largest group being children aged 0–14 years, accounting for as much as 33.8 per cent. It is interesting to note that the group of children below five years of age (under-fives) was dominated by boys, while the age groups between the ages of 5 and 35 were dominated by girls and women. Looking at the population composition, the number of children is in proportion to the number of adults of productive age (20–49 years), with the latter group accounting for 40.29 per cent of the total population. Most of the people of productive age were women, indicating that they bear a heavier economic burden than the men.

Figure C: Kalibaru Precinct population by age and sex, 2009



Source: Monthly Report, Kelurahan Kalibaru, 2009

To support the large number of children there are adequate education facilities in the precinct, especially at the primary school level. There are 9 kindergartens (TK), 27 primary schools (SD), 7 junior secondary schools (SMP), and 2 senior secondary schools (SMA). Based on data from the kelurahan office, the precinct population included 13,086 people who had not completed primary school, 12,250 people who graduated from primary school only and another 7,837 people who did not attend school at all. Meanwhile, those with more education included 378 people who had graduated from junior secondary school, 9,627 people who graduated from senior secondary school, and 1,929 people who had graduated from college or university. Findings from the qualitative assessment indicated that some children had dropped out of school. Most of them discontinued their education at the transition point between junior and senior secondary schools (age 15 years). The main reason for this was limited family finances. Some of those who dropped out were working, while others were unproductive and unemployed.

The qualitative assessment also found that many of the children in Kalibaru who were living near the sea shore worked shucking shellfish at processing establishments. Some of them were still enrolled at school and only did the work before or after school hours. Shellfish shucking is mostly done by girls. Boys usually do the boiling or stripping of shells. Older boys can transport the shellfish from the ships to the shellfish processing place and/or participate in diving for the shellfish. Some children worked to help their parents who were also working at the shellfish processing place, in which case they were not paid directly, but obtained money from their parents. But there were other children who worked independently and got paid directly.

Having to work helping parents restricts children's time for play and recreation. Lack of open spaces and play equipment in the neighbourhood also deprives them of entertainment. There was only one soccer field located in RW 015, three badminton courts located in RW 02 and RW 03, and two volleyball courts located in RW 02 and RW 012. Not all children could access these, because they were

located far from their area. As an alternative form of entertainment, most of the children now played online games or surfed the Internet at Internet cafes. The qualitative assessment also found that many children living near the sea shore often played and swam at the beach, which was full of rubbish and shellfish waste.

Dwellings located in unhealthy living conditions deprived children of appropriate shelter. The slum area in the *kelurahan* can be described as a densely-populated neighbourhood with inadequate sanitation and clean water facilities. Most of the houses had permanent walls and ceramic floors, but some had walls made of timber, plywood or sheet metal, with a metal roof, especially those located near coastal areas.

One house often accomodated more than one family, whether this included extended family members or another family renting the same house. Some houses had their own wells, but many of them also used piped water, since the well water tasted salty. Usually people *nyelang* (piped) water from their neighbour's connection to the state water service and a payment system was established among them. Similarly, many residents share the electrical supply (*nyantol*) from their neighbour's home. For toilet facilities, many houses had their own bathrooms, while other families had to use public toilets, especially people living in rented houses or people living in houses located near the sea shore. In the rainy season, the Kalibaru area often floods, and it also often floods in the dry season due to high tides. As as result of no adequate drainage facilities, when the floods come trash and debris overflow into residential areas. With these unhealthy living conditions, it is no wonder that many children living in Kalibaru suffered from diarrhoea, dengue haemorrhagic fever, acute respiratory infections (ARI) and skin diseases.

The precinct has adequate health facilities, including one community health centre (*puskesmas*), six health post units (*poskes*), six maternity practices (operated by midwives), and two doctor's practices. In addition to this, there are 26 *posyandu* (integrated services posts) scattered in every RW except RW 011. Although the precinct has adequate health facilities, many people still lack access to health care due to a low awareness and preference to use other alternative treatments which are considered more practical, such as drugs purchased at a nearby shop. Clearly the existence of adequate public health facilities is not a guarantee of accessibility, especially for people who lack knowledge and awareness.

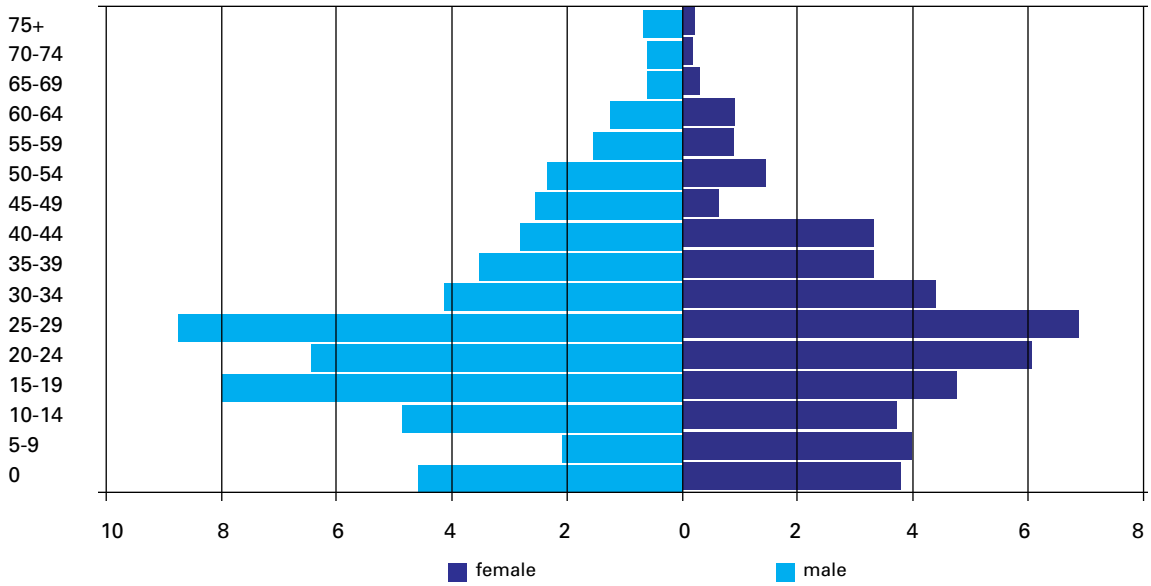
Rawa Badak Selatan Precinct

The precinct of Rawa Badak Selatan is located in the sub-district of Koja. Different from Kalibaru, which located near the coast, Rawa Badak Selatan lies near Jakarta's commercial area and close to a main street and highway. Close to the area, there is a fuel depot owned by the state oil company, PT Pertamina. There are also industrial areas and a seaport not too far from the precinct. Trucks and containers pass by the area frequently.

The Rawa Badak region covers an area of 1,016 hectares and is divided into 7 RW and 72 RT. As many as 37,516 people reside there, consisting of 13,451 households, including approximately 3,154 female-headed households.

Based on the population pyramid (see Figure B), the population of the *kelurahan* is dominated by people in the productive age group (20–49 years), accounting for 53 per cent of the total population. Among the productive age group, people aged 25–29 years are the largest population group, accounting for 15.66 per cent of this group. In addition to the productive age population, the next largest population group is children. Those aged 0–19 years of age made up 35.82 per cent of the total population; children aged 0–14 years accounted for as much as 23.7 per cent of the population.

Figure D: Rawa Badak Selatan Precinct, population by age and sex, 2009



Source: Monograph, Kelurahan Rawa Badak Selatan, 2009

According to data from the *kelurahan*'s monograph in 2009, most of the people living in Rawa Badak Selatan were working as private employees, which accounted for as many as 11,843 people. In addition to private sector employees, many other residents were working as civil servants, in the military, as traders, or were retirees. Only a few people worked as labourers and casual labourers. The data showed a large number of private employees due to the presence of a large housing complex for employees of one of the state-owned enterprises located in RW 06 and RW 07.

Results of the qualitative assessment indicated that the welfare conditions of the Rawa Badak population were better than in Kalibaru. The level of education in Rawa Badak was better, with as many as 1,653 people having graduated from college or university, while another 8,894 had completed senior secondary school and 10,603 had completed junior secondary school. Meanwhile, 9,256 people had only completed primary school, 3,943 had not completed primary school and 3,155 had never enrolled at school at all.

The qualitative assessment activities in Rawa Badak Selatan Precinct were focused on the slum area, known as Tanah Merah. Tanah Merah is located on disputed land situated right next to the oil depot owned by PT Pertamina (the national oil company). Actually, Tanah Merah not only lies within the region of Rawa Badak Selatan but also crosses into two other precincts: Tugu Selatan and Kelapa Gading Barat. The *kelurahan* office of Rawa Badak Selatan administrated Tanah Merah as an RT (neighbourhood). For administrative purposes, ID cards (KTP) and other identity documents are prepared by the RW (head of a group of RT neighbourhoods). But generally the existence of Tanah Merah is unrecognized by the *kelurahan* office. People who live there often experience difficulties in obtaining their formal identification documents, and most of them are migrants who have lived there illegally for years. Without legal identification and residence documents, access to public services is barred for them and their children.

Considering its specific characteristics, the Tanah Merah area was very interesting as a case study of the living conditions of people in illegal settlements. However, because of its illegality, official data about the area do not exist. From the results of the field assessment, at the time of the 2010 population census, the residents of Tanah

Merah were included in the census but were listed as living in an unidentified region.

Observations revealed that the environmental conditions at Tanah Merah were very unhealthy. The area was characterized by dense housing, a large area covered by garbage, inadequate sanitation facilities, a lack of clean water sources, and unhealthy housing conditions. Most of the area is a marshland. Many *getek* houses[5] were built over the swamp that is covered by waste.

There were no adequate open spaces for children's playgrounds. There was a large open area, but it could only be used during the dry season because during the rainy season it turned into a swamp. Health and education facilities in the area were limited since the area is not a legal settlement, so residents were essentially excluded from government services. There was only one school, established by an NGO, and the health facilities in the area were also mostly operated by NGOs, but were limited in number.

The absence of public services had in the area had led to the establishment of social services operated by NGOs. There was the Himmata Foundation, an NGO which organized teaching and learning activity centres (PKBM) for the Tanah Merah community, especially the children. Himmata also ran an orphanage to accommodate street children and keep them off the streets. At Himmata, children were taught various skills so that they could obtain work, other than work on the street. An interesting fact revealed during several interviews with families in the area was that some of them had moved to Tanah Merah in order to be closer to the community learning centre (PKBM), so that their children could attend school there, where enrolment was relatively cheap and easy. Some parents also let their children stay at the orphanage, so that their children could live in decent conditions. Some of the parents lived nearby but others lived far away from the orphanage. The Himmata Foundation also operated a clinic. Besides being accessed by children at the orphanage, clinic services were also available to the general public.

The qualitative assessment found that the existence of NGOs like Himmata was very important for members of the community who lacked access to public services, so that their children could obtain adequate education and have other basic rights fulfilled.

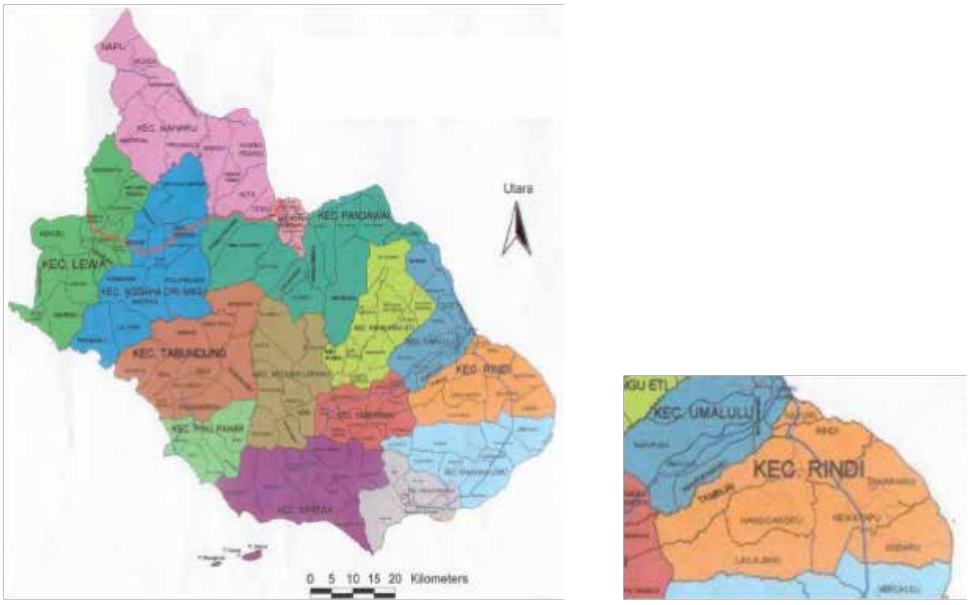
East Sumba District, in East Nusa Tenggara Province

East Nusa Tenggara (Nusa Tenggara Timur, NTT) is a province located in the eastern part of the Nusa Tenggara Islands. The province consists of about 550 islands, with the three main islands being Flores, Sumba and Timor. With a GRDP of IDR 11.5 trillion in 2008, NTT is one of the provinces making the smallest contribution to the national GDP. The per capita GRDP of NTT Province was just IDR 2.89 million, which was far below Jakarta and the Indonesian average. Poverty remains a big problem in this province. The qualitative study was conducted in one of the poorest regions in the province located on the island of Sumba, to give a picture of the poverty situation experienced in isolated territories.

East Sumba (Sumba Timur) is one of the districts located in the province of NTT. The total population in 2008 was 220,559 people, who lived spread out in 22 sub-districts and 156 villages.[6] Based on statistical data, the most common occupation in East Sumba is in the agricultural sector, which accounts for 66.37 per cent of the overall local work force. The agricultural sector in East Sumba is the most productive sector. Agricultural production in the district includes cassava, maize, rice, sweet potatoes and beans. The livestock sub-sector is a major contributor to the agricultural sector. Since the time of Dutch rule, the island of Sumba has been the centre of cattle breeding, famous for its *Ongole* cows. In East Sumba, there were also horse breeding centres, famous for *Sandel* horses. The geographical conditions are hilly with steep slopes covering 40 per cent of the area. Erratic climatic conditions and a very short rainy season often create problems in the development of agriculture, especially food crops, such that East Sumba still lags behind other regions.

5 Houses floated on bamboo floor
6 Based on population registration in 2008.

Figure E: Map of East Sumba



Source: Regional Development Planning Agency, Research and Development Unit (Litbang BAPPEDA) East Sumba, 2003

As part of the study on child poverty and disparities, the qualitative assessment conducted in East Sumba aimed to construct a portrait of children living in poverty in the context of a rural, agricultural society with limited access to public services and close adherence to local traditions.

The qualitative assessment in East Sumba focused on two villages located in the sub-district of Rindi; namely, Tanaraing Village and Lailanjang Village. The level of poverty in these villages included both extreme and moderate poverty. This was one reason for choosing these villages as case study locations. Potential disparity between these villages was another reason for selecting these two different villages. Tanaraing Village represents the characteristics of a village which is located in the capital district, where access to public services and governance is relatively good compared to other villages within the sub-district area. Lailanjang Village, situated relatively far from the capital district, represents more isolated villages.

In addition, the case study villages within the Rindi sub-district were selected based on information obtained from discussions with government officials. The people of Rindi sub-district still adhere to an East Sumba societal caste system which includes a class of nobles (*maramba*) and class of slaves (*ata*). Interestingly, in the village of Lailanjang there was an area that was home to the family of *maramba's ata*. There were approximately 30 *ata* families who had been living there for generations. In addition, Rindi sub-district's population included transmigrants from other islands near to Sumba. Resettlement activities were carried out in 1990 in the Rindi sub-district. Because it is a transmigration area, almost all the residents have farm land, each consisting of 0.25 hectare of square yard (for the family household), 0.75 hectare of dry land, and 1 hectare of paddy field. Because the locations of the dry land and paddy field areas are far from the housess, most of the agricultural activity was conducted on the square yard land (*pekarangan*).

Tanaraing Village

Tanaraing Village (*desa*) is located in the capital of the Rindi sub-district. This village has an area of 41.3 square kilometres which is divided into 2 hamlets, 5 RW and 10 RT. With a population of 1,309, Tanaraing is the village with the highest population density within the Rindi sub-district.

There are 294 households in the village, with an average household size of 4 persons. Most of the residents in Tanaraing are farmers and ranchers, while others work as fishermen, traders, civil servants, in the military, and other occupations.

Because it lies in the capital of the sub-district, villagers' access to public services – including civil services, health and education – is relatively easy. The living conditions of children in the village could be considered limited, but still better than in the other villages of Rindi sub-district.

In the village, at the time of the qualitative assessment, there were two primary schools and one private junior secondary school. The private junior secondary school was the only junior secondary school in Rindi sub-district. In 2008, the number of primary school pupils in the village was recorded as 91 boys and 91 girls, divided among six classes. Meanwhile, there wer 175 junior secondary school students consisting of 87 boys and 88 girls. Although the facilities for basic education (primary and junior secondary schools) were quite adequate, distance was still an obstacle for children who wanted to continue their education to the senior secondary school level. The nearest senior secondary school was about 20 kilometres away from Tanaraing Village. Those who attended secondary school usually stayed at a relative's house closer to the secondary school. Of all households in the village, 16.27 per cent were sending their children to college or university. Based on the qualitative assessment, in Tanaraing Village, most children complete primary and junior secondary school, and many continue to the senior secondary school level, while some even continue to college level education.

Health facilities available in Tanaraing Village included a community health centre (*puskesmas*) and a midwifery post. The health workers who served the community included a doctor, a midwife, five nurses/paramedics, and a trained traditional midwife. In addition, for health care of pregnant women, infants and toddlers, the village had two *posyandu* with 10 people who were active as medical personnel. According to records made by the Rindi Sub-District Health Centre, the number of visits to the *posyandu* during 2008 was 58 pregnant women, 31 infants and 154 children. The immunization services provided in the village were quite comprehensive, including tetanus toxoid (TT), DPT, polio, Hepatitis B and measles. In 2008, the TT immunizations were received by 10 people, DPT by 40 people, polio by 41 people, Hep. B by 41 people and measles by 36 people. In terms of coverage of iron supplements, in 2008 as many as 33 people had received iron tablets Fe1 and 29 people had received the Fe2 tablets. In relation to family planning programmes, in 2008 the data recorded 93 people as actively using family planning. The total number of couples of reproductive age was around 155, so the percentage of couples actively using family planning was around 60 per cent, which is quite a high level of coverage for a remote and relatively poor village.

Lailanjang Village

The village of Lailanjang has an area of 32.4 square kilometres and a population of 877 people. Village population density was relatively low compared to the other villages in the Rindi sub-district, with only 27 people per square kilometre. The village is divided into two *dusun* (hamlets), four RW and two RT. There were 252 households in the village with an average household size of 3 people.

Most of the villagers of Lailanjang work as farmers and small ranchers. Others are craftsmen, civil servants, military personnel and retirees. Unlike the residents of Tanaraing, none of the villagers in Lailanjang working as fishermen, given their inland location.

Lailanjang village is located far from the capital of Rindi sub-district. It can take approximately two hours to drive to the village on a 30-kilometre road in very poor condition. At the time of the assessment, there was no public transportation to the main village of the sub-district except by *ojek* (motorcycle taxi). This was not the usual *ojek*, but usually just friends or neighbours asked to provide transport if necessary. The location of the village is quite isolated, such that the children of Lailanjang

have great difficulty in accessing public services, including education and health.

The education facilities in the village of Lailanjang were still very limited. Until recently there was only one primary school; a private school established by the church. Conditions improved slightly when, four years ago, the government established a small primary school for students up to 4th grade only. Then two years ago a junior secondary school was funded by the church. The establishment of new schools is expected to make it easier for children in Lailanjang Village to attend school. For years children who lived in the farthest hamlet had to travel more than 12 kilometres every day to go to the school. Moreover, if children wished to continue their education to junior secondary school, they had to travel to the sub-district capital or neighbouring districts, approximately 26 to 33 kilometres away.

Nevertheless, the condition has not improved for children who want to continue education to the senior secondary school level, because there are no senior secondary schools in the village or in the capital of Rindi sub-district. To attend senior secondary school, children have to move to neighbouring sub-districts or to the city. This requires them to stay in a dormitory or at a relative's house closer to the school. These conditions hamper the child's ability to continue their education to senior secondary school because many do not want to live separately from their parents. The limited number of schools and far distances led to low levels of education in this village. Based on the qualitative assessment in the village of Lailanjang, there were quite a lot of children who had not completed primary school and many children were unable to continue to a senior secondary school level. In one of the hamlets in the village for example, there were only two girls who attended senior secondary school, while other children dropped out after primary or junior secondary school.

Similar conditions also applied with regard to health. Health-care facilities in the village of Lailanjang were far from adequate. Based on data from Rindi Sub-District Health Centre in 2008, there was only one health facility in the village, but it had been closed for over a year because there was no health worker. Before it closed, it was only open for services once a month or once every two months. Now the health worker stationed there has left the job without giving any explanation. Village officials said that the health worker probably does not wish to stay in their village because of the isolated conditions. Nevertheless, health services for pregnant women, infants and toddlers are provided by four *posyandu* run by 15 active volunteers who served 41 pregnant women, 21 infants, and 166 infants in 2008. Immunization services were available in the village, including TT, DPT, polio, Hepatitis B and measles immunizations. In 2008, 7 people received TT, 23 received DPT, 24 received polio immunization, 25 received Hep. B immunization, and 16 people received measles immunization. In terms of coverage of iron supplements in 2008, as many as 31 people had received iron tablets Fe1 and 26 people received the Fe2 tablets. However, when compared with the total number of infants and toddlers, one might say that coverage of immunization and other health services was inadequate.

Appendix 3

Number of children by province, 2009

Province	Number of children (aged under 18 years)				
	Total	Urban	Rural	Girls	Boys
Aceh	1,508,810	411,822	1,096,988	744,441	764,369
North Sumatra	5,108,508	2,103,728	3,004,780	2,428,128	2,680,380
West Sumatra	1,695,827	528,577	1,167,250	806,594	889,233
Riau	2,175,857	1,078,976	1,096,881	1,031,760	1,144,097
Jambi	1,009,856	322,715	687,141	471,468	538,388
South Sumatra	2,544,974	956,202	1,588,772	1,244,911	1,300,063
Bengkulu	635,466	231,063	404,403	291,992	343,474
Lampung	2,657,017	679,272	1,977,745	1,283,657	1,373,360
Bangka Belitung	358,578	167,344	191,234	165,597	192,981
Riau Islands	545,815	286,517	259,298	251,350	294,465
Jakarta	2,634,851	2,634,851	0	1,290,147	1,344,704
West Java	14,759,795	8,593,266	6,166,529	7,166,791	7,593,004
Central Java	10,185,237	4,889,881	5,295,356	4,940,809	5,244,428
Yogyakarta	862,500	552,827	309,673	426,235	436,265
East Java	10,763,845	5,223,102	5,540,743	5,174,499	5,589,346
Banten	3,751,902	2,125,646	1,626,256	1,816,237	1,935,665
Bali	1,073,780	627,121	446,659	534,075	539,705
West Nusa Tenggara	1,757,950	739,716	1,018,234	861,777	896,173
East Nusa Tenggara	1,885,244	310,451	1,574,793	922,370	962,874
West Kalimantan	1,770,380	468,161	1,302,219	860,687	909,693
Central Kalimantan	853,087	274,050	579,037	408,685	444,402
South Kalimantan	1,220,458	487,335	733,123	614,759	605,699
East Kalimantan	1,123,791	680,509	443,282	532,842	590,949
North Sulawesi	739,091	316,355	422,736	351,057	388,034
Central Sulawesi	1,008,732	196,644	812,088	498,400	510,332
South Sulawesi	2,842,829	857,636	1,985,193	1,410,432	1,432,397
Southeast Sulawesi	956,136	199,321	756,815	481,958	474,178
Gorontalo	352,157	107,606	244,551	165,675	186,482
West Sulawesi	460,600	141,407	319,193	212,432	248,168
Maluku	579,955	141,554	438,401	281,468	298,487
North Maluku	393,758	105,602	288,156	191,216	202,542
West Papua	312,211	62,248	249,963	144,501	167,710
Papua	889,504	178,902	710,602	432,976	456,528
TOTAL	79,418,501	36,680,407	42,738,094	38,439,926	40,978,575

Appendix 4

Monetary child poverty by province, 2009

Province	Poverty line		% Children living below provincial poverty line				% Children living below IPL $1 PPP/capita/day			% Children living below IPL $2 PPP/capita//day	
	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural
Aceh	292,428	249,546	25.56	19.49	27.84	3.89	1.36	4.84	48	28.3	55.4
North Sumatra	234,712	189,306	15.24	15.55	15.03	5.8	2.51	8.1	54.3	38.2	65.6
West Sumatra	248,525	201,257	12.96	10.95	13.87	3.14	0.43	4.37	44.9	24.3	54.3
Riau	265,707	226,945	11.39	10.08	12.68	0.82	0	1.62	30.7	19.9	41.4
Jambi	244,516	178,107	11.68	17.13	9.12	4.61	3.24	5.25	50.8	35.7	57.9
South Sumatra	247,661	190,109	19.86	22.05	18.54	8.13	5.9	9.46	58.6	42.8	68.2
Bengkulu	242,735	192,351	21.42	20.59	21.90	8.82	6.56	10.1	60.6	50	66.6
Lampung	224,168	175,734	24.39	22.86	24.92	17.2	9.41	19.9	70.4	49.2	77.7
Bangka Belitung	272,809	261,378	9.12	7.74	10.34	0.9	1.08	0.75	22.4	17	27.1
Riau Islands	308,210	256,742	11.05	9.78	12.45	2.73	2.96	2.49	16.4	11.4	22
Jakarta	316,936	-	5.54	5.54	0.00	0	0	12.8	6.35	6.35	68.9
West Java	203,751	175,193	14.97	12.60	18.27	7.95	4.48	19.7	52.9	41.5	79.7
Central Java	196,478	169,312	21.16	19.21	22.97	14.6	9.06	20.5	70.1	59.7	71.9
Yogyakarta	228,236	182,706	20.28	16.46	27.10	10.1	4.25	19.3	52	40.9	78.1
East Java	202,624	174,628	19.60	14.13	24.75	12.6	5.41	9.16	62.5	46.1	67.4
Banten	212,310	178,238	9.69	7.52	12.52	5.18	2.14	4.59	43.5	25.2	55.4
Bali	211,461	176,003	6.09	5.11	7.47	3.1	2.04	21.3	35.6	21.5	76.8
West Nusa Tenggara	213,450	164,526	27.50	34.85	22.16	20.8	20.1	42.5	72.6	66.7	88
East Nusa Tenggara	218,796	142,478	27.59	16.63	29.75	36.2	4.16	10.7	80.1	40	62.1
West Kalimantan	194,881	166,815	11.35	9.27	12.10	8.79	3.35	3.54	56.8	42.2	54.2
Central Kalimantan	209,317	199,157	9.19	6.16	10.63	2.8	1.23	3.37	44.5	23.9	51.6
South Kalimantan	216,538	181,509	6.96	6.82	7.05	2.36	0.84	6.04	44.1	32.8	48.9
East Kalimantan	283,472	224,506	9.69	5.23	16.54	2.38	0	11.2	25	9.4	66.1
North Sulawesi	193,251	178,271	13.30	11.13	14.92	8.22	4.18	19.8	63	58.9	68.2
Central Sulawesi	217,529	182,241	23.77	12.35	26.53	16.8	4.49	31.5	61.1	31.5	85.3
South Sulawesi	177,872	142,241	15.45	6.93	19.13	23.7	5.63	29.6	70.2	35.3	83.2
Southeast Sulawesi	175,070	157,554	23.15	7.30	27.32	24.2	3.65	42.9	72.2	30.7	84.2
Gorontalo	173,850	156,873	30.16	11.10	38.55	32.2	7.93	23.8	78	63.8	73.9
West Sulawesi	175,901	156,866	19.87	17.75	20.82	21.2	15.4	19.2	73.4	72.2	80.9
Maluku	230,913	199,596	32.80	13.58	39.00	14.8	1.17	7.26	71.6	42.8	57
North Maluku	226,732	190,838	11.88	2.17	15.43	5.32	0	12	43.8	7.83	64.9
West Papua	304,730	269,354	43.84	7.43	52.91	9.59	0	19.5	53.9	9.65	68.2
Papua	285,158	234,727	42.12	6.36	51.12	15.5	0	15.5	56.4	9.39	56.4
TOTAL			17.35	13.41	20.73	10.63	4.64	15.76	55.78	38.79	70.36

Appendix 5

Child shelter deprivation by province, 2009

Province	% Children living in house < 8m^2/person			% Children living in house with earth floor			% Children living in house without proper toilet			% of Children without electricity connection		
	Total	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural
Aceh	33.30	22.37	37.40	10.41	6.61	11.84	48.70	17.29	60.49	9.05	2.20	11.63
North Sumatra	32.98	22.44	40.36	5.73	3.42	7.35	39.23	11.33	58.76	8.51	0.96	13.80
West Sumatra	27.90	19.20	31.83	3.76	1.56	4.75	48.22	15.08	63.22	10.79	2.13	14.71
Riau	26.85	26.33	27.36	2.96	2.71	3.20	26.55	7.15	45.64	12.22	1.84	22.44
Jambi	18.40	17.82	18.67	3.56	0.69	4.91	41.22	11.34	55.25	11.05	4.17	14.29
South Sumatra	34.76	37.71	32.98	6.62	1.81	9.52	44.55	16.51	61.43	13.13	2.05	19.80
Bengkulu	27.04	21.26	30.34	6.39	1.58	9.14	33.77	6.56	49.31	14.75	1.36	22.40
Lampung	14.94	19.83	13.26	17.92	5.71	22.11	41.64	17.48	49.94	8.58	1.18	11.12
Bangka Belitung	19.44	21.27	17.83	1.18	0.64	1.65	30.89	13.77	45.88	8.52	3.01	13.35
Riau Islands	25.00	24.35	25.73	2.60	3.07	2.07	41.09	9.56	75.93	8.71	3.07	14.94
Jakarta	43.96	43.96	0.00	1.29	1.29	0.00	5.52	5.52	0.00	0.11	0.11	0.00
West Java	26.01	25.64	26.52	5.52	3.94	7.73	26.10	14.93	41.66	1.53	0.50	2.97
Central Java	7.34	9.27	5.55	22.06	13.00	30.42	36.00	25.10	46.08	1.21	0.71	1.68
Yogyakarta	7.94	9.99	4.28	9.36	4.72	17.64	16.56	11.38	25.81	0.37	0.00	1.04
East Java	11.68	13.75	9.72	17.37	7.41	26.76	38.05	20.41	54.69	1.16	0.24	2.03
Banten	20.86	21.85	19.56	7.73	4.02	12.59	31.67	13.88	54.92	2.52	0.00	5.81
Bali	21.99	18.87	26.37	4.26	2.23	7.11	14.44	4.46	28.44	1.96	0.09	4.59
West Nusa Tenggara	37.29	39.77	35.49	9.17	6.97	10.77	46.10	38.75	51.44	10.81	6.69	13.80
East Nusa Tenggara	47.87	35.24	50.36	38.60	7.92	44.65	50.39	9.31	58.49	50.21	4.56	59.21
West Kalimantan	34.87	18.53	40.74	1.59	1.16	1.75	44.10	9.65	56.48	21.63	1.16	28.99
Central Kalimantan	27.15	30.30	25.66	3.23	2.22	3.72	52.19	14.53	70.01	23.65	3.69	33.10
South Kalimantan	21.62	23.20	20.58	1.89	0.84	2.59	42.66	20.10	57.67	5.22	1.20	7.90
East Kalimantan	26.83	27.24	26.20	3.36	2.24	5.07	24.11	14.32	39.13	3.05	0.32	7.25
North Sulawesi	40.74	41.15	40.43	6.34	5.57	6.92	26.78	11.13	38.49	2.71	0.40	4.43
Central Sulawesi	31.25	28.37	31.95	8.85	1.40	10.65	47.98	12.93	56.47	21.95	0.84	27.06
South Sulawesi	19.35	17.44	20.17	3.44	1.52	4.27	34.93	11.70	44.97	6.89	0.65	9.59
Southeast Sulawesi	27.79	28.71	27.55	10.42	9.49	10.67	48.81	9.49	59.16	19.83	2.19	24.48
Gorontalo	40.93	42.84	40.09	7.71	0.64	10.83	58.34	32.06	69.90	18.18	3.49	24.64
West Sulawesi	33.09	15.38	40.94	6.56	2.96	8.15	63.50	46.75	70.92	33.25	22.49	38.01
Maluku	40.47	46.36	38.56	20.39	3.51	25.84	55.69	33.03	63.01	28.27	4.22	36.03
North Maluku	31.57	33.48	30.87	14.09	1.74	18.62	53.16	18.26	65.94	21.10	0.00	28.83
West Papua	48.91	37.53	51.74	15.91	6.32	18.30	56.10	23.42	64.23	31.95	1.86	39.44
Papua	66.53	42.42	72.60	25.52	2.12	31.41	62.81	12.43	75.50	53.44	3.64	65.97
TOTAL	23.90	22.79	24.85	10.76	5.20	15.53	35.60	16.17	52.27	7.49	0.98	13.07

Appendix 6

Child deprivation in terms of safe water and health by province, 2009

Province	% Children without access to safe water			% of Children suffering from asthma					% Children suffering from diarrhoea				
	Total	Urban	Rural	Total	Urban	Rural	Girl	Boy	Total	Urban	Rural	Girl	Boy
Aceh	49.07	30.00	56.23	0.52	0.34	0.59	0.59	0.45	1.98	0.34	0.52	0.59	0.45
North Sumatra	54.45	30.62	71.14	0.70	0.27	1.00	0.68	0.72	2.35	0.27	0.70	0.68	0.72
West Sumatra	46.12	23.04	56.56	1.27	0.57	1.58	1.02	1.49	2.01	0.57	1.27	1.02	1.49
Riau	63.11	51.57	74.47	0.49	0.43	0.54	0.40	0.57	1.30	0.43	0.49	0.40	0.57
Jambi	55.82	31.02	67.47	0.25	0.23	0.26	0.28	0.22	0.43	0.23	0.25	0.28	0.22
South Sumatra	43.94	22.05	57.11	1.26	1.81	0.93	1.37	1.16	1.09	1.81	1.26	1.37	1.16
Bengkulu	69.62	48.42	81.73	0.27	0.23	0.30	0.00	0.50	0.46	0.23	0.27	0.00	0.50
Lampung	54.70	41.85	59.12	0.52	0.34	0.59	0.48	0.57	0.85	0.34	0.52	0.48	0.57
Bangka Belitung	43.89	36.98	49.93	0.26	0.22	0.30	0.17	0.33	1.32	0.22	0.26	0.17	0.33
Riau Islands	41.72	20.14	65.56	0.95	0.68	1.24	1.37	0.59	0.97	0.68	0.95	1.37	0.59
Jakarta	23.35	23.35	0	0.70	0.70	0	0.71	0.69	2.26	0.70	0.70	0.71	0.69
West Java	58.52	50.61	69.54	0.96	0.91	1.03	1.05	0.88	1.51	0.91	0.96	1.05	0.88
Central Java	50.77	41.28	59.54	0.57	0.56	0.58	0.49	0.64	1.29	0.56	0.57	0.49	0.64
Yogyakarta	41.35	37.55	48.12	0.65	0.65	0.65	0.83	0.47	1.30	0.65	0.65	0.83	0.47
East Java	46.62	36.60	56.07	0.66	0.62	0.70	0.67	0.65	1.63	0.62	0.66	0.67	0.65
Banten	56.53	44.36	72.44	0.88	0.97	0.75	0.84	0.91	1.64	0.97	0.88	0.84	0.91
Bali	32.29	17.85	52.56	1.38	1.39	1.35	1.14	1.61	1.77	1.39	1.38	1.14	1.61
West Nusa Tenggara	42.67	31.32	50.91	1.15	1.58	0.84	1.10	1.20	2.54	1.58	1.15	1.10	1.20
East Nusa Tenggara	68.76	32.67	75.87	1.46	1.98	1.36	1.19	1.73	4.86	1.98	1.46	1.19	1.73
West Kalimantan	84.80	73.10	89.00	1.06	1.03	1.07	1.05	1.06	2.39	1.03	1.06	1.05	1.06
Central Kalimantan	70.55	41.38	84.36	0.65	0.00	0.95	0.37	0.90	1.31	0.00	0.65	0.37	0.90
South Kalimantan	50.83	17.46	73.01	0.36	0.12	0.52	0.48	0.24	1.12	0.12	0.36	0.48	0.24
East Kalimantan	27.96	8.01	58.57	1.36	1.07	1.81	1.42	1.31	1.65	1.07	1.36	1.42	1.31
North Sulawesi	43.27	18.89	61.51	0.56	0.60	0.54	0.44	0.68	1.85	0.60	0.56	0.44	0.68
Central Sulawesi	60.44	37.92	65.89	1.21	0.56	1.37	0.96	1.46	2.12	0.56	1.21	0.96	1.46
South Sulawesi	50.95	22.65	63.18	0.62	0.33	0.74	0.68	0.55	1.15	0.33	0.62	0.68	0.55
Southeast Sulawesi	54.61	36.01	59.51	0.95	0.73	1.01	0.94	0.96	1.71	0.73	0.95	0.94	0.96
Gorontalo	47.80	34.59	53.61	0.60	0.32	0.72	0.81	0.41	2.33	0.32	0.60	0.81	0.41
West Sulawesi	62.89	44.98	70.83	1.02	1.78	0.69	1.48	0.63	2.54	1.78	1.02	1.48	0.63
Maluku	58.33	43.57	63.09	0.85	0.23	1.05	1.08	0.64	2.31	0.23	0.85	1.08	0.64
North Maluku	43.38	21.74	51.31	0.83	0.00	1.14	0.51	1.13	1.88	0.00	0.83	0.51	1.13
West Papua	70.20	19.33	82.87	0.96	1.49	0.83	0.61	1.27	1.02	1.49	0.96	0.61	1.27
Papua	78.00	33.94	89.10	0.59	0.61	0.59	0.79	0.41	0.79	0.61	0.59	0.79	0.41
TOTAL	52.60	38.21	64.94	0.80	0.74	0.85	0.79	0.80	0.80	0.74	0.85	0.79	0.80

Appendix 7

Child educational deprivation by province, 2009

Province	% of Children aged 3–6 years not enrolled in early childhood education					% of Children aged 7–17 years not enrolled in primary and secondary schools				
	Total	Urban	Rural	Girl	Boy	Total	Urban	Rural	Girl	Boy
Aceh	55.49	47.59	58.20	55.48	55.50	7.22	5.85	7.72	6.06	8.36
North Sumatra	55.17	50.77	58.02	54.09	56.09	8.50	5.95	10.27	7.89	9.07
West Sumatra	50.40	52.53	49.57	53.02	47.82	6.84	4.66	7.89	4.74	8.62
Riau	54.01	51.16	56.71	52.75	55.11	8.72	6.06	11.32	9.56	7.96
Jambi	53.33	44.88	56.95	54.14	52.63	9.36	5.58	11.09	9.43	9.29
South Sumatra	51.44	47.70	53.52	48.19	54.47	11.91	6.09	15.44	10.16	13.57
Bengkulu	55.16	54.03	55.72	52.47	57.36	9.10	5.00	11.44	5.53	12.17
Lampung	50.39	45.93	51.73	52.02	48.83	11.49	5.50	13.62	8.81	13.95
Bangka Belitung	48.18	42.61	52.04	51.22	45.80	14.64	10.45	18.50	9.75	19.11
Riau Islands	51.36	51.63	50.91	48.08	54.25	7.20	5.50	8.80	4.18	9.79
Jakarta	42.30	42.30	0	36.84	47.04	8.09	8.09	0	9.37	6.80
West Java	51.42	50.18	53.12	50.82	51.99	13.21	10.55	16.83	12.77	13.63
Central Java	45.98	43.67	48.06	46.02	45.94	9.88	8.41	11.23	8.65	11.09
Yogyakarta	33.23	37.66	25.57	33.57	32.97	4.84	3.75	6.83	4.15	5.55
East Java	42.70	40.54	44.58	41.14	44.13	9.55	7.08	11.90	9.33	9.76
Banten	50.89	48.06	54.18	49.95	51.69	13.32	10.64	16.70	13.67	12.99
Bali	46.85	43.58	50.78	45.85	47.92	4.35	3.35	5.76	4.95	3.78
West Nusa Tenggara	50.62	50.57	50.65	50.59	50.65	9.49	10.60	8.68	9.93	9.05
East Nusa Tenggara	54.12	46.58	55.27	55.20	53.09	13.29	7.62	14.52	12.23	14.31
West Kalimantan	57.46	50.75	59.76	57.81	57.15	15.64	9.76	17.66	13.53	17.71
Central Kalimantan	60.96	46.67	66.16	61.56	60.42	9.80	6.39	11.51	7.98	11.41
South Kalimantan	46.93	41.95	50.35	47.75	46.04	12.98	9.36	15.30	10.85	15.08
East Kalimantan	50.02	46.91	54.85	50.96	49.21	5.44	3.83	7.80	4.13	6.66
North Sulawesi	55.65	53.63	56.95	55.83	55.46	8.15	5.59	10.12	6.50	9.56
Central Sulawesi	52.59	51.29	52.91	50.03	55.25	10.91	8.53	11.47	9.64	12.09
South Sulawesi	48.64	47.89	48.94	46.02	51.16	12.99	9.29	14.62	11.86	14.12
Southeast Sulawesi	50.33	46.55	51.22	50.70	49.98	10.29	3.64	11.97	9.52	11.09
Gorontalo	44.27	43.76	44.49	39.84	48.25	15.46	9.23	18.26	13.76	16.95
West Sulawesi	49.58	44.64	51.81	49.23	49.82	12.11	7.92	13.99	12.18	12.05
Maluku	53.94	46.27	56.28	51.91	55.67	7.03	5.36	7.58	5.89	8.16
North Maluku	54.23	35.21	59.94	49.64	58.38	8.96	11.80	7.85	7.92	9.97
West Papua	56.13	52.22	57.01	53.25	58.40	11.57	3.01	13.80	11.36	11.76
Papua	63.87	53.28	66.87	63.65	64.11	23.46	4.89	27.49	24.53	22.52
TOTAL	50.01	46.77	52.58	49.25	50.70	10.78	8.13	13.05	10.05	11.48

Appendix 8

Child labour by province, 2009

Province	% of Children performing economic labour without going to school					% of Children performing economic labour and go to school				
	Total	Urban	Rural	Girl	Boy	Total	Urban	Rural	Girl	Boy
Aceh	1.51	2.01	1.34	0.89	2.15	1.73	0.67	2.09	1.11	2.37
North Sumatra	1.12	0.37	1.64	1.23	1.02	3.00	0.37	4.82	1.91	4.03
West Sumatra	1.17	0.48	1.50	0.00	2.09	1.44	0.97	1.67	1.39	1.49
Riau	0.60	0.00	1.23	0.42	0.77	1.10	1.16	1.03	0.00	2.11
Jambi	1.27	0.89	1.43	0.41	2.10	0.41	0.00	0.57	0.00	0.80
South Sumatra	1.80	1.98	1.69	0.30	3.35	1.16	0.00	1.88	0.23	2.11
Bengkulu	2.67	0.89	3.61	0.63	4.62	1.56	1.79	1.44	0.63	2.46
Lampung	1.73	0.53	2.18	0.00	3.25	2.30	1.06	2.76	0.99	3.45
Bangka Belitung	2.68	1.53	3.66	1.08	4.43	0.35	0.77	0.00	0.68	0.00
Riau Islands	0.42	0.90	0.00	0.00	0.76	1.38	0.00	2.56	3.03	0.00
Jakarta	1.07	1.07	0	1.72	0.42	0.43	0.43	0	0.65	0.21
West Java	1.23	1.12	1.37	0.96	1.49	0.43	0.37	0.51	0.22	0.63
Central Java	0.99	0.40	1.52	0.62	1.35	0.95	0.59	1.26	0.36	1.52
Yogyakarta	0.39	0.33	0.50	0.45	0.33	0.78	0.67	0.99	0.36	1.18
East Java	1.11	0.74	1.47	0.52	1.64	1.18	0.74	1.60	0.20	2.05
Banten	1.21	1.01	1.45	0.79	1.62	0.44	0.00	0.97	0.45	0.43
Bali	0.66	0.68	0.63	1.06	0.27	4.00	2.04	6.64	4.96	3.06
West Nusa Tenggara	1.57	1.72	1.46	1.19	1.96	4.81	2.76	6.21	1.77	7.95
East Nusa Tenggara	2.27	0.79	2.55	0.00	4.52	2.61	1.58	2.81	1.33	3.88
West Kalimantan	2.41	1.45	2.74	0.47	4.32	2.20	2.42	2.13	0.91	3.48
Central Kalimantan	1.52	0.00	2.36	1.44	1.58	2.10	1.64	2.36	2.08	2.11
South Kalimantan	2.26	0.89	3.11	0.56	3.88	2.05	1.77	2.22	3.08	1.07
East Kalimantan	1.08	1.17	0.93	0.50	1.64	0.42	0.39	0.47	0.00	0.82
North Sulawesi	0.51	0.75	0.36	0.00	0.98	0.43	0.00	0.72	0.45	0.41
Central Sulawesi	1.90	1.21	2.06	0.00	3.71	2.52	0.00	3.08	0.43	4.51
South Sulawesi	3.32	1.56	4.09	0.66	5.92	3.78	2.33	4.40	2.08	5.44
Southeast Sulawesi	1.03	0.00	1.30	0.65	1.46	7.05	0.00	8.89	3.25	11.33
Gorontalo	2.38	2.41	2.36	0.81	3.70	1.91	0.00	2.76	0.60	3.02
West Sulawesi	1.79	0.00	2.66	0.00	3.45	4.26	2.08	5.32	2.48	5.91
Maluku	0.97	0.87	1.00	0.00	2.01	2.47	0.87	3.00	1.45	3.58
North Maluku	1.45	3.08	0.83	0.64	2.16	2.23	1.54	2.50	0.00	4.20
West Papua	1.39	0.00	1.74	0.96	1.78	1.85	0.00	2.33	0.96	2.68
Papua	6.99	0.00	8.53	5.15	8.51	9.13	0.00	11.14	7.30	10.64
TOTAL	1.4	0.87	1.85	0.74	2.03	1.59	0.67	2.35	0.86	2.28

Appendix 9

Child deprivation in access to a birth certificate by province, 2009

Province	% Children aged 0–5 years without a birth certificate				
	Total	Urban	Rural	Girl	Boy
Aceh	54.26	35.08	62.09	51.93	56.58
North Sumatra	80.17	70.26	87.08	80.24	80.1
West Sumatra	63.87	47.49	70.72	65.17	62.53
Riau	59.93	51.11	68.84	61.36	58.71
Jambi	45.49	20.59	56.99	43.14	47.45
South Sumatra	57.59	44.71	65.57	58.31	56.9
Bengkulu	40.87	18.52	53.94	39.24	42.22
Lampung	54.54	36.16	60.25	52.92	56.04
Bangka Belitung	35.22	17.78	48.84	36.07	34.59
Riau Islands	32.75	21.85	48.53	31.35	34
Jakarta	15.08	15.08	0	16.48	13.76
West Java	48.58	36.77	66.02	48.23	48.92
Central Java	33.59	25.9	40.88	32.33	34.7
Yogyakarta	11.64	9.65	15.07	12.11	11.23
East Java	36.94	23.8	49.38	37.14	36.76
Banten	51.05	35.12	73.36	51.49	50.65
Bali	46.03	34.36	62.00	45.05	47.09
West Nusa Tenggara	76.01	70.76	79.90	76.97	75.12
East Nusa Tenggara	74.4	42.6	80.04	76.16	72.74
West Kalimantan	56.66	32.59	66.26	57.16	56.24
Central Kalimantan	57.83	35.54	67.96	59.8	56.08
South Kalimantan	49.78	39.35	57.39	49.92	49.64
East Kalimantan	32.93	25.37	45.86	35.67	30.51
North Sulawesi	51.27	33.12	64.53	51.83	50.72
Central Sulawesi	62.7	34.17	69.56	63.78	61.58
South Sulawesi	57.45	36.23	66.12	57.63	57.28
Southeast Sulawesi	67.13	40	75.23	68.36	65.98
Gorontalo	70.5	54.45	77.32	73.07	68.25
West Sulawesi	70.02	50.01	78.57	67.02	72.36
Maluku	74.12	45.33	82.91	75.57	72.82
North Maluku	73.28	38.9	84.64	74.64	72.11
West Papua	63.61	33.32	70.76	61.43	65.4
Papua	57.21	27.05	67.05	55.86	58.65
TOTAL	49.52	34.03	63.01	49.54	49.49

Appendix 10

Number of children and child income poverty by district, 2009

Province/ District		Population	Children (aged <18 years)	% Children living below		
			Number	IPL$1/day	Provincial poverty line	IPL $2/day
Aceh						
	Simeulue	77,275	33,781	9.61	76.91	94.23
	Aceh Singkil	96,318	42,717	0.00	11.40	21.96
	Aceh Selatan	202,359	73,837	2.99	22.71	42.43
	Aceh Tenggara	166,152	69,856	6.57	64.23	79.56
	Aceh Timur	320,192	136,845	15.03	45.53	76.83
	Aceh Tengah	178,084	67,087	0.00	7.62	32.99
	Aceh Barat	149,064	52,326	0.00	17.27	41.92
	Aceh Besar	293,552	96,765	0.00	7.28	13.10
	Pidie	362,531	142,990	0.00	3.37	41.82
	Bireuen	336,892	120,091	1.81	30.28	62.38
	Aceh Utara	500,648	204,829	18.38	59.01	69.96
	Aceh Barat Daya	117,198	44,894	0.00	8.79	52.73
	Gayo Lues	70,542	30,418	0.00	14.00	27.99
	Aceh Tamiang	226,869	86,242	0.79	25.76	55.52
	Nagan Raya	117,723	43,010	0.00	18.17	50.64
	Aceh Jaya	78,357	27,731	0.00	9.57	26.59
	Bener Meriah	107,508	41,127	2.96	10.37	46.67
	Pidie Jaya	127,295	48,552	0.00	16.54	54.89
	Kota Banda Aceh	199,734	62,787	0.00	0.00	0.00
	Kota Sabang	27,385	9,515	0.00	3.54	3.54
	Kota Langsa	131,755	51,529	0.00	20.04	31.82
	Kota Lhoksumawe	149,443	56,101	0.00	25.44	48.15
	Kota Subulussalam	62,500	27,757	8.00	40.00	65.33
North Sumatra						
	Nias	438,333	202,590	32.20	44.91	88.56
	Mandailing Natal	424,354	169,672	0.00	6.71	51.56
	Tapanuli Selatan	262,284	111,584	3.77	16.09	74.65
	Tapanuli Tengah	319,757	143,068	0.00	16.02	63.68
	Tapanuli Utara	267,976	122,001	4.26	7.80	50.35
	Toba Samosir	172,216	79,040	0.00	5.88	54.41
	Labuhan Batu	1,036,812	434,410	8.13	14.75	59.66
	Asahan	691,754	280,867	2.48	19.67	62.33
	Simalungun	848,343	327,302	1.69	11.39	49.10
	Dairi	270,153	117,624	6.58	9.43	48.75
	Karo	366,217	141,408	0.00	2.79	44.23
	Deli Serdang	1,767,362	642,853	3.33	11.81	45.08
	Langkat	1,044,153	392,246	4.16	11.21	62.16
	Nias Selatan	269,955	130,542	34.25	54.69	98.89

Province/ District		Population	Children (aged <18 years)	% Children living below		
			Number	IPL$1/day	Provincial poverty line	IPL $2/day
	Humbang Hasundutan	156,077	68,916	6.12	10.21	65.31
	Papak Bharat	42,359	18,954	42.42	54.54	96.97
	Samosir	130,205	59,635	5.26	21.05	85.26
	Serdang Bedagai	634,957	245,444	6.73	18.92	57.05
	Batu Bara	384,616	162,547	7.27	9.92	65.08
	Kota Sibolga	94,800	38,092	0.00	16.00	40.00
	Kota Tanjung Balai	165,462	68,738	0.00	5.88	27.44
	Kota Pematang Siantar	237,729	83,565	0.00	10.18	44.44
	Kota Tebing Tinggi	140,847	50,822	0.00	12.76	14.89
	Kota Medan	2,092,785	708,559	0.00	7.17	26.56
	Kota Binjai	253,858	89,211	0.00	16.41	43.28
	Kota Padang Sidempuan	189,496	77,735	6.38	34.04	44.68
West Sumatra						
	Kepulauan Mentawai	64,412	27,907	22.92	64.58	97.92
	Pesisir Selatan	418,932	158,515	0.00	10.87	52.33
	Solok	336,036	131,726	1.77	8.75	40.43
	Sawahlunto/Sijunjung	193,487	80,227	6.66	14.07	48.89
	Tanah Datar	314,107	107,988	2.96	12.69	47.35
	Padang Pariaman	363,824	145,929	2.16	14.48	39.65
	Agam	402,373	142,982	4.66	23.64	69.10
	Lima Puluh Koto	311,719	112,102	3.65	10.50	58.90
	Pasaman	244,386	99,173	5.28	14.42	57.03
	Solok Selatan	124,974	48,004	0.00	4.41	55.87
	Dharmasraya	174,300	62,160	5.49	20.87	65.92
	Pasaman Barat	316,307	133,467	10.50	23.42	57.45
	Kota Padang	818,367	266,851	0.00	4.49	22.67
	Kota Solok	55,936	21,420	0.00	0.00	10.00
	Kota Sawah Lunto	51,051	18,323	0.00	11.11	11.11
	Kota Padang Panjang	52,887	19,903	0.00	8.34	8.34
	Kota Bukittinggi	100,721	37,056	0.00	6.85	12.33
	Kota Payakumbuh	99,821	36,355	0.00	2.07	28.28
	Kota Pariaman	65,999	25,392	0.00	6.63	19.92
Riau						
	Kuantan Singingi	296,360	106,399	1.93	3.87	11.60
	Indragiri Hulu	350,887	122,728	1.24	14.40	58.52
	Indragiri Hilir	725,407	249,716	1.43	27.85	64.81
	Pelalawan	303,435	120,635	0.00	8.93	25.60
	Siak	353,395	155,641	0.00	1.96	16.08
	Kampar	653,440	249,646	0.59	5.27	28.66
	Rokan Hulu	439,148	171,870	0.00	19.43	49.18
	Bengkalis	802,262	304,756	1.94	12.91	24.92
	Rokan Hilir	600,704	245,632	1.65	7.32	27.83
	Kota Pekanbaru	852,431	304,733	0.00	1.71	6.35

Province/ District		Population	Children (aged <18 years)	% Children living below		
			Number	IPL$1/day	Provincial poverty line	IPL $2/day
	Kota Dumai	257,443	103,125	0.00	26.09	40.64
Jambi						
	Kerinci	314,832	110,129	4.96	5.51	63.75
	Merangin	295,157	108,614	0.00	3.98	24.87
	Sarolangun	220,589	84,606	9.16	14.50	51.14
	Batanghari	225,198	81,628	0.00	0.00	62.93
	Muaro Jambi	317,820	115,180	5.60	10.28	65.88
	Tanjung Jabung Timur	215,913	76,357	16.74	34.49	81.75
	Tanjung Jabung Barat	258,746	95,980	2.61	17.06	33.30
	Tebo	259,961	95,524	4.88	8.13	56.90
	Bungo	274,738	102,597	3.68	7.01	51.62
	Kota Jambi	481,143	158,524	2.67	16.89	36.00
South Sumatra						
	Ogan Komering Ulu	266,293	96,347	5.53	5.53	44.73
	Ogan Komering Ilir	706,124	255,879	6.79	17.56	55.59
	Muara Enim	666,662	250,713	4.02	17.39	68.63
	Lahat	339,923	122,464	11.06	17.31	62.43
	Musi Rawas	504,760	184,307	6.18	28.09	71.91
	Musi Banyu Asin	522,289	197,068	5.22	10.97	33.22
	Banyu Asin	817,141	297,484	12.96	31.58	84.73
	OKU Selatan	330,971	123,157	17.32	30.71	81.10
	OKU Timur	580,078	197,444	17.31	26.50	75.23
	Ogan Ilir	383,849	141,999	0.00	2.63	41.49
	Empat Lawang	213,174	75,103	20.51	25.64	70.08
	Kota Palembang	1,435,816	487,469	5.32	18.63	41.20
	Kota Prabumulih	137,440	47,071	11.32	24.53	41.51
	Kota Pagar Alam	116,106	41,344	0.00	22.63	65.97
	Kota Lubuk Linggau	185,623	67,996	0.00	10.09	41.59
Bengkulu						
	Bengkulu Selatan	150,384	58,120	11.66	23.53	67.62
	Rejang Lebong	270,816	97,372	7.66	22.67	61.05
	Bengkulu Utara	364,873	135,824	5.31	19.75	58.78
	Kaur	123,961	44,270	24.73	37.63	83.87
	Seluma	174,012	61,483	16.66	32.10	73.45
	Mukomuko	153,133	59,094	0.00	3.33	46.66
	Lebong	97,345	35,714	28.16	42.24	83.09
	Kepahing	124,957	44,856	3.46	16.41	67.07
	Kota Bengkulu	293,190	102,716	3.77	14.26	43.33
Lampung						
	Lampung Barat	415,428	143,989	21.05	25.72	84.79
	Tanggamus	884,104	327,760	15.74	19.32	75.79
	Lampung Selatan	974,786	356,114	25.79	34.64	78.86

Province/ District		Population	Children (aged <18 years)	% Children living below		
			Number	IPL$1/day	Provincial poverty line	IPL $2/day
	Lampung Timur	988,952	345,423	18.29	22.72	69.98
	Lampung Tengah	1,235,343	421,006	13.80	17.02	64.41
	Lampung Utara	590,557	211,707	26.63	36.66	84.94
	Way Kanan	378,586	129,439	15.03	16.76	84.39
	Tulang Bawang	827,821	301,538	19.18	24.38	71.23
	Kota Bandar Lampung	861,061	290,960	2.95	20.98	43.93
	Kota Merto	140,809	44,959	4.88	9.76	34.14
Bangka Belitung						
	Bangka	249,781	81,235	0.00	7.90	22.14
	Belitung	127,216	42,267	0.00	14.43	25.27
	Bangka Barat	144,967	50,618	3.12	14.83	26.38
	Bangka Tengah	132,455	47,410	0.00	9.36	22.75
	Bangka Selatan	147,900	55,068	0.00	6.14	27.75
	Belitung Timur	83,662	28,685	0.00	6.99	23.45
	Kota Pangkal Pinang	145,514	47,896	3.17	5.07	10.75
Riau Archipelago						
	Karimun	239,847	83,778	6.26	21.09	32.21
	Kepulauan Riau	131,736	43,737	0.00	9.45	9.45
	Natuna	100,969	37,670	0.00	9.54	9.54
	Lingga	92,767	31,267	11.73	31.96	51.52
	Kota Batam	810,552	270,148	0.46	1.23	4.68
	Kota Tanjung Pinang	194,024	64,135	2.65	13.90	14.57
Jakarta						
	Kepulauan Seribu	18,977	6,800			
	Jakarta Selatan	2,091,848	620,967	0.00	4.21	4.70
	Jakarta Timur	2,371,808	711,140	0.00	4.34	5.08
	Jakarta Pusat	873,899	246,181	0.00	4.23	5.35
	Jakarta Barat	2,151,536	626,651	0.00	6.01	6.12
	Jakarta Utara	1,425,479	446,532	0.00	9.48	11.57
West Java						
	Bogor	4,125,854	1,589,631	8.43	15.79	56.64
	Sukabumi	2,253,337	857,310	16.85	26.46	72.24
	Cianjur	2,200,346	841,221	9.36	22.35	75.60
	Bandung	2,881,488	1,028,509	4.92	12.36	49.65
	Garut	2,327,239	916,039	32.78	43.08	85.85
	Tasikmalaya	1,727,478	205,416	13.25	25.27	80.12
	Ciamis	1,554,605	483,296	7.17	15.83	73.36
	Kuningan	1,098,431	390,817	2.41	14.64	56.60
	Cirebon	2,143,635	776,422	9.77	21.88	75.12
	Majalengka	1,210,319	386,971	6.76	18.96	64.42
	Sumedang	1,061,669	345,383	3.64	6.82	53.23
	Indramayu	1,776,223	620,281	8.86	14.19	60.16
	Subang	1,428,441	458,417	2.15	4.00	49.29

Province/ District		Population	Children (aged <18 years)	% Children living below		
			Number	IPL$1/day	Provincial poverty line	IPL $2/day
	Purwakarta	808,133	289,150	8.07	8.94	36.95
	Karawang	2,053,410	694,848	0.60	3.28	37.29
	Bekasi	2,287,843	798,732	0.00	2.06	25.28
	Bandung Barat	1,451,989	514,751	15.51	25.07	68.71
	Kota Bogor	1,040,398	347,882	2.73	6.36	29.54
	Kota Sukabumi	332,054	110,925	0.00	9.72	33.33
	Kota Bandung	2,450,560	790,320	0.00	4.23	28.43
	Kota Cirebon	344,117	111,067	0.00	4.62	40.00
	Kota Bekasi	2,319,518	719,001	0.83	2.90	16.78
	Kota Depok	1,606,862	487,631	0.00	0.00	14.19
	Kota Cimahi	654,050	209,497	4.10	6.56	27.05
	Kota Tasik Malaya	594,914	602,410	5.43	21.53	58.96
	Kota Banjar	169,472	60,233	0.00	14.45	64.91
Central Java						
	Cilacap	1,603,704	563,331	23.91	31.34	80.72
	Banyumas	1,486,149	456,575	22.76	32.94	69.52
	Purbalingga	821,119	281,249	21.06	26.44	79.42
	Banjarnegara	861,403	285,399	42.33	45.55	83.79
	Kebumen	1,203,249	429,057	16.95	22.49	76.99
	Purworejo	713,424	217,652	12.43	17.24	78.49
	Wonosobo	748,720	253,801	15.38	20.32	72.94
	Magelang	1,161,824	377,731	19.17	23.04	82.20
	Boyolali	929,106	296,683	19.95	34.59	87.08
	Klaten	1,118,687	321,122	5.07	7.43	53.63
	Sukoharjo	820,609	231,205	1.86	6.43	43.90
	Wonogiri	969,221	261,866	29.40	37.79	81.20
	Karanganyar	806,444	244,088	3.40	8.18	62.51
	Sragen	849,098	250,097	7.80	14.13	65.21
	Grobogan	1,324,817	440,080	16.01	19.78	77.88
	Blora	824,799	243,143	22.09	30.99	85.52
	Rembang	569,058	163,732	14.05	14.05	67.41
	Pati	1,156,451	349,828	3.23	14.33	68.95
	Kudus	785,605	230,415	0.00	4.44	58.98
	Jepara	1,091,403	360,009	13.44	22.84	75.95
	Demak	1,026,713	343,106	4.31	8.21	73.23
	Semarang	907,777	273,298	8.67	11.98	51.29
	Temanggung	703,366	218,704	33.41	36.75	77.66
	Kendal	951,269	305,654	9.11	14.56	63.29
	Batang	675,163	219,734	23.69	30.50	82.68
	Pekalongan	845,621	287,670	18.49	23.71	71.90
	Pemalang	1,370,021	487,062	23.57	35.77	82.52
	Tegal	1,397,874	508,799	9.80	16.61	65.60
	Brebes	1,772,730	614,031	15.22	24.18	83.73

Province/ District		Population	Children (aged <18 years)	% Children living below		
			Number	IPL$1/day	Provincial poverty line	IPL $2/day
	Kota Magelang	135,035	39,581	0.00	11.42	45.71
	Kota Surakarta	520,061	144,879	0.00	0.00	30.21
	Kota Salatiga	179,581	48,377	0.00	0.00	23.53
	Kota Semarang	1,510,642	457,373	0.97	3.81	31.62
	Kota Pekalongan	272,717	87,945	6.06	36.36	72.72
	Kota Tegal	237,203	78,301	0.00	3.95	36.84
Yogyakarta						
	Kulon Progo	364,828	107,210	18.48	35.98	82.68
	Bantul	898,744	244,490	3.00	14.73	44.91
	Gunung Kidul	669,719	172,094	26.81	33.69	74.16
	Sleman	1,026,261	273,230	6.85	17.76	43.93
	Kota Yogyakarta	450,663	104,709	0.85	5.08	27.96
East Java						
	Pacitan	541,365	151,425	37.47	46.08	81.40
	Ponorogo	871,310	232,374	20.14	26.80	75.06
	Trenggalek	654,736	176,753	28.62	36.14	68.64
	Tulungagung	961,400	283,237	3.25	9.49	44.89
	Blitar	1,037,112	302,357	11.15	15.52	63.08
	Kediri	1,406,665	433,074	19.35	32.45	79.28
	Malang	2,350,662	715,097	15.15	20.56	67.15
	Lumajang	996,326	276,614	18.61	29.00	87.02
	Jember	2,255,983	667,113	19.60	30.08	79.12
	Banyuwangi	1,488,162	458,985	7.76	17.95	64.60
	Bondowoso	686,947	190,975	22.22	31.47	83.65
	Situbondo	605,563	169,195	28.55	34.81	71.88
	Probolinggo	1,011,740	312,295	35.21	49.91	86.76
	Pasuruan	1,407,703	426,813	13.08	26.59	78.68
	Sidoarjo	1,748,511	513,256	0.00	3.69	34.50
	Mojokerto	983,077	303,998	2.60	3.30	51.02
	Jombang	1,262,178	411,756	3.64	9.57	59.75
	Nganjuk	971,481	281,584	8.14	16.76	70.43
	Madium	622,634	175,081	7.31	13.28	62.06
	Magetan	606,635	167,159	6.79	17.20	69.73
	Ngawi	810,845	216,223	31.26	36.44	83.37
	Bojonegoro	1,231,863	357,705	13.17	17.87	64.27
	Tuban	1,047,456	294,564	9.92	11.77	63.59
	Lamongan	1,152,585	343,654	3.18	6.15	68.48
	Gresik	1,179,413	347,888	11.16	18.85	63.23
	Bangkalan	944,697	365,390	28.83	33.02	79.22
	Sampang	892,288	352,943	21.58	34.92	84.89
	Pamekasan	826,501	273,889	36.33	47.24	82.38
	Sumenep	985,490	264,172	23.36	34.25	93.58
	Kota Kediri	264,298	83,893	0.00	18.00	66.00

Province/ District		Population	Children (aged <18 years)	% Children living below		
			Number	IPL$1/day	Provincial poverty line	IPL $2/day
	Kota Blitar	129,342	41,646	0.00	0.00	11.76
	Kota Malang	795,618	211,622	0.00	4.00	29.09
	Kota Probolinggo	223,593	71,561	3.81	11.31	49.30
	Kota Pasuruan	168,753	54,995	0.00	1.62	48.62
	Kota Mojokerto	109,805	32,581	0.00	0.00	2.50
	Kota Madium	173,890	49,146	0.00	2.13	46.80
	Kota Surabaya	2,549,404	751,671	0.46	1.83	16.97
	Kota Batu	183,841	51,397	7.26	15.72	37.90
Banten						
	Pandeglang	1,168,077	478,458	10.62	17.57	83.32
	Lebak	1,338,563	540,441	21.06	28.50	82.56
	Tangerang	3,912,203	1,382,206	2.64	7.30	31.12
	Serang	1,429,500	561,239	2.88	8.35	55.26
	Kota Tangerang	1,652,590	524,750	0.00	0.21	7.90
	Kota Cilegon	371,150	128,075	0.00	0.00	7.69
Bali						
	Jembarana	258,895	85,021	0.00	7.14	36.69
	Tabanan	415,877	107,802	2.55	7.30	39.43
	Badung	425,269	128,116	0.00	0.87	21.45
	Gianyar	442,023	128,235	0.28	1.91	18.76
	Klungkung	168,243	51,352	1.91	1.91	30.60
	Bangli	219,701	67,573	0.83	6.91	64.53
	Karangasem	387,469	126,846	7.35	10.81	71.52
	Buleleng	633,088	199,251	11.18	16.36	58.60
	Kota Denpasar	606,433	189,936	0.00	0.57	7.45
West Nusa Tenggara						
	Lombok Barat	867,908	322,057	15.41	24.32	77.73
	Lombok Tengah	895,944	332,582	10.90	17.87	71.25
	Lombok Timur	1,129,393	439,770	27.43	36.82	78.87
	Sumbawa	440,100	155,599	14.31	17.23	69.40
	Dompu	227,546	97,762	51.67	52.36	80.48
	Bima	439,257	184,945	41.04	41.45	88.84
	Sumbawa Barat	105,772	36,692	0.00	5.30	32.29
	Kota Mataram	393,410	133,301	3.76	12.21	40.37
	Kota Bima	138,402	51,597	8.26	14.63	57.67
East Nusa Tenggara						
	Sumba Barat	102,649	49,602	52.80	31.30	90.19
	Sumba Timur	220,734	94,491	42.86	29.24	72.83
	Kupang	372,632	164,795	51.76	40.89	89.13
	Timor Tengah Selatan	396,320	168,713	44.10	35.44	84.28
	Timor Tengah Utara	202,788	85,865	38.13	25.00	79.37
	Belu	441,483	205,430	55.29	46.22	84.70
	Alor	171,706	68,982	31.42	25.34	84.81

Province/ District		Population	Children (aged <18 years)	% Children living below		
			Number	IPL$1/day	Provincial poverty line	IPL $2/day
	Lembata	102,162	39,200	48.99	36.74	87.75
	Flores Timur	224,980	88,972	22.27	8.58	87.65
	Sikka	263,676	105,816	41.45	25.97	89.19
	Ende	224,698	90,304	5.00	6.25	56.29
	Ngada	127,769	56,075	14.92	9.69	77.60
	Manggarai	259,709	118,071	37.74	30.63	88.14
	Rote Ndao	109,431	43,950	32.60	17.38	80.44
	Manggarai Barat	200,028	94,653	21.81	10.30	75.75
	Sumba Tengah	251,708	111,563	65.37	49.02	93.27
	Sumba Barat Daya	57,983	30,035	50.01	41.38	100.00
	Nagekeo	119,710	47,338	19.63	19.63	64.27
	Kota Kupang	283,051	97,415	0.55	16.58	38.12
West Kalimantan						
	Sambas	540,183	208,390	10.59	13.34	68.24
	Bengkayang	228,595	95,277	8.62	9.77	85.63
	Landak	360,573	144,944	27.11	27.55	82.22
	Pontianak	239,724	95,674	9.64	15.70	67.88
	Sanggau	430,022	148,954	5.98	8.38	45.44
	Ketapang	455,232	166,647	1.74	5.52	46.02
	Sintang	406,653	154,828	0.00	0.00	16.88
	Kapuas Hulu	242,675	91,274	16.10	17.79	71.18
	Sekadau	196,608	72,945	0.00	2.70	58.56
	Melawai	186,562	67,411	2.99	2.99	55.22
	Kayong Utara	100,537	37,941	29.44	33.33	73.89
	Kota Pontianak	573,499	197,879	2.75	3.85	40.11
	Kota Singkawang	193,402	76,922	0.00	1.52	26.00
Central Kalimantan						
	Kotawaringin Barat	258,733	92,226	0.00	0.00	24.26
	Kotawaringin Timur	375,237	148,060	4.87	9.05	43.86
	Kapus	395,017	147,973	7.90	25.63	81.12
	Barito Selatan	147,437	53,411	0.00	0.00	15.81
	Barito Utara	134,956	50,591	0.00	0.00	2.85
	Sukamara	44,612	17,529	0.00	0.00	21.87
	Lamandau	67,985	24,793	0.00	4.34	73.89
	Seruyan	130,064	49,931	0.00	7.72	73.03
	Katingan	158,144	61,669	2.56	5.99	43.64
	Pulang Pisau	139,216	51,131	6.76	24.78	71.09
	Gunung Mas	106,594	44,987	0.00	0.00	10.10
	Barito Timur	101,320	35,849	0.00	0.00	32.28
	Murung Raya	103,602	42,091	0.00	0.00	42.45
	Kota Palangkaraya	219,544	77,806	0.00	6.40	22.37
South Kalimantan						
	Tanah Laut	271,289	99,545	1.77	6.61	33.99

Province/ District		Population	Children (aged <18 years)	% Children living below		
			Number	IPL$1/day	Provincial poverty line	IPL $2/day
	Kotabaru	277,806	102,254	3.39	10.73	55.52
	Banjar	492,298	170,414	1.67	3.88	39.15
	Barito Kuala	271,765	95,889	10.07	18.50	66.13
	Tapin	152,060	51,392	0.00	2.22	50.69
	Hulu Sungai Selatan	207,007	69,389	7.15	13.79	55.55
	Hulu Sungai Tengah	243,047	84,187	0.53	3.16	67.78
	Hulu Sungai Utara	215,404	77,610	0.00	4.84	55.18
	Tabalong	192,720	70,946	2.88	10.57	63.15
	Tanah Bumbu	228,510	78,866	0.00	3.67	27.46
	Balangan	101,381	36,418	0.00	0.00	31.38
	Kota Banjarmasin	631,484	211,669	1.58	5.35	25.19
	Kota Banjarbaru	169,557	56,321	0.00	5.50	28.42
East Kalimantan						
	Pasir	181,740	67,915	5.83	12.30	37.56
	Kutai Barat	159,437	56,390	4.12	5.15	26.79
	Kutai Karta Negara	528,851	181,330	1.67	11.41	28.96
	Kulai Timur	192,708	70,792	0.00	5.92	42.92
	Berau	171,738	67,712	8.69	20.29	39.50
	Malinau	62,493	26,163	0.00	0.00	3.71
	Bulongan	103,360	40,079	5.88	22.06	38.25
	Nunukan	139,880	56,047	27.55	39.80	65.74
	Penajam Paser Utara	125,720	45,886	0.00	22.16	68.85
	Kota Balikpapan	515,846	175,925	0.00	4.88	7.47
	Kota Samarinda	598,318	194,265	0.00	2.54	11.14
	Kota Tarakan	190,781	67,405	0.00	15.07	28.16
	Kota Bontang	135,450	53,648	0.00	2.70	2.70
North Sulawesi						
	Bolaang Mongondow	622,616	110,820	11.74	15.82	78.06
	Minahasa	606,776	88,014	13.13	13.13	61.69
	Kepulauan Sangihe	263,522	39,461	9.64	15.18	79.88
	Kepulauan Talaud	151,504	24,158	0.00	0.00	38.70
	Minahasa Selatan	369,364	61,130	13.55	26.56	76.99
	Minahasa Utara	356,816	60,211	0.00	1.30	45.91
	Bolaang Mongondow Utara	162,682	29,031	17.17	19.19	76.77
	Siau Tagulandang Biaro	124,812	18,324	0.00	0.00	52.94
	Minahasa Tenggara	193,016	35,503	23.81	31.75	82.54
	Kota Manado	879,320	143,508	1.79	8.48	48.21
	Kota Bitung	365,230	66,299	8.27	15.61	71.04
	Kota Tomohon	169,190	25,469	4.52	25.26	55.03
	Kota Kotamobagu	240,774	39,937	5.63	5.63	52.23
Central Sulawesi						
	Banggai Kepulauan	164,127	64,509	26.40	40.81	84.80
	Banggai	310,470	113,745	22.16	33.67	66.14

Province/ District		Population	Children (aged <18 years)	% Children living below		
			Number	IPL$1/day	Provincial poverty line	IPL $2/day
	Morowali	187,960	68,883	8.21	11.19	55.22
	Poso	178,545	66,566	12.23	18.13	60.76
	Donggala	498,942	201,406	26.53	31.72	75.25
	Toli-Toli	209,816	84,791	11.19	18.71	64.87
	Buol	124,444	52,679	29.01	49.45	83.87
	Parigi Moutong	394,957	160,391	17.01	20.35	58.65
	Tojo Una-Una	199,384	76,868	0.00	7.21	45.34
	Kota Palu	327,737	107,984	5.28	8.37	24.23
South Sulawesi						
	Selayar	120,878	44,951	0.00	0.00	89.36
	Bulukumba	391,748	140,253	22.31	11.15	75.62
	Bantaeng	172,809	61,614	46.67	42.51	91.19
	Jeneponto	331,493	119,042	31.78	18.60	91.47
	Takalar	256,021	90,322	6.99	6.00	46.93
	Gowa	613,038	235,486	39.13	27.13	82.54
	Sinjai	226,564	86,314	36.91	17.50	76.22
	Maros	304,376	116,908	2.31	2.31	62.30
	Pangkajene Kepulauan	296,464	111,154	35.67	27.80	84.27
	Barru	161,707	57,624	20.15	19.21	87.59
	Bone	706,214	251,151	48.87	32.08	86.92
	Soppeng	228,890	73,746	12.65	2.44	59.60
	Wajo	378,047	117,743	15.57	8.43	68.36
	Sidenreng Rappang	250,493	85,523	11.78	6.43	71.27
	Pinrang	348,402	130,301	19.79	8.33	73.94
	Enrekang	189,169	82,725	14.61	4.49	69.66
	Luwu	325,726	134,174	23.81	11.90	92.06
	Tana Toraja	466,054	201,689	40.93	31.09	90.79
	Luwu Utara	319,945	126,728	24.58	15.25	85.59
	Luwu Timur	235,889	95,543	43.18	28.79	73.01
	Kota Ujung Pandang	1,262,600	431,739	1.59	2.28	24.51
	Kota Pare-Pare	117,938	43,076	0.00	0.00	49.09
	Kota Palopo	145,617	55,097	5.94	5.94	42.35
Southeast Sulawesi						
	Buton	310,530	150,446	59.64	58.46	97.08
	Muna	270,890	122,434	34.41	33.20	82.22
	Konawe	254,311	104,297	18.49	17.89	62.42
	Kolaka	313,450	122,426	4.94	4.52	68.12
	Konawe Selatan	266,222	104,727	36.52	33.21	91.51
	Bombana	121,590	50,306	3.25	3.25	60.16
	Wakatobi	112,844	46,841	18.92	12.16	85.14
	Kolaka Utara	129,619	52,303	4.05	4.05	73.72
	Buton Utara	53,626	23,956	55.07	53.37	94.07

Province/ District		Population	Children (aged <18 years)	% Children living below		
			Number	IPL$1/day	Provincial poverty line	IPL $2/day
	Konawe Utara	50,883	20,904	18.84	15.22	76.80
	Kota Kendari	284,795	102,480	4.31	7.66	31.58
	Kota Bau Bau	142,844	57,579	17.43	17.43	43.00
	Gorontalo	117,563				
	Boalemo	311,534	44,746	34.36	31.23	85.16
Gorontalo			116,226	27.63	27.84	70.63
	Pohuwato	106,343	40,555	42.36	32.76	90.39
	Bone Bolango	120,592	44,242	33.20	34.83	76.76
	Gorontalo Utara	88,298	34,768	51.54	47.76	92.10
	Kota Gorontalo	155,970	55,785	5.90	5.90	60.34
West Sulawesi						
	Majene	131,871	57,355	2.26	2.26	63.76
	Polewali Mandar	358,273	133,278	26.74	24.40	73.82
	Mamasa	124,845	52,753	18.16	14.76	78.98
	Mamuju	312,465	131,596	30.51	30.27	79.32
	Mamuju Utara	110,307	46,629	8.60	8.60	61.28
Maluku						
	Maluku Tenggara Barat	158,103	66,946	6.83	38.49	88.19
	Maluku Tenggara	97,890	42,309	10.26	28.05	68.74
	Maluku Tengah	333,855	145,167	23.81	42.60	76.97
	Buru	136,412	63,195	3.49	22.85	75.81
	Kepulaun Aru	73,507	34,040	43.77	53.31	65.60
	Seram Bagian Barat	144,868	65,688	32.90	59.60	85.74
	Seram Bagian Timur	84,497	38,071	0.00	0.00	40.97
	Kota Ambon	277,668	96,270	0.00	8.69	53.50
Nort Maluku						
	Halmahera Barat	96,286	37,101	4.42	7.96	48.65
	Halmahera Tengah	34,240	15,410	0.00	0.00	14.81
	Kepulauan Sula	128,024	55,039	19.30	33.23	68.95
	Halmahera Selatan	189,260	80,551	4.49	13.06	70.60
	Halmahera Utara	191,665	83,518	4.66	15.55	53.09
	Halmahera Timur	68,924	29,446	0.00	0.00	15.79
	Kota Ternate	169,770	55,953	0.00	0.00	0.00
	Kota Tidore Kepulauan	80,879	30,563	0.00	0.00	14.29
West Papua						
	Fakfak	66,312	27,488	15.93	44.46	50.43
	Kaimana	41,675	17,246	7.02	77.19	89.47
	Teluk Wondama	22,944	10,804	0.00	0.00	0.00
	Teluk Bintuni	54,348	24,176	0.00	18.00	38.00
	Manokwari	172,181	69,893	17.54	59.67	71.91
	Sorong Selatan	157,977	27,681	6.25	43.98	61.44
	Raja Ampat	40,744	18,079	12.12	84.85	96.97
	Kota Sorong	167,997	63,573	0.00	5.25	5.25

Province/ District		Population	Children (aged <18 years)	% Children living below		
			Number	IPL$1/day	Provincial poverty line	IPL $2/day
Papua						
	Merauke	171,686	69,600	6.77	22.46	50.28
	Jayawijaya	98,075	41,757	24.36	84.82	86.69
	Jayapura	98,327	40,623	1.53	38.93	82.43
	Nabire	101,619	39,804	19.80	50.63	57.57
	Yapen Waropen	77,224	31,841	8.56	51.33	74.41
	Biak Namfour	108,163	47,008	12.70	33.69	39.00
	Paniai	121,338	50,955	5.63	16.90	69.01
	Puncak Jaya	73,260	27,268	0.00	3.90	12.99
	Mimika	144,108	57,560	0.00	11.47	21.51
	Boven Digoel	34,616	15,425	0.00	0.00	0.00
	Mappi	69,868	33,891	70.00	95.71	97.14
	Asmat	67,319	35,095	7.69	88.46	98.08
	Yahukimo	150,147	64,926	46.15	93.01	100.00
	Pegunungan Bintang	95,532	41,208	0.00	15.38	20.00
	Tolikara	49,172	19,871	92.31	100.00	100.00
	Sarmi	23,098	10,709	0.00	0.00	42.08
	Keerom	45,098	18,313	0.00	14.82	27.78
	Waropen	15,292	6,903	0.00	35.48	87.10
	Supiori	12,295	5,905	0.00	0.00	0.00
	Kota Jayapura	218,479	80,626	0.00	7.76	13.91

Appendix 11

Child deprivation in shelter, sanitation and water dimensions by district, 2009

Province/ District		% Children deprived in shelter dimension			% Children without proper toilet	% Children without access to safe water
		Area <8m2 per person	Earth floor	No electricity for lighting		
Aceh						
	Simeulue	40.12	4.94	23.50	53.44	54.19
	Aceh Singkil	40.35	9.71	3.53	65.70	62.17
	Aceh Selatan	31.20	4.00	11.20	71.87	50.53
	Aceh Tenggara	48.41	9.04	8.54	74.01	61.40
	Aceh Timur	48.63	20.18	15.24	66.70	44.49
	Aceh Tengah	23.75	14.52	8.80	45.01	52.05
	Aceh Barat	19.29	4.20	11.55	53.67	31.23
	Aceh Besar	37.03	3.24	2.22	30.72	11.09
	Pidie	29.42	15.79	7.69	76.11	21.86
	Bireuen	35.22	13.40	10.38	44.68	21.81
	Aceh Utara	39.51	10.81	6.36	54.13	24.26
	Aceh Barat Daya	31.59	5.98	12.44	74.27	46.46
	Gayo Lues	40.98	5.12	2.93	69.76	61.71
	Aceh Tamiang	30.52	8.04	3.05	36.22	40.28
	Nagan Raya	31.76	16.89	18.65	60.54	38.51
	Aceh Jaya	34.56	6.66	18.84	37.68	25.21
	Bener Meriah	23.58	14.45	6.40	54.86	61.73
	Pidie Jaya	26.25	19.35	9.39	59.77	25.10
	Kota Banda Aceh	19.93	0.54	0.36	0.72	2.69
	Kota Sabang	27.41	2.51	0.97	33.40	11.39
	Kota Langsa	25.87	6.78	2.87	13.24	27.00
	Kota Lhoksumawe	25.34	4.31	1.58	29.02	5.36
	Kota Subulussalam	38.52	10.11	5.57	48.07	45.34
North Sumatra						
	Nias	66.67	22.04	44.26	70.62	81.67
	Mandailing Natal	52.79	0.88	20.16	80.11	44.47
	Tapanuli Selatan	46.07	1.28	15.71	79.09	71.23
	Tapanuli Tengah	60.94	2.56	6.61	66.89	72.01
	Tapanuli Utara	56.54	2.49	10.83	56.78	79.87
	Toba Samosir	38.05	3.62	7.33	43.31	65.66
	Labuhan Batu	33.98	6.92	14.51	44.14	57.97
	Asahan	31.65	3.98	7.29	44.29	64.66
	Simalungun	26.25	5.20	3.94	36.65	64.07
	Dairi	41.49	6.95	11.55	43.74	84.74
	Karo	36.92	2.92	2.10	37.03	64.25
	Deli Serdang	19.75	3.59	0.83	12.57	33.22

Province/ District		% Children deprived in shelter dimension			% Children without proper toilet	% Children without access to safe water
		Area <8m2 per person	Earth floor	No electricity for lighting		
	Langkat	29.08	12.51	2.93	41.42	48.40
	Nias Selatan	64.99	16.84	51.59	76.87	80.56
	Humbang Hasundutan	58.03	2.26	6.10	51.59	82.53
	Papak Bharat	60.73	2.56	17.80	62.07	80.98
	Samosir	67.64	2.35	5.27	67.96	86.86
	Serdang Bedagai	23.54	3.65	2.60	30.00	66.67
	Batu Bara	35.64	4.38	4.38	44.41	53.40
	Kota Sibolga	50.66	1.82	0.10	20.38	15.24
	Kota Tanjung Balai	36.82	1.58	4.04	21.97	6.94
	Kota Pematang Siantar	18.55	2.17	0.72	7.95	13.98
	Kota Tebing Tinggi	12.72	1.06	1.30	6.24	61.37
	Kota Medan	18.84	1.79	0.22	1.86	13.70
	Kota Binjai	16.92	3.34	0.23	4.14	30.72
	Kota Padang Sidempuan	36.58	2.47	3.75	43.40	60.42
West Sumatra						
	Kepulauan Mentawai	54.65	4.72	71.71	82.94	93.76
	Pesisir Selatan	24.72	5.64	14.29	61.00	39.94
	Solok	35.81	2.79	14.67	69.34	58.60
	Sawahlunto/Sijunjung	27.08	4.56	10.55	59.43	54.87
	Tanah Datar	34.73	1.28	9.79	50.47	57.58
	Padang Pariaman	19.77	1.31	10.02	60.02	46.17
	Agam	23.39	2.07	8.16	52.34	66.59
	Lima Puluh Koto	28.12	1.59	8.28	61.56	45.35
	Pasaman	45.02	3.40	25.87	82.30	61.02
	Solok Selatan	38.63	2.93	15.32	73.87	40.77
	Dharmasraya	18.51	7.20	9.83	41.83	32.80
	Pasaman Barat	42.50	1.24	17.66	69.12	53.95
	Kota Padang	19.79	2.83	1.50	18.82	29.77
	Kota Solok	35.47	3.48	1.39	16.97	4.17
	Kota Sawah Lunto	31.95	1.12	8.95	26.04	50.64
	Kota Padang Panjang	22.10	4.29	1.91	13.35	27.50
	Kota Bukittinggi	30.82	1.16	1.45	5.21	28.08
	Kota Payakumbuh	22.69	1.96	5.04	22.69	14.85
	Kota Pariaman	14.44	2.41	1.20	33.06	38.80
Riau						
	Kuantan Singingi	30.67	3.94	20.37	50.46	43.17
	Indragiri Hulu	26.23	7.03	19.56	36.65	43.68
	Indragiri Hilir	19.54	10.81	29.91	50.44	88.97
	Pelalawan	33.23	3.85	24.69	36.98	51.04
	Siak	41.10	4.45	9.09	21.97	56.91
	Kampar	20.40	2.01	4.21	26.15	29.69
	Rokan Hulu	31.26	8.09	17.49	41.97	35.19
	Bengkalis	21.40	3.07	13.86	27.19	61.05

Province/ District		% Children deprived in shelter dimension			% Children without proper toilet	% Children without access to safe water
		Area <8m2 per person	Earth floor	No electricity for lighting		
	Rokan Hilir	41.77	7.36	12.26	35.55	70.23
	Kota Pekanbaru	22.11	1.62	2.03	4.16	29.92
	Kota Dumai	26.33	2.19	4.28	12.55	41.92
Jambi						
	Kerinci	20.08	2.39	5.06	42.13	27.53
	Merangin	25.21	5.63	20.16	41.85	50.18
	Sarolangun	21.97	7.29	13.90	45.85	50.45
	Batanghari	32.93	8.89	20.20	53.79	44.24
	Muaro Jambi	23.30	7.55	9.19	45.51	48.25
	Tanjung Jabung Timur	19.40	10.36	25.90	72.77	96.27
	Tanjung Jabung Barat	21.13	6.73	33.06	63.87	80.87
	Tebo	17.56	10.47	19.42	47.67	42.67
	Bungo	19.79	5.76	11.73	49.84	42.93
	Kota Jambi	18.86	1.61	1.36	5.33	11.41
South Sumatra						
	Ogan Komering Ulu	26.41	5.00	10.84	45.51	30.68
	Ogan Komering Ilir	25.77	7.80	14.51	48.77	38.50
	Muara Enim	36.75	6.52	9.42	52.90	38.61
	Lahat	40.48	8.10	13.57	55.95	44.64
	Musi Rawas	28.05	11.22	19.14	69.53	45.43
	Musi Banyu Asin	41.50	15.61	10.84	55.33	38.50
	Banyu Asin	31.41	10.74	17.72	52.75	51.28
	OKU Selatan	30.47	11.61	27.90	72.21	61.27
	OKU Timur	18.75	25.52	16.41	57.55	32.42
	Ogan Ilir	43.64	2.84	16.93	50.11	53.30
	Empat Lawang	34.97	3.57	18.68	69.27	65.70
	Kota Palembang	44.48	0.72	0.36	8.23	2.80
	Kota Prabumulih	30.04	0.82	3.16	15.91	19.07
	Kota Pagar Alam	34.55	3.37	4.54	56.81	36.31
	Kota Lubuk Linggau	34.00	4.12	8.50	20.85	16.47
Bengkulu						
	Bengkulu Selatan	23.40	3.90	22.97	32.61	66.09
	Rejang Lebong	17.42	1.25	7.02	31.08	56.39
	Bengkulu Utara	27.01	9.83	11.75	48.36	67.12
	Kaur	31.33	5.90	24.97	50.74	42.34
	Seluma	31.80	13.71	27.06	53.52	70.39
	Mukomuko	22.61	15.76	23.48	44.13	60.54
	Lebong	36.54	3.83	15.43	65.31	60.44
	Kepahing	27.10	5.09	10.18	27.10	50.41
	Kota Bengkulu	25.50	1.42	2.14	18.74	22.18
Lampung						
	Lampung Barat	25.32	23.14	30.58	49.71	46.05
	Tanggamus	13.57	25.23	13.11	45.26	46.72

Province/ District		% Children deprived in shelter dimension			% Children without proper toilet	% Children without access to safe water
		Area <8m2 per person	Earth floor	No electricity for lighting		
	Lampung Selatan	19.35	15.62	9.54	39.06	32.97
	Lampung Timur	7.56	16.98	17.91	44.62	53.11
	Lampung Tengah	7.03	13.15	8.94	35.64	44.78
	Lampung Utara	24.84	19.13	15.86	42.92	36.68
	Way Kanan	21.61	26.09	25.96	63.85	28.94
	Tulang Bawang	13.63	19.54	7.31	57.52	44.69
	Kota Bandar Lampung	26.20	2.97	1.43	10.95	34.49
	Kota Merto	6.04	4.07	4.92	5.48	27.25
Banka Belitung						
	Bangka	20.55	1.54	8.05	26.88	14.04
	Belitung	19.50	1.61	5.13	31.38	23.46
	Bangka Barat	19.53	6.09	5.00	43.75	35.31
	Bangka Tengah	18.05	0.44	3.35	25.04	24.02
	Bangka Selatan	17.84	1.83	8.43	35.96	21.63
	Belitung Timur	28.43	2.55	8.63	55.59	47.81
	Kota Pangkal Pinang	16.91	2.62	2.36	4.59	28.57
Riau Archipelago						
	Karimun	31.29	1.59	8.16	36.28	26.19
	Kepulauan Riau	27.08	3.82	5.44	30.21	31.25
	Natuna	33.23	9.98	11.70	64.59	63.34
	Lingga	41.81	7.47	24.64	70.91	59.78
	Kota Batam	27.01	2.61	1.18	8.18	9.48
	Kota Tanjung Pinang	27.55	1.85	2.89	11.46	10.53
Jakarta						
	Kepulauan Seribu	15.70	5.17	0.83	50.00	48.35
	Jakarta Selatan	36.69	1.11	0.63	3.13	49.83
	Jakarta Timur	45.27	1.69	0.58	3.31	31.26
	Jakarta Pusat	45.25	3.19	0.14	12.49	8.74
	Jakarta Barat	46.22	5.89	0.13	4.35	7.37
	Jakarta Utara	58.52	3.19	0.85	10.73	0.52
West Java						
	Bogor	27.22	3.67	1.59	38.06	60.57
	Sukabumi	30.69	3.09	3.89	42.19	56.38
	Cianjur	25.74	2.64	3.04	37.65	46.04
	Bandung	37.66	1.23	1.39	22.88	41.66
	Garut	41.85	2.25	4.58	49.21	52.97
	Tasikmalaya	38.54	3.38	1.46	55.89	65.84
	Ciamis	14.63	6.17	1.60	36.80	45.14
	Kuningan	5.94	1.68	0.26	14.84	61.81
	Cirebon	18.32	10.37	1.30	28.26	36.56
Lampung	Majalengka	8.76	2.26	0.00	24.72	52.68
	Sumedang	25.21	0.97	0.42	15.93	45.15
	Indramayu	18.25	16.19	0.10	24.85	42.68

Province/ District		% Children deprived in shelter dimension			% Children without proper toilet	% Children without access to safe water
		Area <8m2 per person	Earth floor	No electricity for lighting		
	Subang	13.73	10.57	0.85	32.20	53.34
	Purwakarta	20.33	2.35	0.00	21.25	75.69
	Karawang	19.23	23.73	0.38	47.18	57.61
	Bekasi	23.16	21.44	0.60	36.96	31.99
	Bandung Barat	25.91	3.73	0.71	17.04	46.47
	Kota Bogor	26.05	1.48	0.00	8.64	34.81
	Kota Sukabumi	22.79	2.04	0.34	9.86	49.66
	Kota Bandung	38.42	1.17	0.45	5.12	22.08
	Kota Cirebon	24.75	3.05	0.34	5.42	10.51
	Kota Bekasi	16.94	2.49	0.10	1.72	42.78
	Kota Depok	19.40	2.76	0.00	0.44	63.62
	Kota Cimahi	31.62	0.21	0.00	5.34	44.87
	Kota Tasik Malaya	24.59	2.70	0.52	29.46	41.70
	Kota Banjar	18.33	4.94	0.31	22.97	22.66
Central Java						
	Cilacap	10.01	26.63	1.61	37.20	37.11
	Banyumas	4.52	13.56	0.99	36.16	42.45
	Purbalingga	6.55	20.73	1.93	43.72	35.02
	Banjarnegara	6.40	21.74	3.02	59.42	78.95
	Kebumen	11.44	29.52	5.31	42.90	32.58
	Purworejo	4.80	25.29	1.74	39.53	43.17
	Wonosobo	14.85	24.07	2.63	39.88	60.60
	Magelang	9.33	27.39	0.48	38.28	53.47
	Boyolali	3.22	35.64	0.62	24.13	40.84
	Klaten	2.75	12.94	0.26	17.65	39.74
	Sukoharjo	3.47	12.50	0.28	20.42	40.83
	Wonogiri	0.29	14.08	0.87	28.16	62.26
	Karanganyar	2.50	9.49	0.26	15.02	42.03
	Sragen	0.00	43.52	0.85	37.89	24.79
	Grobogan	0.85	68.36	0.61	43.64	54.30
	Blora	0.94	63.59	0.40	61.45	25.03
	Rembang	1.25	41.74	0.47	47.20	50.93
	Pati	4.71	35.16	0.00	31.50	44.97
	Kudus	5.37	6.47	0.00	13.64	30.99
	Jepara	7.62	28.29	0.22	45.05	40.26
	Demak	7.11	30.70	0.34	32.51	47.97
	Semarang	3.40	21.24	0.36	17.60	56.67
	Temanggung	4.50	21.46	0.00	25.96	55.76
	Kendal	4.84	34.42	0.00	35.43	42.07
	Batang	5.54	32.63	1.06	47.23	33.33
	Pekalongan	8.90	15.64	0.22	39.74	47.01
	Pemalang	9.43	28.67	5.54	54.91	55.00
	Tegal	6.99	16.64	1.98	33.84	54.16

Province/ District		% Children deprived in shelter dimension			% Children without proper toilet	% Children without access to safe water
		Area <8m2 per person	Earth floor	No electricity for lighting		
	Brebes	12.24	19.17	0.72	47.97	40.32
	Kota Magelang	18.97	3.59	0.00	9.40	20.00
	Kota Surakarta	24.79	3.40	0.00	9.85	33.45
	Kota Salatiga	14.26	9.29	0.17	9.95	23.55
	Kota Semarang	24.73	10.00	0.11	9.23	24.51
	Kota Pekalongan	11.29	5.91	0.27	14.78	23.66
	Kota Tegal	14.59	8.50	0.28	5.95	5.10
Yogyakarta						
	Kulon Progo	2.79	26.58	0.44	29.52	36.12
	Bantul	15.30	13.56	0.00	13.56	23.97
	Gunung Kidul	2.45	13.38	1.14	42.09	35.89
	Sleman	5.51	3.96	0.69	11.19	26.51
	Kota Yogyakarta	30.41	0.20	0.00	3.27	40.41
East Java						
	Pacitan	5.19	27.18	1.22	54.20	59.08
	Ponorogo	1.69	21.66	1.13	36.71	61.74
	Trenggalek	4.83	19.00	0.90	54.00	49.17
	Tulungagung	6.13	10.42	1.72	27.82	37.87
	Blitar	2.32	9.14	0.26	34.62	42.86
	Kediri	7.09	11.64	0.85	32.28	68.36
	Malang	9.83	10.89	1.77	21.61	41.36
	Lumajang	10.51	5.31	1.77	42.62	29.28
	Jember	9.94	8.49	2.12	56.56	33.59
	Banyuwangi	10.40	11.25	1.18	38.37	41.16
	Bondowoso	8.21	18.88	2.13	70.77	47.13
	Situbondo	17.82	28.91	3.36	57.31	53.78
	Probolinggo	8.65	24.73	3.53	62.97	69.79
	Pasuruan	15.72	10.23	0.54	43.81	61.57
	Sidoarjo	7.16	1.18	0.00	9.81	35.92
	Mojokerto	6.32	11.32	0.36	33.25	68.06
	Jombang	9.57	13.76	0.65	29.14	57.20
	Nganjuk	8.52	30.95	1.00	48.25	69.42
	Madium	2.36	25.81	0.44	32.30	62.98
	Magetan	2.53	9.08	0.74	22.32	39.88
	Ngawi	0.76	54.53	0.45	46.07	44.56
	Bojonegoro	3.61	55.77	0.84	50.00	61.78
	Tuban	4.31	39.35	2.75	57.52	47.45
	Lamongan	5.70	32.29	0.45	31.40	24.02
	Gresik	9.98	12.16	1.26	17.78	34.52
	Bangkalan	21.52	26.27	4.66	65.71	17.27
	Sampang	18.07	57.60	1.52	67.40	37.25
	Pamekasan	21.54	34.00	0.95	52.69	44.14
	Sumenep	16.76	9.97	6.65	56.09	34.90

Province/ District		% Children deprived in shelter dimension			% Children without proper toilet	% Children without access to safe water
		Area <8m2 per person	Earth floor	No electricity for lighting		
	Kota Kediri	15.56	3.60	0.14	5.91	69.45
	Kota Blitar	16.49	2.84	0.14	6.49	20.41
	Kota Malang	13.75	0.54	0.00	7.55	34.23
	Kota Probolinggo	12.31	1.92	0.00	21.15	59.87
	Kota Pasuruan	18.16	3.11	0.00	29.03	36.44
	Kota Mojokerto	13.76	2.93	0.00	11.57	62.37
	Kota Madium	13.12	1.92	0.48	2.72	29.12
	Kota Surabaya	41.45	2.31	0.00	3.25	1.45
	Kota Batu	7.84	7.94	0.42	7.63	40.75
Banten						
	Pandeglang	25.47	20.60	6.77	59.53	53.35
	Lebak	26.78	10.83	4.16	60.83	45.67
	Tangerang	25.48	13.60	1.86	25.48	55.66
	Serang	23.07	14.38	1.96	54.14	53.58
	Kota Tangerang	29.70	1.38	0.59	8.85	40.12
	Kota Cilegon	8.80	3.46	0.49	13.35	26.01
Bali						
	Jembarana	23.66	4.64	0.44	24.09	29.75
	Tabanan	11.06	3.43	0.16	10.12	42.52
	Badung	18.34	0.78	0.26	4.55	19.12
	Gianyar	24.78	0.99	0.12	7.40	29.96
	Klungkung	20.67	5.51	5.67	23.74	25.88
	Bangli	36.71	5.49	1.59	34.83	47.40
	Karangasem	35.50	9.36	7.41	54.10	49.02
	Buleleng	39.39	11.21	5.61	31.38	57.94
	Kota Denpasar	26.82	1.21	0.27	9.97	16.98
West Nusa Tenggara						
	Lombok Barat	56.78	7.32	11.16	63.03	37.94
	Lombok Tengah	37.52	13.53	11.32	55.10	32.72
	Lombok Timur	38.37	7.51	14.70	60.90	40.15
	Sumbawa	27.03	5.64	1.65	42.19	24.32
	Dompu	48.63	13.93	16.48	54.10	63.66
	Bima	42.51	8.56	9.14	51.85	68.19
	Sumbawa Barat	26.25	7.45	2.78	37.60	27.03
	Kota Mataram	39.15	1.46	0.93	14.65	7.19
	Kota Bima	44.24	5.93	3.84	33.70	51.70
East Nusa Tenggara						
	Sumba Barat	63.11	15.75	66.07	75.06	72.17
	Sumba Timur	53.95	24.37	61.61	62.61	64.44
	Kupang	54.88	52.71	63.55	55.71	70.23
	Timor Tengah Selatan	64.34	71.89	76.58	78.11	76.10
	Timor Tengah Utara	42.72	56.75	60.99	59.93	50.84
	Belu	48.67	46.57	60.22	56.55	50.08

Province/ District	% Children deprived in shelter dimension			% Children without proper toilet	% Children without access to safe water
	Area <8m2 per person	Earth floor	No electricity for lighting		
Alor	48.75	38.83	48.29	44.49	41.80
Lembata	57.42	50.05	33.72	28.92	55.82
Flores Timur	43.35	35.12	30.72	27.37	76.46
Sikka	63.51	37.75	49.46	49.91	58.23
Ende	56.10	23.01	29.94	32.07	57.39
Ngada	49.80	41.15	43.43	48.70	59.40
Manggarai	50.68	37.44	53.42	57.76	73.74
Rote Ndao	46.80	47.85	55.11	63.13	30.28
Manggarai Barat	58.63	46.82	65.77	66.39	84.42
Sumba Tengah	74.67	21.63	71.27	85.48	78.27
Sumba Barat Daya	72.43	23.05	85.10	89.47	93.83
Nagekeo	54.34	38.24	62.64	37.99	71.45
Kota Kupang	52.56	7.79	2.91	3.60	14.30
West Kalimantan					
Sambas	16.47	2.78	3.10	35.19	95.40
Bengkayang	43.26	5.18	29.19	49.48	80.31
Landak	44.13	2.79	45.38	70.29	90.87
Pontianak	42.71	2.28	8.26	32.34	93.06
Sanggau	18.79	4.32	40.14	55.43	86.46
Ketapang	36.86	2.78	32.74	57.57	61.80
Sintang	35.85	3.12	53.00	55.04	84.05
Kapuas Hulu	30.74	3.26	39.65	52.20	82.81
Sekadau	41.03	3.92	43.27	70.96	80.94
Melawai	34.65	2.76	43.31	61.94	63.39
Kayong Utara	45.77	4.51	31.69	55.21	89.86
Kota Pontianak	18.95	0.33	1.85	3.70	83.22
Kota Singkawang	24.70	1.39	3.24	18.78	56.15
Central Kalimantan					
Kotawaringin Barat	20.68	6.43	8.76	40.65	42.41
Kotawaringin Timur	26.91	1.27	13.56	54.34	56.67
Kapus	30.37	2.04	32.05	71.07	85.23
Barito Selatan	27.67	4.96	23.45	62.66	54.71
Barito Utara	24.57	3.19	31.57	54.30	53.81
Sukamara	26.48	6.42	19.65	62.12	56.21
Lamandau	29.48	5.72	36.18	70.04	61.14
Seruyan	20.00	3.60	37.39	54.16	68.82
Katingan	28.64	3.09	16.67	65.06	77.78
Pulang Pisau	27.57	5.64	16.29	77.69	87.34
Gunung Mas	44.06	1.25	44.90	55.10	74.06
Barito Timur	21.71	3.62	20.03	31.52	45.09
Murung Raya	21.76	2.75	63.34	86.48	86.71
Kota Palangkaraya	36.08	5.17	0.99	11.58	60.22
South Kalimantan					

Province/ District		% Children deprived in shelter dimension			% Children without proper toilet	% Children without access to safe water
		Area <8m2 per person	Earth floor	No electricity for lighting		
	Tanah Laut	25.49	6.95	4.39	44.51	66.71
	Kotabaru	23.12	2.91	17.43	42.13	46.73
	Banjar	26.83	0.26	5.76	41.23	51.05
	Barito Kuala	27.60	1.76	9.61	82.68	80.38
	Tapin	34.87	4.62	6.56	39.49	57.53
	Hulu Sungai Selatan	25.07	0.55	10.41	58.77	73.01
	Hulu Sungai Tengah	18.13	0.00	5.58	47.98	81.31
	Hulu Sungai Utara	14.27	0.48	6.41	57.44	70.98
	Tabalong	17.61	0.62	9.11	35.10	41.01
	Tanah Bumbu	24.41	4.71	4.46	36.56	55.51
	Balangan	10.92	0.54	3.64	37.87	51.75
	Kota Banjarmasin	28.96	0.00	0.39	17.40	2.60
	Kota Banjarbaru	21.43	4.31	1.35	4.18	24.12
East Kalimantan						
	Pasir	27.69	5.72	11.66	30.94	48.43
	Kutai Barat	24.53	2.12	25.28	55.54	66.87
	Kutai Karta Negara	20.13	3.58	2.39	35.29	42.74
	Kulai Timur	17.14	3.82	9.07	31.59	52.97
	Berau	25.33	4.97	11.52	25.58	30.18
	Malinau	10.22	2.88	15.11	30.65	79.14
	Bulongan	24.89	1.13	8.06	25.18	60.68
	Nunukan	31.88	5.76	18.57	44.94	73.88
	Penajam Paser Utara	29.54	4.27	2.97	37.13	48.28
	Kota Balikpapan	31.01	0.81	0.51	6.77	11.01
	Kota Samarinda	27.87	1.31	0.00	6.53	7.67
	Kota Tarakan	42.30	5.89	0.40	23.29	46.05
	Kota Bontang	24.34	4.92	0.88	10.97	12.48
North Sulawesi						
	Bolaang Mongondow	43.95	13.32	11.10	61.71	30.74
	Minahasa	32.43	9.61	2.70	17.72	40.24
	Kepulauan Sangihe	52.58	22.04	23.86	34.35	58.81
	Kepulauan Talaud	30.15	12.20	6.87	21.32	30.01
	Minahasa Selatan	38.54	10.08	4.42	20.03	53.04
	Minahasa Utara	40.58	14.76	6.46	26.35	33.20
	Bolaang Mongondow Utara	57.63	7.93	11.08	58.83	17.22
	Siau Tagulandang Biaro	27.62	9.76	4.52	15.71	71.43
	Minahasa Tenggara	46.62	9.41	1.76	27.35	31.32
	Kota Manado	52.86	8.76	0.80	11.02	25.23
	Kota Bitung	40.00	4.42	0.65	10.91	26.62
	Kota Tomohon	28.96	5.90	1.05	3.93	48.36
	Kota Kotamobagu	40.84	3.73	0.62	31.83	21.89
Central Sulawesi						
	Banggai Kepulauan	34.35	20.13	50.16	63.65	66.81

Province/ District		% Children deprived in shelter dimension			% Children without proper toilet	% Children without access to safe water
		Area <8m2 per person	Earth floor	No electricity for lighting		
	Banggai	26.46	11.28	11.39	48.16	36.12
	Morowali	20.90	10.90	25.73	53.82	65.51
	Poso	37.38	17.40	15.90	26.10	51.13
	Donggala	49.33	3.79	27.07	64.25	71.84
	Toli-Toli	36.62	4.08	29.89	64.33	56.93
	Buol	35.35	7.71	37.92	57.12	61.62
	Parigi Moutong	40.34	7.29	27.46	68.94	61.65
	Tojo Una-Una	29.34	7.85	25.32	52.40	55.74
	Kota Palu	26.88	2.39	0.60	12.78	57.95
South Sulawesi						
	Selayar	23.02	3.60	21.74	67.56	30.81
	Bulukumba	7.73	3.47	8.51	35.50	32.59
	Bantaeng	17.80	2.77	23.70	50.52	60.00
	Jeneponto	12.77	1.42	2.94	65.45	41.64
	Takalar	27.06	3.55	2.51	45.25	54.34
	Gowa	24.75	3.05	4.25	28.44	62.70
	Sinjai	13.03	2.17	17.79	46.54	55.53
	Maros	22.95	6.64	4.15	48.20	41.38
	Pangkajene Kepulauan	33.10	1.12	3.45	51.98	34.92
	Barru	23.22	1.84	11.49	39.08	42.76
	Bone	15.71	2.95	13.90	50.67	51.71
	Soppeng	10.84	0.90	7.74	14.45	68.90
	Wajo	14.85	2.65	8.89	43.63	46.68
	Sidenreng Rappang	21.04	5.21	5.75	22.67	76.14
	Pinrang	20.58	2.01	2.71	19.78	61.75
	Enrekang	26.96	5.36	5.70	29.17	81.04
	Luwu	21.51	3.06	24.03	54.91	61.21
	Tana Toraja	48.54	4.04	23.71	51.03	82.47
	Luwu Utara	22.28	12.25	28.93	52.94	53.71
	Luwu Timur	25.23	6.91	12.34	40.15	52.85
	Kota Ujung Pandang	33.71	1.60	0.47	6.21	6.03
	Kota Pare-Pare	26.89	1.84	3.58	15.34	31.29
	Kota Palopo	32.67	5.87	7.10	19.03	28.13
Southeast Sulawesi						
	Buton	46.96	4.57	24.69	49.94	46.67
	Muna	44.18	4.67	23.72	69.09	29.65
	Konawe	18.41	18.91	20.43	54.20	47.25
	Kolaka	25.26	7.73	15.94	44.51	47.59
	Konawe Selatan	19.07	18.66	18.57	65.34	35.82
	Bombana	30.72	7.24	35.71	67.62	74.14
	Wakatobi	21.39	5.04	18.66	40.46	39.37
	Kolaka Utara	24.32	11.36	23.98	46.36	74.09
	Buton Utara	48.41	7.63	51.40	64.73	27.92

Province/ District		% Children deprived in shelter dimension			% Children without proper toilet	% Children without access to safe water
		Area <8m2 per person	Earth floor	No electricity for lighting		
	Konawe Utara	20.05	15.97	41.45	58.21	63.99
	Kota Kendari	29.27	8.81	2.67	23.04	37.72
	Kota Bau Bau	36.28	6.45	5.77	16.72	24.29
Gorontalo						
	Boalemo	49.95	9.95	34.07	72.15	29.76
	Gorontalo	49.26	5.65	24.55	58.59	26.92
	Pohuwato	41.56	11.10	19.54	64.30	26.91
	Bone Bolango	41.92	14.93	17.79	58.18	27.10
	Gorontalo Utara	42.60	6.69	33.33	84.81	51.22
	Kota Gorontalo	25.76	1.75	2.95	27.40	19.87
West Sulawesi						
	Majene	49.93	5.29	5.66	43.52	47.69
	Polewali Mandar	27.79	4.84	9.05	40.31	51.37
	Mamasa	66.51	12.65	34.44	61.27	93.63
	Mamuju	36.61	7.03	26.36	60.25	58.39
	Mamuju Utara	38.66	5.01	26.36	58.88	51.23
Maluku						
	Maluku Tenggara Barat	59.76	33.25	58.22	71.01	48.99
	Maluku Tenggara	56.26	16.99	38.58	50.52	58.55
	Maluku Tengah	30.49	17.06	17.91	50.32	43.71
	Buru	35.03	34.24	28.13	72.92	75.00
	Kepulaun Aru	66.23	5.91	66.13	88.48	60.92
	Seram Bagian Barat	43.97	26.65	27.86	63.73	68.90
	Seram Bagian Timur	52.90	22.67	49.47	83.57	43.94
	Kota Ambon	38.36	5.31	0.68	10.96	36.64
North Maluku						
	Halmahera Barat	28.59	30.84	23.13	56.35	48.87
	Halmahera Tengah	32.88	28.13	16.50	52.50	77.88
	Kepulauan Sula	31.92	20.31	38.09	52.12	50.91
	Halmahera Selatan	30.67	27.17	49.15	77.72	45.95
	Halmahera Utara	36.12	39.09	38.56	62.50	36.65
	Halmahera Timur	29.82	28.85	21.07	65.32	50.89
	Kota Ternate	19.51	4.12	4.40	10.71	16.07
	Kota Tidore Kepulauan	8.65	10.53	12.41	21.99	29.32
West Papua						
	Fakfak	30.71	5.16	19.29	32.61	47.83
	Kaimana	30.23	26.28	36.28	63.95	52.79
	Teluk Wondama	55.71	2.90	83.56	63.25	89.17
	Teluk Bintuni	59.44	3.58	40.95	32.01	59.44
	Manokwari	38.71	2.97	45.80	53.87	64.42
	Sorong Selatan	50.92	10.53	56.61	65.43	86.63
	Raja Ampat	43.26	5.62	46.07	66.29	55.90
	Kota Sorong	41.87	5.96	4.51	13.04	19.48

Province/ District		% Children deprived in shelter dimension			% Children without proper toilet	% Children without access to safe water
		Area <8m2 per person	Earth floor	No electricity for lighting		
Papua						
	Merauke	55.21	25.21	36.62	56.62	43.24
	Jayawijaya	91.59	65.61	86.36	90.65	93.46
	Jayapura	38.44	10.61	13.21	39.39	50.47
	Nabire	31.34	1.76	16.55	29.93	44.01
	Yapen Waropen	70.26	7.29	51.90	62.68	60.06
	Biak Namfour	59.77	8.32	19.34	35.40	64.41
	Paniai	89.63	30.69	100.00	83.33	100.00
	Puncak Jaya	94.19	33.20	91.70	91.70	92.53
	Mimika	43.87	3.18	17.25	21.18	40.70
	Boven Digoel	62.50	24.66	79.39	83.78	97.64
	Mappi	60.14	9.20	76.18	80.66	68.16
	Asmat	89.81	1.42	94.55	92.89	95.73
	Yahukimo	80.92	95.80	96.37	97.14	98.85
	Pegunungan Bintang	76.44	36.84	99.25	86.97	100.00
	Tolikara	92.72	84.77	93.05	97.02	100.00
	Sarmi	58.71	2.25	34.55	42.98	62.64
	Keerom	36.63	1.98	3.47	60.15	65.10
	Waropen	64.75	8.50	59.50	67.25	86.25
	Supiori	66.51	9.34	52.62	32.35	84.51
	Kota Jayapura	45.57	3.52	4.22	14.77	17.86

Appendix 12

Child deprivation in health, education and labour dimensions by district, 2009

Province/ District		% Children deprived in health dimension		% Children deprived in education dimension		% Children engaged in economic labour	
		Asthma	Diarrhoea	Aged 3–6 years not enrolled in early childhood education	Aged 7–17 not enrolled in primary and secondary schools	Perform economic labour without attending school	Perform economic labour and attend school
Aceh							
	Simeulue	0.30	0.90	89.31	33.51	1.77	1.77
	Aceh Singkil	0.38	1.89	75.32	41.86	4.92	4.92
	Aceh Selatan	0.40	1.47	71.27	30.73	2.46	2.46
	Aceh Tenggara	0.00	2.68	86.02	29.00	3.42	3.42
	Aceh Timur	1.15	3.26	91.65	34.62	6.68	6.68
	Aceh Tengah	0.59	3.08	52.61	34.48	3.90	3.90
	Aceh Barat	0.92	3.54	62.56	33.00	1.65	1.65
	Aceh Besar	0.68	5.29	68.85	37.96	2.76	2.76
	Pidie	2.16	2.56	80.27	33.22	2.65	2.65
	Bireuen	1.18	4.34	66.09	32.49	2.58	2.58
	Aceh Utara	1.59	1.27	81.23	34.14	1.93	1.93
	Aceh Barat Daya	0.00	1.59	64.00	30.21	4.22	4.22
	Gayo Lues	0.85	4.27	94.84	34.52	3.69	3.69
	Aceh Tamiang	0.41	2.24	64.40	34.83	1.14	1.14
	Nagan Raya	0.14	2.16	84.14	39.39	5.40	5.40
	Aceh Jaya	1.13	5.52	80.33	38.52	2.41	2.41
	Bener Meriah	1.54	4.27	80.43	39.91	4.08	4.08
	Pidie Jaya	1.92	3.83	68.39	35.00	0.89	0.89
	Kota Banda Aceh	0.54	0.90	47.66	40.03	1.44	1.44
	Kota Sabang	0.39	1.93	40.21	39.51	5.52	5.52
	Kota Langsa	0.62	2.57	60.90	32.04	0.69	0.69
	Kota Lhoksumawe	1.37	1.68	74.04	36.20	2.72	2.72
	Kota Subulussalam	0.00	1.14	91.28	37.01	3.68	3.68
North Sumatra							
	Nias	0.49	3.15	88.65	41.44	7.48	7.48
	Mandailing Natal	0.27	1.24	88.99	39.74	4.45	4.45
	Tapanuli Selatan	0.72	2.88	87.80	35.18	4.95	4.95
	Tapanuli Tengah	0.50	4.29	78.02	39.37	5.35	5.35
	Tapanuli Utara	0.32	3.21	73.30	34.82	3.80	3.80
	Toba Samosir	0.26	1.47	83.47	37.20	2.32	2.32
	Labuhan Batu	0.68	2.18	80.41	42.57	6.86	6.86
	Asahan	0.08	2.11	80.39	38.64	5.19	5.19
	Simalungun	0.27	1.52	74.56	34.29	2.58	2.58

Province/ District		% Children deprived in health dimension		% Children deprived in education dimension		% Children engaged in economic labour	
		Asthma	Diarrhoea	Aged 3–6 years not enrolled in early childhood education	Aged 7–17 not enrolled in primary and secondary schools	Perform economic labour without attending school	Perform economic labour and attend school
	Dairi	0.20	1.66	89.88	37.50	2.91	15.21
	Karo	0.35	1.99	79.59	39.37	3.93	4.21
	Deli Serdang	0.35	2.42	76.39	38.69	5.65	6.68
	Langkat	0.43	1.21	79.75	36.41	6.01	4.07
	Nias Selatan	0.25	2.35	92.95	41.56	5.60	3.39
	Humbang Hasundutan	0.08	2.17	78.71	31.81	1.48	24.72
	Papak Bharat	0.24	5.49	66.69	35.60	4.51	25.46
	Samosir	0.57	2.03	93.05	33.85	2.26	35.42
	Serdang Bedagai	0.52	4.17	72.22	42.13	5.72	5.99
	Batu Bara	0.58	2.77	85.79	37.33	5.00	8.16
	Kota Sibolga	0.20	3.53	75.42	34.44	8.42	6.36
	Kota Tanjung Balai	0.18	3.34	67.84	39.88	3.51	0.70
	Kota Pematang Siantar	0.24	1.69	59.77	33.37	4.02	3.62
	Kota Tebing Tinggi	0.35	2.59	68.10	37.21	1.87	0.53
	Kota Medan	0.22	1.34	63.08	34.48	2.84	3.13
	Kota Binjai	0.35	1.27	70.50	35.25	2.84	0.89
	Kota Padang Sidempuan	0.22	2.10	73.81	33.88	4.85	0.77
West Sumatra							
	Kepulauan Mentawai	0.55	3.74	92.31	46.31	1.72	2.40
	Pesisir Selatan	0.28	2.63	82.32	35.28	7.25	2.17
	Solok	2.01	7.51	74.82	37.93	2.79	1.93
	Sawahlunto/Sijunjung	1.01	4.06	59.85	43.45	5.43	5.63
	Tanah Datar	0.93	2.80	64.81	36.06	4.79	3.19
	Padang Pariaman	1.05	4.18	86.91	35.22	4.19	5.76
	Agam	0.44	2.29	74.75	41.23	3.95	9.02
	Lima Puluh Koto	0.57	1.81	68.57	42.74	5.18	3.89
	Pasaman	0.34	2.13	88.68	43.77	4.60	2.45
	Solok Selatan	1.46	3.83	73.79	39.44	8.23	2.06
	Dharmasraya	1.26	3.31	72.69	41.20	4.96	3.92
	Pasaman Barat	1.15	2.57	76.74	44.31	4.05	1.16
	Kota Padang	0.44	1.50	65.10	36.26	7.83	3.48
	Kota Solok	0.97	1.67	58.20	39.23	2.50	2.08
	Kota Sawah Lunto	0.96	3.19	40.91	39.36	4.74	0.73
	Kota Padang Panjang	1.11	1.75	59.95	36.24	3.92	0.78
	Kota Bukittinggi	0.87	2.17	62.83	37.38	1.11	4.43
	Kota Payakumbuh	0.56	2.24	57.00	38.64	2.33	1.33
	Kota Pariaman	1.20	4.17	62.23	28.61	3.83	2.44
Riau							
	Kuantan Singingi	0.81	2.43	76.82	38.81	3.08	2.50
	Indragiri Hulu	0.47	4.57	89.15	36.12	5.18	0.27

Province/ District		% Children deprived in health dimension		% Children deprived in education dimension		% Children engaged in economic labour	
		Asthma	Diarrhoea	Aged 3–6 years not enrolled in early childhood education	Aged 7–17 not enrolled in primary and secondary schools	Perform economic labour without attending school	Perform economic labour and attend school
	Indragiri Hilir	0.76	1.64	91.09	43.23	4.71	0.26
	Pelalawan	1.15	4.58	77.97	43.97	11.20	3.13
	Siak	2.27	9.38	71.37	40.98	7.32	2.98
	Kampar	0.86	2.59	76.24	37.13	1.23	1.23
	Rokan Hulu	1.09	2.40	72.80	43.18	2.61	0.65
	Bengkalis	0.79	2.28	64.75	38.33	7.32	3.25
	Rokan Hilir	0.35	2.28	78.59	37.86	2.60	3.69
	Kota Pekanbaru	1.62	2.33	62.17	42.24	3.34	0.21
	Kota Dumai	1.05	1.43	71.88	40.22	3.17	1.06
Jambi							
	Kerinci	1.12	2.67	57.51	34.97	3.10	0.95
	Merangin	0.82	0.70	74.64	38.18	2.27	1.29
	Sarolangun	0.78	1.57	58.55	40.91	4.51	0.00
	Batanghari	1.10	2.74	68.40	39.36	6.05	2.02
	Muaro Jambi	0.77	1.53	79.62	41.85	5.09	1.02
	Tanjung Jabung Timur	0.96	0.72	68.59	41.08	6.55	0.00
	Tanjung Jabung Barat	0.59	1.89	72.22	41.14	7.47	3.45
	Tebo	0.81	1.98	74.15	40.14	10.26	2.85
	Bungo	1.05	2.20	71.74	39.77	7.34	0.54
	Kota Jambi	0.25	0.25	75.09	39.20	5.96	0.00
South Sumatra							
	Ogan Komering Ulu	0.65	2.78	72.24	35.98	3.06	0.31
	Ogan Komering Ilir	0.79	2.17	84.58	43.25	6.77	0.63
	Muara Enim	0.41	0.93	87.63	38.97	9.04	0.26
	Lahat	1.31	2.98	75.82	35.33	7.54	0.97
	Musi Rawas	0.44	2.97	89.01	42.57	3.08	0.00
	Musi Banyu Asin	0.37	2.80	77.90	39.53	11.36	0.51
	Banyu Asin	0.27	2.28	90.80	39.25	6.25	0.45
	OKU Selatan	0.33	4.46	87.76	40.16	10.06	0.29
	OKU Timur	0.52	1.43	73.51	38.33	7.01	2.08
	Ogan Ilir	2.73	3.07	62.68	39.58	8.38	2.10
	Empat Lawang	1.02	6.11	82.93	33.12	6.75	1.30
	Kota Palembang	0.45	2.53	58.26	36.89	8.90	0.71
	Kota Prabumulih	0.55	1.92	60.90	31.62	3.69	0.20
	Kota Pagar Alam	0.44	3.22	63.87	36.25	3.86	2.08
	Kota Lubuk Linggau	0.53	2.52	65.28	37.24	4.80	0.74
Bengkulu							
	Bengkulu Selatan	0.22	1.73	56.79	35.68	4.97	1.24
	Rejang Lebong	0.38	1.63	69.16	35.49	2.64	1.68
	Bengkulu Utara	0.45	2.49	74.41	42.22	5.88	2.52

Province/ District	% Children deprived in health dimension		% Children deprived in education dimension		% Children engaged in economic labour	
	Asthma	Diarrhoea	Aged 3–6 years not enrolled in early childhood education	Aged 7–17 not enrolled in primary and secondary schools	Perform economic labour without attending school	Perform economic labour and attend school
Kaur	1.25	1.25	67.06	34.73	5.97	2.27
Seluma	1.21	2.55	84.78	40.89	1.50	0.50
Mukomuko	0.98	3.26	65.05	44.15	5.35	3.94
Lebong	0.58	3.25	86.86	35.12	10.06	2.79
Kepahing	0.83	3.43	83.38	38.41	9.07	3.19
Kota Bengkulu	0.24	1.19	75.36	34.26	5.85	1.86
Lampung						
Lampung Barat	0.92	2.29	82.89	41.74	1.86	0.27
Tanggamus	0.82	2.28	75.90	34.33	6.13	4.00
Lampung Selatan	0.54	2.18	81.40	39.25	7.20	3.91
Lampung Timur	1.35	1.76	57.34	37.07	8.49	1.45
Lampung Tengah	0.90	3.01	56.90	40.75	3.47	4.17
Lampung Utara	0.42	1.69	76.14	37.55	5.69	3.32
Way Kanan	0.12	1.74	77.04	41.49	6.89	1.02
Tulang Bawang	0.40	1.30	72.00	41.59	8.17	1.97
Kota Bandar Lampung	1.54	2.15	62.50	38.70	6.57	4.14
Kota Merto	0.70	1.12	48.84	37.23	4.73	2.55
Banka Belitung						
Bangka	2.40	3.60	64.24	42.91	3.06	0.00
Belitung	0.73	2.05	49.49	39.17	2.67	0.00
Bangka Barat	3.44	4.22	64.47	44.05	5.19	3.46
Bangka Tengah	1.89	5.24	69.06	47.74	4.18	0.35
Bangka Selatan	1.12	2.53	80.83	46.36	6.67	2.59
Belitung Timur	1.13	1.70	67.05	40.07	13.33	2.11
Kota Pangkal Pinang	1.05	2.10	56.32	40.74	12.59	1.75
Riau Archipelago						
Karimun	0.91	1.02	83.58	33.11	7.48	1.36
Kepulauan Riau	0.81	0.58	62.18	39.68	2.68	0.00
Natuna	2.18	2.34	74.29	41.45	3.75	0.00
Lingga	1.91	3.97	69.52	43.15	5.26	0.88
Kota Batam	1.54	1.90	69.59	44.76	3.78	2.10
Kota Tanjung Pinang	0.69	1.39	64.76	37.50	2.85	0.00
Jakarta						
Kepulauan Seribu	0.21	3.51	69.09	31.79	1.59	0.00
Jakarta Selatan	0.49	1.11	46.23	37.94	2.79	0.84
Jakarta Timur	0.52	0.97	58.31	40.53	2.84	0.95
Jakarta Pusat	0.62	1.94	49.85	39.35	4.94	0.85
Jakarta Barat	0.40	1.27	58.63	42.60	4.85	0.65
Jakarta Utara	1.17	2.67	60.17	42.91	5.37	1.14
West Java						

Province/ District		% Children deprived in health dimension		% Children deprived in education dimension		% Children engaged in economic labour	
		Asthma	Diarrhoea	Aged 3–6 years not enrolled in early childhood education	Aged 7–17 not enrolled in primary and secondary schools	Perform economic labour without attending school	Perform economic labour and attend school
	Bogor	1.42	2.46	75.20	42.64	8.64	0.86
	Sukabumi	0.63	1.27	71.32	41.78	4.84	0.00
	Cianjur	0.96	1.76	74.78	40.62	5.57	0.56
	Bandung	1.08	2.41	75.10	40.88	5.48	0.95
	Garut	0.60	0.53	75.58	41.95	4.12	0.20
	Tasikmalaya	1.10	1.83	57.56	45.74	6.11	1.78
	Ciamis	1.14	2.51	61.56	42.07	5.29	0.18
	Kuningan	0.90	1.55	68.14	36.84	6.96	0.46
	Cirebon	0.69	1.99	73.85	40.34	3.79	0.54
	Majalengka	1.55	3.25	60.63	40.47	2.35	1.18
	Sumedang	0.83	1.52	64.65	39.66	3.98	0.42
	Indramayu	0.62	2.16	73.85	38.17	3.68	2.68
	Subang	1.09	1.94	74.62	39.29	4.19	0.65
	Purwakarta	1.23	2.76	73.63	43.61	5.67	0.95
	Karawang	0.57	1.05	75.74	42.12	4.30	2.58
	Bekasi	0.94	1.20	70.74	40.25	6.28	1.01
	Bandung Barat	1.11	1.11	76.84	44.70	5.33	0.24
	Kota Bogor	0.86	1.73	50.92	35.56	4.97	0.41
	Kota Sukabumi	1.19	1.36	57.52	37.32	6.42	0.00
	Kota Bandung	0.90	1.35	55.56	39.76	4.05	0.29
	Kota Cirebon	0.68	2.88	60.70	37.62	2.39	0.80
	Kota Bekasi	0.57	1.15	58.69	38.28	6.98	0.23
	Kota Depok	0.66	0.44	48.36	43.65	2.92	0.00
	Kota Cimahi	0.96	1.07	45.08	39.21	4.39	0.23
	Kota Tasik Malaya	0.83	3.73	46.52	40.79	3.33	1.11
	Kota Banjar	0.82	0.82	38.59	38.03	2.27	0.25
Central Java							
	Cilacap	0.09	0.66	70.36	37.88	8.23	0.73
	Banyumas	0.55	1.98	50.79	39.81	1.84	0.00
	Purbalingga	0.32	1.50	55.27	35.40	4.72	2.02
	Banjarnegara	0.35	1.16	52.71	46.42	5.33	1.07
	Kebumen	0.41	2.35	57.79	39.32	6.44	2.39
	Purworejo	0.44	0.73	52.75	34.54	10.47	0.29
	Wonosobo	0.72	1.92	52.01	40.35	6.16	3.94
	Magelang	0.48	1.79	43.49	37.93	7.23	4.40
	Boyolali	0.74	2.35	37.35	34.09	7.93	1.98
	Klaten	0.13	0.78	42.12	32.68	3.92	0.28
	Sukoharjo	0.14	0.83	40.42	33.42	2.96	4.03
	Wonogiri	0.44	1.16	53.15	34.98	1.39	1.94
	Karanganyar	0.26	1.19	38.93	35.16	0.29	0.00

Province/ District		% Children deprived in health dimension		% Children deprived in education dimension		% Children engaged in economic labour	
		Asthma	Diarrhoea	Aged 3–6 years not enrolled in early childhood education	Aged 7–17 not enrolled in primary and secondary schools	Perform economic labour without attending school	Perform economic labour and attend school
	Sragen	0.28	0.99	51.92	36.53	2.54	0.95
	Grobogan	1.09	1.70	54.53	36.89	1.69	1.41
	Blora	0.40	0.80	40.73	34.68	1.68	1.68
	Rembang	0.62	0.47	37.52	31.28	4.49	3.93
	Pati	0.13	0.78	46.87	36.07	5.16	2.87
	Kudus	0.28	0.96	41.53	34.26	3.16	0.70
	Jepara	0.33	1.52	54.88	40.34	2.48	0.62
	Demak	0.45	1.02	51.16	36.07	4.53	0.57
	Semarang	0.49	1.58	35.75	37.77	7.59	1.05
	Temanggung	0.66	0.93	35.23	38.60	2.48	0.00
	Kendal	0.45	1.35	51.57	35.53	3.08	0.00
	Batang	0.47	2.00	51.91	42.27	10.80	1.11
	Pekalongan	0.11	2.17	52.92	42.72	4.53	1.19
	Pemalang	0.68	1.36	73.28	38.70	6.72	0.27
	Tegal	0.57	2.55	63.41	37.83	11.71	0.47
	Brebes	1.62	5.04	67.67	43.55	7.17	0.00
	Kota Magelang	0.00	0.85	36.76	35.53	5.86	0.87
	Kota Surakarta	0.51	0.68	30.64	34.14	5.66	1.74
	Kota Salatiga	1.16	2.82	30.72	38.37	1.88	0.00
	Kota Semarang	0.33	1.32	41.24	36.09	1.83	1.83
	Kota Pekalongan	0.40	1.61	50.29	37.31	1.54	0.00
	Kota Tegal	1.13	0.99	58.61	32.86	3.61	0.48
Yogyakarta							
	Kulon Progo	0.44	0.73	17.68	34.07	6.14	0.29
	Bantul	1.42	1.26	27.98	34.98	2.36	0.30
	Gunung Kidul	0.82	1.63	30.74	36.55	1.50	0.30
	Sleman	1.20	1.72	38.76	36.24	1.39	1.39
	Kota Yogyakarta	0.61	1.84	16.13	38.97	1.83	0.73
East Java							
	Pacitan	0.15	2.14	47.80	35.69	1.17	1.17
	Ponorogo	0.28	1.69	40.47	38.23	0.00	0.96
	Trenggalek	0.60	1.06	35.28	41.97	5.18	14.24
	Tulungagung	1.59	1.23	48.16	41.91	3.69	4.70
	Blitar	0.26	1.93	42.48	43.48	2.84	1.06
	Kediri	1.16	1.06	40.65	42.00	3.55	0.59
	Malang	0.62	2.21	43.02	40.68	5.79	2.13
	Lumajang	1.06	0.83	47.27	41.26	4.38	2.06
	Jember	1.45	2.41	50.76	41.49	8.16	2.86
	Banyuwangi	0.64	2.57	43.67	41.25	9.55	1.69
	Bondowoso	0.82	3.12	38.66	45.90	5.95	0.95

Province/ District		% Children deprived in health dimension		% Children deprived in education dimension		% Children engaged in economic labour	
		Asthma	Diarrhoea	Aged 3–6 years not enrolled in early childhood education	Aged 7–17 not enrolled in primary and secondary schools	Perform economic labour without attending school	Perform economic labour and attend school
	Situbondo	0.34	3.19	39.32	42.50	3.38	1.04
	Probolinggo	1.10	4.75	45.39	45.67	4.78	4.38
	Pasuruan	0.32	2.05	44.08	38.92	4.84	3.23
	Sidoarjo	0.49	1.96	34.84	35.68	8.52	1.58
	Mojokerto	0.72	2.74	35.58	37.48	6.20	1.03
	Jombang	0.75	4.09	34.26	40.21	0.92	0.23
	Nganjuk	1.38	1.50	41.12	40.09	2.17	1.90
	Madium	0.44	0.74	36.42	38.20	4.10	5.13
	Magetan	0.30	0.30	42.74	34.34	3.96	4.27
	Ngawi	0.76	0.30	58.90	37.71	1.79	1.79
	Bojonegoro	0.48	0.96	35.72	36.85	2.68	10.74
	Tuban	0.26	0.92	51.22	38.87	4.47	1.37
	Lamongan	0.45	1.12	20.54	35.84	3.99	2.56
	Gresik	0.34	1.03	29.75	35.93	6.99	0.61
	Bangkalan	0.65	0.57	70.44	45.00	1.33	0.80
	Sampang	0.76	1.60	66.77	40.24	1.91	0.27
	Pamekasan	0.74	1.58	47.55	37.33	5.64	0.19
	Sumenep	0.42	1.25	50.10	38.44	6.52	5.49
	Kota Kediri	0.43	0.86	24.21	39.34	1.94	2.43
	Kota Blitar	0.54	1.89	30.75	36.36	3.75	0.34
	Kota Malang	0.54	3.64	24.54	36.80	1.39	1.05
	Kota Probolinggo	0.64	2.05	38.53	40.24	1.82	0.30
	Kota Pasuruan	1.19	1.55	40.77	40.01	4.88	1.83
	Kota Mojokerto	0.29	2.20	26.26	39.99	1.49	0.30
	Kota Madium	0.48	1.76	46.66	41.93	1.52	0.00
	Kota Surabaya	0.34	2.31	29.39	38.97	1.03	0.69
	Kota Batu	0.31	2.30	28.50	36.43	0.83	0.41
Banten							
	Pandeglang	1.53	2.69	87.11	43.39	1.48	0.00
	Lebak	1.04	1.04	93.55	43.47	4.72	0.71
	Tangerang	0.97	1.66	69.08	40.95	4.53	0.54
	Serang	0.77	1.33	74.78	37.96	5.21	1.04
	Kota Tangerang	0.59	1.67	52.54	42.18	5.19	1.04
	Kota Cilegon	0.20	0.99	72.43	36.11	2.45	1.53
Bali							
	Jembarana	1.89	1.74	61.95	37.23	1.96	0.87
	Tabanan	1.09	1.09	52.79	35.87	5.85	0.47
	Badung	0.78	0.52	53.76	38.28	3.55	1.61
	Gianyar	0.99	1.48	61.33	35.81	1.76	1.06
	Klungkung	1.68	2.91	56.78	33.30	0.64	0.96

Province/ District		% Children deprived in health dimension		% Children deprived in education dimension		% Children engaged in economic labour	
		Asthma	Diarrhoea	Aged 3–6 years not enrolled in early childhood education	Aged 7–17 not enrolled in primary and secondary schools	Perform economic labour without attending school	Perform economic labour and attend school
	Bangli	1.16	1.59	77.82	39.12	2.29	8.00
	Karangasem	1.82	1.56	90.36	41.11	1.09	7.66
	Buleleng	2.80	3.87	71.02	37.75	8.39	9.94
	Kota Denpasar	0.67	1.35	44.00	36.39	6.63	5.76
West Nusa Tenggara							
	Lombok Barat	1.20	2.28	87.67	42.08	0.65	1.29
	Lombok Tengah	0.62	1.23	59.43	36.43	2.63	0.33
	Lombok Timur	2.50	3.65	68.70	42.80	6.58	2.19
	Sumbawa	0.94	1.53	52.33	42.12	5.07	13.07
	Dompu	0.64	6.38	65.06	36.76	10.35	10.82
	Bima	0.49	3.31	61.94	35.83	3.74	6.03
	Sumbawa Barat	2.22	3.67	53.71	43.42	2.14	6.21
	Kota Mataram	2.00	2.13	69.87	37.97	4.22	10.67
	Kota Bima	0.55	4.50	48.40	35.25	3.69	2.77
East Nusa Tenggara							
	Sumba Barat	3.02	5.91	60.59	42.39	1.24	0.31
	Sumba Timur	1.69	5.75	82.90	48.67	1.08	7.84
	Kupang	2.92	9.92	79.24	45.70	3.08	4.62
	Timor Tengah Selatan	1.53	6.02	75.90	47.71	6.51	3.90
	Timor Tengah Utara	0.97	9.44	55.14	45.21	4.28	4.28
	Belu	1.01	4.21	80.02	43.17	6.70	3.49
	Alor	2.97	8.71	65.22	43.95	3.17	1.71
	Lembata	1.81	2.67	59.61	45.17	8.61	2.05
	Flores Timur	1.24	2.58	61.28	44.85	8.62	4.90
	Sikka	0.72	1.34	71.79	42.62	4.24	1.21
	Ende	2.68	2.22	74.26	40.46	7.00	2.66
	Ngada	2.44	3.54	84.10	44.44	8.25	1.21
	Manggarai	1.29	8.07	94.99	50.34	6.26	1.39
	Rote Ndao	0.86	2.10	79.45	47.02	9.81	5.01
	Manggarai Barat	1.61	7.06	95.90	48.05	9.78	0.41
	Sumba Tengah	2.68	8.65	83.27	44.60	8.27	0.80
	Sumba Barat Daya	4.36	8.97	91.21	51.35	9.77	2.05
	Nagekeo	1.51	0.88	78.48	43.79	5.99	7.78
	Kota Kupang	1.40	4.42	60.32	41.57	10.63	6.33
West Kalimantan							
	Sambas	1.60	2.25	87.39	43.68	5.67	6.67
	Bengkayang	1.47	1.30	90.26	40.87	12.70	6.25
	Landak	1.15	3.37	93.61	38.94	2.12	0.61
	Pontianak	1.05	1.41	85.20	41.90	9.25	4.18
	Sanggau	0.58	3.38	90.42	41.59	8.32	3.12

Province/ District	% Children deprived in health dimension		% Children deprived in education dimension		% Children engaged in economic labour	
	Asthma	Diarrhoea	Aged 3–6 years not enrolled in early childhood education	Aged 7–17 not enrolled in primary and secondary schools	Perform economic labour without attending school	Perform economic labour and attend school
Ketapang	0.67	3.01	90.48	43.89	13.74	1.58
Sintang	0.24	1.44	87.77	47.34	7.88	1.53
Kapuas Hulu	1.51	3.14	90.32	38.88	10.45	2.54
Sekadau	1.46	7.74	91.51	43.90	6.69	1.74
Melawai	0.92	5.91	91.43	41.52	11.01	1.26
Kayong Utara	2.25	3.52	96.93	43.51	11.04	4.18
Kota Pontianak	0.65	1.85	71.36	39.87	12.76	2.34
Kota Singkawang	0.83	2.04	76.57	38.26	14.46	2.15
Central Kalimantan						
Kotawaringin Barat	1.29	3.74	70.80	38.43	9.15	2.11
Kotawaringin Timur	1.27	1.69	77.78	39.26	7.07	1.46
Kapus	1.80	1.56	77.80	38.49	4.52	0.85
Barito Selatan	2.11	3.10	60.43	40.51	7.23	4.26
Barito Utara	1.11	2.58	79.30	37.24	6.56	0.79
Sukamara	1.22	2.04	69.90	41.38	7.24	0.54
Lamandau	1.34	3.29	59.01	37.28	10.34	1.81
Seruyan	0.25	2.73	73.24	36.34	7.03	1.92
Katingan	1.60	5.43	74.27	37.31	5.57	0.93
Pulang Pisau	1.63	4.01	64.85	36.96	6.81	1.17
Gunung Mas	1.35	4.69	78.74	35.84	4.42	1.18
Barito Timur	1.29	4.52	58.93	35.18	13.45	0.24
Murung Raya	0.34	1.03	91.33	39.85	9.42	3.05
Kota Palangkaraya	1.11	1.23	66.09	40.49	8.28	7.32
South Kalimantan						
Tanah Laut	0.98	2.44	52.12	45.13	8.02	3.12
Kotabaru	0.36	3.03	60.47	44.78	5.13	4.27
Banjar	1.96	4.19	59.35	44.06	10.43	0.92
Barito Kuala	0.95	3.65	63.47	40.87	4.67	0.00
Tapin	0.89	1.19	62.59	41.34	9.06	2.81
Hulu Sungai Selatan	0.82	2.74	59.84	42.90	5.86	3.26
Hulu Sungai Tengah	0.28	2.09	58.00	36.66	12.08	2.01
Hulu Sungai Utara	1.21	4.96	58.22	42.08	10.86	1.32
Tabalong	0.37	3.57	57.20	40.90	8.99	0.00
Tanah Bumbu	1.12	1.98	65.10	43.84	6.01	0.63
Balangan	0.40	2.29	58.46	37.94	8.25	2.86
Kota Banjarmasin	1.69	1.82	57.37	38.24	12.35	2.65
Kota Banjarbaru	1.62	2.43	41.48	36.95	5.26	3.41
East Kalimantan						
Pasir	0.90	4.60	73.14	38.94	6.23	0.31
Kutai Barat	0.75	3.36	79.59	40.08	7.84	3.27

Province/ District		% Children deprived in health dimension		% Children deprived in education dimension		% Children engaged in economic labour	
		Asthma	Diarrhoea	Aged 3–6 years not enrolled in early childhood education	Aged 7–17 not enrolled in primary and secondary schools	Perform economic labour without attending school	Perform economic labour and attend school
	Kutai Karta Negara	0.55	1.01	71.26	40.62	5.85	1.23
	Kulai Timur	1.42	3.12	74.22	36.35	4.58	0.35
	Berau	1.45	1.21	54.91	42.54	5.57	0.53
	Malinau	0.29	2.01	89.91	38.39	1.84	2.76
	Bulongan	0.71	1.41	61.39	40.51	5.40	0.94
	Nunukan	1.79	2.82	75.82	41.40	5.07	2.03
	Penajam Paser Utara	0.47	1.54	76.96	38.02	3.73	0.62
	Kota Balikpapan	1.31	1.92	63.14	39.59	3.83	1.92
	Kota Samarinda	0.78	1.83	68.74	40.88	3.54	2.76
	Kota Tarakan	1.20	2.28	68.58	41.62	5.28	2.05
	Kota Bontang	0.63	1.77	52.88	36.88	6.65	1.94
North Sulawesi							
	Bolaang Mongondow	1.22	2.22	74.03	41.53	2.08	0.00
	Minahasa	0.30	1.20	45.26	33.44	2.82	0.51
	Kepulauan Sangihe	0.46	0.30	66.36	36.03	2.75	0.46
	Kepulauan Talaud	1.12	1.26	56.26	32.96	1.39	0.00
	Minahasa Selatan	1.38	1.24	39.89	37.19	1.47	0.88
	Minahasa Utara	0.53	1.58	55.08	33.31	10.40	0.53
	Bolaang Mongondow Utara	2.25	7.04	61.53	37.39	2.56	2.56
	Siau Tagulandang Biaro	1.19	2.38	44.90	30.66	4.42	1.02
	Minahasa Tenggara	1.18	2.65	45.82	37.21	2.84	2.52
	Kota Manado	0.66	1.20	54.06	33.88	0.35	0.35
	Kota Bitung	0.39	1.30	57.79	35.50	2.85	0.00
	Kota Tomohon	1.44	2.10	49.83	30.57	3.31	0.37
	Kota Kotamobagu	0.31	3.11	59.33	33.70	4.28	0.00
Central Sulawesi							
	Banggai Kepulauan	1.90	2.21	75.60	41.55	11.85	2.22
	Banggai	1.30	3.25	60.24	41.91	2.89	0.32
	Morowali	2.25	6.74	61.25	45.18	3.32	0.33
	Poso	1.18	2.47	64.79	36.84	2.15	1.23
	Donggala	0.84	2.11	74.26	43.59	2.91	0.00
	Toli-Toli	1.99	6.07	81.68	44.89	3.67	1.69
	Buol	1.10	2.30	85.44	44.34	4.34	1.73
	Parigi Moutong	2.56	3.22	72.39	44.25	2.82	2.19
	Tojo Una-Una	1.67	3.53	60.78	42.82	8.93	1.28
	Kota Palu	1.43	2.63	62.56	38.47	10.23	2.71
South Sulawesi							
	Selayar	0.93	1.28	45.61	43.36	8.93	3.72
	Bulukumba	0.67	1.23	64.06	40.97	8.56	5.29
	Bantaeng	1.50	3.47	80.30	40.65	7.06	4.62

Province/ District		% Children deprived in health dimension		% Children deprived in education dimension		% Children engaged in economic labour	
		Asthma	Diarrhoea	Aged 3–6 years not enrolled in early childhood education	Aged 7–17 not enrolled in primary and secondary schools	Perform economic labour without attending school	Perform economic labour and attend school
	Jeneponto	1.01	2.53	2.53	41.90	7.20	2.77
	Takalar	1.36	2.93	2.93	39.60	1.39	0.28
	Gowa	0.46	2.77	2.77	37.67	7.08	1.54
	Sinjai	0.62	1.45	1.45	36.90	8.44	10.03
	Maros	0.65	1.75	1.75	39.62	12.34	7.81
	Pangkajene Kepulauan	0.51	1.32	1.32	43.86	11.30	8.41
	Barru	0.23	0.80	0.80	39.34	11.37	3.08
	Bone	1.05	1.71	1.71	40.70	7.00	4.32
	Soppeng	0.00	0.39	0.39	38.79	6.44	12.62
	Wajo	0.80	2.12	2.12	46.84	6.68	1.72
	Sidenreng Rappang	1.74	1.84	1.84	39.73	10.28	2.19
	Pinrang	0.50	0.90	0.90	40.24	6.91	1.23
	Enrekang	0.26	1.96	1.96	36.51	10.07	5.49
	Luwu	0.72	2.16	2.16	40.31	6.59	2.87
	Tana Toraja	0.60	1.89	1.89	33.83	11.22	1.56
	Luwu Utara	1.74	2.41	2.41	37.42	8.62	2.46
	Luwu Timur	1.47	3.22	3.22	40.04	11.09	6.93
	Kota Ujung Pandang	0.75	2.35	2.35	42.15	5.53	13.73
	Kota Pare-Pare	0.41	1.53	1.53	39.33	4.60	7.11
	Kota Palopo	0.95	1.52	1.52	38.43	3.96	10.25
Southeast Sulawesi							
	Buton	0.90	3.78	3.78	38.96	5.83	8.74
	Muna	0.74	2.89	2.89	39.55	1.75	4.81
	Konawe	2.32	3.77	3.77	39.12	7.45	2.16
	Kolaka	0.87	1.97	1.97	38.83	5.73	0.95
	Konawe Selatan	1.58	1.24	1.24	40.97	1.26	1.26
	Bombana	1.90	1.30	1.30	44.65	3.29	17.74
	Wakatobi	0.82	2.59	2.59	35.57	3.25	5.99
	Kolaka Utara	1.82	3.75	3.75	37.50	3.91	8.88
	Buton Utara	0.39	0.39	0.39	41.19	7.13	11.07
	Konawe Utara	1.59	3.74	3.74	37.72	5.75	7.34
	Kota Kendari	1.25	2.14	2.14	37.40	9.01	13.24
	Kota Bau Bau	1.12	2.55	2.55	35.86	2.51	16.61
	Gorontalo						
	Boalemo	2.78	4.21	4.21	41.39	4.37	13.66
Gorontalo		1.80	5.89	5.89	44.67	2.96	3.70
	Pohuwato	2.58	6.13	6.13	42.12	6.80	6.23
	Bone Bolango	1.64	3.58	3.58	40.57	2.65	1.02
	Gorontalo Utara	1.93	4.76	4.76	46.68	1.25	2.67
	Kota Gorontalo	1.31	3.71	3.71	38.64	9.15	3.89

Province/ District		% Children deprived in health dimension		% Children deprived in education dimension		% Children engaged in economic labour	
		Asthma	Diarrhoea	Aged 3–6 years not enrolled in early childhood education	Aged 7–17 not enrolled in primary and secondary schools	Perform economic labour without attending school	Perform economic labour and attend school
West Sulawesi							
	Majene	0.89	1.71	64.44	43.69	8.20	1.60
	Polewali Mandar	0.55	2.10	66.98	46.65	7.88	1.31
	Mamasa	1.43	4.09	68.29	36.34	6.42	0.49
	Mamuju	1.44	5.76	65.24	42.15	9.60	0.93
	Mamuju Utara	2.02	3.60	77.47	43.50	2.68	0.49
Maluku							
	Maluku Tenggara Barat	2.60	6.75	66.99	38.96	6.07	1.10
	Maluku Tenggara	3.44	3.21	79.29	37.09	8.86	3.64
	Maluku Tengah	1.17	1.07	84.58	35.49	4.27	2.70
	Buru	1.17	3.26	93.02	41.99	8.63	9.26
	Kepulaun Aru	1.10	4.11	89.50	40.27	10.49	3.96
	Seram Bagian Barat	2.13	2.33	80.33	38.22	1.86	2.79
	Seram Bagian Timur	3.16	5.89	91.70	40.05	3.28	1.79
	Kota Ambon	0.68	0.51	72.92	33.79	2.08	1.30
North Maluku				90.48	37.12		
	Halmahera Barat	1.78	4.27	79.39	31.91	5.09	11.27
	Halmahera Tengah	2.13	11.25	75.61	40.01	4.84	2.85
	Kepulauan Sula	0.12	2.54	94.58	36.11	2.20	4.12
	Halmahera Selatan	0.80	2.70	86.39	41.68	2.83	4.95
	Halmahera Utara	0.32	3.28	78.78	40.39	0.40	0.00
	Halmahera Timur	0.81	3.40	84.09	43.94	2.10	0.79
	Kota Ternate	0.14	0.82	78.18	36.89	3.07	1.68
	Kota Tidore Kepulauan	0.19	3.01	49.41	35.94	0.00	1.83
West Papua							
	Fakfak	0.00	1.09	91.38	45.73	3.70	5.25
	Kaimana	0.47	3.49	96.83	44.87	5.77	5.22
	Teluk Wondama	1.35	3.48	81.11	42.52	3.19	3.19
	Teluk Bintuni	0.40	3.38	83.70	46.75	4.29	4.29
	Manokwari	0.99	1.65	77.41	39.31	0.65	2.59
	Sorong Selatan	0.71	1.42	88.01	52.35	0.47	3.72
	Raja Ampat	0.28	1.40	98.09	47.66	3.52	0.00
	Kota Sorong	1.13	3.70	72.72	41.83	4.88	12.20
Papua							
	Merauke	2.39	2.11	75.52	42.03	5.91	2.46
	Jayawijaya	0.00	3.55	96.02	45.47	3.55	0.59
	Jayapura	0.71	1.18	82.40	50.70	6.78	7.63
	Nabire	1.41	2.11	52.31	32.26	19.31	5.52
	Yapen Waropen	4.66	7.00	88.91	45.29	4.85	4.85
	Biak Namfour	0.19	0.58	82.75	41.92	2.76	1.38

Province/ District		% Children deprived in health dimension		% Children deprived in education dimension		% Children engaged in economic labour	
		Asthma	Diarrhoea	Aged 3–6 years not enrolled in early childhood education	Aged 7–17 not enrolled in primary and secondary schools	Perform economic labour without attending school	Perform economic labour and attend school
	Paniai	1.02	2.64	98.46	39.70	2.27	0.91
	Puncak Jaya	1.24	2.90	93.24	58.13	4.96	7.85
	Mimika	0.45	1.36	86.92	73.87	19.40	28.36
	Boven Digoel	1.01	5.07	98.78	55.72	2.04	0.00
	Mappi	1.42	3.54	96.66	53.02	11.11	8.33
	Asmat	0.00	2.13	97.98	47.18	4.48	1.49
	Yahukimo	2.29	2.29	97.69	53.08	0.98	0.98
	Pegunungan Bintang	2.01	6.77	80.45	60.11	25.71	2.86
	Tolikara	0.33	0.33	100.00	61.91	54.44	14.44
	Sarmi	0.56	5.06	93.85	66.24	9.34	0.00
	Keerom	0.25	0.99	70.85	44.91	9.80	0.98
	Waropen	0.00	5.00	100.00	39.82	12.04	5.24
	Supiori	0.91	0.46	65.99	53.85	15.19	25.95
	Kota Jayapura	1.13	1.55	54.78	40.23	19.74	11.84

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